

Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION REPORT DATE (YYY-MM-DD)
778-452-2000 7900 TRASER HARK DRIVE BBY B.C: 2012-12-30
LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME FILE No.
s.22
YEARS OF SERVICE TIME ON PRESENT JOB OCCUPATION HOURS WORKED IN PREVIOUS 24-HOURS
CORRECTION & OFFICER.
INCIDENT LOCATION (DEPARTMENT OR AREA) INCIDENT DATE (YYYY-MM-DD) TIME 1708 C AM
INCIDENT CATEGORY (CHECK)
Injury or Illness Equipment Malfunction Motor Vehicle Property Damage
Fire Other
SEVERITY OF INJURY OR ILLNESS (CHECK)
No Injury or First Aid Only Medical Treatment Time Loss Fatal
NATURE OF INJURY OR ILLNESS
OPEN CUT HOUSE K. EUE NEEDING STITCHES
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)
5.22 PULLED DOER CPUN HARD INTO HEAD
WERE WRITTEN SAFE WORK PROCEDURES ESTABLISHED AND AVAILABLE? WERE THEY ADEQUATE? USED IN TRAINING?
C Yes C No K N/A C Yes C No K N/A C Yes C No K N/A
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS
s.22
CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED
NOME
CORRECTIVE ACTION REFERRED TO: TO BE COMPLED BY (YYYY-MM-00)
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC.
INVOLVED IN THIS INCIDENT.
NONE
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name Occupation - Phone
Jaconio Hannis Somien constions afferen 778-452-200
SIGNATURE OF WORKER'S REPRESENTATIVE DATE (TYTY-MIM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE DATE (TYTY-MIM-DD)
4. Harris 2012/12/3
NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER:
Name Phone

INT ACCIDENT INVESTIGATION FOR

PSC 38

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Ministry $\mathcal{H}CFD$	Tel.#	Location B.Y	c S		Date of Report	26,2012
Last Name of Injured (or ill) Pe	erson	First Nema	s.22	•	File No.	
Years of Service	Time on Present Job s.22	Occupation C	oppletion Field Sulph	nds . Wison	Hours Worked Hour Period	in Previous 24
Accident Location (Dept. or Ar	ea)	Date of Accident INFECTION SAN DOCTOR	DOTED D	6c 23/12	Time	
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	Fire	Other (specify)
Severity of injury or illness (ch	eck)	No Injury or	First Aid Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illness	ron .	· .				
		s .22				
Were Written Safe Work Proc Established and Available? Yes No N/A	edures	Were they Adequ		4	Were these Si Procedures us	séd in Training?
Basic Cause (and Contributor	v Factors)	EXPLAIN FULLY U	NSAFE CONDI	TIONS	Yesi Noi	J N/ALJ
		s.22, s.	79 YCJA			-
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Corrective Measures Taken and/or Recommended	d '
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545 W	WALLACE ONGOWL
Corrective Action Referred To: A Will	of 17/6 DIE DOWN INTERNAL
Corrective Action Referred To:	Date To Be Completed By: /
1	
Additional Comments or Observations. Where app	plicable give details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate shee	et ir necessary)
WIA	
<i>' ' ' ' ' ' ' ' ' '</i>	
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	100000000000000000000000000000000000000
Name(s) & occupations of person (s) who investig	gated accident: Why A Q W
	78452-2050 My V- (1920) 278-452-2055
Grandon Ihistle	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Print Name & Occupation	Phone Print Name & Occupation Phone
997c - 400	10/13 DOLG-(1820) Jan 10/13
Signature of Workers' Representative	Date Signature of Employer Representative Date
	•
Name(s) of Witness(s) (include phone number)	
1. 1/0	
1 10/5/	
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Revised July 2004

if this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

INT ACCIDENT INVESTIGATION FOR

PSC 38

Ministry MCFD	Tel.#	Location B	YC5		Date of Report	24/12
Last Name of Injured (or ill) Pe	erson s.22	First Name			File No.	
Years of Service	Time on Present Job	Occupation C	10		Hour Period	in Previous 24
Accident Location (Dept. or A	rea)	Date of Accident	12012		Time	900
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	Fire	Other (specify)
Severity of Injury or Illness (cl	•	No Injury or		Medical Treatment	Time Loss	Fatal *
SAW CGNTRG A Nature of Injury or Illness YOVVECTOR QUINS Description of Accident or En	large bui t wall nployee's Account wet yloc	mp on hi , neck bu s.22 t of Occupational D	eacl -richt off no formalisease (eg. RSI) anour	ow and (use separate she	et if necessary)	s.22
Description of Accident or En Slipped on i head an wa agravated	U, and	I hit sho	vldu b	on Wall	unci,	MIEKTS.
Were Written Safe Work Pro Established and Avallable? Yes No N/A	ocedures	Were they Adec			Were these S Procedures to Yes Mo	used in Training?
Basic Cause (and Contribute	ory Factors)	EXPLAIN FULLY				
THE WE7 146 50	Deadic	conil (F		s.22	
WAS U	CAY	A WARE	But	STILL	HAD I	4a)
ACCIDA	JTAL	SLLP.		•		
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Corrective Measures Taken and/or Recomm	nended		
CAREFUL DI	LIGENCE	•	
Chicarott			
•	r P		•
	., ,}		
	**************************************	,	
			\$
Corrective Action Referred To: $N\partial \mathcal{N}_{\mathcal{S}}$	AT THIS Tem	⊈ √ Date To Be Completed By:/_	
Additional Comments or Observations. Whete, involved in this accident. (Use separa	ere applicable give det te sheet If necessary)	alls of makes & models of machines, equipr	ment, tools, structures,
•		,	,
		•	•
·			·
Name(s) & occupations of person (s) who	investigated accident:	1 Salron	
$D \sim 1 < 1 \qquad \text{and } V$		SYS DUALLACE YOUTH	178 452 2050
Print Name & Occupation	Phone	Print Name & Occupation	Phone
Print Name & Occupation	,	5/5 () /) //	1)6174201
BOX	12.12.24	Signature of Employer Representative	Date 29 2012
Signature of Workers' Representative	Date }	Signature of Employer Representative	Dato
Name(s) of Witness(s) (include phone nur	mber)		
•			
	· ;		
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Revised July 2004

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office



Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION 1784522050 BYCS FRASE PARK Drive Bby VSSSHI	2013 01 02
LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME S.22	FILE No.
YEARS OF SERVICE TIME ON PRESENT JOB OCCUPATION HOURS WORLD	KED IN PREVIOUS 24-HOURS
incident Location (Department or area) Incident Location (Department or area) Incident Location (Department or area) Incident Location (Department or area)	TIME O AM
IMMENSON UNIT 2012 13 18	<u></u>
	erty Damage
Fire Other	
SEVERITY OF INJURY OR ILLNESS (CHECK)	
No Injury or First Aid Only Medical Treatment Time Loss Fatal	l
NATURE OF INJURY OR ILLNESS	
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)	والمساورة
Resident punched Stall @ Sine of TAW / Face	2.
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE SAFE WORK	PROCEDURES
	O N/A
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS	
Violent RSident with NO coping skills	
CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	
Staff to use acution when wonling.	
CORRECTIVE/ACTION REFERRED TO: TO BE	COMPLED BY (YYYY-MM-DO)
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TO INVOLVED IN THIS INCIDENT.	OOLS, STRUCTURES, ETC.
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:	
Name Occupation	Phone
	718 452 2055
SIGNATURE OF WORKER'S REPRESENTATIVE DATE (YYY-MM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE 2030/03	DATE (YYYY-MM-DD) 20/3 07 02
TNAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER:	@UIJ UI V Z
Name	Phone
NONE	



Joint Incident Investigation Form

`	TELEPHONE NUMBER	REPORT DATE (YYYY-MM-DD)
77	8-452 2050 7900 FRISH PAR DRIVE	20/2/11/15
	LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME	FILE No.
	s.22	
	YEARS OF SERVICE TIME ON PRESENT JOB OCCUPATION HOURS W	ORKED IN PREVIOUS 24-HOURS
	S22 CONNECTION OFFICER	15 HOS.
	INCIDENT LOCATION (DEPARTMENT OR AREA) INCIDENT DATE (YYY-MM-DD)	TIME ON AM
	Gymn AS/4M 20/2/12/1	\$ 1999 gZPM
	INCIDENT CATEGORY (CHECK)	/
	Thijury or Illness Equipment Malfunction Motor Vehicle	operty Damage
	Fire Other	
	SEVERITY OF INJURY OR ILLNESS (CHECK)	•
	No Injury or First Aid Only Medical Treatment Time Loss	atal
	NATURE OF INJURY OR ILLNESS	
	RIGHT CALF	
	DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)	
	S.22 WAS BRETHING UP A PHYSI	(a) ALANCAT
	WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE SAFE W USED IN TRAINING?	ORK PROCEDURES
	C Yes C No C N/A C Yes C No C N/A C Yes C No C N/A	ONIA
	BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS	
	Responding to a youth aftercation	
	CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	
	Nothing to recommend. Injured while resp	ponding to Includer
		O BE COMPLED BY (YYYY-MM-DD)
	N/A-	<u>, </u>
	ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMEN INVOLVED IN THIS INCIDENT.	IT, TOOLS, ȘTRUCTURES, ETC.
	•	
	NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name Occupation	- Phone
	P 1 1/2 (00/05) 200	8778-452-2050
	SIGNATURE OF WORKER'S REPRESENTATIVE DATE (TYPHIM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYY-MM-DD)
	73/0 Dec 15/12.	10/11/15
	NAME (S) OF WITNESS(ES). INCLUDE PHONE NUMBER:	
	Name s.15, s.22	778 -451
		2050



Joint Incident Investigation Form

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s.22	FILE No.
YEARS OF SERVICE TIME ON PRESENT JOB OCCUPATION HOURS WORK S.22 HOURT SUFERVISOR /	ED IN PREVIOUS 24-HOURS
INCIDENT LOCATION (DEPARTMENT OR AREA) INCIDENT DATE (YMY-MY-OD) INCIDENT DATE (YMY-MY-OD)	TIME STORY OF AM
1998119 UNII - 134C3 [WIC/19/13]	O/SO JO PM
INCIDENT CATEGORY (CHECK) Injury or Illness Equipment Malfunction Motor Vehicle Proper	erty Damage
Fire Other	
. SEVERITY OF INJURY OR ILLNESS (CHECK)	
☐ No Injury or First Aid Only Medical Treatment ☐ Time Loss ☐ Fatal	
NATURE OF INJURY OR ILLNESS	1
1615/ED RESTEL RACE	
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI) HISSEY STEP WALKING DOWN STANDS AND TOUSTED K	Mt
WERE WRITTEN SAFE WORK PROCEDURES ESTABLISHED AND AVAILABLE? WERE THEY ADEQUATE? WERE THESE SAFE WORK USED IN TRAINING?	PROCEDURES .
Yes C No C N/A Yes C No O N/A Yes C No	O N/A.
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS	
s.22 CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED `	
NA	
CORRECTIVE/ACTION REFERRED TO:	COMPLED BY (TYT-MM-DD)
NIA	
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TO INVOLVED IN THIS INCIDENT.	OOLS, STRUCTURES, ETC.
Nove	
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:	
MAYAL CAMPANON SPANNON SOLOUPAHON SOLOUPAHON SOLOUPAHON	Phone Phone
SIGNATURE OF MORKERS REPRESENTATIVE DATE (YYYMM+DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
*/ X A A A A A A A A A	
NAME(S OF VITTNESS(ENLY)CLUDE PRONE NUMBER:	Phone
Name	Phone



Joint Incident Investigation Form

BUCS GYM AST NAME OF INJURED (OR ILL) PERSON S. 22 YEARS OF SERVICE TIME ON PRESENT JOB COCUPATION S. 22 NOLIDENT LOCATION (DEPARTMENT OR AREA) ROLLIUM LOCATION (DEPA	Protection of Privacy Act. Any questions about the collection, use or disclosure of this information should be discussed with the social	REPORT DATE (YYYY-MM-DD)
AST NAME OF INJURIED (OR ILL) PERSON S. 22 YEARS OF SERVICE TIME ON PRESENT JOB OCCUPATION S. 22 NICIDENT LOCATION (DEPARTMENT OR AREA) NICIDENT DATE OF INJURY OR ILLNESS Property Demage C AM NICIDENT DATE OF INJURY OR ILLNESS (CHECK) NO Injury or Illness Equipment Malfunction Motor Vehicle Property Damage Fitre Other SENEBITY OF INJURY OR ILLNESS (CHECK) NO Injury or First Aid Only Medical Treatment Time Loss Fatal NATURE OF INJURY OR ILLNESS (CHECK) NO Injury or REVICES (COCODIT OF OCCUPATION) NATURE OF INJURY OR ILLNESS (CHECK) NATURE OF I		2012-12-14
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Fire Other SEVERITY OF INJURY OR ILLNESS (CHECK) V No Injury or First Aid Only Medical Treatment Time Loss Fatal NATURE OF INJURY OR ILLNESS PUNCTURE OF INJURY OR ILLNESS PONCTURE OF INJURY OR ILLNESS WERE THEY ADEQUATE? WERE THEY ADEQUATE. TO BE COMPILED BY MYYY-MAN-DO) TO BE COMPILED BY MYY-MAN-DO) TO BE COMPILED BY MYY-MAN-DO)		Droperty Demage
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NATURE OF INJURY OR ILLNESS DESCRIPTION OF INCIDENT OR EMPLOYEES ACCOUNT OF OCCUPATIONAL DISEASE (E.G., RSI). TOOTH MICHAEL ON MAN OF INCIDENT OR EMPLOYEES ACCOUNT OF OCCUPATIONAL DISEASE (E.G., RSI). WERE THESE SAFE WORK PROCEDURES ESTABLISHED AND AVAILABLE? C YES C NO CNIA BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND JOST RECOMMENDES CORRECTIVE MEASURES TAKEN AND JOST RECOMMENDES CORRECTIVE ACTION REFERRED TO: TO BE COMPLED BY MYMANDO ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. INVOLVED IN THIS INCIDENT. NAMES AND OCCUPATIONS) OF PERSONS WHO INVESTIGATED INCIDENT: Name And Gerupation So Persons who investigated incident: Nation Phone 176 Y 2 20 SIGNATURE OF MORKER'S REPRESENTATIVE DATE (MYMANDO) NAMES OF MORKER'S REPRESENTATIVE DATE (MYMANDO)	SEVERITY OF INJURY OR ILLNESS (CHECK)	·
DESCRIPTION OF INCIDENT OR EMPLOYEES ACCOUNT OF OCCUPATIONAL DISEASE (E.G., RSI). TOOTH FUNCTURE ON NAME OF CONTROL OF COCUPATIONAL DISEASE (E.G., RSI). MERRE WRITTEN SAFE WORK PROCEDURES ESTABLISHED AND AVAILABLE? C YES C NO CYN/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND JOYR RECOMMENDES CORRECTIVE MEASURES TAKEN AND JOYR RECOMMENDES CORRECTIVE ACTION REFERRED TO: TO BE COMPLED BY (MYMAND) ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. INVOLVED IN THIS INCIDENT. NAME AND OCCUPATIONS OF PERSONS) WHO RIVESTIGATED INCIDENT: NAME AND OCCUPATIONS OF PERSONS WHO RIVESTIGATED INCIDENT: NAME OF MORKER'S REPRESENTATIVE DATE (MYMANDO) NAME OF MORKER'S REPRESENTATIVE DATE (MYMANDO) DATE (MYMANDO) DATE (MYMANDO) DATE (MYMANDO) DATE (MYMANDO)	No Injury or First Aid Only Medical Treatment Time Loss	Fatal
DESCRIPTION OF INCIDENT OR EMPLOYEES ACCOUNT OF OCCUPATIONAL DISEASE (E.G., RSI), TOOTH WICH ON hand (L) WERE THESE SAFE WORK PROCEDURES ESTABLISHED AND AVAILABLE? C YES C NO CN/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND TOK RECOMMENDED CORRECTIVE ACTION REFERRED TO: TO BE COMPLED BY (YMYMMOD) ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. INVOLVED IN THIS INCIDENT. Name WERE THESE SAFE WORK PROCEDURES USED IN TRAINING? C YES C NO CN/A C YES C NO CN/A TO BE COMPLED BY (YMYMMOD) TO BE COMPLED BY (YMYMMOD) TO BE COMPLED BY (YMYMMOD) ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. INVOLVED IN THIS INCIDENT: NAMES AND OCCUPATIONS; OF PERSONS; WHO ENVESTIGATED INCIDENT: NAME SIGNATURE OF MORKER'S REPRESENTATIVE DATE (YMYMMOD)	NATURE OF INJURY OR ILLNESS	
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ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. INVOLVED IN THIS INCIDENT. NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name Name Signature of Morker's Representative DATE (YYY-MM-DD) NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER.	CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. INVOLVED IN THIS INCIDENT. NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name Name Signature of Morker's Representative DATE (YYY-MM-DD) NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER.		
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name	CORRECTIVE ACTION REFERRED TO:	TO BE COMPLED BY (YYYY-MM-DD)
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name		
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name Varia Georgation Phone 176 YS 2 205 SIGNATURE OF NORMER'S REPRESENTATIVE DATE (YYYY-MM-DD) NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER	ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUINACTIVED IN THIS INCIDENT.	JIPMENT, TOOLS, STRUCTURES, ETC.
Name Name Volume Securities Signature of Morker's representative DATE (MYY-MM-DD) Signature of EMPLOYER'S REPRESENTATIVE DATE (MYY-MM-DD) NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER: DEC 14/2012 DEC 14/2012		
Name Name Volume Securities Signature of Morker's representative DATE (MYY-MM-DD) Signature of EMPLOYER'S REPRESENTATIVE DATE (MYY-MM-DD) NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER: DEC 14/2012 DEC 14/2012	NAME(S) AND OCCUPATIONS OF PERSON(S) WHO INVESTIGATED INCIDENT:	
SIGNATURE OF WORKER'S REPRESENTATIVE DATE (YYY-MM-DD) DATE (YYY-MM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE DATE (YYY-MM-DD) DOC 14/2612 NAMESTOF WITNESSES). INCLUDE PHONE NUMBER:		_ Phone
NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER: Dec 14/2012 Dec 14/2012		178452205
NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER:	SIGNATURE OF MORKER'S REPRESENTATIVE DATE (YYYY-MM-DD) SIGNATURE OF EMPLOYER'S REPRESENT	ATIVE DATE (YYYY-MM-00)
	Dec 14/2012	URC 14/20
Maine		Phone
	Name .	



Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION S.22 PK-452-7079 BURNAMY YOUTH CISCODY CONNE	70/2/12/01
LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME	FiLE No.
s.22	
	KED IN PREVIOUS 24-HOURS
s.22 Your SUREWYOU 75	2
INCIDENT LOCATION (DEPARTMENT OR AREA) INCIDENT DATE (YYYY (AMADD)	TIME
VENTURE DAY KOOM 12/12/06	1948 C AM
INCIDENT CATEGORY (CHECK)	-
Injury or Illness	erty Damage
Fire Other	
SEVERITY OF INJURY OR ILLNESS (CHECK)	
No Injury or First Aid Only Medical Treatment Time Loss Fatal	
PLECATIONAMY REPORT - HAD A DECIC OF CAPUS TAME	DAN AT PACE
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)	
RESURDE THERE DECK OF CARDS, HT STAW ON PUBLICS	DE OF ME
WERE WRITTEN SAFE WORK PROCEDURES ESTABLISHED AND AVAILABLE? WERE THEY ADEQUATE? WERE THEY ADEQUATE? WERE THEY ADEQUATE? WERE THEY ADEQUATE?	
	O N/A
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS EXPLAIN FULLY UNSAFE CONDITIONS	
thereof we or the but - to homen with	
CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	
N/H	E COURT ED DV sossettiv ED
CORRECTIVE ACTION REFERRED TO:	E COMPLED BY (YYYY-MM-DD)
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TO	OOLS STRUCTURES ETC
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, INVOLVED IN THIS INCIDENT.	
NONE	
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:	
Name Occupation	Phone Phone
SIGNATURE OF A DEVERSE REPRESENTATIVE DATE (MYMMPD) SIGNATURE OF A PLOT OF THE PROPERTY OF THE	DATE (YYY-MM-DD)
SIGNATURE OF MORKERS REPRESENTATIVE DATE (MYY-MM-DD) SIGNATURE OF PAPPLOYER'S REPRESENTATIVE (2/12/06)	JAIL (III-MARA)
NAMES) OF STINESS(ES). WOLUDE PHONE NUMBER:	Phone
Name	1 110116
Λ	1



BRITISH | Ministry of Children | COLUMBIA | and Family Development

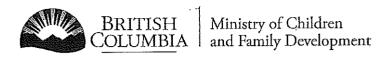
Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION	REPORT DATE (YYY-MM-DD)
778-452-2050 Burnaby Youth Custody Services	2012-11-12
LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME	FILE No.
s.22	
YEARS OF SERVICE TIME ON PRESENT JOB OCCUPATION HOURS WORLD	KED IN PREVIOUS 24-HOURS
s.22 Youth Supervisor 12	hrs
INCIDENT LOCATION (DEPARTMENT OR AREA) INCIDENT DATE (YYYY-MM-DD)	TIME
Healthcare Corridor 2012-11-12	20:15 C AM
INCIDENT CATEGORY (CHECK)	
Injury or Illness Equipment Malfunction Motor Vehicle Prop	erty Damage
Fire Other	
SEVERITY OF INJURY OR ILLNESS (CHECK)	
No Injury or First Aid Only ✓ Medical Treatment ☐ Time Loss ☐ Fatal	f
NATURE OF INJURY OR ILLNESS	
HIT HEAD, PUNCHES IN HEAD	
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)	
LANDED AND SECTIVED PUNCH IN RIGHT 5 1	HOAD
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE SAFE WORK ESTABLISHED AND AVAILABLE? USED IN TRAINING?	PROCEDURES
C Yes C No C/N/A C Yes C No	€ N/A
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS	
FALLING HITTING HEAD INVACT FROM	RESIDINOT
CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	
NA	
CORRECTIVE ACTION REFERRED TO: TO BI	E COMPLED BY (YYYY-MM-DO)
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TO INVOLVED IN THIS INCIDENT.	OOLS, STRUCTURES, ETC.
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:	
Name Occupation	Phone
(SOMENI BILL SHOKAN S/ YOUTH SURY	778-452-2050
SIGNATURE OF WORKER'S REPRÉSENTATIVE DATE MY MADDI SIGNATURE OF EMPLOYES REPRÉSENTATIVE	DATE (YYYY-MM-DD)
Nov. 1/12 K. Show	2012-11-12
NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER:	Dhara
Name	Phone
	1



Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION	REPORT DATE (YYYY-MM-DD)
778-453-2050 Burnaby Youth Custody Services	2012-11-12
LAST NAME OF INTERED FOR HIT DEPSON FIRST NAME	FILE No.
s.22	
YEARS OF SERVICE TIME ON PRESENT JOB OCCUPATION HOURS WO	RKED IN PREVIOUS 24-HOURS
s.22, Youth Supervisor 12	hrs
INCIDENT LOCATION (DEPARTMENT OF AREA) INCIDENT DATE (YYY-MM-DD)	TIME C AM
Healthcare Corridor 2012-11-12	20:15 @ PM
INCIDENT CATEGORY (CHECK)	
Injury or Iliness Equipment Malfunction Motor Vehicle Pro	perty Damage
Fire Other	
SEVERITY OF INJURY OR ILLNESS (CHECK)	
No Injury or First Aid Only Medical Treatment Time Loss Fata	al
NATURE OF INJURY OR ILLNESS	
LOWER AND MIDDLE BACK TIGHT	
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)	
RESTRAINING A RESIDUT DURING AT LMG	Ubrey
Manager and a second	
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE SAFE WORK PROCEDURES SAFE WORK PROCEDURES USED IN TRAINING?	RK PROCEDURES
WEIGH WHITE TO BE THOUGHT THE SECOND OF THE	
ESTABLISHED AND AVAILABLE? USED IN TRAINING?	
ESTABLISHED AND AVAILABLE? O Yes C No O N/A C Yes C No O N/A C Yes C No	€ N/A
ESTABLISHED AND AVAILABLE? O Yes C No O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS USED IN TRAINING? C Yes C No O N/A EXPLAIN FULLY UNSAFE CONDITIONS	€ N/A
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ESTABLISHED AND AVAILABLE? O Yes O No ON/A C YES O NO ON O	BE COMPLED BY (YYY-MM-DD) TOOLS, STRUCTURES, ETC. Phone Phone
ESTABLISHED AND AVAILABLE? O YES ONO ONIA C YES ONO ONIA C YES ONO ONIA EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: TO ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, INVOLVED IN THIS INCIDENT. NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name Occupation SIGNATURE OF EMPLOYER'S REPRESENTATIVE DATE (YYYYMM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	BE COMPLED BY (YYY-MM-DD) TOOLS, STRUCTURES, ETC. Phone DATE (YYY-MM-DD)
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ESTABLISHED AND AVAILABLE? O Yes O No O N/A C Yes O No O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: TO ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, INVOLVED IN THIS INCIDENT. NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name OCCUPATION SIGNATURE OF WORKER'S REPRESENTATIVE DATE (MYTYMM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE DATE (MYTYMM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE TO TO TO TO TO TO SIGNATURE OF WORKER'S REPRESENTATIVE DATE (MYTYMM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE TO TO TO TO TO TO TO TO TO T	BE COMPLED BY (YYY-MM-DD) TOOLS, STRUCTURES, ETC. Phone DATE (YYY-MM-DD)



Joint Incident Investigation Form

	TELEPHONE NUMBER LOCATION	REPORT DATE (YYYY-MM-DD)
٠	778-452-2050 Burnaby Youth Cushody Services	2012-11-12
	LAST NAME	FILE No.
	s.22	
	YEARS OF S	KED IN PREVIOUS 24-HOURS
	s.22 Youth Supervisor 12	hrs
	INCIDENT LOCATION (DEPARTMENT OR AREA) INCIDENT DATE (YYYY-MM-DD)	TIME C AM
	Healthcare Corridor Nov 12-12	20:15 0/PM
	INCIDENT CATEGORY (CHECK)	
	Injury or Illness Equipment Malfunction Motor Vehicle Prop	erty Damage
	Fire Other	
	SEVERITY OF INJURY OR ILLNESS (CHECK)	
	No Injury or First Aid Only Medical Treatment Time Loss Fatal	
	[] The figure of the control of the	
	Hamstriaa pull on Left Lea	
	DESCRIPTION OF INCIDENT OF EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)	
	(-(-() // /	king.
	WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE SAFE WORK	PROCEDURES ·
	C Yes C No C N/A C Yes C No C N/A C Yes C No	© N/A

	BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS	12/
	Kunning very tast responding to lode	Ked.
	CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	
	Unavoidable injury	
	CORRECTIVE ACTION REFERRED TO:	E COMPLED BY (YYYY-MM-DD)
	N/A	NA
	ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TO INVOLVED IN THIS INCIDENT.	OOLS, STRUCTURES, ETC.
	NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:	
	Name, Occupation	Phone
	LET STOMORY BILL SHOKEANS / VOUTH SOR-	778-452-2050
	SIGNATURE OF WORKER'S REPRESENTATIVE DATE MYY-MM-DDY SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
•	NOV. 11/12 B. Storin	2012-18-12
	NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER:	
	Name	Phone
		1



Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION	REPORT DATE (YYYY-MM-DD)
718-452-2050 Burnery Vauth Custody Services, 1900 Fraser	2012-10-30
LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME	FILE No.
s.22	
YEARS OF SERVICE TIME ON PRESENT JOB OCCUPATION HOURS WOF	KED IN PREVIOUS 24-HOURS
s.22 Senior Youth Supervisor 12	2 hrs.
INCIDENT LOCATION (DEPARTMENT OR AREA) INCIDENT DATE (YYYY-MM-DD)	TIME (D'AM
7900 FRASER PARK DrivE Burnely BC. LINIT 2012-10-30	07:15 C PM
INCIDENT CATEGORY (CHECK)	
Injury or Illness Equipment Malfunction Motor Vehicle Prop	perty Damage
Fire Other	
SEVERITY OF INJURY OR ILLNESS (CHECK)	
No Injury or First Aid Only Medical Treatment Time Loss Fata	l
NATURE OF INJURY OR ILLNESS	
Left Kneeswalen Bloody/SCRADIED, Right neck & shalder stif	FROXE PUR HIT IN
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)	H. Bolhstoff& resid
Per on too of officers Injury to left knee, Head, MERC,	shoulder
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE SAFE WOR	K PROCEDURES
ESTABLISHED AND AVAILABLE?	C N/A
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS	
Resident Attempted to assault offerer by Punching, Take day	an restraint app
CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	to compative your
Stall USED Rostraint procedures to deal with assault	he resident
	BE COMPLED BY (YYYY-MM-DD)
Methods used to defend himself aumopriate.	VA ·
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TINVOLVED IN THIS INCIDENT.	TOOLS, STRUCTURES, ETC.
Restraint truining provided yearly a Due to restrain	t outlination of
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENTS: WAS CAULDS From V	esibleuds!
PAMELA DREW Assistant Director Operations	2012-10-30
4.11	
SIGNATURE OF EMPLOYER'S REPRESENTATIVE DATE (YYYY-MM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYY-MM-DD)
My F OCH30/12 tamelus treu	<u> 505-10-39</u>
NAJE(S) OF WITNESS(ES), INCLUDE PHONE NUMBER: Name	Phone
s.15, s.22 <u>Name</u>	77X-4Q-2050



Joint Incident Investigation Form

(Fluection of Privacy Act. Any questions about the contection, use of discussing of this information should be discussed with the social worker have	Urved With this agreement.
TELEPHONE NUMBER LOCATION	REPORT DATE (YYYY-MM-DD)
778-452-2050 Burnaby Youth Custody Services Dr. Burnaby BC	80B-10-30
LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME	FILE No.
s.22	
YEARS OF SERVICE TIME ON PRESENT 108 OCCUPATION HOURS WORK	KED IN PREVIOUS 24-HOURS
s.22 Youth Supervisor, Corrections 8	,
INCIDENT LOCATION (DEPARTMENT OR AREA) OFFILEDENT DATE (YYY-MM+DD)	TIME .
EIKhan Unit-Bycs - Day Room 202-10-30	07:15 C PM
INCIDENT CATEGORY (CHECK)	N_ / W
Trijury or Illness Equipment Malfunction Motor Vehicle Prope	erty Damage
Fire Other	
SEVERITY OF INJURY OR ILLNESS (CHECK)	•
No Injury or First Aid Only Medical Treatment Time Loss Fatal	
NATURE OF INJURY OR ILLNESS	
QNeek @ shoulder, Neek Kink & Shoulder	
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)	1100 100001111110
Injured white conducting Take down restraint on Comba	tive / Assoulting
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE SAFE WORK ESTABLISHED AND AVAILABLE? USED IN TRAINING?	PROCEDURES KO STOULT
OYes O No O N/A OYes O No O N/A OYes O No	O N/A
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS	W 11 6 7
VOUTH ATTEMPTED TO ASSAULT STAFF-YOUTH VESTVAINED BY TO CORRECTIVE MEASURES TAKEN AND FOR RECOMMENDED YOUTH WAS VESTSTANT A COM-	no Youth Supervisors bout in a Take down
	col 20000 a lequier
None-Use of restraint training provided and was w	sea abbitrated.
	COMPLED BY (YYYY-MM-OD)
N/A	NA
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TO INVOLVED IN THIS INCIDENT.	- 1
Restraint Training Provided Yearly Of restraint Application &	Freezent-yorkonane,
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:	
tamella Drew Assistant Director operations	778-452-2050
SIGNATURE OF EMPLOYER'S REPRESENTATIVE DATE (YYY-MM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
My 1/x OCH30/12 tample Drew	202-10-30
N/ME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER:	
// // Name	Phone
s.15, s.22	778-452-2050



Joint Incident Investigation Form

Protection of Privacy Act. Any questions about the confection, use of discussive of this information should be discussed with the social worker invo	olved with this agreement.
TELEPHONE NUMBER LOCATION 7900 FRASEIZ PARK	REPORT DATE (YYYY-MM-DD)
De la	2012-10-30
LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME	FILE No.
s.22	
YEARS OF SERVICE TIME ON PRESENT JOB OCCUPATION HOURS WORK	ED IN PREVIOUS 24-HOURS
Vouth Syservisors Correctional	•
	TIME
	C AM
INCIDENT CATEGORY (CHECK)	
injury or Illness Equipment Malfunction Motor Vehicle Prope	rty Damage
Fire Other	
SEVERITY OF INJURY OR ILLNESS (CHECK)	
No Injury or First Aid Only Medical Treatment Time Loss Fatal	
NATURE OF INJURY OR ILLNESS	
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)	
Applied restraint on resident during an assault on a	inother resignant,
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE SAFE WORK RESTABLISHED AND AVAILABLE?	PROCEDURES -
CYes C No C N/A CYes C No C N/A CYes C No C	D N∕A
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS	
Hit on left side of head by ambative Youth while to	ying to vestrain hor
CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	
None-Restraint training provided and was used appropriat	-ely
	COMPLED BY (YYYY-MM-DO)
NIA	ÀH.
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOO INVOLVED IN THIS INCIDENT.	DLS, STRUCTURES, ETC.
Restruint training Provided Yearly Occupation has risk of I	murd all 10 use
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:	Jugus,
Hamela Prew Assistant Director aproling.	178452-2077
SIGNATURE OF WORKER'S REPRESENTATIVE DATE (MY MILEO) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
Tamolastalen	202-10-30
NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER:	
Name	Phone
·	778-452-20\$6



Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION REPORT DATE (MYY-MAN D)
778 452-2050 Burnary Yorth Custody Services 2012/10/26
LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME FILE No.
s.22
YFARS OF SERVICE TIME ON PRESENT JOB OCCUPATION HOURS WORKED IN PREVIOUS 24-HOUF
s.22 Yorth Supervisor 8 hrs
INCIDENT LOCATION (DEPARTMENT OR AREA) INCIDENT DATE (YYYY-MM-DD) TIME
B. V. C.S - Asperity Unit 2012/10/24 2210 C AM
INCIDENT CATEGORY (CHECK)
Injury or Illness Equipment Malfunction Motor Vehicle Property Damage
· Fire Other
SEVERITY OF INJURY OR ILLNESS (CHECK)
No Injury or First Aid Only Medical Treatment Time Loss Fatal
NATURE OF INJURY OR ILLNESS
Punch to the face
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)
Assaulted by a relident
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? ESTABLISHED AND AVAILABLE? WERE THESE SAFE WORK PROCEDURES USED IN TRAINING?
Yes C No C N/A Yes C No C N/A Yes C No C N/A
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS
Youth with a history of assault
CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED
Youth was on 2-1 Status assault still happened due to resident behaviour
CORRECTIVE ACTION REFERRED TO: TO BE COMPLED BY (YYYY-MM-DD)
N/H
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. INVOLVED IN THIS INCIDENT.
N(A
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:
Name Occupation Phone
TODDWATSON MATTANNAN CORRECTION ACTING DIRECTOR 778-452-2050
SIGNATURE OF WORKER'S REPRESENTATIVE DATE (YTT-MM-DD) SIGNATURE OF EMPLOYEES REPRESENTATIVE DATE (YTT-MM-DD)
$\frac{1}{1} \frac{1}{1} \frac{1}$
2012/10/24 //the dem 2012/10/24
2012/10/26



Joint Incident Investigation Form

_	TELEPHONE NUMBER LOCATION	REPORT DATE (YYYY-MM-DD)
778	452-2050 Burnary Youth Custady Services	2012/10/26
	LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME	FILE No.
	s.22	
		RKED IN PREVIOUS 24-HOURS
	s.22 Youth Supervisor	
	INCIDENT LOCATION (DEPARTMENT OR AREA) INCIDENT DATE (YMY-MM-DD)	TIME C AM
	13.4.C.S - Hsperity Unit 2012/10/24	22/0 PM
	INCIDENT_CATEGORY_(CHECK)	
	Injury or Illness Equipment Malfunction Motor Vehicle Pro	perty Damage
	Fire Other	
	SEVERITY OF INJURY OR ILLNESS (CHECK)	
	No Injury or First Aid Only Medical Treatment Time Loss Fata	al
	NATURE OF INJURY OR ILLNESS	
	Several punches to the back of the head	
	DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)	
	. Assaulted by a resident	
	WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE SAFE WOR	K PROCEDURES
	ESTABLISHED AND AVAILABLE? USED IN TRAINING?	
	ESTABLISHED AND AVAILABLE? USED IN TRAINING? Ves C No C N/A Ves C No C N/A Ves C No	C N/A
		C N/A
	Yes O No O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS EXPLAIN FULLY UNSAFE CONDITIONS	C N/A
••	Yes O No O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS EXPLAIN FULLY UNSAFE CONDITIONS	C N/A
	BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS YOUTH WITH a history of assault CORRECTIVE MEASURES TAKEN AND FOR RECOMMENDED	C N/A esident behavia
	EXPLAIN FULLY UNSAFE CONDITIONS BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS York with a history of assault CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED York Was on 2-1 Status Assault Still happened due to re	
	EXPLAIN FULLY UNSAFE CONDITIONS BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS York with a history of assault CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED York Was on 2-1 Status Assault Still happened due to re	esident behavior
	EXPLAIN FULLY UNSAFE CONDITIONS BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS York with a history of assault CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED York Was on 2-1 Status Assault Still happened due to re	esident behavier DE COMPLED BY MYYMMADD) N/A
	EXPENDING CN/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS EXPLAIN FULLY UNSAFE CONDITIONS EXPLAIN FULLY UNSAFE CONDITIONS EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND/OR RECOMMENDED FOR CORRECTIVE ACTION REFERRED TO: TO E ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TO	esident behavier DE COMPLED BY MYYMMADD) N/A
	EXYES ONO ON/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS YOUTH WITH Chistory of assault CORRECTIVE MEASURES TAKEN AND/OR RECOMMENDED YOUTH WAS ON 2-1 Status. Assault still happing due to re CORRECTIVE ACTION REFERRED TO: TO E MACHINES OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TINVOLVED IN THIS INCIDENT. NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:	E SI COST BERAVIES BE COMPLED BY MYMMADD) N/A TOOLS, STRUCTURES, ETC.
	EXPLAIN FULLY UNSAFE CONDITIONS BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS YOUTH WITH A history of assault CORRECTIVE MEASURES TAKEN AND OR RECOMMENDED YOUTH WAS ON 2-1 Status. Assault still happinal due to re CORRECTIVE ACTION REFERRED TO: TO E NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name Occupation	Phone
	EXPES ONO ON/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS LYOUTH WITH A history of assault CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED LOTH WAS ON 2-1 Status Assault Still happing due to see CORRECTIVE ACTION REFERRED TO: TO E NAME ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TO INVOLVED IN THIS INCIDENT. NAME OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name OCCUPATION OCCUPATION Name OCCUPATION O	Phone PSI CONF DENGLOR Phone 778-452-2050
	EXPLAIN FULLY UNSAFE CONDITIONS BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: TO BE ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TO BE NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: NAME NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: NAME OCCUPATION SIGNATURE OF EMPLOYER'S REPRESENTATIVE DATE MYYLMADD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	Phone
	EXPES ONO ONA BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS EXPLAIN FULLY UNSAFE CONDITIONS EXPLAIN FULLY UNSAFE CONDITIONS EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: TO E ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TO INVOLVED IN THIS INCIDENT. NAME NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name OCCUPATION SIGNATURE OF WORKER'S REPRESENTATIVE DATE MYYMANDO) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	Phone PATE (TYY-MA-DD) PATE (TYY-MA-DD) DATE (TYY-MA-DD)
	EXPESIONO ONA BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS FOR CORRECTIVE MEASURES TAKEN AND FOR RECOMMENDED CORRECTIVE MEASURES TAKEN AND FOR RECOMMENDED FOR CORRECTIVE ACTION REFERRED TO: TO E ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TINVOLVED IN THIS INCIDENT. NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name OCCUPATION OCCUPATION SIGNATURE OF WORKER'S REPRESENTATIVE DATE (MYM-MM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	Phone PATE (TYY-MA-DD) PATE (TYY-MA-DD) DATE (TYY-MA-DD)



Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION		REPORT DATE (YYYY-MM-DO)
778-452-2050 BURNABY YOUTH CUSTODY	CENTER	2012/10/26
LAST NAME OF INJURED (OR ILL) PERSON FIRST	NAME	FILE No.
s.22		
YEARS OF SERVICE TIME ON PRESENT JOB OCCUPATION		WORKED IN PREVIOUS 24-HOURS
s.22 CORRECTIONS OFF	705L 7	5
INCIDENT LOCATION (DEPARTMENT OR AREA)	INCIDENT DATE (YYY-MM-DD	CAM
BYCS - ELKHORN UNIT	2012/10 22	1200 CPM
INCIDENT CATEGORY (CHECK)		
Injury or Illness Equipment Malfunction	Motor Vehicle	roperty Damage
Fire Other		
SEVERITY OF INJURY OR ILLNESS (CHECK)		
No Injury or First Aid Only Medical Treatment	Time Loss F	atal
NATURE OF INJURY OR ILLNESS	Summen	
TWISTED BACK		
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G.	RSI)	
FELT A PAIN IN MY BACK RESTRAINING	YOUTH	
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE?	WERE THESE SAFE V	WORK PROCEDURES
ESTABLISHED AND AVAILABILE? CYES C No C N/A EYES C No C N/A	A USED IN TRAINING?	o C N/A
	INSAFE CONDITIONS	<u> </u>
TWISTED BACK RESTRAING YOUT		
CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	·	
NONE AT THIS TIME		·
CORRECTIVE ACTION REFERRED TO:		TO BE COMPLED BY (YYYY-MM-DD)
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAI INVOLVED IN THIS INCIDENT.	KES AND MODELS OF MACHINES, EQUIPMEN	NT, TOOLS, STRUCTURES, ETC.
	٠,	
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:		
Name Contact (Contact	Occupation JS ACTING DIRECT	Phone
TODD WATSON, MATTANNAN CORRECTION	ITEL / DIFFATIONS	170432 2030
SIGNATURE OF WORKER'S REPRESENTATIVE DATE (TWY/MADD) SIGN.	ATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
NAME(S) OF WITHESS (EV. SCLUDE PHONE NUMBER:		Phone
Name		Phone
l		•

INT ACCIDENT INVESTIGATION FOR

PSC 38

P30 30						
Ministry Tel. # MCFD 778-452-2052	Location Rurnalis Gouth Cust	tody Services	Date of Report	12.		
Last Name of Injured (or III) Person	First Name		File No.	•		
s.22	Filotivanio		, ,,_			
Years of S	Occupation Youth Su presently progra	pervisor m officer)	Hours Worked in Hour Period,	Previous 24		
Accident Location (Dept. or Area) Frac/4 / Field	Date of Accident Oct 8/12		Time / 92	0		
Accident Category (check) Injury or Illness	Equipment Motor Malfunction Vehicle	Property Damage	☐ Fire	Other (specify)		
Severity of Injury or Illness (check)	No Injury or First Ald Only	Medical Treatment	Time Loss	Fatal *		
Nature of Injury or Illness Small cuts/punc From climbia Description of Accident or Employee's Account Youth Jumped over and field to assaut from the Fence. The Causing cuts on s.22	of Occupational Disease (eg. RSI) PHAMIS FEACE FROM JB. another Youth. To top eman Spiles both hands MAMA	(use separate she bashedball is employed	et If necessary) Court to E fulls werd Encl End both hands	track him us en us		
Were Written Safe Work Procedures Established and Available? Yes No N/A	Were they Adequate? Yes ☑ No ☐ N/A ☐	V	Were these Saf Procedures use	od in Training?		
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS Yes No N/AL Yes No N/AL						
	•	j. →				

, Corrective Measures Taken and/or Recommended
Will consult with programs to densure no-contacts are not
censure no-contacts are not
programmed next to each other
Corrective Action Referred To: 1090000 Super Spate To Be Completed By: 15000000000000000000000000000000000000
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident: Name(s) & occupations of person (s) who investigated accident (s) who investigated accident (s) who investigated accident (s) who investigated (s) who investiga
Print Name & Occupation Phone Print Name & Occupation Phone
Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)

Revised July 2004

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office



Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION		REPORT DATE (YYYY-MM-DD)
178-452-2059 17900 Fraser Kart	K DUNG RIMADY R.C.	
LAST NAME OF INJURED (OR ILL) PERSON	FIRST NAME	FILE No.
s.22		1
YEARS OF SERVICE TIME ON PRESENT JOB OCCUPATION	HOURS WORL	KED IN PREVIOUS 24-HOURS
NOODENT LOCATION (DEPARTMENT OR AREA)	INCIDENT DATE (YYYY-MM-DD)	J(2 ,
BUTTON (DEPARTMENT OR AREA) BUTTON YOUTH CUSTON SERVICE	25 Sept. 25 Jan 20	13'27 C AM
INCIDENT CATEGORY (CRECK)		LOS I CAM
Injury or Illness Equipment Malfunc	tion Motor Vehicle Prop	erty Damage
Fire Vother ASSCU	ulted.	
SEVERITY OF INJURY OR ILLNESS (CHECK)	_	
No Injury or First Aid Only Medical Treatment	Time Loss Fatal	
NATURE OF INJURY OR ILLNESS	under a still be in low	dago kirke
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATION	unched & Stabled In Viol	u arto starc
s.79 YCJA	was punched in the	d XU SVO
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADE	COUATE? WERE THESE SAFE WORK	PROCEDURES KICKED II
ESTABLISHED AND AVAILABLE?	USED IN TRAINING?	21011
OYes C No O N/A OYes C	No O N/A O Yes O No	O N/A
	s.79 YCJA	
CORRECTIVE MEASURES TAKEN AND J OR RECOMMENDED		1
Enhance staffing,	s.79 YCJA	
CORRECTIVE ACTION REFERRED TO:	TO BI	COMPLED BY (YYYY-MM-DD)
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIV INVOLVED IN THIS INCIDE	E DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TO ENT.	DOLS, STRUCTURES, ETC.
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDEN Name	Cocupation	Phone
Kalle	Cocupation	7 110110
SIGNATURE OF WORKER'S REPRESENTATIVE DATE (YYY)	(-MM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
	Ť .	
NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER:	me	Phone
TYC	шь	, none
1		



Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION			R	EPORT DATE (YYYY-MI
LAST NAME OF INJURED (OR ILL) PERSON		FIRST NAME		FILE No.
	s.22			
	CCUPATION	A. C.	HOURS WORKE	D IN PREVIOUS 24-HO
s.22	Correction			
INCIDENT LOCATION (DEPARTMENT OR AREA)	10100.10	INCIDE	NT DATE (YYYY-MM-DD) T	16011 C A
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	nngsorm	. [00]	99105	(00 4 C)
INCIDENT CATEGORY (CHECK)	r i kir le i ti	- Barran Vahiala	Droper	tu Domono
☑ Injury or Iliness ☐ Equi	pment Malfunction	Motor Vehicle		ty Damage
Fire Othe	er			
SEVERITY OF INJURY OR ILLNESS (CHECK)		•		-
No Injury or First Aid Only Med	ical Treatment	Time Loss	Fatal	ē.
NATURE OF INJURY OR ILLNESS	_			
(R) ex Dev Acm 16	DSide 18	rele Showle	Lev Stiff.	uss/ Dre
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOU				
cae por 12				
WERE WRITTEN SAFE WORK PROCEDURES	WERE THEY ADEQUATES	}	WERE THESE SAFE WORK P	ROCEDURES
ESTABLISHED AND AVAILABLE?			USED IN TRAINING?	S AUA
C Yes C No C N/A	C Yes O No	C N/A	C Yes C No C	→ N/A
BASIC CAUSE (AND CONTRIBUTORY FACTORS)	EXPLAII	N FULLY UNSAFE CONDITIONS		
YOUN				
CORRECTIVE MEASURES TAKEN AND / OR RECOMM	ENDED	A116/1/2	ATTA. PRI 6	L.
TO respina while	SPORT REAL	xarry nu	1.700 fect	
CORRECTIVE ACTION REFERRED TO:			TO BE 0	COMPLED BY (YYYY-MI)
				0/1 (
ADDITIONAL COMMENTS OR OBSERVATIONS. WHE	RE APPLICABLE GIVE DETAIL DEVED IN THIS INCIDENT.	LS OF MAKES AND MODELS OF M	AACHINES, EQUIPMENT, TOC	JLS, STRUCTURES, E
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO	INVESTIGATED INCIDENT:			
Name	-/-	Occupation	>	Phone
1Thoras Such	US	1/2N/ 07/2/1	7	
100 to 6000 to	- 1	Cerroro		
SIGNATURE OF YERKERS REPRESENTATIVE	DATE (YYYY-MM-DD)	SIGNATURE OF EMPLOYER	S REPRESENTATIVE	DATE (YYYY-MS
SIGNATURE OF VERKERS REPRESENTATIVE		SIGNATURE OF EMPLOYER	S REPRESENTATIVE	DATE (YYYY-MM
SIGNATURE OF YORKERS KEPRESENTATIVE		SIGNATURE OF EMPLOYER	S REPRESENTATIVE	DATE (YYYY-MS

4/5 was watching horre with residents and s.79 YCJA laying on Kotchen Comber Ys staff asked youth to please remner her Sett Boon tou courter Youth agrived director Up call Supersort adding cent. 10 second later 41s heard res s.79 YCJA Yelling No" U/S STATE Glorend and Saw Youth Charging toward & me and Youth Fruit myarm as I put my arm upt protect my head and forer.

s.79 YCJA

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

F3C 36						
Ministry MCF	Tel. #	Location 19 m F	ngier 1	lock	Date of Report	1/2012
Last Name of Injured (or ill) Pe	erson	First Name			File No.	
	s.22					·
Years of Service	Time on	Occupation Youth	wptavis	vA	Hours Worked Hour Period	in Previous 24
Accident Location (Dept. or Ar	<u>.</u> _	Date of Accident X/y Z 6	2012		Time : 20/0	
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	Fire	Other (specify)
Severity of Injury or Illness (ch		No Injury or F	First Aid Only	Medical Treatment	Time Loss	☐ Fatal *
KNUCKLES	OF A16		<i>-</i>			UI-TH
Description of Accident or Em STARP ME POYSICAL THE STARP	MALL	MON . H	NED IN VALE S	e per mi	rolat Nout	VS
Were Written Safe Work Prod Established and Available	cedures	Were they Adequ	/	-	Were these Sa Procedures us	,
Yes No N/A Yes No N/A Yes No N/A Yes No N/A						
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS YOUTH INVOLVED IN FIGHT IND MEDICINE BE STOPPED BY STAPF.						

Corrective Measures Taken and/or Recommended	
Optionity Measures failer and a freezintional	
i/ A	
	•
•	
Corrective Action Referred To: Date To Be Complete	ted Bv: /
Concessive Action Action to Service Services	
·	
Additional Comments or Observations. Where applicable give details of makes & models of r	machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)	
N/A	
·	
·	
Name(s) & occupations of person (s) who investigated accident:	gs nd
A. ROORIGHEE 778-452 2050 YOUTH SUPERIV	1/50 N 778-452-2050
Print Name & Occupation Phone Print Name & Occupat	
her hand July 26/2010 A	- July 26/2012
Signature of Workers' Representative Date Signature of Employer F	
Gignature of Tropicsoniauro	
Name(s) of Witness(s) (include phone number)	
-719-452-2050 5.15, 5.22 -719-452-2050	
s.15, s.22	

Revised July 2004

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency



Joint Incident Investigation Form

,	
(778	BUTNALLY YOUTH CLUSTERY SONICES 2012.07.17.
	LAST NAME OF INJURED (OR II.1) PERSON . FIRST NAME
	s.22
	S.22 TIME ON PRESENT JOB OCCUPATION HOURS WORKED IN PREVIOUS 24-HOURS OCCUPATION HOURS WORKED IN PREVIOUS 24-HOURS Q - 58
	INCIDENT LOCATION (DEPARTMENT OR AREA) NOCIDENT LOCATION (DEPARTMENT OR AREA) NOCIDENT LOCATION (DEPARTMENT OR AREA) TIME ZO(Z. 0.7.77 8:15 O AM (2015)
	INCIDENT CATEGORY (CHECK)
	Injury or Illness Equipment Malfunction Motor Vehicle Property Damage
	Fire Other
	SEVERITY OF INJURY OR ILLNESS (CHECK)
=	No Injury or First Aid Only
	NATURE OF INJURY OR ILLNESS
	IN WASCIETS HOWEVER, LETT THAT I WELL
	DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT, OF ODCUPATIONAL DISEASE (E.G. RSI) 1 STORE JULIEU WILL OF COLUMN (R. OLDON) TIME TO DEPUT OF COMMON TO DESCRIPTION OF COLUMN (R. OLDON) TIME TO DESCRIPTI
	WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE SAFE WORK PROCEDURES USED IN TRAINING?
	CYes O No O N/A Ves O No O N/A
	BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAINIFILLY UNSAFE CONDITIONS TO THE DAY COLD (1500)
	NONE EVERYday Job hazzavol
	CORRECTIVE ACTION REFERRED TO: TO BE COMPLED BY (YYYY-MM-DD) NAME (ACTION FOR THE COMPLED BY (YYYY-MM-DD))
	ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC.
	INVOLVED IN THIS INCIDENT.
	NAME OF A STOCK CONTRACTOR OF THE STOCK CONTRACTOR OF
	NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Occupation Name Possians 2. UNIT SUPPLIED TO NO CONTAINS OF CONTAINS
	SIGNATURE OF WORKER'S REPRESENTATIVE DATE (MYY-MM-DD) SIGNATURE OF EVPLOYER'S REPRESENTATIVE DATE (MYY-MM-DD)
	505 11 BM 90 00 7017.
•	NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER: Phone (7-75) US2-2050
	15.00



Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION	REPORT DATE (YYY-MADD)
778 452 2050 89CS	JUNE 28/2012
LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME	FILE No.
s.22	
	WORKED IN PREVIOUS 24-HOURS
s.22 YOUTH SUPERVISOR	1 hr. 30min.
INCIDENT LOCATION (DEPARTMENT OR AREA) INCIDENT DATE (YYYY-MM-DI) TIME C AM
FITNESS ROOM 2012/06/28	0900 O PM
INCIDENT CATEGORY (CHECK) Injury or Illness Equipment Malfunction Motor Vehicle	Property Damage
SEVERITY OF INJURY OR ILLNESS (CHECK)	
·	Fatal
NATURE OF INJURY OR ILLNESS	
CUT OR ABRAISON ON FOREHEAD	
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)	1/
43515ting to install a bar, in weight voon, to 5	tabddized weight
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE SAFE VERE THESE SAFE VERE THESE SAFE VERE THESE SAFE VERE THEY ADEQUATE?	WORK PROCEDURES
C Yes O No Ø N/A C Yes O No Ø N/A C Yes O N	o 🕜 N/A
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS	
equipment meetracher.	
CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	
Call weight some equipment repair to co	
CORRECTIVE ACTION REFERRED TO:	TO BE COMPLED BY (YYY-MM-DD)
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPME	100111
INVOLVED IN THIS INCIDENT.	
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name Occupation	Phone
SIGNATURE OF WORKER'S REPRESENTATIVE DATE (TYTH MADD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY,MM-DD)
100 201/28 × M/M)*	2012/06/28
NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER: Name	Phone



Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION	REPORT DATE (YYYY-MM-DD)
778 452 2050 ByCS 7900 Frager Vork Verve. Bby BC V5J5H1	2012 07 01
LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME	FILE No.
s.22	
YEARS OF SERVICE THE ON PRESENT YOB OCCUPATION HOURS WE	ORKED IN PREVIOUS 24-HOURS
s.22 Correctional Officer	9-58
INCIDENT LOCATION (DEPARTMENT OR AREA) INCIDENT DATE (YYYY-MM-DD)	TIME
Gymras, 1, m 2012 06 36	1 30 C AM
INCIDENT CATEGORY (CHECK)	
Injury or Illness Equipment Malfunction Motor Vehicle Pro	operty Damage
Fire Other	
SEVERITY OF INJURY OR ILLNESS (CHECK)	
No Injury or First Aid Only Medical Treatment Time Loss Fat	ital
NATURE OF INJURY OR ILLNESS	
Sprained left trans Linear.	
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)	
Landed antword of Knew bruckled and but	Daekwords
MEDITALISM AND	
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE SAFE WO USED IN TRAINING?	ORK PROCEDURES
established and available? See Yes C No O N/A Used in training? See Yes C No O N/A	
ESTABLISHED AND AVAILABLE? USED IN TRAINING?	
established and available? Setablished and available?	
established and available? Setablished and available?	
ESTABLISHED AND AVAILABLE? Ves C No O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS WE YES O NO EXPLAIN FULLY UNSAFE CONDITIONS	
ESTABLISHED AND AVAILABLE? Ves C No O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	
ESTABLISHED AND AVAILABLE? WE YES C NO O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	Ç N/A
ESTABLISHED AND AVAILABLE? WE YES C NO O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED	C N/A D BE COMPLED BY (YYYY-MM-DD)
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ESTABLISHED AND AVAILABLE? We yes C No O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT INVOLVED IN THIS INCIDENT.	C N/A D BE COMPLED BY (YYY-MM-DD) T, TOOLS, STRUCTURES, ETC.
ESTABLISHED AND AVAILABLE? Yes O No O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT INVOLVED IN THIS INCIDENT.	C N/A D BE COMPLED BY (YYYY-MM-DD) T, TOOLS, STRUCTURES, ETC. Phone
ESTABLISHED AND AVAILABLE? We Yes C No O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT INVOLVED IN THIS INCIDENT. NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name Occupation Occupation	C N/A O BE COMPLED BY (YYYY-MM-DD) T, TOOLS, STRUCTURES, ETC. Phone Phone Phone
ESTABLISHED AND AVAILABLE? PYES C NO O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT INVOLVED IN THIS INCIDENT. NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name Occupation SIGNATURE OF WORKER'S REPRESENTATIVE. DATE (YYYY-MM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	C N/A D BE COMPLED BY (YYY-MM-DD) T, TOOLS, STRUCTURES, ETC. Phone TR +52 2350 DATE (YYY-MM-DD)
ESTABLISHED AND AVAILABLE? Wes C No O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT INVOLVED IN THIS INCIDENT. Name Occupation SIGNATURE OF WORKERS REPRESENTATIVE. DATE CYTY-MIN-DD) SIGNATURE OF WORKERS REPRESENTATIVE.	C N/A O BE COMPLED BY (YYYY-MM-DD) T, TOOLS, STRUCTURES, ETC. Phone Phone Phone
ESTABLISHED AND AVAILABLE? PYES C NO O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT INVOLVED IN THIS INCIDENT. NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name Occupation SIGNATURE OF WORKER'S REPRESENTATIVE. DATE (YYYY-MM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE	C N/A D BE COMPLED BY (YYY-MM-DD) T, TOOLS, STRUCTURES, ETC. Phone TR +52 2350 DATE (YYY-MM-DD)
ESTABLISHED AND AVAILABLE? Wes C No O N/A BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT INVOLVED IN THIS INCIDENT. NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT: Name Occupation SIGNATURE OF WORKER'S REPRESENTATIVE DATE (TYTY-MM-DD) SIGNATURE OF EMPLOYER'S REPRESENTATIVE NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER:	Phone THE HSD 2050 DATE (TYPY-MM-DD) 2012 07-01



Joint Incident Investigation Form

Protection of Privacy Act. Any questions about the co					
TELEPHONE NUMBER LOCATION				REPORT DATE (YYYY-MM-DD)	
718452 2050 BUCS			-	2012/06/28	
LAST MANE OF INTEREST OF BUY DEDGON		FIRST NAME		FILE No.	
s	3.22				
YEARS OF SERVICE TIME ON PRESENT JOB	OCCUPATION			ED IN PREVIOUS 24-HOURS	
s.22	YOUTH SU	BEZVISOR		9.5	
INCIDENT LOCATION (DEPARTMENT OR AREA)		INCIDE	7, 7 - 2	TIME C AM	
BYCS GYMNASIU	M	201	2/6/20	/950 PM	
INCIDENT CATEGORY (CHECK)		<u> </u>			
Injury or Illness Eq	uipment Malfunction	Motor Vehicle	Prope	erty Damage	
Fire	ner				
SEVERITY OF INJURY OR ILLNESS (CHECK)					
No Injury or First Aid Only Me	dical Treatment	Time Loss	Fatal	•	
NATURE OF INJURY OR ILLNESS			<u> </u>	Management of the second	
INJURED KNEE WHI	LE PLAYING A	BASKETBALL W EASE (E.G. RSI) HIS TEET. FE	ZESIDENTS	. FELL ON)	CNEE
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCO	DUNT OF OCCUPATIONAL DISE	EASE (E.G. RSI)			
BODY CHECKED AFTE	Z LEAUING	HIS FET. FE	LL TO FLOO.	R ONTO KNE	E
WERE WRITTEN SAFE WORK PROCEDURES ESTABLISHED AND AVAILABLE?	WERE THEY ADEQUATE		WERE THESE SAFE WORK USED IN TRAINING?	PROCEDURES	
Yes C No C N/A	Yes C No	 1 [C N/A	
BASIC CAUSE (AND CONTRIBUTORY FACTORS)	EYPI AI	N FULLY UNSAFE CONDITIONS			
	LAI LAI				
ACCIDENTAL CONTA		RESIDENT W	IHILE PEAG	ING BYSICET	BALL
ACCIDENTAL CONTACORRECTIVE MEASURES TAKEN AND FOR RECOM	ACT WITH		HILE PLAY	ING BYSICET	BAU
ACCIDENTAL CONTACONTACONTECON NONE	ACT WITH		1HILE PLAY	ING BUSICET	BAU
ACCIDENTAL CONTACON CORRECTIVE MEASURES TAKEN AND FOR RECOMMENTAL CORRECTIVE ACTION REFERRED TO:	ACT WITH			COMPLED BY (YYY-MM-DD)	BAU
NONE	ACT WITH			COMPLED BY (YYYY-MM-DD)	BAU
CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. W	ACT WITH	Resident u	TO BE	COMPLED BY (YYY-MA-DD)	BAU
CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. WI	ACT W(TI+ IMENDED HERE APPLICABLE GIVE DETAL	Resident u	TO BE	COMPLED BY (YYY-MA-DD)	BAU
CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. W	ACT W(TT+ IMENDED HERE APPLICABLE GIVE DETAL VOLVED IN THIS INCIDENT.	Resident u	TO BE	COMPLED BY (YYY-MA-DD)	BAU
CORRECTIVE ACTION REFERRED TO: NAA. ADDITIONAL COMMENTS OR OBSERVATIONS. WINTER NOW ON THE PROPERTY OF T	MENDED HERE APPLICABLE GIVE DETAL VOLVED IN THIS INCIDENT.	DESIDENT (A	TO BE WA MACHINES, EQUIPMENT, TO	COMPLED BY (YYY-MM-DD) OT SUFE. Phone	BAU
CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. WI IN NAME(S) AND OCCUPATION(S) OF PERSON(S) WE Name GRANT BUNKER	HERE APPLICABLE GIVE DETAIN VOLVED IN THIS INCIDENT.	DENT U	TO BE NO MACHINES, EQUIPMENT, TO SUITED VISUR	COMPLED BY (YYY-MM-DD) OT SURE. DOLS, STRUCTURES, ETC. Phone 178452 2050	BAU
CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. WIND NAME(S) AND OCCUPATION(S) OF PERSON(S) WIND	HERE APPLICABLE GIVE DETAIN VOLVED IN THIS INCIDENT.	Occupation SENION VATAL SIGNATURE DARM LOYER	TO BE NO MACHINES, EQUIPMENT, TO SUITED VISUR	Phone 178452 2050 PATE (MYY-MM-DD) OT SURE, Phone	BAU
CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. WI IN NAME(S) AND OCCUPATION(S) OF PERSON(S) WIN Name CIZANT BUN YER SIGNATURE OF WORKER'S BEPRESENTATIVE	HERE APPLICABLE GIVE DETAIN VOLVED IN THIS INCIDENT. DATE (YYY-MANDS) 20/2/6/28	Occupation SENION VATAL SIGNATURE DARM LOYER	TO BE NO MACHINES, EQUIPMENT, TO SUITED VISUR	COMPLED BY (YYY-MM-DD) OT SURE. DOLS, STRUCTURES, ETC. Phone 178452 2050	BAU
CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. WI IN NAME(S) AND OCCUPATION(S) OF PERSON(S) WE Name GRANT BUNKER	HERE APPLICABLE GIVE DETAIN VOLVED IN THIS INCIDENT. DATE (YYYY-MM-DD) 20/2/6/28 BER:	Occupation SENION VATAL SIGNATURE DARM LOYER	TO BE NO MACHINES, EQUIPMENT, TO SUITED VISUR	Phone 178452 2050 PATE (MYY-MM-DD) OT SURE, Phone	BAU
CORRECTIVE ACTION REFERRED TO: ADDITIONAL COMMENTS OR OBSERVATIONS. WI IN NAME(S) AND OCCUPATION(S) OF PERSON(S) WIN Name CIZANT BUN YER SIGNATURE OF WORKER'S BEPRESENTATIVE	HERE APPLICABLE GIVE DETAIN VOLVED IN THIS INCIDENT. DATE (YYY-MANDS) 20/2/6/28	Occupation SENION VATAL SIGNATURE DARM LOYER	TO BE NO MACHINES, EQUIPMENT, TO SUITED VISUR	Phone 778452 2050 PATE (MYY-MM-DD) OLS, STRUCTURES, ETC.	BAU



Joint Incident Investigation Form

778.452.2050 Burnaly Youth Custody Services 12.06.16
EIRST NAME OF INTEREST OF HIT OFFISCAL S.22
years of service time on present Job Occupation Hours worked in previous 24-hours s.22 Incident Location (Department or area) Incident Location (Department or area)
Gymnasium 12.06.16 1500 CAM
Injury or Illness Equipment Malfunction Motor Vehicle Property Damage
Fire Other
SEVERITY OF INJURY OR ILLNESS (CHECK) No Injury or First Aid Only Medical Treatment Time Loss Fatal
Swelling left eye brow area.
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI) Elbowed in left eyebrow over during basketball
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? ESTABLISHED AND AVAILABLE? WERE THESE SAFE WORK PROCEDURES USED IN TRAINING?
Mario Cause (and contributory factors) Explain fully unsafe conditions Explain fully unsafe conditions
CYes C No C N/A CYes O No C N/A
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS ACCIDENTAL
PASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS ACCIDENTAL CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: TO BE COMPLED BY (YYYY-MM-DD)
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS ACCIDENTAL CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: TO BE COMPLED BY (YYYY-MM-DD) AND AC ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC.
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS ACCIDENTAL CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED NONE CORRECTIVE ACTION REFERRED TO: NONE TO BE COMPLED BY (YYYY-MM-DD) A/A A
CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED CORRECTIVE ACTION REFERRED TO: TO BE COMPLED BY (YYYY-MM-DD) ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:
EXPLAIN FULLY UNSAFE CONDITIONS HECT DESCRIPTIONS EXPLAIN FULLY UNSAFE CONDITIONS ACCIDENTAL CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED NONE CORRECTIVE ACTION REFERRED TO: TO BE COMPLED BY (YYYY-MM-DD) AND A ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. INVOLVED IN THIS INCIDENT.
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EXPLAIN FULLY UNSAFE CONDITIONS ACCIDENTAL

UNT ACCIDENT INVESTIGATION FOR

PSt 38

Ministry Tel.# MCF 778-452-2050	Location BYCS,		Date of Report TUNE	2,2012
Last Name of Injured (or ill) Person	First Name		File No.	
Years of Service s.22 Time on Present Job s.22	Occupation You Tu Subcavis	OIN.	Hours Worked in Hour Period	n Previous 24
Accident Location (Dept. or Area)	Date of Accident TUNE 2, 2012		Time 092	0
Accident Category (check) Injury or	Equipment Motor Malfunction Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (check)	No Injury or First Aid Only	Medical Treatment	Time Loss	Fatal *
Nature of Injury or Illness MINON BRUISE TO LEFT CHECK.				
CHOCK BEI	VED AN ACCIDING LOW HIS LEFT EYE, BETWEEN TWO Y	WHILE	BREAKIN)Ce
Were Written Safe Work Procedures Established and Available? Yes No N/A	Were they Adequate? Yes□ No□ N/A□	k	Were these Saf Procedures use Yes No	d in Training?
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDITION	DNS		
ACCIDENTAL IN THE COURSE OF DUTLES.				
) a		

Corrective Measures Taken and/or Recommend	ded		
N/A.			
		,	,
Corrective Action Referred To:		Date To Be Completed By:/_	
Additional Comments or ObservationsWhereetc., involved in this accident. (Use separate s	applicable give detail heet if necessary)	s of makes & models of machines, equipr	nent, tools, structures,
Name(s) & occupations of person (s) who inverse of Workers' Representative		Print Name & Occupation Signature of Employer Representative	778-452-2050 Phone Tune 2/12 Date
Name(s) of Witness(s) (include phone number 5.15, s.22) 18-452-2050		
. ·			

Revised July 2004

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office



BRITISH Ministry of Children COLUMBIA and Family Development

Joint Incident Investigation Form

TELEPHONE NUMBER LOCATION	REPORT DATE (YYYY-MM-0b)			
778-452-2050 BURNINGY YOUTH CUSTODY SERVICES	2012:05-17			
LAST NAME OF INJURED (OR ILL) PERSON FIRST NAME FILE No.				
s.22				
YEARS OF SERVICE TIME ON PRESENT JOB OCCUPATION HO	DURS WORKED IN PREVIOUS 24-HOURS			
S.22 YOUTH SUPERVISOR	NIL			
INCIDENT LOCATION (DEPARTMENT OR AREA) INCIDENT DATE (YYYY				
BICS MOSIAIC ROOM. 2012-05-1	S 0825 OPM			
INCIDENT CATEGORY (CHECK)				
Injury or Illness Equipment Malfunction Motor Vehicle	Property Damage			
Fire Other				
SEVERITY OF INJURY OR ILLNESS (CHECK)				
V No Injury or First Aid Only Medical Treatment Time Loss MAY 16/12	Fatal			
NATURE OF INJURY OR ILLNESS				
© KNEE INJURY				
DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)				
RESPONDED TO A CODE VELLOW IN MUSTIC ROOM, WITH OTHER STATT RETRIVED IN THE PROCESS, MYSELF + COMBATANTS FELL TO FLOOR AG.	AND WHILL ONE YOUT			
WERE WRITTEN SAFE WORK PROCEDURES WERE THEY ADEQUATE? WERE THESE S ESTABLISHED AND AVAILABLE? USED IN TRAINI	AFE WORK PROCEDURES NG?			
C Yes C No S N/A C Yes C No S N/A C Yes C	No O N/A			
BASIC CAUSE (AND CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS				
ACCIDENT, DURING RESTRAINT, COMBATANTS NES	D. CROWNED AREA			
CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED				
NONE AT THE TIME				
CORRECTIVE ACTION REFERRED TO: TO BE COMPLED BY (YYYY-MM-DD)				
ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. INVOLVED IN THIS INCIDENT.				
NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:				
Name Occupation /	Phone			
TODD WATSON PAY DREW CORRECTIONS OF FICE A.D. O. SIGNATURE OF WORKER'S REPRESENTATIVE DATE MYYMMODI,—SIGNATURE OF EMPLOYER'S REPRESENTATIVE	1/15/10			
SIGNATURE OF WORKER'S REPRESENTATIVE DATE CONTINUED SIGNATURE OF EMPLOYER'S REPRESENTATIVE 2012-05-17 DOING OF THE CONTINUED) ([2, 2)			
NAME STORE WITNESS(ES), INCLUDE PHONE NUMBER:				
√ Name	Phone			
s.15. s.22	778-452-2050			

	•					·
Ministry Tel.#		Location Burnally	Burnaby Youth Clistady		Date of Report)3-2C
Last Name of Injured (or III) Person		First Nama Ser UCC		File No.		
		s.22				
Years of Service	Present Job 1/ 1/4		Hours Worked in Previous 24 Hour Period //.5 // // // // // // // // // // // // //			
Accident Location (Dept. or A	1	Date of Accident 2012 03 25		Time 09(0		
Accident Category (check)	Injury or Illness	Equipment Malfunction	□.Motor Vehicle	Property Damage	Fire	Other (specify)
Severity of Injury or Illness (ch	neck)	No Injury or I	First Ald Only	Medical Treatment	Time Loss ALC	☐ Fatal *
Nature of Injury or Illness Opened a Large metal door. and injured his right block						
Description of Accident or Em	ployee's Account	of Occupational Dis	sease (eg. RSI) (use separate shee	t if necessary)	
(Nhil.	e sco	rting c	L Vest	dost 7	5	
Records 522 oppened a large metal door trijuving his right bicop			90			
ne	tal di	or mi	uong.	his re	ut bic	P
Were Written Safe Work Procedures Established and Available?		Were they Adequate?		Were these Safe Work Procedures used in Training?		
Yes No No N/A		Yes W No N/A		Yes No NA		
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS						
Unfortunate occurrance, accidental						
) hc	don't r	esulti	is in a	$g_{\mathcal{N}}$	
Mury						
				•		

	•
Corrective Measures Taken and/or Recommended	-
NONE (N/A)	
Corrective Action Referred Toy N/A	NA
Corrective Action Referred To: Date To Br	e Completed By: // Off. 17
Additional Comments or Observations. Where applicable give details of makes & metc., involved in this accident. (Use separate sheet if necessary)	odels of machines, equipment, tools, structures,
None	
hamols) a occupations of person (s) who investigated accident.	or Youth Supervisor) That (778)452-2050
Print Name & Occupation Phone Print Name &	Occupation Phone ZO(2.03.25
	mployer Representative Date
Name(s) of Witness(s) (include phone number)	
Only witness was a you tresident in custoding	rung of Fender

Revised July 2004

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office

1 00 00	<u> </u>		* • • • • • • •		
Ministry	Tel.#	Location	2 Daine	Date of Report	
MCFD		7900 FRASEN 1	ANZIMIVE	Manch 2	6/2012
Last Name of Injured (or ill) Pe	erson	First Name		File No.	
	s.22				
Years of Service	Time on Present Job	Connection of	licer	Hours Worked I Hour Period	n Previous 24 んて・
Accident Location (Dept. or Ar	rea)	Date of Accident 2012/02/19		Time /2:α	5 pin
Accident Category (check)	Injury or	Equipment Motor Malfunction Vehicle	Property Damage	Fire	Other (specify)
Severity of Injury or Illness (ch		No Injury or First Aid Only	Medical . Treatment	Time Loss	☐ Fatal*
Description of Accident or Emp	ployee's Account	of Occupational Disease (eg. RS)	l) (use separate shee		Hit
Were Written Safe Work Proce Established and Available? Yes No N/A	edures	Were they Adequate?		Were these Safe Procedures used	
YesLi NoLi N/ALA		TGO ESS TOURS TOUR		Yes No No	VA 🖸
Basic Cause (and Contributory	Factors) E	XPLAIN FULLY UNSAFE COND	ITIONS.		

Corrective Action Referred To:	Corrective Measures Taken and/or Recommended	
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: Under Structures Structures Structures (s) who investigated accident: Print Name & Occupation Phone Print Name & Occupation Phone Phone Print Name & Occupation Phone March 26 (r) Signature of Workers' Representative Date Name(s) of Witness(s) (include phone number)		
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: Under Structures Structures Structures (s) who investigated accident: Print Name & Occupation Phone Print Name & Occupation Phone Phone Print Name & Occupation Phone March 26 (r) Signature of Workers' Representative Date Name(s) of Witness(s) (include phone number)	N/A	
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: Under Structures Structures Structures (s) who investigated accident: Print Name & Occupation Phone Print Name & Occupation Phone Phone Print Name & Occupation Phone March 26 (r) Signature of Workers' Representative Date Name(s) of Witness(s) (include phone number)		
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Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: Under Structures Structures Structures (s) who investigated accident: Print Name & Occupation Phone Print Name & Occupation Phone Phone Print Name & Occupation Phone March 26 (r) Signature of Workers' Representative Date Name(s) of Witness(s) (include phone number)		
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, fools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: **DIRECT FROM Mea SIS 1843.351 USS OCCUPATION Phone Print Name & Occupation Phone Phone Print Name & Occupation Phone **March 26/12 Signature of Workers' Representative Date Name(s) of Witness(s) (include phone number)		
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, fools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: **DIRECT FROM Mea SIS 1843.351 USS OCCUPATION Phone Print Name & Occupation Phone Phone Print Name & Occupation Phone **March 26/12 Signature of Workers' Representative Date Name(s) of Witness(s) (include phone number)		
Name(s) & occupations of person (s) who investigated accident: **District Shambles** 515** 718.453-2051** Value & Occupation Phone Print Name & Occupation Phone Print Name & Occupation Phone March 26/12 Signature of Workers' Representative Date Name(s) of Wilness(s) (Include phone number)	Corrective Action Referred To:	Date To Be Completed By:/
Name(s) & occupations of person (s) who investigated accident: **District Shambles** 515** 718.453-2051** Value & Occupation Phone Print Name & Occupation Phone Print Name & Occupation Phone March 26/12 Signature of Workers' Representative Date Name(s) of Wilness(s) (Include phone number)		
Name(s) & occupations of person (s) who investigated accident: **District Shambles** 515** 78.453-2051** USS Sociolate** 7-8452-7051** Print Name & Occupation Phone **Print Name & Occupation Phone **March 16 **Signature of Workers' Representative Date **Name(s) of Witness(s) (Include phone number)		
Print Name & Occupation Phone Print Name & Occupation Phone Wards African March 26/12 Signature of Workers' Representative Date Signature of Employer Representative Date Name(s) of Witness(s) (include phone number)	Additional Comments or Observations. Where applicable give details etc., involved in this accident. (Use separate sheet if necessary)	s of makes & models of machines, equipment, tools, structures,
Print Name & Occupation Phone Print Name & Occupation Phone Wards African March 26/12 Signature of Workers' Representative Date Signature of Employer Representative Date Name(s) of Witness(s) (include phone number)		
Print Name & Occupation Phone Print Name & Occupation Phone Wards African March 26/12 Signature of Workers' Representative Date Signature of Employer Representative Date Name(s) of Witness(s) (include phone number)	N/A	
Print Name & Occupation Phone Print Name & Occupation Phone Warch 26/12 Signature of Workers' Representative Date Signature of Employer Representative Date Name(s) of Witness(s) (include phone number)		
Print Name & Occupation Phone Print Name & Occupation Phone Wards African March 26/12 Signature of Workers' Representative Date Signature of Employer Representative Date Name(s) of Witness(s) (include phone number)		
Print Name & Occupation Phone Print Name & Occupation Phone Wards African March 26/12 Signature of Workers' Representative Date Signature of Employer Representative Date Name(s) of Witness(s) (include phone number)		
Print Name & Occupation Phone Print Name & Occupation Phone Warch 26/12 Signature of Workers' Representative Date Signature of Employer Representative Date Name(s) of Witness(s) (include phone number)	Namo(a) & coaunations of paragraph (a) who investigated coalders	
Print Name & Occupation Phone Print Name & Occupation Phone March 26/12 Signature of Workers' Representative Date Signature of Employer Representative Date Name(s) of Witness(s) (include phone number)	Name(s) & occupations of person (s) who investigated accident:	
Much 26/12 Signature of Workers' Representative Date Signature of Employer Representative Date Name(s) of Witness(s) (include phone number)		[/81/20]
Signature of Workers' Representative Date Signature of Employer Representative Date Name(s) of Witness(s) (include phone number)	Print Name & Occupation Phone	
Name(s) of Witness(s) (include phone number)	Vibra Hrong March 26/12	March 26/42
	Signature of Workers' Representative Date	Signature of Employer Representative Date
	Name(s) of Witness(s) (include phone number)	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Ministry MCA	Location	Date of Report FRB 78/12
Las' 11 61-1	Eirot Name	File No.
Years of Service Time on Present Job s.22	Occupation SUPERUSIN	Hours Worked in Previous 24 Hour Period /2
Accident Location (Dept. or Area)	Date of Accident FBB 19/7012	Time /2.30
Accident Category Injury or Illness	Equipment	Fire Other (specify).
Severity of Injury or Illness (check)	No Injury or First Aid Only Medical .	Time Fatal*
Nature of Injury or Illness LEFT MIDDLE BACK	Morny	
Description of Accident or Employee's Account Was involved in The Civilis Inturoution	of Occupational Disease (eg. RSI) (use separate shi Restraint for two of training.	Movapetic
Were Written Safe Work Procedures Established and Available?	Were they Adequate?	Were these Safe Work Procedures used in Training?
Yes No N/A	Yes No N/A	Yes No N/A
Basic Cause (and Contributory Factors) back tubled wh training group.	explain fully unsafe conditions 12 hvo Wed n a	controlled

Corrective Measures Taken and/or Rec	ommended			·
Hone at Phis to	me			
			-	
Corrective Action Referred To:		Date To Be Completed	Ву:/	
		-		
etc., involved in this accident. (Use sep				
Name(s) & occupations of person (s) w	ho investigated accident: THY 152 UT	THARDIS Print Name & Occupation		<u>-452-2</u> 05 Phone
Signature of Workers' Representative	kb 18/12 Date	Signature of Employer Re	1	Date 12
Name(s) of Witness(s) (include phone r	number)	1 ft - 7 15		
s.15, s.22	7 18	-456-10S	<i>O</i>	

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		7			<u> </u>	
LAILDREN & LAMI	CHILDREN : LAMILIES		ASER fl	Jek Drive	Date of Report	•
Last Name of Injured (or III) Pers	on	First Name			File No.	
s.22	<u> </u>	s.22			T no ivo.	
	ime on resent Job s.22	Occupation CORLECTIONAL OFFICER		Hours Worked i Hour Period	in Previous 24	
Accident Location (Dept. or Area		Date of Accident	F		Time 14:35	
J (***** - 19 .	injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (check	()	☐ No Injury or I	First Aid Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of injury or Illness Description of Accident or Employ	yee's Account c	of Occupational Dis	ease (eg. RSI) (use separate shee	et if necessary)	
WHILE BREAKING UP A FIGHT BETWEEN TWO RESIDENTS AND RESTRAINING, ONE OF THEM TWISTED & TOROUGD LEFT KNEE						SIDENTS
Were Written Safe Work Procedu Established and Available?	res	Were they Adequa	ate?		Were these Safe Procedures used	
Yes No N/A		Yes No No No	/ALL		Yes No No	
Basic Cause (and Contributory Fa	ctors) E	KPLAIN FULLY UN	ISAFE CONDITI	ONS		
Hasic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS Triumy Coursed during resident Rostraint.						
Part of Regular Duties.						

Corrective Measures Taken and/or Recommended
No Recommendation at this time.
No Recommendation
NA
Corrective Action Referred To: Date To Be Completed By:/
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of person (s) who investigated accident:
SILL GARDNER AADO 779452-2017 GRANT BUNCER SYS 778-452-2077
Print Name & Occupation Phone Print Name & Occupation Phone
Hours topiz/12 / DMM. BINGE FEB. 12/12
Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)

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JOINT ACCIDENT INVESTIGATION FC. ...

Ministry Minist	PSC 38 , ,						
Last Name of Injured (or III) Person Second	Ministry	Tel.#	Location			Date of Report	į
Years of Service Time on Present Inh S.22 SWFF SUPERVICEN Hour Period Q. 5K No. Accident Location (Dept. or Area) Date of Accident Time D6 50	Bucs 778-1	452 02 050	Burnaby		Feb 10/2012		
Years of Service Time on S.22			First Name			File No.	:
Accident Location (Dept. or Area) Accident Location (Dept. or Area) Accident Category (check) Accident Accident Accident Acc		s.22					
Accident Location (Dept. or Area) Purking bot Fub 9 (2072 Date of Accident Fub 9 (2072 Dept. or Area) Accident Category (check) Accident Category Injury or Equipment Motor Vehicle Damage Fire Other (specify) Severity of Injury or Illness (check) No Injury or First Aid Only Medical Treatment Loss Fatal* Nature of Injury or Illness O knce Step Intre Mour ut and treatment Loss Fatal* Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) White Ctopping out of my vehicle Step Intre Step	Years of Service				4.	D	.
Accident Gategory Injury or Equipment Motor Property Fire Other (specify) Severity of Injury or Illness (check) No Injury or First Aid Only Medical Treatment Loss Nature of Injury or Illness Occupational Disease (eg. RSI) (use separate sheet if necessary) White Ctpping out of My vehicle Fatal* Were Written Safe Work Procedures Were they Adequate? Yes No NA	s.22		Swift !	supervi	1807	Hour Feriou (1.58 hour
Accident Category (check)		rea)	Date of Accident				
Check Illness Malfunction Vehicle Damage (specify)	Parking tot		Feb 9	12012	•	0650	
Severity of Injury or Illness Malfunction Vehicle Damage (specify)		Injury or	Equipment	☐ Motor	Property	Fire	Other
Nature of Injury or Illness Nature of Injury or Illness O Knce / Step Intre May rut and twisted lenee Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) White Stepping out of my vehicle of Stepping out of My vehicle out o	(check)						(specify)
Nature of Injury or Illness O Knce Step In time Way rut and twisted Loss Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) White Stepping out of my vehicle, f Stepper Mathematical Control of Stepping out of my vehicle, f Stepper Were Written Safe Work Procedures Stablished and Available? Yes No N/A Yes No N/A Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS	Severity of Injury or Illness (ch	neck)	☐ No Injury or	First Aid Only	Medical	☐ Time	☐ Fatal *
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) While Ctpping out of My Vehicle, F Stepped Were Written Safe Work Procedures Established and Available? Yes No N/A Procedures EXPLAIN FULLY UNSAFE CONDITIONS	O Knu				Treatment	Loss	
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) White Ctpping out of My Vehicle, F Stepped Were Written Safe Work Procedures Established and Available? Yes No N/A Procedures Explain Fully Unsafe Conditions Explain Fully Unsafe Conditions	Nature of Injury or Illness	1	1	C . 1.	1	instead	1/11-6
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) White Ctpping out of my vehicle. Fully Stepped to the Company of the Control of the Co	O Knee	/Step	inthre 1	pourut	and 1	WISITER	gric -
Were Written Safe Work Procedures Established and Available? Yes No N/A EXPLAIN FULLY UNSAFE CONDITIONS		()					
Were Written Safe Work Procedures Established and Available? Yes No N/A N/A Yes No N/A N/A Yes No N/A N/A Procedures used in Training? Yes No N/A	Description of Accident or En	nployee's Account	of Occupational Di	sease (eg. RSI)	(use separate she	et if necessary)	71 > ~ 1
Were Written Safe Work Procedures Established and Available? Yes No N/A N/A Yes No N/A N/A Yes No N/A N/A Procedures used in Training? Yes No N/A	white che	point of	outot	My	vehici	c , + ;	stepped
Were Written Safe Work Procedures Established and Available? Yes No N/A N/A Yes No N/A N/A Yes No N/A N/A Procedures used in Training? Yes No N/A	in a the	Vuta	na tusi	'Stra	Knec		, ,
Established and Available? Yes No N/A No N/A Basic Cause (and Contributory Factors) Explain Fully Unsafe Conditions	11/10/11/0	1001 001	100	-,	. '		·
Established and Available? Yes No N/A No N/A No N/A Basic Cause (and Contributory Factors) Explain Fully Unsafe Conditions							
Established and Available? Yes No N/A No N/A No N/A Basic Cause (and Contributory Factors) Explain Fully Unsafe Conditions			•				
Established and Available? Yes No N/A No N/A Basic Cause (and Contributory Factors) Explain Fully Unsafe Conditions			<u> </u>				
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS	1	cedures		1			
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS	B /		Yes No 1	V/A 🔯		Yes No	N/A 🖸
			EVOLABLE III I V	NOAFE CONDI	TIONS	100= 110=	
Tire vut in gravel		•			HUNS		•
	Tire vu	+ in	9 rave	. (
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∦						, 2	
		,	r				
Ψ	4	•	r				

Corrective Measures Taken and/or Recommended
Vehicle that left thre rut should
in + have parked at opining of parking
1st - Email to all Stuff re parking
rostrictions, WSI NOTHERD TO FUL.
whe - Signage to be posted - NO PARKING
Corrective Action Referred To: Director. Date To Be Completed By Feby 10 /2012
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of person (s) who investigated accident: Assistant Director
TO I I DEPATIONS
1 Sales 1 10-132000 James 1-100 718-482-2077
Print Name & Occupation Phone Print Name & Occupation Phone
JUNE Feb. 10/2012 Jamela Trew Feb. 10/2012
Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)

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	*		
Ministry Childrems family Tol.# Development	Location Burnaby Yuth Services, 7900 FRAS DR. Burnaby B.C.	LUSTOCKY REP. PAPIL	Date of Report Feb. 10/20/2
Last Name of Infured (or III) Person s.22	Firet Nama		File No.
Years of Service Time on Present Joh s.22	Occupation Frogram (officer	Hours Worked in Previous 24 Hour Period 9,58
Accident Location (Dept. or Area) Gym at Burnely Youth Cystady	Date of Accident		Time 20,00hrs
Accident Category (check) Illness	Equipment Motor Malfunction Vehicle	Property Damage	Fire Other (specify).
Severity of injury or illness (check)	☐ No Injury or First Ald Only	Medical Treatment	Time Fatal *
l	a Ring Fire	and the second second	FIGHT Hend VEN/ Dislocated by Doctor
Description of Accident or Employee's Account To Gym Playing Directly o Dislocated Ring May be Broke	saskatball, Bu		Ring Finger
Were Written Safe Work Procedures Established and Available? Yes □ No□ N/A□	Were they Adequate? Yes□ No□ N/A□		Were these Safe Work Procedures used in Training?
Rapic Course (and Contributory Ecotors)	VDI AIN EUU I VIINOAEE PONDIT	10MC	Yes No N/A
Basic Cause (and Contributory Factors) East Accide Holin	SYPLAIN FULLY UNSAFE CONDIT	e Plac	fing

Corrective Measures Taken and/or Recommended	
NA	
Corrective Action Referred To:	Date To Be Completed By:/
Additional Comments or Observations. Where applicable give details etc., involved in this accident. (Use separate sheet if necessary)	of makes & models of machines, equipment, tools, structures,
Name(s) & occupations of person (s) who investigated accident:	Assistant Directors mela Directors Operations 788-452-207
Print Name & Scrupation Phone	Print Name & Occupation Phone
	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number) s.15, s.22	enison

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Ministry Tel.#	Location Ry	1C5		Date of Report	7/12
Last Name of Injured (or iil) Person	First Name			File No.	
s.22		_	· · · · · ·		
Years of Service Time on Present Job	Occupation .	bing Su	PERVISON	Hours Worked in Hour Period	n Previous 24
Accident Location (Dept. or Area)	Date of Accident	N 26/	2812	Time 17	40
Accident Category (check) Illness	Equipment Malfunction	□.Motor Vehlole	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (check)	☐ No Injury or F	First Ald Only	Medical Treatment	Time 7	☐ Fatal *
Nature of Injury or Illness Neck and Sho	Ider p	air			
Description of Accident or Employee's Account	of Occupational Dis	ease (eg. RSI) (rise separate shee	f If necessary)	
Description of Accident or Employee's Account Was mub wed in were Englishing	of Occupational Dis	sease (eg. RSI)	use separate shee	et If necessary) lexits Ti	rat
Was must wed in weve from the weve from the west work Procedures	of Occupational Dis	ra ta	(use separate shee	lents //	e Work
was mis wed in were lighting.	separati	ra tav	(use separate shee	lents 16	e Work

Corrective Measures Taken and/or Recommended	
Nh	
Corrective Action Referred To:	Date To Be Completed By:
Additional Comments or Observations. Where applicable give details o etc., involved in this accident. (Use separate sheet if necessary)	f makes & models of machines, equipment, tools, structures,
Nh	
Name(s) & occupations of person (s) who investigated accident:	Shey1 Husneth ADD 778-452-20
	rint Name & Occupation Phone
Signature of Workers' Representative Date Signature	gnature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	
All the second of the second from the second from the second of the seco	

*if fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

"ychildren & Family Bevelopenent &	<i>4</i> ∙ {	Briwopt	0 Frær 13.C. I 452-20.	- PARKDR 3YCS 50	Date of Report	(2012, 11
Last Name of Injured (or ill) Person	s.22	îrst Name	,		File No.	
Years of Service Time or Present		occupation V	que alkuc	eruisae.	Hours Worked i	n Previous 24
Accident Location (Dept. or Area)		ate of Accident	5/2012		Time 16:3	ohrsi
Accident Category [VInju Inju Illness		Equipment Malfunction	☐ Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (check)		No Injury or F		Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illness Dinny by Ball or Elbou Nose, Accidento	Basket Control	tbell for the for	orgian Loui ca n hiri	in Gyn used g dge of	lasses t	nit to cut
Description of Accident or Employee's A		ccupational Dis	ease (eg. RSI) (use separate sheet	•*	
Were Written Safe Work Procedures Established and Available? Yes No N/A	,	ere they Adequa			Were these Safe Procedures used	Work in Training?
		51_1 NU1_1N/	ALLI		Yes No No N	I/A 🗓
Basic Cause (and Contributory Factors) Accidental Busketbull Caused glas My nose o	w jaml	as h	Ball	ace est	sow u	shich
	•		•			

Corrective Measures Taken and/or Recommended
Corrective Measures Taken and/or Recommended A ciclottal Injury while Playing Sports.
No corrective Measures recommended.
Corrective Action Referred To: Date To Be Completed By:/
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of person (s) who investigated accident: ASSISTANT DIRECTOR BYCS Print Name & Occupation Phone Print Name & Occupation Phone Tan 25 7077 Page 1077 Phone Tan 25 7077
Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (Include phone number)

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-

Ministry Tel.#	Location 7900 Fraser Park	Date of Report
Children of Family	Burnaby BC	Jan 20 2012
Last Name of Inlured (or III) Person	First Name	File No.
s.22	2	
Years of Service Time on	Occupation	Hours Worked in Previous 24
S.22 Present Job	Youth Sugarisor	Hour Period 8
Accident Location (Dept. or Area) Filmess Room - Burnaley Youth Custody Services	Date of Accident Jan 20 20/2	Time 16:00 Hrs
Accident Category	Equipment	☐ Fire ☐ Other
Illness	Malfunction Vehicle Damage	(specify)
Severity of Injury or Illness (check)	No Injury or First Ald Only Medical Treatment	Time Fatal*
Nature of Injury or Illness Ut to left thum	6	
Staff member wa Litness equipment 1	of Occupational Disease (eg. RSI) (use separate she some of Strating a part of a part	Fines of
Were Written Safe Work Procedures Established and Available ✓	Were they Adequate?	Were these Safe Work Procedures used in Training?
Yes No N/A	Yes No N/A	Yes No N/A
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDITIONS	
Loose Splmte. Ceil to th	of metal car	est

Correctiv	e Measures Taken and/or Recommended
	REPAIR FOR REPLACE PULL DOWN BAR.
	AS SOON AS
Corrective	e Action Referred To: PROGRAMS SUPPOLISAL Date To Be Completed By: 1 POSS VBLIS
etc., invol	l Comments or Observations. Where applicable give details of makes & models of machines, equipment, fools, structures, led in this accident. (Use separate sheet if necessary)
-7	Piece of Fitness equipment
- K	Piece of Fitness equipment letal bar used for polling weight:
	formy weight
Name(s)	& occupations of person (s) who investigated accident:
	7001660.2004
1	VATSON F18-452-2050 B.SHOKAR 778-452-2050 Phone Print Name & Occupation Phone
1	JAN 20/2 B. Shohar San 20/2012
Signature	of Workers Representative Date Signature of Employer Representative Date
7.7	
Name(s)	of Witness(s) (include phone number)
/	Vo witnesses. Might be visible on
	DVR.

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry	Tel.#	Location		Date of Report	_	
	l			January	3 2012	
Last Name of Injured (or ill) Pe	erson	First Name		File No.		
	s.22					
Years of Service	Time on	Occupation		Hours Worked in	n Previous 24	
· s.22	Present Job Yorth Supervisor		Hour Penou			
Accident Location (Dept. or Area)		Date of Accident		Time	Time	
Elkhorn Unit		Janvary 2 20	II	1100 hrs		
Accident Category	☐ Injury or	Equipment Motor	Property	Fire	Other	
(check)	-Illness	Malfunction Vehicle	Damage		(specify)	
Severity of Injury or Illness (ch	neck)	No Injury or First Aid Only	☐ Medical	☐ Time	☐ Fatal *	
	,	M NO IIIJury or First Aid Oray	Treatment	Loss		
	Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) During a restraint slipped on floor and banged tines					
Were Written Safe Work Prod	cedures	Were they Adequate?	` .	Were these Sat	fe Work	
Established and Available? Yes No No N/A		Yes No N/A	Yes No No N/A		Procedures used in Training?	
				Yes No D		
Basic Cause (and Contributor	y Factors)	EXPLAIN FULLY UNSAFE COND	ITIONS			
. A	Slif Youth.	explain fully unsafe condi	while V.	lestrain-	7	

Corrective Measures Taken and/or Recommended
None
Corrective Action Referred To: Date To Be Completed By:/
Date 10 be completed by
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)
Worl
Name(s) & occupations of person (s) who investigated accident: Sanoly '42-205 Mathew Annan A, D 718-452-2650 Print Name & Occupation Phone Print Name & Occupation Phone Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)
s.15, s.22 778 452 295 /

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Ministry	Tel. #	Location By	CS-EM	renalD.	Date of Report	1/12
Last Name of Injured (or ill) Person		First Name			File No.	
Years of Service	Time on Present Job s.22	Occupation Solon Youth Salbavisol.		Hours Worked in Previous 24 Hour Period /2		
Accident Location (Dept. or Area) EMEAHLD GHIT		Date of Accident		Time 1959		
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (ch	éck)	No Injury or I	First Aid Only	Medical Treatment	Time Loss	Fatal *
Nature of Injury or Illness SMALL S	RATCH	70	LEFT	"Thum	В	
Description of Accident or Emp Dushyla USED FIN	265 CM	MIT OF	= A		, - Ros	sida)7 Jurril
Were Written Safe Work Proce Established and Available? Yes No N/A	edures	Were they Adequate? Yes □ No □ N/A □		Were these Safe Work Procedures used in Training?		
Test Not N/AL				_	Yes No N/A	
Basic Cause (and Contributory	Factors) E	XPLAIN FULLY UI	NSAFE CONDIT	TIONS		

Corrective Measures Taken and/or Recommended	
Nonk.	
Corrective Action Referred To: Date To Be	Completed By:/
Additional Comments or Observations. Where applicable give details of makes & mo	odale of machines aguinment tools structures
etc., involved in this accident. (Use separate sheet if necessary)	naels of Machines, equipment, tools, structures,
Name(s) & occupations of person (s) who investigated accident: Levyson Kopk as F 720452 zon a Market Print Name & Occupation Phone Print Name & Signature of Workers' Representative Date Signature of En	Occupation Phone Manual 18432-2050 Occupation Phone Manual 1000 Date
Name(s) of Witness(s) (include phone number)	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

PSC 38

Ministry Tel. #		Location B4C5		Date of Report $\Delta \epsilon c$ 30	0 2011	
Last Name of injured (or ill) Person		First Name			File No.	
s.22		I				
Years of Service s.22	Time on Present Job	ob YOUTH SUPERVISOR			Hours Worked in Previous 24 Hour Period 75 DEC 29/11	
Accident Location (Dept. or Area) BYCS ROTUNDA STAIRS. Date of Accident 30, 20/1			Time 1900 HBS.			
Accident Category (check)	injury or Illness	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (ch	neck)	☐ No Injury or	First Aid Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illness LEFT KNEE B SAW CGUTRE	NURSE	- REMAINS	UNSTHBLO 8.22	· .		
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) WHILE WALKING A FILLBUT OF STAIRS IN THE BYCS ROTUNDA THE LEFT KNEE BUCKLED & REMAINED WILSTABLE.						
Were Written Safe Work Prod Established and Available?	cedures	Were they Adequate?			Were these Safe Work Procedures used in Training?	
Yes No NA		Yes No N/A		Yes No N/A		
Basic Cause (and Contributor	y Factors)	EXPLAIN FULLY U	INSAFE CONDI	TIONS		

Phase 2 . Page 57 CFD-2013-00082

Corrective Measures Taken and/or Recom	mended		
•			
	•	•	
orrective Action Referred To:			
		1	
dditional Comments or Observations. Whatc., involved in this accident. (Use separa	nere applicable give deta te sheet if necessary)	ails of makes & models of machines, equip	ment, tools, structures,
dditional Comments or Observations. Wh	nere applicable give deta te sheet if necessary)	ails of makes & models of machines, equip	ment, tools, structures,
c., involved in this accident. (Use separa	te sheet if necessary)	ails of makes & models of machines, equip	oment, tools, structures,
c., involved in this accident. (Use separa	investigated accident:	,	
ame(s) & occupations of person (s) who	investigated accident:	A/ADO DARRYC WALUACE Print Name & Occupation	
ame(s) & occupations of person (s) who rint Name & Occupation	investigated accident: 278-452-2050 Phone	A/ADO DARRYC WALLACE	778-452-20sã
ame(s) & occupations of person (s) who person with your snaw rint Name & Occupation	investigated accident:	A/ADO DARRYC WALLACE	778-452-20sã
ame(s) & occupations of person (s) who person with your snaw rint Name & Occupation	investigated accident: 278-452-2050 Phone	Print Name & Occupation	778-452-2050 Phone
ame(s) & occupations of person (s) who rint Name & Occupation Ignature of Workers' Representative ame(s) of Witness(s) (include phone num	investigated accident: 278-452-2050 Phone Dec 304 Date	Print Name & Occupation	778-452-2050 Phone
ame(s) & occupations of person (s) who rint Name & Occupation gnature of Workers' Representative	investigated accident: 278-452-2050 Phone Dec 304 Date	Print Name & Occupation	778-452-2050 Phone
ame(s) & occupations of person (s) who rint Name & Occupation Ignature of Workers' Representative	investigated accident: 278-452-2050 Phone Dec 304 Date	Print Name & Occupation	778-452-2050 Phone

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

· · · · · · · · · · · · · · · · · · ·						· ·
Ministry MeK	Tel.#	Location	3405		Date of Report	4/2011
Le ·	s.22	I	•		File No.	•
Years of Service s.22	Time on Present Job	Occupation	t SUPEK	ensor	Hours Worked I Hour Period	n Previous 24
Acadent Location (Dept. or Ar	ea)	Date of Accident	23/1	7	Time Z/O	0
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of injury or illness (ch	eck)	☐ No Injury or	First Ald Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illness A	HILES	TENDO	W 8th	HW		
Description of Accident or Em HYTER SUPE	NUSING	644 P	No f No	4, ler	T ACHIL	ES
Were Written Safe Work Proc Established and Available?	edures	Were they Adeq	1-/		Were these Saf Procedures use	
Yes No N/A		Yes No No No	V/AIZI		Yes□ No□	N/ACK
Basic Cause (and Contributor		EXPLAIN FULLY L	INSAFE CONDIT			

Phase 2 Page 59 CFD-2013-00082

		· · · · · · · · · · · · · · · · · · ·
Corrective Measures Taken and/or Recommended		
tlow		
None		
	•	
		\ \
Corrective Action Referred To:	Date To Be Complete	ad By:
Conective Action (Aelenett 10.	Date to be complete	м ру
Additional Comments or Observations. Where applicable giv	e details of makes & models of m	achines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necess	ary)	
None		
	*	
Name(s) & occupations of person (s) who investigated accid	ent:	
M. Should 271.472.71	579 PNL/1661	1 178.452 2080
Print Namy & Occupation Phone	Print Name & Occupation	·
	Y 11	De 4/11
Street Sold Representative Del 9/11	Signature of Employer D	oprocentative Date
Signature of Workers' Representative Date	Signature of Employer R	epresentative Date
Name(s) of Witness(s) (include phone number)		

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry Hin Childre I	Tol. #	Location R4C	. ς		Date of Report	18/2011
Last Name of Injured (or iii) Perso		First Name			File No.	/
	s.22	,	**************************************			
	me on resent Job	Occupation C. C) -		Hours Worked in Hour Period	n Previous 24
Accident Location (Dept. or Area)		Date of Accident	<i>1</i>		Time 12:4	5
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (check))	No Injury or I	First Aid Only	Medical . Treatment	Time Loss	☐ Fatal*
Nature of Injury or Illness	Knee					
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) TWIST LEFT IZNEE WHON RESIDUOTUG TO LODE						
Were Written Safe Work Procedur Established and Available?	res	Were they Adequ			Were these Safe Procedures used	Work in Training?
Yes No N/A		Yes No N	!/AL_		Yes□ No□ i	N/A□
Basic Cause (and Contributory Fac	ctors) E	EXPLAIN FULLY UI	NSAFE CONDIT	IONS		

Corrective Measures Taken and/or Recor	nmended		
	/V	one	
Corrective Action Referred To:		Date To Be Completed By:	
Additional Comments or Observations. Wetc., involved in this accident. (Use separ	ate sheet if necessary)	iis of makes & models of machines,	equipment, tools, structures,
Name(s) & occupations of person (s) who	*	2051 Mafter An	nan 18-452-2051
Print Name & Occupation	Phone	Print Name & Occupation	Phone // ///
Signature of Workers' Representative	Date /	Signature of Employer Represent	ative Date
Name(s) of Witness(s) (Include phone nur	nber)		
	s.15, s.22		
	178 452	2051	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry Min Mildue	Tel.#	Location \mathcal{B} \forall	65		Date of Report	9/2011
Last Name of Injured (or ill) P	•	First Name	-		File No.	
	s.22					
Years of Service	Time on Present Job	Occupation .	•		Hours Worked In Hour Period	n Previous 24
Accident Location (Dept. or A	rea)	Date of Accident	19/20	17.	Time /Z.u	15
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of injury or Illness (ci	neck)	☐ No Injury or	First Ald Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of injury or illness						
	7	aek				
	K	respond	1/2 /a	lode		
Were Written Safe Work Pro Established and Available?	cedures	Were they Adeq	·		Were these Safe Procedures use	e Work d in Training?
Yes No No N/A		Yes No No	WALL .		Yes No	n/A 🎞
Basic Cause (and Contributo	ry Factors) I	EXPLAIN FULLY U	INSAFE CONDI	TIONS		
		Tw 151			Dhoc	e 2 Page 63
<u> </u>		· · · · · · · · · · · · · · · · · · ·				2013-00082

Corrective Measures Taken and/or Recomm	rended		-	
				, ·
	4		* .	
	Alba	\mathcal{M}_{\bullet}		
		Nove	••	
	-			
		·		
			•	
Corrective Action Referred To:	,	Date To Be Complete	ed By:	
	•			
Additional Comments or Observations. Whe	re applicable give deta	ils of makes & models of m	achines, equipment,	tools, structures,
etc., involved in this accident. (Use separate	sheet if necessary)			
		•	·	
			· · · ·	
Name(s) & occupations of person (s) who in	vestigated accident:	•		•
163500CY,	10778915	205 Matthew As	nnia 718	-452-2051
Print Name & Occupation	Phone	Print Name & Occupation		/3 2 / 2 / 5 / hone
	1.			
40	Ne1.19/200			OV/19/11
Signature of Workers' Representative	Date /	Signature of Employer Re	presentative	Date
Name(s) of Witness(s) (include phone numb	er)			
	s.15, s.22	·		
	,			
7 -~	452	205-1		
778	452		• •	
			·	•

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

	·		
Ministry 778-452-250 Tel. #	Location		Date of Report
CHILDREN + FAMILIES	7900 TAA SA	2011.118	
Last Name of Injured (or III) Person s.22	First Name		File No.
Years of Service Time on Present Job	Occupation COLLECTIONS	OFFICER	Hours Worked in Previous 24 Hour Period // 5
Accident Location (Dept. or Area)	Date of Accident	•	Time
COURTYARD 2	2311-11-18		1930
Accident Category Injury or Illness	Equipment Malfunction Ve	otor Propert	
Severity of Injury or Illness (check)	☐ No Injury or First Aid	Only	
Nature of Injury or Illness DULLEO LOUSE BACK	SEPARATING	3 yourns	PIGHTING,
LISTARF MANARO ALIL	IN FOR DANK	1 11 M Dust	sheet if necessary)
STAPF MEMBER CALL			- HAD TO ATTEMPT
Were Written Safe Work Procedures			HAO TO ATTEMPT THIRD. Were these Safe Work
TO BREAK up 2 you	MUS ASSAUL		HAD TO ATTEMPT. THIRD.

Corrective Measures Taken and/or Recommended	
Abre	
Corrective Action Referred To:	Date To Be Completed By: /
Additional Comments or Observations. Where applicable give detailetc., involved in this accident. (Use separate sheet if necessary)	ils of makes & models of machines, equipment, tools, structures,
Name(s) & occupations of person (s) who investigated accident:	
1.18 8000 GT 778457 2051	J.HARRIS 778-452-2050
Print Name & Occupation Phone	Print Name & Occupation Phone
Signature of Workers' Representative Date	Signature of Employer Representative Date
Name(s) of Witness(s) (Include phone number)	
DVD recorded.	

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry MCFD	Tel.# Location	100		Date of Report	1 -
1000		${}$		· 11:100	114
La	.22	•		File No.	
	.22				· · · · · · · · · · · · · · · · · · ·
Years of S Time on Present s.22	111	Super	21/150R	Hours Worked in Hour Period の630	Previous 24
Accident Location (Dept. or Area)	Date of Accident			Time	
MPRZ	2 18/11	116		150	5
Accident Category Injur	y or Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
	iviality lollori	Venicie	Damago		
Severity of Injury or)Illness (check)	No Injury or	Irst Ald Only	Medical Treatment	Time Loss	L Fatal*
Nature of Injury or Illness					
JAMMED (RT) THUN	B			*
Description of Accident or Employee's A	ccount of Occupational Di	sease (eg. RSI) (use separate shee	t if necessary)	
While Se	parching	a V	ig Il in	MP.	RZ
s.22	jammed.	his f	Rumb (14.).	
Were Written Safe Work Procedures Established and Available?	Were they Adequ			Were these Safe Procedures use	
Yes 🗹 No 🗆 N/A 🗆	Yes No No	v∧Ll		Yes No No	N/A 🗆
Basic Cause (and Contributory Factors)	EXPLAIN FULLY U	NSAFE CONDIT	IONS		
Cla	*	Jews	Oning	Yo Se	paralle
ky.	s.22 (v				
2 resido	nt wh	ile a	light	Yng Co	ensed
Lasial,)			
	NNM				
V		· · · · · · · · · · · · · · · · · · ·			e 2 Page 67 2013-00082

Corrective Measures Taken and/or Recommended	^
As disussed y	newed by both
	s.22
if was recommen	ded that intervention
Should not occur	until back-up
Anomoder assist.	s.22 acknow Cedge
responders arrive	the DURCE S.22
Corrective Action Referred Te:	Date To Be Completed By:/
(AS above	٤)
75.00	
	etails of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)	
C/A.	
2 1/0	
Name(s) & occupations of person (s) who investigated accident:	
778-1573	A CRC - M
Print Name & Occupation Phone	В. В. See п-) Aurs 778-452-2050 Print Name & Occupation Phone
	d. Olll 0 112
Simply - OM-1 and Barrens till	Afford iffe !!
Signature of Workers' Representative Date	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	8.

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

		•			
Ministry CHILDREN & FAL		Location BYCS BURNABY	B. C.	Date of Report	11/03
DEVELOPME	:या			2011	((0)
Last Name of Injured (or III) Person		First Name		File No.	
	s.22				
Years of Service Time		Occupation		Hours Worked i	n Previous 24
s.22 Pres	sent Joh s.22	PROSPAM O	TECH!	Hour Period	12_
Accident Location (Dept. or Area)		Date of Accident		Time	
ROTUNDA.	•••	2011/11/0		135	30:
Accident Category	Injury or	☐ Equipment ☐ Motor	☐ Property	☐ Fire	Other
(check)		· Malfunction Vehicle	Damage	L-L FIIB	(specify)
				,	(opecay)
Severity of Injury or Illness (check)		No Injury or First Aid Only	Medical . Treatment	Time Loss	L Fatal *
Nature of Injury or Illness				<u> </u>	
	LEFT	HEAL - SHA	RP PAIN	1 WHE	N
			rued.		
Description of Accident or Employee	's Account o	of Occupational Disease (eg. RSI)	(use separate shee	t if necessary)	
RUNNING	(77)	STAIRS RESI	SONDING	70	
		1			
CODE 16	LEON	JASH TIM - L		(0)	
Were Written Safe Work Procedures Established and Available?	3	Were they Adequate?		Were these Safe Procedures used	
Yes No No N/A		Yes No N/A			
	· · ·			Yes No	N/AL_]
Basic Cause (and Contributory Factor	ors) E	XPLAIN FULLY UNSAFE CONDI	TIONS		
ACCI	シミジー	TAC			
				:	· · ·
		·			:

	Corrective Measures Taken and/or Recommended
	ACCIDENTAL INJURY.
-	Corrective Action Referred To: Date To Be Completed By:
-	Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures,
•	etc., involved in this accident. (Use separate sheet if necessary)
	Name(s) & occupations of person (s) who investigated accident:
	PAUL TIFFIN 728/452/2020M-Streety 778-472-2079
	Print Name & Occupation Phone Print Name & Occupation Phone
·	Signature of Workers' Representative Date Signature of Employer Representative Date
	Name(s) of Witness(s) (include phone number)
,	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Ministry MCD Tel.	# Location BURNABY WITH	Date of Report
Last Name of Injured (or III) Person	First Name	File No.
s.22		
Years of Service Time on Present Job	Occupation Court Swennigor	Hours Worked in Previous 24 Hour Period
Accident Location (Dept. or Area)	Date of Accident	Time
Accident Category	Equipment D Motor D Property Malfunction Vehicle Damage	Fire Other (specify)
Severity of injury or Illness (check)	No Injury or First Ald Only Medical . Treatment	☐ Time ☐ Fatal * Loss
Nature of Injury or Illness TW 51ED	RIGHT FARE	
Knee and "loc Mastant in Mig.	unt of Occupational Disease (eg. RSI) (use separate show NIE WIT, Pulled door head from head fro	was
Were Written Safe Work Procedures Established and Available?	Were they Adequate?	Were these Safe Work Procedures used in Training?
Yes No N/A	Yes No N/A	Yes No N/A
Basic Cause (and Contributory Factors) This (Heat while of our our of the out of the ou	explain fully unsafe conditions reumy door and the	The para
		Phase 2 Page 71 ————————————————————————————————————

	· · · · · · · · · · · · · · · · · · ·		•
Corrective Measures Taken and/or Recommen	ded		
NA			
Corrective Action Referred To:		Date To Be Completed By: /	· · · · · · · · · · · · · · · · · · ·
Additional Comments or Observations. Where a stc., involved in this accident. (Use separate sh	applicable give details (eet if necessary)	of makes & models of machines, equipme	nt, fools, structures,
Nove			
Name(s) & occupations of person (s) who inves	tigated accident:		
Print Name & Occupation Nov	Phone 7	Print Name & Occupation	Phone () () ()
Signature of Workers' Representative	Date S	Ignature of Employer Representative	Date
Name(s) of Witness(s) (include phone number)			
s.15, s.22			i.

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

JUNT ACCIDENT INVESTIGATION FOLL

F3C 30							
Ministry Tel.# M CF 778-452-2050		Location Burnaby		Date of Report			
Last Name of Injured for ill December		First Name		File No.			
Lastit							
Years of Service	Time on Pracant Inb				Hours Worked in Previous 24 Hour Period 7		
Accident Location (Dept. or Area)		Date of Accident Of 4/207/			Time 19 20		
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	Fire	Other (specify)	
Severity of Injury or Illness (cl	neck)	☐ No Injury or	First Aid Only	Medical Treatment	Time Loss	☐ Fatal *	
Nature of Injury or Illness Playing Basket ball Jammed @PINKY. Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) White playing basket ball intu ggm; the ball Jamma my het Pinky Roger							
				(119)	Were these Sa		
Were Written Safe Work Pro Established and Available?	ocedures	Were they Adequate?		Procedures used in Training?			
Yes No No N/A	Yes No No N/A		Yes No N/A				
1	Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS						
Ball hithing my fire er							

Corrective Measures Taken and/or Recommended	
Conscieve integratics Taxon and of Trosonimonaes	
. (A	
NA	
· ·	
·	•
Corrective Action Referred To:	Date To Be Completed By:/
Additional Comments or Observations. Where applicable give detail	s of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)	
· / /	
NA	
	<u>, </u>
	· · · · · · · · · · · · · · · · · · ·
Name(s) & occupations of person (s) who investigated accident:	
TC 11	
Print Name & Occupation Phone	Print Name & Occupation Phone
M/10 Det 4/2011	1)906 1808 00 5/11
Signature of Workers' Representative Date	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	
•	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

2SC 38

Ministry Tel.# M CF 778-452-7000		Location Burnaby		Date of Report OCT 4/2011		
Last Name of injured (or ill) Person		First Name			File No.	
Years of Service	Time on Present Joh s.22	Correction officer			Hours Worked in Previous 24 Hour Period	
Accident Location (Dept. or Area)		Date of Accident OCT 3/2011		Time 1600		
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	Fire	Other (specify)
Severity of Injury or Illness (che	eck)	☐ No Injury or	First Aid Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illness Bash across	: nose /	Beye	Impeo	ted by	Soccon	r peell
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) Blocking a Shot / Goalre. fall hit The Side of his head						
Were Written Safe Work Proc	edures	Were they Adequ	uate?		Were these Sar	
Established and Available? Yes No No N/A		Yes No No N/A		Procedures used in Training? Yes No N/A		
Basic Cause (and Contributory	r Factors)	EXPLAIN FULLY U	NSAFE CONDI	TIONS	<u> </u>	-
Ball hitting s.22 in The head				read		
		•	·			

Corrective Measures Taken and/or Recommended
$\mathcal{V} / \mathcal{T}$
Corrective Action Referred To: Date To Be Completed By:/
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)
\mathcal{V}/\mathcal{A}
Name(s) & occupations of person (s) who investigated accident:
TSac16 1 778-452-2050
Print Name & Occupation Phone Print Name & Occupation Phone
Signature of Workers' Representative Date Date Date Date Date
Name(e) of Witnese(e) (include phone number)
s.15, s.22

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office

Tel.#	Location BURNABY YOUTH CUSTODY SERVICES			Date of Report	30/11	
Person	First Name	s.22		File No.		
s.22					<u> </u>	
Time on Present Job s.22	Occupation 6AZ			Hours Worked In Previous 24 Hour Period 7.78-		
Accident Location (Dept. or Area) PHCS OUTER PARKING LOT			SEPT 29 / II			
Illness	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)	
heck)	☑ No Injury or €Ir	st Ald Only	Medical Treatment	Time Loss	☐ Fatal *	
Nature of Injury or Illness INJURED ® KNEE, ® ANKLE, ® HIP /GLUTEOUS. SORENESS IN MID BACK AREA						
WALLING THROUGH PARKING STALL, STEPPED UP TO CURB, GRASS AREA WITH @ FOOT, SUPPED ON WET GRASS AND FELL ON KNEE @ & @ HIP AREA. SORE HAND AS WELL FROM BREAKING MY FALL.						
		₽ E A :	sore Ha	NOAS	J∈N_	
	Y FAU.	te?	SORE HA	Were these Safe	→ Work	
tking M	Y FAU.	te?	SORE HA	Were these Safe	Work	
cedures	Y FAU.	te?		Were these Safe	Work	
	Time on Present Job s.22 Area) LOT Minjury or Illness Check) TO RED SPENESS mployee's Account THROUGH WITH @	Person First Name s.22 Time on Present Job s.22 Area) Date of Accident SE Minjury or Equipment Malfunction Check) Mo Injury or First Name SE Minjury or Date of Accident SE Minjury or III Equipment Malfunction Check) Mo Injury or First Name The Count of Occupational Diserter Check PARKING WITH © FOOT, S	CUSTODY SERV Person First Name s.22 S.22 Time on Present Job s.22 Area) Date of Accident SEPT 29 Minjury or Equipment Motor Vehicle Check) Mo Injury or First Aid Only IN JURED R KNEE, R AND SPENESS IN MID BACK Imployee's Account of Occupational Disease (eg. RSI) of the County of County STATE WITH ROUGH PARKING STATE WITH ROUGH FOOT, SUPPED	CUSTODY SERVICES Person First Name s.22 S.22 Time on Present Job s.22 Area) Date of Accident SEPT 29 / II Minjury or Equipment Motor Property Illness Malfunction Vehicle Damage Sheck) MNo Injury or First Aid Only Medical Treatment INJURED PROPERTY ANKLE, PARKLE,	CUSTODY SERVICES SEPT Person First Name S.22 File No. S.22 Time on Present Job S.22 Area) Pate of Accident RKIDK LOT Date of Accident SEPT 29 / II Property Illness Malfunction Vehicle Damage Check) Mo Injury or First Aid Only Medical Treatment Loss INJURED REPT GRANKLE RHP/GWTT SPENESS IN MID BACK AREA Imployee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) THROUGH PARKLING STAM STEPPED UP TO	

	Corrective Measures Taken and/or Recommended
	ENSURE FOOTWEAR IS IN GOOD WORKING ORDER
	AND CONDITION AS TO PROVIDE GRIP TO GROUND,
,	Corrective Action Referred To: Date To Be Completed By:/
-	
	Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)
	NA
	Name(s) & occupations of person (s) who investigated accident:
	TODD WATSON 2778-452-2050 CAKLA DEVITA 778-452-2058.
	Print Name & Occupation Phone Print Name & Occupation Phone SEPT 30/11
,	Signature of Workers' Representative Date Signature of Employer Representative Date
	Name(s) of Witness(s) (Include phone number)

^{*}if fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

PSC 38

Ministry	1					
l	Tel.#	Location	, r		Date of Report	
Choldren E. Families					Sept. 2	4,2011
Last Name of Injured (or III) Person		First Name		•	File No.	
	s.22					
Years of Service Time on Present Job		Occupation .	Super	112	Hours Worked in Hour Period	n Previous 24
Accident Location (Dept. or Area)		Date of Accident	Suppor	NSDE	Time	
Accident Location (Dept. of Area)	•	Date of Accident			Time	
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of injury or Illness (check)		No Injury or F	First Ald Only	Medical Treatment	Time Loss	☐ Fatal*
Nature of Injury or Illness STRAINED RI	1 _ (²./ / 3 .				
Description of Accident or Employee Hurt Right Youth Invo	156	houlder	TRYIN	TO V	estRAIN	A
	lved	IN A	physic	AC AC	1-41 22476 65	
Were Written Safe Work Procedure Established and Available?		Were they Adequ	uate?	AC AC	Were these Safe	e Work
Were Written Safe Work Procedure			uate?	AC AC	Were these Safe	e Work d in Training?

CFD-2013-00082

	* T	
Corrective Measures Taken and/or Recom	mended	
	•	
	•	
	•	
	•	
	•	
Corrective Action Referred To:		Date To Be Completed By:/
	· · · · · · · · · · · · · · · · · · ·	
Additional Comments or Observations. Wheelc., involved in this accident. (Use separa	ere applicable give deta	ails of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Ose separa	to sheet if hecessary)	
	•	
Name(s) & occupations of person (s) who i	nvestigated accident:	la la companya di salah sa
MILLI Am	118-452-203	Mata 1
Matthew Annan		
Print Name & Occupation	Phone	Print Name & Occupation Phone
P. Marshy	Sept 24/11	
Signature of Workers' Representative	Date	Signature of Employer Representative Date
	· · · · · · · · · · · · · · · · · · ·	
Name(s) of Witness(s) (include phone num	iber)	
	• •	
	. •	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry 718-452-205 Pel.	* Location 7900 FRASER PARK INCIVE BURNABY B. C- V5I-SHI	Date of Report Sept 21/2011				
Last Name of Injured (or ill) Person	First Name	File No.				
s.22						
Years of Service Time on Present Job	Occupation Supervisor	Hours Worked in Previous 24 Hour Period 75				
Accident Location (Dept. or Area)	Date of Accident Sept 21/2011	Time 10:00 Am.				
Accident Category Injury or	Equipment Motor Property Malfunction Vehicle Damage	Fire Other (specify)				
Severity of Injury or Iliness (check)	No Injury or First Aid Only Medical . Treatment	Time Fatal*.				
Nature of Injury or Illness - BACK (L	outer)					
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) STRAMED LOWEN BACK DURING CHERWING						
Were Written Safe Work Procedures Established and Available?	Were they Adequate?	Were these Safe Work Procedures used in Training?				
Yes No No N/A	Yes No N/A	Yes No N/A				
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS						
Restraint training class of twistings;						
Uncomfortable movements, twisting						
fight & S	ORE	.Phase 2 Page 81 CFD-2013-00082				

Corrective Measures Taken and/or Recommend	ded	
MA		
Corrective Action Referred To:		Date To Be Completed By:/
etc., involved in this accident. (Use separate sh	eet if necessary)	s of makes & models of machines, equipment, tools, structures,
Stuff seen by H	ealtha	re and healthcare, to go have and
recommended	stufet	, 40 go name and
We & heat	2 13F	profren taken, Rest,
	-	
Name(s) & occupations of person (s) who invest	igated accident: <	
		Tamelia ADD Septial 201
Print Name & Occupation	Phone	Print Name & Occupation Phone
	$\underline{\hspace{1cm}}$	Sanota New Sept 21/2011
Signature of Workers' Representative	Date	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)		
s.15, s.22		

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

100 30		• • •			•	
Ministry MCF	Tel.#	Location Bus	nalsej		Date of Report	7/2011.
Last Name of Initired for III) Pers	enn -	Firet Name			File No.	
	s.22					
,,	Time on Present Job s.22	Occupation ON COT	tional.	officer	Hours Worked in Hour Period	n Previous 24
Accident Location (Dept. or Area Glace Unit		Date of Accident	1/2011		Time 0 \$4	<i>t</i> 3
	Injury or	Equipment Malfunction	☐ Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (chec	:k)	☐ No Injury or I	First Ald Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illness Small Cut Under Chin Linch / Neck back						
Description of Accident or Emplo	ovee's Account	of Occupational Dis	sease (eg. RSi)	fuse separate shee	et if necessary)	
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) While directions a youth to his room another youth						
Threwa bowl of Cernal at 5,22 and					M	
HUEK hin	n on	the chi	h			
Were Written Safe Work Proced Established and Available	lures	Were they Adequ			Were these Safe Procedures used	
Yes No No N/A		Yes No No	I/A 🔲		Yes No	N/A□
Basic Cause (and Contributory F	actors) E	EXPLAIN FULLY U	NSAFE CONDIT	TIONS ,		
The other 4	outh	stuck	_ his	nose in	nan ir	reiduit
that didn						
				1.0		
	. · · · · · · · · · · · · · · · · · · ·					

Corrective Measures Taken and/or Recommended	
Corrective Action Referred To:	Date To Be Completed By:
Additional Comments or Observations, Where applicable give date	ille of maken & models of machines, equipment, feels attractures
Additional Comments or Observations. Where applicable give deta etc., involved in this accident. (Use separate sheet if necessary)	ills of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Ose separate sheet it necessary)	
Name(s) & occupations of person (s) who investigated accident:	
T. Coult	
1 Sacy A 778 45 20 2050	
Print Neyrig/& Occupation Phone	Print Name & Occupation Phone
MAG ATO	
/11/4/1/1	SQT17/20/1
Signature of Workers' Representative Date	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	
Trainers of Thireself (Instage Priorie Trainer)	
ancia in Glacker	
and in amoior	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry MCF BYCS 798	Tel.#	Location Bwaby	Date of Report Sup + 19 (2011)
Li	s.22	12 40.000,00	File No.
	me on resent Job	Occupation . SWFT SUPINV	Hours Worked in Previous 24 Hour Period
Accident Location (Dept. or Area)		Date of Accident Sept-19 2011	Time 2011
	Unjury or	Equipment	operty
Severity of Injury or Illness (check	k)	No Injury or First Aid Only Trea	edical Time Fatal*
Nature of Injury or Illness (P Knce/(R) <	shoulde	r Osidi of nee	le
During a escur testamed to 8711 had a	othe hold !	k his knee to t	neh los sery unto
Were Written Safe Work Proced Established and Available? Yes No N/A		Were they Adequate? Yes□ No□ N/A□	Were these Safe Work Procedures used in Training? Yes□ No□ N/A□
			

	Corrective Measures Taken and/or Recommended
	Practice Physical restrants and practice TCI
	practice TCI
	Corrective Action Referred To: Date To Be Completed By: /
	Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures,
	etc., involved in this accident. (Use separate sheet if necessary)
.	
.	
	Nama(a) & gazinations of paragraph (a) who Invadilizated at 14-15
	Name(s) & occupations of person (s) who investigated accident: TSAUGHO THE TRUETORY SHOWER AND ARCHET TOTAL
1	Print Name & Occupation Phone Print Name & Occupation Phone
	Myll Septiakui Budpak ADO Septialso1
	Signature of Workers Representative Date Signature of Employer Representative Date
ŀ	
ŀ	Name(s) of Witness(s) (include phone number)
	s.15, s.22
L	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & Phase 21 Properties

PSC 38

Ministry Tel.#	Location		Date of Report
THE MONTH of Children's CHAMILIES	BURNIBY		Aug 29/201
Last Name of Injured (or ill) Person	First Name		File No.
s.22		<u> </u>	
Years of Service Time on Present lob s.21	Occupation SUPERI	/lsox	Hours Worked in Previous 24 Hour Period
Accident Location (Dept. or Area) WHILE DN ISSP - WMMVNITY.	Date of Accident August 28	2011	Time 1500
Accident Category Injury or Illness	Equipment Motor Malfunction Vehicle	Property Damage	Fire Other (specify)
Severity of injury or lilness (check)	No injury or First Aid Only	Medical Treatment	Time Fatal*
Description of Accident or Employee's Account Went to bet on Bike, Foot BACKWALDS Rec	of Occupational Disease (eg. RSI) (SLIPPED of PedONE	use separate shee	tifnecessary) This on Right:
Were Written Safe Work Procedures Established and Available?	Were they Adequate?		Were these Safe Work Procedures used in Training?
Yes No No N/A	Yes No NA		Yes No N/A
	EXPLAIN FULLY UNSAFE CONDIT	IONS	
Biké mishap No un	sofe convirions		

Phase 2 . Page 87 CFD 2013 00082

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Corrective Measures Taken and/or Recommended	
Noné	
Corrective Action Referred To:	Date To Be Completed By:
Additional Comments or Observations. Where applicable give details of	makes & models of machines, equipment, tools, structures
etc., involved in this accident. (Use separate sheet if necessary)	marios a moders of madilines, equipment, toda, sudduliss,
Name(s) & occupations of person (s) who investigated accident:	
VIBEKE SKROMBREN SYS 778-452-2050 -	TAGOLUIS HARRIS 778-452-2050
Print Name & Occupation Phone Pr	int Name & Occupation Phone
Nitre Aromy 798-452-2050	negues Harris 778-452-2350
Signature of Workers' Representative Date Signature	nature of Employer Representative Date
Name(s) of Witness(s) (include ahone number)	
s.15, s.22, s.79	

*if fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry 778-452-3		Location Burn	naby Yuu	Hr Custody	Date of Report	
CÉF Devel	aponient	Burnety	iser park B.C. VSJ-	HI CUSTOCY EDINE SHI	August . 6	7/2011
Last Name of Injured (or ill) P	erson	First Name			File No.	
	s.22	 				· · · · · · · · · · · · · · · · · · ·
Years of Service s.22	Time on Present .loh s.22	Occupation Youth 5	ilperu is	OR 1	Hours Worked i Hour Period	n Previous 24
Accident Location (Dept. or A BYCS, ASPENTY OPEN CUSTO	unit	Date of Accident	1001	1	Time 1513	31 pm
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (cl	neck)	No Injury or	First Ald Only	Medical Treatment	Time Loss	Fatal *
Nature of Injury or Illness FEST RUNNY (bulbal Beduve	inodor	wh!	/owerb	owk w	nie.
Description of Accident or En						
Strainal	midd	le lor	nerloo	el w	hile re	Strainin
and lift	ind o	r com	bativ	e you		,
		•	•	,		,
Were Written Safe Work Pro Established and Available?	cedures	Were they Adequ			Were these Saf Procedures use	
Yes No NA	٠	Yes No D	v/A□		Yes No No	N/A 🗆
Basic Cause (and Contributo	ry Factors) I	EXPLAIN FULLY U	INSAFE CONDI	TIONS		
Rostraining volatile and combative youth. Strained middle Lower back						Q.,
Hury	. Stra	whol	mide	de lo	WET	back
while	Uptio	y res	tusbiz	T 40 '	nor ro	ma.

Corrective Measures Taken and/or Recommended	A Section 1
"NA. Officer has	completed restraint
training and follow	und proper procedure
Due to rature of I	satus Frjuries
de occur.	3
Corrective Action Referred To: Date	e To Be Completed By:
·	·
Additional Comments or Observations. Where applicable give details of mak etc., involved in this accident. (Use separate sheet if necessary)	es & models of machines, equipment, tools, structures,
Name(s) & occupations of person (s) who investigated accident:	Assistant 778+452-207=
July 100/27/1/ Sor	Name & Occupation Phone Aur. 27/2011 ure of Employer Representative Date
Name(s) of Witness(s) (include phone number)	- 1050
s.15, s.22	17/8-452.2000 BYCS

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry Tel.#	Location MUMMY		Date of Report
Last Name of Injured (or III) Person	Firet Name		File No.
Years of Service Time on	Occupation SVH	ELVER	Hours Worked in Previous 24 Hour Period Z
Accident Location (Dept. or Area) SHARAW LEADING TO PRONCESTO	Date of Accident	12011	Time 09.17
Accident Category (check) Injury or Illness	Equipment Motor Malfunction Vehicl		Fire Other (specify).
Severity of Injury or Illness (check)	☐ No Injury or First Ald On	ly Medical Treatment	Time Fatal*
Nature of Injury or Illness Sorre Lower	LEFT BACK		
Description of Accident or Employee's Account Went by Open The Hallmay of to Open Cvach	door londing	from H	alth care
Were Written Safe Work Procedures	Were they Adequate?		Were these Safe Work
Established and Available?	Yes No No N/A		Procedures used in Training? Yes No N/A

	,
Corrective Measures Taken and/or Recommended	
N/A-	
Corrective Action Referred To: Date To Be Completed By:/	7
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipmetc., involved in this accident: (Use separate sheet if necessary) NAA Name(s) & occupations of person (s) who investigated accident: Mak Will: TWWWWALL Amnar All	778-452-205
Print Name & Occupation Print Name & Occupation	Phone
Signature of Workers' Representative Date Signature of Employer Representative	Date
Name(s) of Witness(s) (Include phone number)	
None	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

				•		
Ministry MCFD	: Tel.#	Location 6/16	NABY		Date of Report	/2011
Last Name of Inlured for III) D	s.22	Firet Name			File No.	
Years of Service s.22	Time on	Occupation YOUT	y SPER	Visor	Hours Worked in Hour Period	n Previous 24
Accident Location (Dept. or A		Date of Accident	8/07		Time /308	APPKOX
Accident Category (check)	injury or	Equipment Malfunction	Motor. Vehicle	Property Damage	Fire	Other (specify).
Severity of Injury or Illness (ci		No Injury or		Medical . Treatment	Loss	☐ Fatal*
Nature of Injury or Illness NETU SUNE; p	TWETED A PULL WA	NA FEU I	W Restl	7 LNEE;	R16tH	SIDE OF
Description of Accident or Em THINE MES (WE) COURT HOTEL PEGET VARE FROM	MS Fight	MA STAN	W IME	NVENED NISTED M	TO SERVEN	L.W.
Were Written Safe Work Prod Estavijehed and Available? Yes A No □ N/A □	cedures	Were they Adequ	uate? √A□		Were these Safe Procedures used Yes No	d in Training?
Basic Cause (and Contributor		EXPLAIN FULLY U	nsafe condi K. ()XX	TIONS A IWW	VED IN	HONT

Corrective Measures Taken and/or Recommended	
LONE	
–Corrective Action Referred To:	Date To Be Completed By:/
etc., involved in this accident. (Use separate sheet if necessary)	tails of makes & models of machines, equipment, tools, structures,
Name(s) & occupations of person (s) who investigated accident: H. Week! SY 5 71842 07	9 DWALLACE 778 4452-2050
Print Name & Oceanation Phone Signature of Workers' Representative Date	Print Name & Occupation Phone Alle 8/19
	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	TZ-20 Zo

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If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Phase 2 Page 94 CFD-2013-00082

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

7 00 30		
Ministry ACF Tel.#	Location BYCS 7900 FRASEN PARK DR. BURNABY BC	Date of Report 2011 08 68
Last Name of Injured (or ill) Person s.22	First Name	File No.
Years of Service Time on Present Joh s.22	Occupation YouTU Sufavisor	Hours Worked in Previous 24 Hour Period
Accident Location (Dept. or Area) GLACICA WAIT DAYROOM LOWER TIER.	Date of Accident 2011 08 07	Time 1253
Accident Category Injury or Illness	Equipment	Fire Other (specify).
Severity of Injury or Illness (check) RIGHT SHOULDER PAINFULL NO MOBILITY	No Injury or First Ald Only Medical . Treatment	Time Fatal*
Nature of Injury or Illness PAWFUL RIGHT SHOULD		
THREE RESIDENT YOUTHS 1.0	of Occupational Disease (eg. RSI) (use separate shee volved) (v. PHYSICAL ALTERCATION) ITE TUG THREE BOYS AND REST	Big) There.
CODO CAU BY THE WHIT	WHITESIDE WAS THE FIRST STAKE TO RESTAIN BIDE AWAY FROM THE FIGHT. THE	or involved over cre
TWISTONC AND FALLING	with THE YOUTH DURING THE	RESTAUNT DISCOMAR UNABLE TO USE R. A
Were Written Safe Work Procedures Established and Available?	WITH THE YOUTH DURING THE WAR WE WERE THIS MORNING WAS WERE THE MORNING WAS WELL THE MORNING THE MORNING THE MORNING THE MORNING WAS NOT NOT NOT THE MORNING THE M	Were these Safe Work Procedures used in Training?
Yes No N/A	100 — 1 NU — 1 N/A — 1	Yes No N/A
Basic Cause (and Contributory Factors) E	XPLAIN FULLY UNSAFE CONDITIONS	

Corrective Measures Taken and/or Recommended
NIK .
Corrective Action Referred To: Date To Be Completed By: /
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, fools, structures, etc., involved in this accident. (Use separate sheet if necessary)
Ame
Name(s) & occupations of person (s) who investigated accident: Way SMS TW: 4(2-M4) OWACIACI 778-452-2050
Print Name & Occupation Phone Print Name & Occupation Phone Aug 8/11
Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (Include phone number)
s.15, s.22 778 452 2050
THE SELECTION CHESTER WITH SELECTION (SELECTION CONTINUED CONTINUED CONTINUED CONTINUED CONTINUED CONTINUED CO

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-

Phase 2 Page 96

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local JHS Commit

Ministry M.C.F.S., Tel.#	Location Burnaby Youth O	ustodyset	Date of Report UOS JUNO 1911				
Last Na	2		File No.				
Years of Service Time on Present Job	Heath Care	YUISC	Hours Worked in Previous 24 Hour Period				
Accident Location (Dept. or Area) Health Cove OFFice	Date of Accident TUNE 19111.		Time 0945				
Accident Category (check) Injury or Illness	Equipment Motor Malfunction Vehicle	Property Damage	Fire Other (specify)				
Severity of Injury or Illness (check)	No Injury or First Aid Only	Medical Treatment	Fatal*				
Nature of Injury or Illness Medle Stub unjury		s.79 YCJA					
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) Removered ance from Aleuce, poked at Under Junger & used Lance from							
Were Written Safe Work Procedures Established and Available?	Were they Adequate?		Were these Safe Work Procedures used in Training?				
Yes No N/A	Yes No N/A		Yes No N/A				
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDIT	IONS .	Texas File (Charles a lite)				
accedental	decirclac	2. 0	s.79 YCJA				
s.79 YCJA							
		•					

Corrective Measures Taken and/or Recommended
s.79 YCJA
Looking at updaking equipment
Corrective Action Referred To: C- Turn C Date To Be Completed By: July 31/11.
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, fools, structures,
etc., involved in this accident. (Use separate sheet if necessary)
NA
Name(s) & occupations of person (s) who investigated accident: C Turn Les Ren 778 2116 SUS Myuro Nak 452-2050
Print Name & Occupation Phone Print Name & Occupation Phone (778) Une 2/11 SUS MUNICIPAL US2-2050
Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)
None

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Assoc 21 (4) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Assoc 21 (4)

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

WA						
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS						
Yes No NA	Yes No No N/A		Yes No	NAC		
Were Written Safe Work Procedures Established and Available?	Were they Adequate?		Were these Safe Procedures use	Work in Training?		
70,000						
went over on Le	fe anne whil			Lairs		
Description of Accident or Employee's Account	of Occupational Disease (eg. RSI) (use separate shee	t if necessary)			
Nature of Injury or Illness LEFE ANKLE SPRA	in (Swollen))				
Severity of Injury or Illness (check)	No injury or First Ald Only	Medical Treatment	Time Loss	☐ Fatal *		
Accident Category Injury or	Equipment Motor Malfunction Vehicle	Property Damage	☐ Fire	Other (specify)		
Accident Location (Dept. or Area) BYCS Open Custody and Stair well Health and	Date of Accident June 13/20	DII.	Time III C	o his		
Years of Service Time on Present Job	Occupation Voulhs Correctional Of	ujenvisor/ Ficer	Hours Worked in Hour Period			
s.22						
Last Name of Injured (or III) Person	Custaly Senu		File No.			
MCFD	Date of Report	13/2011				
Ministry : Tel.#	Location Burnsby Yo					

Corrective Measures Taken and/or Recom	mended	
TO DE MORE	careful	when going up stairs.
No Physical	Corrective	Measures Required.
	NA	
	4 / 7 %	
Corrective Action Referred Tr	s.12	Date To Be Completed By: ONGOIN
Additional Comments or Observations. Wheetc., involved in this accident. (Use separate	ere applicable give detail te sheet if necessary)	s of makes & models of machines, equipment, fools, structures,
	N/A	
Name(s) & occupations of person (s) who ir	vestigated accident:	
C.O Avanto Pertisue	> 778 452 2050	
Print Name & Occupation	Phone	Print Name & Occupation Phone
Signature of Workers' Representative	NN4/14/11.	
olynatuje or vvoikers. Representative 5	Date	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone numl	per)	
Poviond July 2004		

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (Phase 2, Phase 2, P

Ministry	Tel.#	Location 7900 Clu	SEN PARK OR.	Date of Report			
McM	, i	BYCS BURNABY	BC.	MAY	14/11		
Last Name of Injured (or ill) Pe	erson	First Name		File No.	•		
•	s.22						
Years of Service	Time on Present lob s.22	Occupation YOUTU SCIP GSWSON	L	Hours Worked i Hour Period	n Previous 24 9-5 MH7 13/1		
Accident Location (Dept. or Al	rea)	Date of Accident MAY (4/1)		Time / 330			
Accident Category (check)	Injury or	Equipment Motor Malfunction Vehicle	Property Damage	Fire	Other (specify)		
Severity of Injury or Illness (cl	neck)	No Injury or First Aid Only	Medical Treatment	Time Loss	Fatal *		
Nature of Injury or Illness — HGHD Ack	CI SMAC	L SCRAPLA/DICA SOCKET. NAM	ABOUE LEF	17 646, 5	ORE		
WHILE ONG RECEIVED A FROM	Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) WHILE ONVOCUED IN BASHEBALL GAME WITH RESIDENTS I LECEVED AN ACCIDENTAL ELBON TO THE LEFT TEMPLE FROM S.79 YCJA						
Were Written Safe Work Pro Established and Available?	cedures	Were they Adequate?		Were these Sa Procedures us			
Yes No NA		Yes No No N/A		Yes No	N/A 🗹		
Basic Cause (and Contributo	ry Factors)	EXPLAIN FULLY UNSAFE COND	ITIONS				
1		LY Dudenla. No	ROTHL/LOUTIN	i Tob 1	Co Que Rossed		

1	
Corrective Measures Taken and/or Recor	mmended
	·
	x 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
7	NIA
	•
Corrective Action Referred To:	Date To Be Completed By:/
	·
Additional Comments or Observations. W	here applicable give details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separ	ate sheet if necessary)
χı	A
/~	
1	
Name(s) & occupations of person (s) who	investigated accident:
7. SACH WTTO	778-452-2050 DWALLACE 778 452 2050
Print Name & Occupation	Phone Print Name & Occupation Phone
MM 41/2	MAY (4/11 Q Will AXX 14/11
Signatura	
Signature/of Workers' Representative	Date Signature of Employer Representative Date
-UU	
Name(s) of Witness(s) (include phone num	
s.15, s.22	778 452 2050
	• .
	·

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JUINT ACCIDENT INVESTIGATION FOR ...

					Date of Bonort	
Ministry	Tel.#	Location	. ^		Date of Report MAT /	4/11
MCFD.		Ø	<u>CS</u>		1 (0) (776
Last Nar		Final Nimes			File No.	
	S	5.22				
Years of Service	Time on	Occupation			Hours Worked in Hour Period	n Previous 24
s.22	Drocont Inh	Your	4 Sulon	RUSOR	Tiouri enou	6 MAY 12/11
Accident Location (Dept. or A	rea)	Date of Accident		•	Time	
B4<5 G1M		M	A4 13/11		./545	΄, Τ
Accident Category	Injury or	Equipment	☐ Motor	Property	Fire	Other
(check)	Illness	Malfunction	Vehicle	Damage		(specify)
Severity of Injury or Illness (cl	neck)	No Injury or	First Aid Only	Medical Treatment	Time Loss	Fatal *
Nature of Injury or Illness みくみん、それていし	ed LEFT	KJEE.			,	
Description of Accident or En PLAYUNG BAS RECEIVED A KNEE AS I	NARD FO WENT UP	ouc From	BENCHO.	HYPEN EXT	CNBA) MY	LGF7
Were Written Safe Work Pro	cedures	Were they Adeq	uate?		Were these Sa	fe Work
Established and Available?	Ceduros	Yes No N/A		Procedures used in Training		
Yes No N/A		YesL NoL	N/ALL		Yes No	N/A 🖾
Basic Cause (and Contributo	ry Factors)	EXPLAIN FULLY	JNSAFE CONDI	TIONS		
ACCIDENTAL	(NJaky	Duride,	NORMAC/1	Contino	JOB REQ	uironado
			,			
					•	
2	,					
i						

Corrective Measures Taken and/or Recommended	
NIA	
Dete To Do C	analated Duy
Corrective Action Referred To: Date To Be C	ompleted By:/
Additional Comments or Observations. Where applicable give details of makes & modetc., involved in this accident. (Use separate sheet if necessary)	els of machines, equipment, tools, structures,
p/A	
!	,
Name(s) & occupations of person (s) who investigated accident:	CVC
178-452-00 DWALLA	CE SYS. 178-452 2050
Print Name & Occupation Phone Print Name & O	1) 1 10 14 /0
May 14/11 (SWd	1747/1/11
Signature of Workers' Representative Date Signature of Emp	loyer Representative Date
Name(s) of Witness(s) (include phone number)	
778-452 .2050	
778-452 2050 778 452 2050	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office

Ministry	Tel.# Location			Date of Report				
MIN - CHILDREN + GAN	1114 BU	WNARY		May 8	mill			
Last Name of Injured (or ill) Person	First Name			File No.	/			
	s.22							
Years of Service Time of Preservice		. 0		Hours Worked In Hour Period	n Previous 24			
Accident Location (Dept. or Area)	Date of Accide	nt		Time				
	May	7		13.00				
Accident Category (check)	Jury or Equipmen Malfunction		Property Damage	☐ Fire	Other (specify)			
Severity of Injury or Illness (check)	No Injury o	or First Aid Only	Medical Treatment	Time Loss	☐ Fatal*			
Nature of Injury or Illness	Nature of Injury or Illness CRUSHOD HAND							
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) Hano w Bood Clushon								
Were Written Safe Work Procedures Established and Available?	Were they Ade	equate?		Were these Safe Procedures use				
Yes No N/A	Yes No L	ľn⁄a□		Yes No	N/A 🗆			
Basic Cause (and Contributory Factor		UNSAFE CONDI	TIONS					

Corrective Measures Taken and/or Recommended
Corrective Action Referred To: Date To Be Completed By: /
bate to be completed by.
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of person (s) who investigated accident:
LB SOMORY 178422051 M. AWNAW 778-412205
Print Name & Occupation Phone Print Name & Occupation Phone
Mr. o Matter Man
Mey 8. May 8. May 8.
Signature of Workers' Representative Date Signature of Employer Representative Date
NEW CONTROL OF THE CO
Name(s) of Witness(s) (include phone number)

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

·		<u></u>			
Ministry	Tel.# Location			Date of Report	1 :
MIN CHILDREN & IAMI	as Bunn	1-13 Y		May 8	/2011
Last Name of Injured (or ill) Person	First Name	•		File No. / /	
	s.22	· -			· · · · · · · · · · · · · · · · · · ·
Years of Service Time on Present	Job Occupation	eviction	Office.	Hours Worked in Hour Period	n Previous 24
Accident Location (Dept. or Area)	Date of Accider	et 6		Time / 7 : 4	10
Accident Category Injurious Illness	ry or Equipment Malfunction		Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (check) SPRAWED RIGHT THUMB	No Injury o	First Ald Only	Medical Treatment	Time Loss	Fatal *
Nature of Injury or Illness SPEAもNED LUCKT で	Tumb - HTPG	I EXTENT	Del.		
Description of Accident or Employee's A THREE STAFF INVOLVE ROWN, S.22 R. 1100011ED TO CF 17, RESIDENT TO RESTR. ALLIH T TAUTE WAS	MYSELF HAD WI THE RESIDENT A	VIL A FEMA THORADA TO LAN AT MEI LANG THE	THE RESIDENT SWANDS THE DO WARDS THE DO THE STRUBBLE	od AS	240 746
Were Written Safe Work Procedures	Were they Ade	quate?		Were these Saf Procedures use	
Established and Available? Yes No No N/A	Yes No	N/AE		Yes No	
Basic Cause (and Contributory Factors)					
ACCIDENTAL INT	ing Dune	wh cou	i256 OF	~ RGGu	LAd
Durces					

	Солгесtive Measures Taken and/or Recommended	
	NOT APPLICABLE	
	Corrective Action Referred To: Date To Be Completed By: /	• • • •
-		:
.	Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)	
-	Name(s) & occupations of person (s) who investigated accident:	· .
,	D. WALLACK/ 278-4522050 Aprimiso Lodranes 770.452	Zesi
	Print Name & Occupation Phone Print Name & Occupation Phone	
	Signature of Workers' Representative Date Signature of Employer Representative Date	
	Signature of Workers' Representative Date Signature of Employer Representative Date	
ŀ		
÷	Name(s) of Witness(s) (include phone number) 778-452 2050	
	778-452 2050 s.15, s.22 778 452 2050	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

PSC 38

Ministry	Tel.#	Location			Date of Report	
Children & Fo	m/V	Burnabo	<u> </u>		April	17/2011
Last Name of Injured (or III) Pe	erson	First Name			File No.	
	s.22				<u>.</u>	
s.22	Time on Present Joh	Occupation Youth So	1000 30		Hours Worked i Hour Period	-
Accident Location (Dept. or Ar	s.22 ea)	Date of Accident	176101561		Time	<u>, </u>
Track of Field			17/2011		16:0	20
Accident Category (check)	☐ Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Flre	Other (specify)
Playing Sports with residents Severity of Injury or Illness (ch	eck)	No Injury or	First Aid Only	Medical Treatment	Time Loss	☐ Fatal*
Nature of Injury or Illness Injury fo	Right	Foot.				
, , , , , , , , , , , , , , , , , , ,	Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) Staff Member Was Playing Societ with Sestents in Track of Field Staff Member Susfained injury Kicking Societ ball.					
Were Written Safe Work Proc Established and Available?	edures	Were they Adequ			Were these Sat Procedures use	
Yes No NA NA		Yes No No	VA 🗹		Yes No No	N/A
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS						
Kiching motter While Striking Social ball. Phase 2 Page 109						
						e 2 Page 109 2013-00082

Corrective Measures Taken and/or Recommended	
n kija	cot this for.
100000	william.
Corrective Action Referred To:	Date To Be Completed By:/
Additional Comments or Observations. Where applicable give d	etails of makes & models of machines, equipment, fools, structures,
etc., involved in this accident. (Use separate sheet if necessary)	
11/2	
Name(s) & occupations of person (s) who investigated accident:	
1 FSRONOG - 177845270	S/Bill SHOKAR/Supervisor (778) 452-2050
Print Name & Occupation - Phone	Print Name & Occupation Phone
1	P. M. J. Jakon
Signature of Workers' Representative Date	Signature of Employer Representative Date
Signature of Workers Representative 7 Date	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	
Just residents in S	Yaff Member's Caro
The state of the s	Thur and the

*if fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry Offidren & Family Tol. #	Location Burnsby Youth Custody	Date of Report		
Development	Services 7900 Friser Park IX Burnaby BC VSJ-5HI	- 3011-03-28°		
Last Name of Injured (or ill) Person	First Name	File No.		
s.22				
Years of Service Time on Present Job s.22	Occupation Service Correctional Officer	Hours Worked in Previous 24 Hour Period 8 h(5.		
Accident Location (Dept. or Area) BYCS, Emerald Unit DayRoom	Date of Accident 2011-03-28	20:05		
Accident Category Injury or Illness	Equipment Motor Property Malfunction Vehicle Damage	Fire Other (specify)		
Severity of Injury or Illness (check)	No Injury of First Ald Only Medical . Treatment	Time Fatal*		
	over on left ankle	Causing pain		
& Swelling	9			
Description of Accident or Employee's Account	of Occupational Disease (eg. RSI) (use separate shee	it if necessary)		
Responding to Ode Yellaw Called Separating				
a girls involved in Pight white pulling off				
one girl fell back on bent leg and turner				
left ankle with vouths weight on top.				
Were Written Safe Work Procedures	Were they Adequate?	Were these Safe Work		
Established and Available?	Yes No N/A	Procedures used in Training?		
Yes No NA	Yes La Notal N/Ala	Yes No N/A		
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDITIONS			
Due to the rature of over work.				
Physical Restraints are necessary				
to keep the youth safe. This was				
a un portanate corcumstance where				
I fell back due to being of Balance				
and landod	on leg and to	mod softo		
and where	011 109 00104	CFD-2013-00082		

Corrective Measures Taken and/or Recommended
officer has been trained recently in
rostraint procedures and this was
just unfortunate outcarre.
No corrective Action Recommended.
Corrective Action Referred To: Date To Be Completed By:/
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)
Assistant Director Operations
rvame(s) & occupations of person (s) who investigated accident:
Tuy a Jacob 778452-2010 Whitamela Item 778-452-207-
Print Name & Occupation Phone Print Name & Occupation Phone
SUMAN March 28/2011
Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

PSC 38

Ministry Tel. #	Location BYCS	Date of Report		
MCFD (778)450050	Science Class.	March 24/2011		
Last Name of Injured (or ill) Person	First Name	File No.		
· s.22	<u></u>			
Years of Service Time on Present Job	Occupation	Hours Worked in Previous 24 Hour Period		
s.22 s.22	Yorth Supervisor	ld hrs-		
Accident Location (Dept. or Area)	Date of Accident	Time		
Science Class	Morch 24/2011	1050 his		
Accident Category Injury or Illness	Equipment Motor Property Malfunction Vehicle Damage	Fire Other (specify)		
Severity of Injury or Illness (check)	No Injury or First Aid Only Medical Treatment	Time Fatal*		
Nature of Injury or Illness				
cut left thom	6- linch length 4 Inch	width		
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) Cut left think or a hieror coffee mug in the Science class				
Were Written Safe Work Precedures Established and Available?	Were they Adequate?	Were these Safe Work Procedures used in Training2		
Yes No No N/A	Yes No N/A	Yes No No N/A		
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS Cacalletta in grabbing a broken coffee mug to throw out. Phase 2 Page 113 OFF 2012 00082				
		CFD-2013-00082		

Signature of Workers' Representative Date Signature of Employer Representative Date	Corrective Measures Taken and/or Recommended		
Corrective Action Referred To: Date To Be Completed By: Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, fools, structures, etc., involved in this accident. (Use separate sheet if necessary) Na. 19(s) & occupations of person (s) who investigated accident: M. W. L. L. S. G. S. M. Y. L. 101 Print Name & Occupation Phone MAR. 24 [1] Signature of Employer Representative Date Date	\mathcal{T}_{Λ}		
Corrective Action Referred To: Date To Be Completed By: Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, fools, structures, etc., involved in this accident. (Use separate sheet if necessary) Na. 19(s) & occupations of person (s) who investigated accident: M. W. L. L. S. G. S. T. G. L.	$(- \Lambda)/H$		
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: M. Styling S4S Print Name & Occupation Phone Print Name & Occupation Phone Mach 24 11 Signature of Employer Representative Date			
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: M. Styling S4S Print Name & Occupation Phone Print Name & Occupation Phone Mach 24 11 Signature of Employer Representative Date			
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: M. Styling S4S Print Name & Occupation Phone Print Name & Occupation Phone Mach 24 11 Signature of Employer Representative Date			
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: M. Styling S4S Print Name & Occupation Phone Print Name & Occupation Phone Mach 24 11 Signature of Employer Representative Date			
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: M. Styling S4S Print Name & Occupation Phone Print Name & Occupation Phone Mach 24 11 Signature of Employer Representative Date			
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: M. Styling S4S Print Name & Occupation Phone Print Name & Occupation Phone Mach 24 11 Signature of Employer Representative Date			
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: M. Styling S4S Print Name & Occupation Phone Print Name & Occupation Phone Mach 24 11 Signature of Employer Representative Date			
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) Name(s) & occupations of person (s) who investigated accident: M. Styling S4S Print Name & Occupation Phone Print Name & Occupation Phone Mach 24 11 Signature of Employer Representative Date			
Rane(s) & occupations of person (s) who investigated accident: M. Weill Sty Mr. 422019 Phone Print Name & Occupation Phone Signature of Workers' Representative Date Signature of Employer Representative Date	Corrective Action Referred To:	Date To Be Completed By:/	<u> </u>
Rane(s) & occupations of person (s) who investigated accident: M. Weill Sty Mr. 422019 Phone Print Name & Occupation Phone Signature of Workers' Representative Date Signature of Employer Representative Date			
Na. 18(s) & occupations of person (s) who investigated accident: M. J. Vei W. S. Th. 42.2019 Print Name & Occupation Phone Print Name & Occupation Phone Print Name & Occupation Phone Signature of Workers' Representative Date Signature of Employer Representative Date			
Na. 1e(s) & occupations of person (s) who investigated accident: M. J. Vei W. S. 71. 42. 1019 Print Name & Occupation Phone Print Name & Occupation Phone Print Name & Occupation Phone Phone Signature of Employer Representative Date	Additional Comments or Observations. Where applicable give detail	ils of makes & models of machines, equir	ment tools structures
M. Weill S45 Print Name & Occupation Phone Print Name & Occupation Phone Phone MAR 24 II Signature of Workers' Representative Date PAUL TITEN 778-452-20 Phone Phone Phone MAR 24 II Signature of Employer Representative Date	etc., involved in this accident. (Use separate sheet if necessary)	is of makes a moders of machines, equip	intern, tools, structures,
M. Weill & S. Mr. 472.7019 PAUL TITTN 778.452.20 Print Name & Occupation Phone Print Name & Occupation Phone Will 3 Mar. 24 11 Signature of Workers' Representative Date Signature of Employer Representative Date			
M. Weill. S45 Print Name & Occupation Phone Print Name & Occupation Phone Phone MAR 24 11 Signature of Workers' Representative Date PAUL TITEN 778-452-20 Phone Phone Phone Date Phone Phone MAR 24 11	AIA .		· · · · · · · · · · · · · · · · · · ·
M. Weill. S45 Print Name & Occupation Phone Print Name & Occupation Phone Phone Mar 24 11 Signature of Workers' Representative Date PAUL TITEN 778-452-20 Print Name & Occupation Phone MAR 24 11 Signature of Employer Representative Date			
M. Weill S4S Print Name & Occupation Phone Print Name & Occupation Phone Phone MAR 24 11 Signature of Workers' Representative Date Part Tith Name & Occupation Phone MAR 24 11			
M. Weill S4S 711-472-2019 PHOTE THEN 778-452-20 Print Name & Occupation Phone Phone Print Name & Occupation Phone Wall 452-20 Signature of Workers' Representative Date Signature of Employer Representative Date			
M. Weill S4S 711-472-2019 PHOTE THEN 778-452-20 Print Name & Occupation Phone Phone Print Name & Occupation Phone Wall 452-20 Signature of Workers' Representative Date Signature of Employer Representative Date			
M. Weill. S45 Print Name & Occupation Phone Print Name & Occupation Phone Phone Mar 24 11 Signature of Workers' Representative Date PAUL TITEN 778-452-20 Print Name & Occupation Phone MAR 24 11 Signature of Employer Representative Date			
Print Name & Occupation Phone Workers' Representative Date Print Name & Occupation Phone MAR 24 1 Signature of Workers' Representative Date			
Print Name & Occupation Phone Workers' Representative Date Print Name & Occupation Phone MAR 24 1 Signature of Workers' Representative Date Date	Name(s) & occupations of person (s) who investigated accident:		
Signature of Workers' Representative Date Signature of Employer Representative Date	\$ <i>f</i>	PHOR TIFTIN	778.452.20
Signature of Workers' Representative Date Signature of Employer Representative Date	M. Strail 845 774.482.2079		
	M. Streit S45 771, 472.7079 Print Name & Occupation Phone		Phone
Name(s) of Witness(s) (include phone number)	M. Streit S45 771, 472.7079 Print Name & Occupation Phone Much 24 11		Phone
Name(s) of Witness(s) (include phone number)	M. Streit S45 771, 472.7079 Print Name & Occupation Phone Much 24 11	Print Name & Occupation	Phone MAR 24/11
realic(s) or samposo(s) (fundra hinting)	M. Streit S45 771, 472.7079 Print Name & Occupation Phone Much 24 11	Print Name & Occupation	Phone MAR 24/11
	Print Name & Occupation Phone Signature of Workers' Representative Date	Print Name & Occupation	Phone MAR 24/11
	Print Name & Occupation Phone With 14 11 Signature of Workers' Representative Date	Print Name & Occupation	Phone MAR 24/11
	Print Name & Occupation Phone With 14 11 Signature of Workers' Representative Date	Print Name & Occupation	Phone MAR 24/11
	Print Name & Occupation Phone With 14 1 Signature of Workers' Representative Date	Print Name & Occupation	Phone MAR 24/11
	M. Strait. S45 771, 472.7079 Print Name & Occupation Phone Much 24 11	Print Name & Occupation	Phone MAR 24/11
	Print Name & Occupation Phone Signature of Workers' Representative Date	Print Name & Occupation	Phone MAR 24/11

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister BC Public Service Agency Minister, BC Public Service Agency

PSC 38

Ministry 7.78-452-252 Tel.#	Location	•. • •	Date of Report	'c
CHILDREN + FAMILIES	Bycs Gym		MARCH 23	311
Last Name of Injured (or III) Person	First Name		File No.	-
s.22				
Years of Service Time on Present Job	Occupation CORRECTIONS OFF	ACER	Hours Worked in Hour Period	Previous 24
Accident Location (Dept. or Area)	Date of Accident 1 MARCH 23 (1		Time 2040	
Accident Category Injury or Illness	Equipment Motor Malfunction Vehicle	Property -Damage	Fire	Other (specify)
Severity of Injury or Illness (check)	1 7 7	Medical reatment	Time Loss	☐ Fatal*
Nature of Injury or Illness HIT R. HAND BN VOLLYE	SALL POST DURING	· 安 G 6	ame Wi	TH KIDS
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) Stoff Member Struck his fancl on Vollyborld post Curino (o game No Sofety Missiere) to be Imployed				
Were Written Safe Work Procedures Established and Available?	Were they Adequate?		Were these Safe	
Were Written Safe Work Procedures Established and Available? Yes No N/A	Were they Adequate? Yes□ No□ N/A□		Procedures used	l in Training?
Established and Available?		3		l in Training?

Phase 2 Page 115 CFD-2013-00082

Corrective Measures Taken and/or Recommended	
None.	
Corrective Action Referred To: Date To Be Completed By:/	
Additional Comments or Observations. Where applicable give details of makes & models of machines, equetc., involved in this accident. (Use separate sheet if necessary)	
Name(s) & occupations of person (s) who investigated accident: THARIS SCO 778-452-252 Print Name & Occupation Phone Print Name & Occupation Print Name & Occupation Signature of Workers' Representative Date Signature of Employer Representative	778-452-205 Phone March 3
Name(s) of Witness(s) (include phone number)	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry M CFD	Tel.# 778-452 2050	Location BYCS		Date of Report	10 1
Last Name of Inlured (or III) Pe	erson s.22	First Name		File No.	
Years of Service	Time on Present Job	Occupation Youth SWEEVISER		Hours Worked i Hour Period	in Previous 24 7—HEC.
Accident Location (Dept. or Ar		Date of Accident 20(1 0) 04		Time 1100	
Accident Category (check)	Injury or	Equipment Motor Malfunction Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of injury or illness (ch	eck)	No Injury or First Aid Only	Medical . Treatment	Time Loss	☐ Fata[*
Nature of Injury or Illness	SORE RIG	HT SHOUDER			
SURING HIS	22 W	of Occupational Disease (eg. RSI) AS DRIVINH ONE AS ISSP WERKER AND IN SHOUDER	OF THE F	LECT VEH	ICLES VEHICLE
Were Written Safe Work Proc Established and Available? Yes No N/A	edures	Were they Adequate? Yes□ No□ N/A□		Were these Safe Procedures use	d in Training? ✓
Basic Cause (and Contributor)		EXPLAIN FULLY UNSAFE CONDI			
No	NE NOTE	DOLOGSELVED			
			·	Phase	e 2 Page 117

Corrective Measures Taken and/or Recommended	
Confedure Measures Takerrandor Neconstitended	
NONE REQUIRED	
	Data To Do Consulated Duy
Corrective Action Referred To:	Date To Be Completed By:
Additional Comments or Observations. Where applicable give details	of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)	
Name(ccupations of person (s) who investigated accident:	
) 1 N N ADA
TODD WATSON 778-452-7050 T	amela Jew - ADO 778-452-2077
Print Name & Occupation Phone	Print Marge & Occupation Phone
(for 1) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
MAR 19/11	Jamela Son 1901 191 11
Signature of Workers' Representative Date	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry MCF6 Tel.#	Burnahy Youth Custool	Date of Report Mar 15/11		
Las ^c N Suction 17 - im D s.22	Fint Nama	File No.		
Years of Source Time on Present Job s.22	Occupation USUP CTUISOT	Hours Worked in Previous 24 Hour Period 4		
Accident Location (Dept. or Area)	Date of Accident Telo, 14(1)	Time (730 (5A		
Accident Category Injury or Illness	Equipment Motor Property Malfunction Vehicle Damage	Fire Other (specify)		
Severity of Injury or Illness (check)	No Injury or First Ald Only Medical Treatment	Tilme Fatal*		
	mation of Lett Sinpizement syndra			
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) TWENDER LEE Shoulder Author restrict AUCE) Two wind				
Were Written Safe Work Procedures Established and Available? Yes□ No□ N/A□	Were they Adequate? Yes□ No□ N/A□	Were these Safe Work Procedures used in Training? Yes No NA		
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS ACCIDENTAL OCCUPYANCE HOAT ACCIDENTAL OCCUPYANCE HOAT SHOCK TRAINING, ON JOB WOHCE.				

Phase 2 Page 119 CFD-2013 00082

Corrective Measures Taken and/or Recommended	
1 x x 10	
None	
11/1/	NA
Corrective Action Referred To:	Date To Be Completed By:/
Additional Community of the National States and States	
Additional Comments or Observations. Where applicable give det etc., involved in this accident. (Use separate sheet if necessary)	alls of makes & models of machines, equipment, tools, structures,
otor, in one a manual desired to the control of the	
None	
7001	
Name(s) & occupations of person (s) who investigated accident:	1
Name(s) & occupations of person (s) who investigated accident.	in Property formal formations
x TSrandon Thotle (TO)(52-	MBurchal (5002) (778)452-
Print Name & Occupation Josh Staure Photos	Print Name & Occupation Phone
_	
Maristit	. metalale (5002) mars(11.
Signature of Workers' Representative Date	1. / .
Olgitature Opysorkers Trepresentative Date	Signature of Employer Representative Date
Name(s) of Wilness(s) (include phone number)	
ramo(s) of realisation (monado briono manisor)	(-7-12/1) -2000
s.15, s.22	(748)452-6050
3.13, 3.22	

*if fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry Tel.#	Location	Date of Report
CHILDREN + FAMILIES	BURNARY TOO FARER PARK DR.	MARCH 611
Last Name of Injured (or ill) Person	First Name	File No.
s.22		
Years of Service Time on Present Job	COLLECTIONS OFFICER	Hours Worked in Previous 24 Hour Period
Accident Location (Dept. or Area)	Date of Accident /	Time
ELKHORN UNIT	MARCH 6 2011	17:18
Accident Category Injury or Illness	Equipment	Fire Other (specify)
Severity of Injury or Illness (check)	No Injury or First Ald Only	Time Fatal*
Nature of Injury or Illness SORE LOWER BACK		
Description of Accident or Employee's Account		
Description of Accident or Employee's Account BLO146 U.P. A PHYSICAG YOUTHS	LALTERCATION BETWEE	N 760
BROKE UP A PHYSICA	HLTERCATION BETWEE	Were these Safe Work
BROKE UP A PHYSICAL	LALTERCATION BETWEE	N 760
BROKE UP A PHYSICAL VGUTHS Were Written Safe Work Procedures Established and Available? Yes \(\text{No} \) N/A \(\text{No} \)	Were they Adequate? Yes No N/A X EXPLAIN FULLY UNSAFE CONDITIONS	Were these Safe Work Procedures used in Training? Yes No N/A

Corrective Measures Taken and/or Recommended
NONE, ACTION WAS JUSTIFIED
Corrective Action Referred To: Date To Be Completed By:/
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, fools, structures,
etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of person (s) who investigated accident:
TODD WATSON 778-452-2050 J. HARRIS SCOTT 778-452-2052
Print Name & Occupation Phone Print Name & Occupation Phone
ARTH MARGIN GHarris March 611
Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)
Recorded on DVD.

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

· ·						
Ministry	Tel.#	Location			Date of Report	
MCF 778-4	52-2056	Buri	rolby		May 4	2011
Last Name of Injured (or III) Pe	rson	First Name			File No.	
-	s.22		· . ·			<u>. </u>
Years of Service	Time on	Occupation	•		Hours Worked	in Previous 24
s.22	Present Job s.22	Correction	Iral off	idir.	Hour Period (8 hours.
Accident Location (Dept. or Ar	ea)	Date of Accident			Time	
Hollyburn land	1/0 R	m kla	rch 4/20	Maria de la companya della companya	10.45	N-X
Accident Category (check)	Injury or	Equipment	☐ Motor	Property	☐ Fire	Other
(driody)	llness	·Malfunction	Vehicle	Damage		(specify).
Severity of Injury or Illness (ch	eck)	No Injury or	First Ald Only	Medical Treatment	Time Loss	☐ Fatal*
Nature of Injury or Illness						
Below						
Description of Accident or Emp	oloyee's Account	of Occupational Di	sease (eg. RSI)	(use separate shee	et if necessary)	
While restrains	2 Youts	n 100 el	ban) M	light ho	ve hit	
While restrained	Jua V	1 object				
Were Written Safe Work Proc	edures	Were they Adeq	uate?		Were these Sa Procedures use	
Established and Available? Yes No N/A		Yes No No	V/A 🔲			
168 NOLINALI					Yes No	N/ALI
Basic Cause (and Contributory		EXPLAIN FULLY U				
Youth action	cup a	not des	troyed	Propert	y les.	Cabnet
handles and	of wast	n med	+ bc	rectar	nel	
Langer Z Street	900					
	*					
		1				
						se 2 Page 123 -2013-00082

Control Manager Tales and los Bass	ammandad		
Corrective Measures Taken and/or Reco	mmenueu		
			٠
			•
			<i>.</i> :
NA			
) (I)			•.
			30
			•
Corrective Action Referred To:		Date To Be Completed By:/	
	· · · · · · · · · · · · · · · · · · ·		<u> </u>
Additional Comments or Observations, V	Vhere applicable give deta	ils of makes & models of machines, equipment, tools, structure	· .88
etc., involved in this accident. (Use sepa	arate sheet it necessary)		• • •
	*		
			*
			• :
	· · · · · ·		
			•
Name(s) & occupations of person (s) wh	o investigated accident:		
T. SACILIOTIO	798-452-2052	s Hudspeth ADO	÷.
Print Nam & Occupation	Phone	Print Name & Occupation Phone	
1 sin I vally de Octobation	. I HOHE	The discard	•
1100		Third netal) My 3/11	
Signature of Workers' Representative	Date	Signature of Employer Representative Date	
organization vivorices representative		or Employor Representative	•
	· · · · · · · · · · · · · · · · · · ·		
Name(s) of Witness(s) (include phone n	umher)		
Transiciol of Thursday (morado priorio in	umbor)		`
s.15, s.22			
- Camurà	•		
1.00			

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry Tel.#	Location Burnaby Youlk	Date of Report Feb. 28(1)	
MCFD	MCFO Custody Services		
Las'	J	File No.	
	s.22		
Years of Service Time on ,	Occupation /	Hours Worked in Previous 24 Hour Period //	
s.22 s.22	Unth Supervisor Corrector blocker	Hour Period // S	
Accident Location (Dept. or Area) State Dowler Ling Cot	Date of Accident	Time OOIS his	
Accident Category Injury or Illness	Equipment Motor Property Malfunction Vehicle Damage	Fire Other (specify)	
Severity of Injury or Illness (check)	No Injury or First Ald Only Medical Treatment	Time Fatal*	
Nature of Injury or Illness We nched	Lack (as a resu	it of the Cau)	
Description of Accident or Employee's Account	of Occupational Disease (eg. RSI) (use separate shee	et If necessary)	
5.22	was walking to the	MQIN	
huilding iprior	to the start of his	shirt when	
The stipped on the	to the start of his ice (pavement) He	landed on	
his buttocks w	renching his book		
Were Written Safe Work Procedures Established and Available?	Were they Adequate?	Were these Safe Work Procedures used in Training?	
Yes No N/A	Yes No No N/A	Yes No N/A	
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDITIONS		
The main Co	ause was the 10e	That was	
built up on 4h	C LWW I C	'salt(sand	
fruck did NOT	- provide the servi	ice through	
the most to	rearly hons of Y	he morning).	

Phase 2 Page 125 CFD-2013-00082

corrective Measures Taken and/or Recommended TO ensure the "Satte Sand" truck makes it's rounds on any potential "treezing or icy nights. Au state members should or icy nights. Au state members should
Consulto Cho Catte Sand Truck
10 ensure to
make it's rounds on any polential
Maces in the Automorphous Should
or ICY NIGHTS. ALL STATE OF THE MISCE
be mindful of icy conditions whenever
be mixered
entering or orating the building.
Corrective Action Referred Tous Tous Tous Tous To Be Completed By: 0500
Corrective Action Referred Town JONN YES Date To Be Completed By: U.S. C.D.
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of person (s) who investigated accident:
Corrections Officer (778)452-2050 MHUVOLOK (5002) (778)452-20
ZISCOTI IVISEE
(7/1016) Feb. 28/11 Marallol (500) Feb. 28/11.
Signature of Workers Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (Include phone number)
s.15, s.22 (57) 457- 2050

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) b.602 | PMGB102ffice

PSC 38		
Ministry Tel.#	Location	Date of Report
		2011/02/18
Look Name of Interest for III Derson	Firet Nama	File No.
s.22		
Years of Service / Time on	Occupation	Hours Worked in Previous 24 Hour Period
s.22 s.22	500	10
Accident Location (Dept. or Area)	Date of Accident	Time
GYMNASIUM	2011/02/18	1100
Accident Category	Equipment Motor Property	Fire Other
(check) Tilness	Malfunction Vehicle Damage	(specify).
Severity of Injury or Illness (check)	No Injury or First Ald Only Medical Treatment	Time Fatal*
SMAFF MEMBER JOG	of Occupational Disease (eg. RSI) (use separate sheet TRAIN/NG I BUMPED IN TING MY (R) SHOULDED WORLD WORLD WORLD WORLD WORLD	TO ANOTHER.
	Wore they Adequate?	Were these Safe Work
Were Written Safe Work Procedures Established and Available?	Were they Adequate?	Procedures used in Training?
Yes No NA NA	Yes A No NA NA	Yes No I N/A
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDITIONS	
Roview strates	hing and expectations	when
interacting.		

Phase 2 Page 127 CFD-2013-00082

	Corrective Measures Taken and/or Recommended
	Review of Lechniques when training
	Corrective Action Referred To: Date To Be Completed By:/
•	
	Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)
	Name(s) & occupations of person (s) who investigated accident: US Force (r) First 28/1, Abo Matt Annun 778 452 2051
,	Print Name & Occupation Print Name & Occupation Phone
	Signature of Workers' Representative Date Date Signature of Employer Representative Date
	Name(s) of Witness(s) (include phone number)
	NIA
	levised July 2004

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an Infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (2) Pose

PSC 38

7SC 38					
Ministry	Tel.#	Location		Date of Report	
MIN. CHILDREN	1 FAM	BURNADY YOUT	14 CUSTROY	F2B.16	2011
Last Name of Injured (or ill) Pe	erson	First Name		File No.	
	s.22				
Years of Service	Time on	Occupation		Hours Worked Hour Period	in Previous 24
	Present Job	YOUTH SURKVUCO	N.	rioui renou	u - 144111 .
Accident Location (Dept. or A	rea)	Date of Accident	•	Time	
HARISSON		FEB 14/2011		1030	
Accident Category	injury or	Equipment Motor	☐ Property	Fire	☐ Other
(check)	Illness	Malfunction Vehicle	Damage		(specify)
Severity of Injury or Illness (ch	neck)	No Injury or First Aid Only	Medical Treatment	Time Loss	Fatal *
	nployee's Account	of Occupational Disease (eg. RSI)			
		HAD TONPHYSO			
A YOUTH T	HAT WO	AS AGGLESIUCZ	1 APPROAG	eHING	ANOTTE
RESIDENT.	-				
				_	· · · · · · · · · · · · · · · · · · ·
Were Written Safe Work Pro	cedures	Were they Adequate?		Were these Sa Procedures us	
Established and Available?		Yes No No N/A		Yes No	
			TIQ11Q	YesLI NoL	I N/ALJ
Basic Cause (and Contributo	ry Factors)	EXPLAIN FULLY UNSAFE CONDI	HONS		
FALL	on RIG	HT SHOULDL	R.		
		•			

Corrective Measures Taken and/or Recommended
TRAINING IN PHYSICAC INTENVENTON
Corrective Action Referred To: OW Go / NG Date To Be Completed By:/
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of person (s) who investigated accident:
Sorroby / TS 452 Lor (HVD5 Per HVD5 Pe
FEB (6/2011 HVIX 12011
Signature of Employer Representative Date / Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)
s.15, s.22
. 778 452 205 1

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

PSC 38

Ministry M.C.F	Tel.#	Location B. Y. C. S		Date of Report January	
Lest Name of Intered for III De	s.22	Elref Name		File No.	
Years of Service	Time on Present Job	Occupation Youth Superv	risor.	Hours Worked i Hour Period	n Previous 24
Accident Location (Dept. or Ar Fair weather Uni		Date of Accident January 9	2011	Time 163	ohrs
Accident Category (check)	Injury or	Equipment Motor Malfunction Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (ch	neck)	No Injury or First Aid Only	Medical Treatment	Time Loss	☐ Fatal*
1/. No. 2 (1)			1 19 1 /10 . K		
Description of Accident or Em	ployee's Account	of Occupational Disease (eg. RSI) age to Left eye	(use separate shee		
Description of Accident or Em	ployee's Account	of Occupational Disease (eg. RSI)	(use separate shee		
Description of Accident or Em **Broken No **Were Written Safe Work Proc	ployee's Account	of Occupational Disease (eg. RSI) Aye to Leff lye Were they Adequate?	(use separate shee		e Work
Description of Accident or Em	ployee's Account	of Occupational Disease (eg. RSI) age to Left lyle	(use separate shee	#S.Auc.	e Work

i	Corrective Measures Taken and/or Recommend	ed -				
	NONE AT THIS .	TIME		: .	* . *	
					. :	
				• • • • •	•	
	Corrective Action Referred To:		Date To Be Com	pleted By: /	<u></u>	
	Additional Comments or Observations. Where ap etc., involved in this accident. (Use separate she	plicable give details	of makes & models	of machines, equip	ment, tools,	structures,
	oto, involved in this accident. (Ose separate site	et ii necessary)			•. •	
:∦:						
ľ				•	•	
\parallel			· · · · · ·		· · · · ·	
	Name(s) & occupations of person (s) who investig	pated accident:	•	•	:	
	TODD WATSON 778	3-452-2050	Matken	Annan A.V.	0 778-	452-2050
	Print Name & Occupation	Phone	Print Name & Occup	ation	Phone	
	2011	01/09	Mitter	/m	Jon	11/09
- ;	Signature of Workers' Representative	Date S	Ignature of Employe		. Date	
Ŀ		<u> </u>	<u> </u>	· · · · · · · · · · · · · · · · · · ·		
1	Name(s) of Witness(s) (include phone number)					
		•				
٠.			• • • • • • • • • • • • • • • • • • • •			
!!	s.15, s.22		•		· · · ·	
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	vised July 2004					

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry MCF	Tel.#	Location SWN alby	Mothe	ustody	Date of Report	3111- /
Last Name of Inlured (or ill) Pe	erson s.22	First Name			File No.	
Years of Sentice s.22	Time on Present Job	Occupation (Suparu	SØ	Hours Worked li Hour Rerife '' -	Previous 24 .
Accident Location (Dept. or Ar Open Stavw		Date of Accident	6 lli		Time 0.03	SO .
Accident Category (check)	Iliness	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire.	Other (specify)
Severity of Injury or Illness (ch	eck)	No Injury or I	First Ald Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illiness	ver le	- Ct Lsio	(e) 60	ick pai	Ż	
Description of Accident or Em	ployee's Account	of Occupational Dis	sease (eg. RSI)	(use separate shee	t if necessary)	
				open?	Ng	
	metal	doors	(@ Ob	poN)		
Were Written Safe Work Proc	edures	Were they Adequ	ıate?		Were these Safe	
Were Written Safe Work Proc Established and Available? Yes No N/A	edures	Were they Adequ			Were these Safe Procedures used	d in Training?
Established and Available?			I/A CI	TONS	Procedures used	d in Training?
Established and Available? Yes No NA NA Residence No NA Residence (and Contribution)	y Factors) E	Yes No No No	NSAFE CONDIT		Procedures used	d in Training?
Established and Available? Yes No No N/A Basic Cause (and Contributor	y Factors) E	Yes No No No	NSAFE CONDIT		Procedures used	d in Training?
Established and Available? Yes No No N/A Basic Cause (and Contributor	y Factors) E Pauden Loins	Yes No No No	NSAFE CONDITION OUTTON	rions Nce l basic	Procedures used	d in Training?

	Согrective Measures Taken and/or Recommended
	None, only thing is to
	possibly slow down a bit
	When opening Numerous
	None, only thing is to possibly slow down a bit when opening numerous metal dows.
	Corrective Action Referred To: Date To Be Completed By: , MA
-#	
. ∦	Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures,
	etc., involved in this accident. (Use separate sheet if necessary)
	None
	Name(s) & occupations of person (s) who investigated accident:
-	Rooning 2 Doll Moundak (AHD) (478) 1050
]] .F	Print Name & Occupation Phone Print Name & Occupation Phone
- 9	July July July July July July July July
	Signature of Workers Representative Date Signature of Employer Representative Date
. V	lame(s) of Witness(s) (include phone number)
	None (IE needed a review of SUR This date to confirm number of doors
•	accesscal that day).
₹e:	vised July 2004

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) சுத்தில்

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

PSC 38					
Ministry	Tel.#	Location		Date of Report	_
MCFD 7	18.45 2. 0089	Burnaby		Jan 5	1106
Last Name of Injured (or ill) Pe	rson	First Name		File No.	
	s.22				
Years of Service Time on Occupation Fresent Job Food Service With		Worker	Hours Worked in Previous 24 Hour Period		
Accident Location (Dept. or Ar Open Custody	ea)	Date of Accident December 25,	2010	Time 11:20 am	
Accident Category -(check)	Injury or lilness	Equipment Motor Malfunction Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (ch	neck)	No Injury or First Aid Only	Medical Treatment	Time Loss	☐ Fatal *
Description of Accident or En	nployee's Account	t of Occupational Disease (eg. RS through do	I) (use separate she	et if necessary) Went Sed or	- to
Were Written Safe Work Pro Established and Available?	cedures	Were they Adequate?		Were these Sa Procedures use	
Yes No No N/A		Yes No N/A		Yes No	N/A 🖸
Basic Cause (and Contributo		EXPLAIN FULLY UNSAFE CON			

Corrective Measures Taken and/or Recommended
wheel one wagon at a time not two. If door closes let the door close do not stick hand in to try to open, it.
Corrective Action Referred To: s.22 _ Date To Be Completed By: <u>ටිව1 වර</u>
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of person (s) who investigated accident:
Print Name & Occupation Phone Print Name & Occupation Phone
Print Name & Occupation Phone Print Name & Occupation Phone
Stewld Hodges Jan 5
Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number) s.15, s.22 173-452-2089

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB Phase 2 Page 136 office CFD-2013-00082

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

PSC 38

	· · · · · · · · · · · · · · · · · · ·		
Ministry Tel. # Children o Family Developet	Location Buriely your	ر اع	Date of Report 2010 - 12-17
Last Name of Injured (or ill) Person	First Name		File No.
Years of Service Time on Present Job	Occupation Youth Sep	211.501.	Hours Worked in Previous 24 Hour Period 6 h.
Accident Location (Dept. or Area)	Date of Accident		Time 19 25
Accident Category Injury or (check)	Equipment Motor Malfunction Vehicle	Property Damage	Fire Other (specify).
Severity of Injury or Illness (check)	No Injury or First Aid Only	Medical Treatment	Time Fatal*
Nature of Injury or Illness R Left by	and swollen.		
s.22 had	1 to break up a	in alterca	to-between
n			
Were Written Safe Work Procedures	Were they Adequate?		Were these Safe Work Procedures used in Training?
Were Written Safe Work Procedures Established and Available? Yes Now N/A Basic Cause (and Contributory Factors) Staff was restr	Yes No N/A		Procedures used in Training?

Phase 2 Page 13 CFD-2013-00082

-	
	Corrective Measures Taken and/or Recommended
	NIA
1.	
.	
	Corrective Action Referred To: V/A Date To Be Completed By: / W/A
-	
	Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)
$\cdot \ $	etc., involved in this accident. (Osc separate shock in necessary)
.∦.	
.	\mathcal{N} / \mathcal{L}
: ∦.	
:	
	Name(s) & occupations of person (s) who investigated accident:
•	
1	S. Sin Hr Houth Seper. 50- 778-482-2050
-	Print Name & Occupation Phone Print Name & Occupation Phone
	July de 1/4 Due/17/10
	Signature of Workers' Representative Date Signature of Employer Representative Date
۱,	Armano Ropricers. Der/17/10.
1	Name(s) of Witness(s) (Include phone number)
	7
	s.15, s.22 5778 - 452 - 2050

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

J 38

Ministry Tel.#	Location 7900 FRASER PARK D	OL. Date of Report
M.CF. 778-452-205	O BURNABY BC	DEC 14/10
Last Name of Injured (or III) Person	First Name	File No.
s.22		
Years of Service Time on Present Inh s.22 s.22	Occupation YouTH SUPERVISOR	Hours Worked in Previous 24 Hour Period 9.58
Accident Location (Dept. or Area)	Date of Accident	Time
GYMMSIUM	DEC. 13, 2010	1530 HRS
Accident Category Injury or	Equipment Motor Property Malfunction Vehicle Damage	
Severity of injury or liiness (check)	No Injury or First Aid Only Medical Treatment	
Nature of Injury or Illness Severe	CHARLIE HORSE	
(Figadithinit of Voolabilt of Filipinage a viccomic	of Occupational Disease (eg. RSI) (use separate s	neet it necessary)
MECEIVED A KNE	TO HIS LEG (ALO	and THE
MECEIVED A KNE	Were they Adequate?	and THE
MECEIVED A KNE THIGH TUST ABOUTED Were Written Safe Work Procedures	VE THE KNEE OF	Were these Safe Work
Were Written Safe Work Procedures Established and Available? Yes No N/A	Were they Adequate?	Were these Safe Work Procedures used in Training?
Were Written Safe Work Procedures Established and Available? Yes No N/A	Were they Adequate? Yes No N/A	Were these Safe Work Procedures used in Training?

7	
Corrective Measures Taken and/or Recommended	
Corrective Action Referred To:	Date To Be Completed By:/
· · · · · · · · · · · · · · · · · · ·	
Additional Comments or Observations. Where applical	ble give details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if n	necessary)
Name(s) & occupations of person (s) who investigated	l accident:
Print Name & Occupation Pho	one Print Name & Occupation Phone
1 mil tallo a boodpalott	
Signature of Workers' Representative Date	
Name(s) of Witness(s) (Include phone number)	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

PSC 38

		· · · · · · · · · · · · · · · · · · ·			
Ministry	Tel.#	Location	Date of Report NoV 350		
Children + Famil	ies	Burnaby Youth Custody		VION 20 110	
Last Name of Injured (or ill) Pe	erson	First Name	•	File No.	
	s.22				
Years of Service	Time on	Occupation		Hours Worked in Previous 24	
	Present Job	Youth Superviso	<u>ه</u> د	Hour Period 8	
Accident Location (Dept. or A	ea)	Date of Accident		Time \$ 1930	
		Nov 29 2010	•	9 170	
Accident Category	Injury or	Equipment Motor	☐ Property	☐ Fire ☐ Othe	er :
(check)	Illness	Malfunction Vehicle	Damage	(specif	у).
Severity of Injury or Illness (ch	eck)	No Injury or First Ald Only	Medical Treatment	Time Fata	1 *
PLAVI	NA BAS	of Occupational Disease (eg. RSI) KETBAU STRETC PAIN IN BACK	HOD TO		
Were Written Safe Work Prod Established and Available?	edures	Were they Adequate?	•	Were these Safe Work Procedures used in Trainir	19?
Yes No N/A		Yes No N/A		Yes No No N/A	
PHYSICAL No UNSAF	Exursi	EXPLAIN FULLY UNSAFE CONDI			

Corrective Measures Taken and/or Reco	mmended			
MEMBER TO	STEETCH M	10RE	· · · · · · · · · · · · · · · · · · ·	
Corrective Action Referred To:		Date To Be Comple	ted By:/_	
Additional Comments or Observations. Vec., involved in this accident. (Use sepa	Vhere applicable give det arate sheet if necessary)	ails of makes & models of r	machines, equipment, too	ols, structures,
N/A				
Name(s) & occupations of person (s) wh	o investigated accident:			
TODA WATSON	778-452-2050)	· · ·	
Print Name & Occupation	Phone	Print Name & Occupat	,	
Signature of Workers Representative	Not 30 / 10 Date	Signature of Employer	1000	<i> 30 20 0</i> ate
Name(s) of Witness(s) (include phone n	ımber)			
s.15, s.22	2, s.79 YCJA			
Revised July 2004				

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

ast Name of Injured (or III) P		DR. Bundby	FRASER PARKL B.C	Date of Report	010
	rerson s.2	V 55-57 First Name	1	File No.	
ears of Service	Time on Present Inh	Hour Peri		Hours Worked in Previous 24 Hour Period	
Accident Location (Dept. or A	rea)	Date of Accident Noo 26/	`	Time [6]	4
Accident Category check)	Injury or	Equipment Moto		☐ Fire	Other (specify)
Severity of Injury or Illness (cl	heck)	No Injury or First Ald O	Medical Treatment	Time Loss	☐ Fatal *
Description of Accident or Em Responded to Novilved In Jouth and Jouth and Description of Accident or Em Jouth and Ivaliable of Accident of Established and Available of Established and Established and Available of Established and Available of Established and Estab	nployee's Account Ode Physica Stop Gi	of Occupational Disease (eg. fellow on a fellow of a f			of knee. 2 Youth to sepant t Knee
to stop Knee Wa	Comba	EXPLAIN FULLY UNSAFE CO	wh. In in Figh bread	King L	d

Corrective Measures Taken and/or Recommended
N/A - STAFF ARE TRAINED IN Physical Restraint and use of force regularly
Paret of our duties to respond to codes our
use force when nessissamy. No conjective measures or Recommendation
Corrective Action Referred To: Date To Be Completed By:/
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)
MA
Name(s) & occupations of person (s) who investigated accident: Rote Murphy Stanford Curve a Jew ADD 78-450-2077 Print Name & Occupation Phone Print Name & Occupation Phone Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number) 578-452-2050 5.15, s.22 DUR BYCS Caught incident on Camera o

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

			0.14	Note of Paner
Ministry MCF	Tel.#	Location 7900 Bycs Lu	FRASAL PARK	NOV 18/10
Last Name of Injured (or ill) Pe	erson	First Name		File No.
	s.22	'	· · · · · · · · · · · · · · · · · · ·	
Years of Service	Time on Present Job s.22	Occupation Youth Sulfer	Visor.	Hours Worked in Previous 24 Hour Period / 7
Accident Location (Dept. or Ar	ea)	Date of Accident		Time
HARRI SON		NOU 18/6		0722
Accident Category (check)	Injury or Illness	Equipment — Motor Malfunction Vehicle	' , '	Fire Other (specify)
Severity of Injury or Illness (ch	neck)	☐ No Injury or First Ald Only	/ Medical Treatment	Time Fatal *
Nature of Injury or Illness SciouLD 6 t	BACK	STALTED HUNTER	IC AT AB	out 230 PM
13 RESTRA	Pacifal	2 0 0 0 0 1 1 C C 2 10	TOP OF M	
Were Written Safe Work Pro- Established and Available?	cedures	Were they Adequate?	1	Were these Safe Work Procedures used in Training?
Yes No NA NA		Yes No N/A		Yes No N/A
Basic Cause (and Contributo	ry Factors)	EXPLAIN FULLY UNSAFE CON	NDITIONS	

Corrective Measures Taken and/or Recomme	· · · · · · · · · · · · · · · · · · ·	
Contective Measures Taxett attoror Meconities	inaea	
	· ·	
Corrective Action Referred To:	·	Date To Be Completed By:
	. (
Additional Comments or Observations, Where	applicable give deta	ils of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate	sheet if necessary)	:
	,	
	•	
	·	
Namo(a) & accumptions of parson (a) who inve		
Name(s) & occupations of person (s) who inve	stigated accident:	QWALLACE SUPOLVISAL 778-452 2050
		() WALLACE SUPONVISOR 778-457 2050
Print Name & Occupation	Phone -	Print Name & Occupation Phone
		$\bigcap_{i \in \mathcal{A}} \mathcal{A}_i$
		Dallo NOV 18/10
Signature of Workers' Representative	Date	Signature of Employer Representative Date
	-	
Name(s) of Witness(s) (include phone number)	
	:	
	,	
	1	

*if fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & Phase 2 Page 146 Committee; & CEP 2013 WHI Profitee

ANT ACCIDENT INVESTIGATION FOR

PSC 38

1 00 00						
Ministry	Tel.#	Location			Date of Report	1
HIN CHILDREN+ F	AMILLED	B4CS	·	·	Soft 27	2010
Last Name of Injured (or ill) Po	• .	First Name			File No.	Þ
	s.22			- *		
Years of Service	Time on	Occupation			Hours Worked I	n Previous 24
s.22	Presen' s.22	Youth SUP.	LUCCOL	-	Hour Period	kours.
Accident Location (Dept. or A	rea)	Date of Accident	,		Time	
Delta		Sept 21	2010		8:3	<i>p</i> .
Accident Category	Injury or		Motor	Property	☐ Fire	☐ Other
(check)	Illness	Malfunction	Vehicle	Damage		(specify)
Severity of Injury or Illness (cl	neck)	☐ No Injury or First	Ald Only	Medical Treatment	Time Loss	- ☐ Fatal *
		RIGHT EC				
Description of Accident or En DUKING CLTO ON WET FLO LEFT ANKLE	FOUR LAN	TIME IN DE	CTA FO	KM EMPL	OYEE S	UPPED WISTED
			•			
Were Written Safe Work Pro Established and Available?	cedures	Were they Adequate			Were these Sar Procedures use	
Yes No No N/A	• .	Yes No N/A	أسأ		Yes No	N/A 🗆
Basic Cause (and Contributo	ry Factors)	EXPLAIN FULLY UNS.	AFE CONDIT	TIONS		
Face	AND T	Welf				• • .
		ť		•		. •
			•			,
	•					
· .	•		•	*		

Corrective Measures Taken and/or Recommended
FLOOR WAS VERY WET. STUARS NOT BEING
USED AND MOP SHOULD HAVE BEEN SQUEEZED
USED AND MOP SHOULD HAVE BEEN SQUEETED MODE FOR USS WATER USE. USE OF DRY MOP
MORPING STYLE.
Corrective Action Referred To: OC / HEACTE Date To Be Completed By: /
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of persoπ (s) who investigated accident:
· LLE SOMORY 1 778 452 2051 NOT STRONGERM 778 452 2051
Print Name & Occupation Phone Print Name & Occupation Phone
alstratost, Milled Myanes 5607 27 /201
Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)
- 778 452 2051
- 778 452 2051

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

<u> </u>						
Ministry CFD.	.# Location Burnaby 1 Custady servi 1900 Frasel Park	Joudh, Cesi Joudh,	Date of Report	~ 20/201		
Last Name of Injured (or ill) Person	First Name		File No.			
s.2	22	•	:	, .		
s.22 Time on Present Ich	Vouth Supervis	50C'	Hours Worked i Hour Period	n Previous 24		
Accident Location (Dept. or Area)	Date of Accident Sept. 221 201	Date of Accident Sept. 2212010		30 am,		
Accident Category Injury or	Equipment Motor Malfunction Vehicle	Property Damage	☐ Fire	Other (specify)		
Severity of Injury or Illness (check)	No Injury or First Aid Only	Medical Treatment	Time Loss	Fatal *		
Nature of Injury or Illness Right Nit in Fuc	cheek swoller e w/ Volleyla	7. due	, to b	eing		
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) Playing volley ball in Gym. Resident Kicked Volley ball and it hit the Mght Check Causing brusing of Swelling. Also Broke my glasses frame						
Were Written Safe Work Procedures Established and Available? Yes□ No□ N/A□	Were they Adequate? Yes□ No□ N/A□		Were these Saf Procedures use Yes No	d in Training?		
Yes No NA YES						

Corrective Measures Taken and/or Recommended	
Accidental injury	while playing volleyba
Instruct Residents r	while playing volleybod not to Kick balls who
playing	
Corrective Action Referred To:	Date To Be Completed By:/
Additional Comments or Observations. Where applicable give etc., involved in this accident. (Use separate sheet if necessar	details of makes & models of machines, equipment, tools, structures,
Name(s) & occupations of person (s) who investigated acciden	nt:
tumela Deu ADO, 778452-200	
Print Name & Occupation Phone	Print Name & Occupation Phone
Signature of Workers' Representative Date	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	
Hame(s) of Williess(s) (include phone hambs)	

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

P3C 30	•			
Ministry Tel.# Children + Families	Location B. Y. C-S		Date of Report Sept. 21	2010
Last Name of Intured (or III) Person	First Name		File No.	
Years of Service Time on s.22 s.22	vidor	Hours Worked in Previous 24 Hour Period		
Accident Location (Dept. or Area) Con Frol Room	Date of Accident Sept 21 2010		Time /5/0/	hrs.
Accident Category Injury or	Equipment Motor Malfunction Vehicle	Property Damage	□ Fire	Other (specify)
Severity of Injury or Illness (check) Swollen Right Knee	No Injury or First Ald Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illness Twisted Ance walking Description of Accident or Employee's Account		use separate she	et if necessary)	
Tout a step down an	d felt my three h	white		
Were Written Safe Work Procedures Established and Available?	Were they Adequate? Yes No N/A		Were these Saf Procedures use	e Work d in Training?
Yes No N/A	Yes La NOLLI WALL		Yes No	N/A 🗆
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDIT	TIONS		
NA				
and the second s				

Compatible Manager T. L.			
Corrective Measures Taken and/or Recomm	ended	•	
		•	
<i>1</i> A			
None		•	
	•		
	•	,	
	•	•	
	•		
		•	
Corrective Action Referred To:		Date To Be Completed By:	
	· · · · · ·		
Additional Comments or Observations. Where etc., involved in this accident. (Use separate	e applicable give detail sheet if necessary)	s of makes & models of machines	, equipment, tools, structures,
Name(s) & occupations of person (s) who inv	estigated accident:		
CAESASouro ar 1	778-452-205	o Mafflew Annan	100 000 400000
Print Name & Occupation	i	7 -17 000 7 773.1041	
Tillic Name & Occupation	Phone	Print Name & Occupation	Phone
		Mother line	- Sept 21/10
Signature of Workers' Representative	Date	Signature of Employer Represent	in the Date
agginary of Frontiers Propresentative	Date .	oliginature of Employer Represent	ative Date
Name(s) of Witness(s) (include phone number	ir)		
None	<i>;</i>		
		ī	
	<u>,</u>		

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & Phase 2 Page 152

F0C 30		•				
Ministry Tel.#	Location	Date of Report				
CHILDREN + FAMILIES	Bycs BBy	AUG 28 10				
Last Name of Intured (or ill) Person	First Name	File No.				
s.22						
Years of Service Time on	Occupation	Hours Worked in Previous 24 Hour Period				
s.22 s.22	COLRECTIONS OFFICER	Hour Period 32				
Accident Location (Dept. or Area)	Date of Accident t	Time 10				
EMBRALD	AUG 28 10	1905				
Accident Category (check) Illness	Equipment	Fire Other (specify)				
Severity of Injury or Illness (check)	No Injury or First Ald Only Nedical Treatment	Time Loss				
Nature of Injury or Illness BRUSING + SWELLING OF R. SHOULDER						
OFFICER WAS INVO	Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) OFFICER WAS INUCLUSIO WITH OTHER STAFF IN THE THIS DOWN + RESTRAINT OF A YOUTH.					
Were Written Safe Work Procedures Established and Available?	Were they Adequate?	Were these Safe Work Procedures used in Training?				
Yes No N/A	Yes No N/A	Yes No No N/A				
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDITIONS					
Escalated you	# needed restrain	ieng.				

Name(s) of Witness(s) (include phone number)

s.15, s.22

778-452-2052

Revised July 2004

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry Tel. #	Location	Date of Report
CHILDREN + TAMILIES 452-2650	BURNABY	AUG 19 13
Last Name of Injured (or III) Person	First Name	File No.
s.22	<u> </u>	
Years of Service Time on Present Job	Occupation CARDISCITIONS OFFICER	Hours Worked in Previous 24 Hour Period
Accident Location (Dept. or Area)	CORRECTIONS OFFICER Date of Accident,	Time
GLACIER UNIT	AUG 18 10	2030
Accident Category Injury or Illness	Equipment Motor Property Malfunction Vehicle Damage	Fire Other (specify)
Severity of Injury or Illness (check) SOFT TISSUE INTURY	No Injury or First Ald Only Medical Treatment	Time Fatal *
Nature of Injury or Illness Injury and Dwelle	ng of right Rand.	
Description of Accident or Employee's Account	of Occupational Disease (eg. RSI) (use separate shee	et if necessary)
Lexith a which cli	involved in a to vino his working; an anjury to his.	Rolling 1
	\mathbf{U}	0
Were Written Safe Work Procedures Established and Available?	Were they Adequate?	Were these Safe Work Procedures used in Training?
Yes No No N/A	Yes No N/A	Yes No N/A
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDITIONS	
Budio Oddoo (and Odimbuloly Factora)	EXTENSION OF THE SECTION OF THE SECT	
Pasic Cause (and Continibutory Factors)		

Corrective Measures Taken and/or Recommended	
\mathcal{N}/\mathcal{Q}	Accioental Ocurrence.
Corrective Action Referred To:	Date To Be Completed By: /
Additional Comments or Observations. Where applicable give details	of makes & models of machines, equipment, tools, structures
etc., involved in this accident. (Use separate sheet if necessary)	· · · · · · · · · · · · · · · · · · ·
Name(s) & occupations of person (s) who investigated accident:	
TACQUUE HARRIS SCO2 778-452-2050	ARMAND RODRIGHEZ C.U. 778452 205
Print Name & Occupation Phone	Print Name & Occupation Phone
acquie Harres Chia 19 10 _	Sep 6 / Avo/19/2010
Signature of Workers' Representative Sate S	ignature of Employer Representative Date
Name(s) of Witness(s) (Include phone number)	
s.15, s.22 778 - 452 - 2	350

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & [4] \$60 & GFD-2013-00082

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel.#	Location			Date of Report	1
MIN. CHILDAN + FRAMILIES		B4C5		JUH 30 /2010		
Last Name of Injured (or ill) Po	erson	First Name			File No.	1
	s.22					
Years of Service	Time on	Occupation			Hours Worked in Previous 24	
s.22	Present Job	YeurH	SUPLANIS	OP	Hour Period	
	Accident Location (Dept. or Area)		/		Time	
SELUNC LIBER	HY	Juy ?	30/2010		1400	
Accident Category (check)	injury or	☐ Equipment	☐ Motor	Property	☐ Fire	Other
(GIBOR)	Illness	Malfunction	Vehicle	Damage		(specify)
Severity of Injury or Iliness (cl	heck)	No injury or I	First Aid Only	Medical Treatment	Time Loss	Fatal *
	Nature of Injury or Illness LEFT KNEE, SORE FROM AROUND RIGHT SHOULDER, SORE FROM CHAIR.					
Description of Accident or En	nployee's Account	of Occupational Di	sease (eg. RSI)	(use separate shee	et if necessary)	
RE3/0NE	DING TO	A PHYSICH	C ALTE	SEANTION	BETWEE	N TWO
RESIDENTS.	Went +	n THE CO	ours /10	EFT VINGE I	HURT) W.	4160 ON
The Cord NO	17415	STAFF WH	18 HII 11	U RIGHT	5/2001	OLR BY
A CHAIR	, ,			•		·
17 01/1/15	•					
Were Written Safe Work Pro Established and Available?	cedures	Were they Adeq	uate?		Were these Sa Procedures use	
Yes No N/A		Yes☑ No□ I	N/A 🗆			N/A
		EVEL AND ELLI VI	NOASE CONDI	TIONO	YesLI NOL	N/ALI
Basic Cause (and Contributo	ry Factors)	EXPLAIN FULLY U	INSAFE CONDI	HONS		
C. 111	ck By	PHAIL.				
STRUC	ck py	CAMILLE				
H					Dhasa 2	Dana 157

CFD-2013-00082

Corrective Measures Taken and/or Recommended
CHAIR REVIEW. ARE CHAIRS TO CLAHI THUS CHN BE BASILY THROWN?
CHN BE EASILY THROWN?
,
Corrective Action Referred To: DC KEALTH Date To Be Completed By: DO //
Date 10 Be Completed By: 12 17
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of person (s) who investigated accident:
Frint Name & Occupation Phone Print Name & Occupation Phone Print Name & Occupation Phone Phone State 3/2010 State 3/2010 State 3/2010 State 3/2010
198452/2651 D. Show 5105 /2010
Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

	Tel.#	Location			Date of Report)
MIN. CHILDRON	+ Formale	BYC	Ś	•	JUU 3	0 ko10
Last Name of Injured (or ill) Pe		First Name			File No.	/
	s.22			:		
Years of Service	Time on Present Job	Occupation South	SUPERVISO	R	Hours Worked in Hour Period	Previous 24
Accident Location (Dept. or Ar	rea)	Date of Accident	1		Time	
GYM		JULY 30	12010		15:45	
Accident Category (check)	Injury or illness	Equipment Malfunction	Motor Vehicle	Property Damage	Fire	Other (specify)
Severity of Injury or Illness (ch	neck)	No injury or I	First Ald Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illness	IDE OF	RIGHT AV	NKLE ST	TRHINGO.		
PLAYING AFTEN THE	PLAYING FROM HOCKEY IN THE GYM AND TRIED TO STRING AFTER THE BACK AND INSULED HY RIGHT FEDT.					
**						
Were Written Safe Work Pro	cedures	Were they Adeq	uate?		Were these Sat	e Work
Were Written Safe Work Pro Established and Available?	cedures	Were they Adeq			Procedures use	ed in Training?
Were Written Safe Work Pro Established and Available? Yes No N/A	cedures	Were they Adeq				ed in Training?

CFD-2013-00082

Corrective Measures Taken and/or Rec	commended
	NOWE
Y	
•	
Corrective Action Referred To:	Date To Be Completed By:/
•	
Name(s) & occupations of person (s) w	ho investigated accident:
	O - /
Print Name & Occupation	<u>178 482 Zes 1 73. SHokak</u> 778 482 Zes 7
	Sist 3/2010 x D. Mohre Sipt 3/25/10
Signature of Workers' Representative	Date Signature of Employer Representative Date
	, , , , , , , , , , , , , , , , , , ,
Name(s) of Witness(s) (include phone	number)

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel.#	Location			Date of Report	1
HIN. CHILDEN FLAMILIES		HOLLYBURY (BYCS)		JULY 30 /2010		
Last Name of Injured (or ill) Person First Name			File No.	1		
	s.22					
Years of Service	Time on Present Job	Occupation Supervisor			Hours Worked in Previous 24 Hour Period	
Accident Location (Dept. or Ar	rea) .	Date of Accident	3		Time 2/:2	- 5
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (ch	neck)	No Injury or I	First Aid Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illness Left el bow (*	vjory.					
HIT EC	Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) HIT ELBOW (R) ON CONCRETE FLOOR RESTARTINING AND AGRICESSIVE + COMBATINE YOUTH. ALSO CUT ECBOW ON MECHANICAL RESTARTING WHILE YOUTH WAS NOT COMPLYING.					
Were Written Safe Work Prod Established and Available? Yes No N/A	Were they Adequate? Yes ☑ No ☐ N/A ☐		Were these Safe Work Procedures used in Training? Yes No N/A			
Basic Cause (and Contributor	ry Factors) TICE }	EXPLAIN FULLY U	INSAFE CONDI	TIONS		

Corrective Measures Taken and/or Recommended
REFRESALA TRAINLING FOR RESTRAING NON
COMP. CA OF VOLETA
Competant govern
Corrective Action Referred To: Do. HEALTH Date To Be Completed By: Do //
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of person (s) who investigated accident:
LB SOMORY, 7784827081 B. SHOKAR 718482 2051
Print Name & Occupation Phone Print Name & Occupation Phone Print Name & Occupation Phone
SUC3/200 D. Slove Ger 3/2010
Signature of Workers' Representative Date Signature of Employer Representative Date
/
Name(s) of Witness(s) (include phone number)

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry 778.452 CHILDREN/FAMILY	4050 Tel.#	Location BURN 7900 FRA BURNABY	JABY YOUTH SEL PARK	H CUST SEAV. PR.	Date of Report 20/0.07	1.19
Last Name of Injured (or iii) Pe		First Name	<u> </u>	-	File No.	
Last hame or initired to an EF		FIRST NAME	•		LIIG MO.	
• •	s.22					
Years of Service	Time on Present Job	Occupation YOVTH S	SUPERVISO	OR	Hours Worked I Hour Period	n Previous 24
Accident Location (Dept. or Ar OUTSIDE OF ADM OFFICE PATIO	ea) IINSTPATION	Date of Accident Z0/0	.07.19		Time	
Accident Category	injury or	☐ Equipment	☐.Motor	☐ Property	☐ Fire	☐ Other
(check)	Illness	- Malfunction	Vehiole	Damage		(specify)
						-
Severity of Injury or Illness (ch	ieck)	No Injury or I	First Aid Only	Medical Treatment	Time Loss	Fatal*
Nature of Injury or Illness		•				
BULN TO 3 F		· ,		• • • • • • • • • • • • • • • • • • • •		
Description of Accident or Fm						
s.22				MD ON		
BOX ON A						DC .
BURNS WE	RE SV.	STAINEZ	> AS	A NESVA	7.7	
Were Written Safe Work Prod Established and Available?	cedures	Were they Adequ			Were these Sat Procedures use	
Yes No No N/A		Yes No No	V/A 🔀		Yes No	NIA
	<u> </u>		· · · · · · · · · · · · · · · · · · ·		1001-110	TN/74-4
Basic Cause (and Contributor		EXPLAIN FULLY U				
BURK BOX A	round t	XHAVST	UNIT	UNMARKE	D AN	D HETS
VERY HOT	rom 1	MAINE	EXHAU	ST. H	AND PL	ACED
on morm	SVANN	ND IN	OPDER	70	STABAU	IZE
STARTING	of m	ACHINE	<i>5</i>			
				•		

I BETIENL CABO	ecommended	DANGER	ZONES	OF
MACHINE			• .	
· WORK SAFE	SAFETY S	HEET EST	AACU SITE	D
		•		*
Corrective Action Referred To:		Date To Be Complete	l By	
		Date To Be Complete		
			· · · · · · · · · · · · · · · · · · ·	• • •
Name(s) & occupations of person (s)	•			
GRANT BUNKER A/SY.	5 118 452 2052	B. Thet	· -	•
,	•	S. Thete	Pho	ne
GRANT BUNKER A/SY.	5 118 452 2052 Phone 2010/1/20		Pho	ne
GRANT BUNKER A/SY. Print Name & Occupation White Control of the C	5 118 452 2052 Phone 20/0/7/20 Date	Print Name & Occupation	Pho	ne y 2012
Print Name & Occupation White Control of Workers' Representative	5 118 452 2052 Phone 20/0/7/20 Date	Print Name & Occupation	Pho	ne y 2012
GRANT BUNKER A/SY. Print Name & Occupation While Company of the	5 118 452 2052 Phone 20/0/7/20 Date	Print Name & Occupation	Pho	y 20/2

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JU...T ACCIDENT INVESTIGATION FOR ...

PSC 38

P3C 36				·	
Ministry	Tel.#	Location		Date of Report	
CHILDREN & FAMILIES		BYCS		July 7,10	
Last Name of Injured (or ill) P	erson	First Name	,	File No.	•
1	s.22				
Years of Service	Time on Present Job	Occupation		Hours Worked in	n Previous 24
	Plesent Job	YOUTH SUPERULOR		Tiodi i onod	
Accident Location (Dept. or A	rea)	Date of Accident		Time	
SCIENCE CLA	ssloom	July 7 2010		11,00	HRS.
Accident Category (check)	Injury or		roperty Damage	Fire	Other (specify)
Severity of Injury or Illness (cl	neck)	1 7 	ledical atment	Time Loss	☐ Fatal *
Nature of Injury or Illness	RIGHT	LEG INJURY	-		.
DESIC & STA	E CLA	SSROOM. CAUGIT EBIDENTS KANDI	T BC	STWEE	N BODY
		· .			
Were Written Safe Work Pro Established and Available?	cedures	Were they Adequate?	•	Were these Saf Procedures use	
Yes No No N/A	. •	Yes No N/A		Yes No	N/A 🗹
Basic Cause (and Contributo		EXPLAIN FULLY UNSAFE CONDITIONS (+f7			
		•			

Corrective Measures Taken and/or Recommer	nded			3
NONE AT	7747 S	TIME		
1001				
•		•		
		•		·
•		•		
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•				
0. " 0." D. T.	•	Data Ta Da Occupitate d Dan		
Corrective Action Referred To:		Date To Be Completed By:	/. · · · · · · · · · · · · · · · · · · ·	
Additional Comments or Observations. Where		s of makes & models of machines, ed	quipment, tools, str	uctures,
etc., involved in this accident. (Use separate s	heet if necessary)	·	,	
NIA	•		, '	
, , , , , , , , , , , , , , , , , , , ,		,	•	
	 			
Name(s) & occupations of person (s) who inve	stigated accident:		•	~
CAROLA. MILLER	77845220	SO SENIOR YOU	TTH SUIPE	
Print Name & Occupation	Phone	Print Name & Occupation	Phone	
BRANDON THISTLE	778452	12050 YOUTH.	SUPERU OSH	150/-
Signature of Workers' Representative	Date	Signature of Employer Representati	•	REP.
· · ·		- 13/OT-		
Name(s) of Witness(s) (include phone number)	-		
s.15, s.22		٠,		
5, 5				
	•			
		•	• •	,
•				

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JONT ACCIDENT INVESTIGATION FORM

PSC 38

				<u>.</u>		
Ministry 778-452	2350 Tel.#	Location			Date of Report	
CHILDREN + TAM	ILLES				JUNE 3	30 10
Last Name of Injured (or III) Pe	rson	First Name		- ,	File No.	
	s.22					
Years of Service	Time on Present Job	Occupation	•	· .	Hours Worked Hour Period	in Previous 24
s.22 .	s.22	COLLECTION	IS OFF	1CBR	Don Pendo	
Accident Location (Dept. or Are	ea)	Date of Accident	\overline{t}		Tlme	
Gym		JUNG	3010		11:40	cem
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of injury or illness (che	eck)	No Injury or	First Ald Only	Medical Treatment	Time Loss	☐ Fatal*
Nature of Injury or Illness TWG760 R. K.	NETE PL	AYING C	OCLLBY BA	JLC.		
Description of Accident or Emp	olovee's Account	of Occupational Di	sease (eg. RSI) (use senarale shee	f if necessary)	
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) TURNED TO GET BALL, KNEE DID NOT FOLGS						
Were Written Safe Work Proce Established and Available?	edures	Were they Adeqเ			Were these Safe Procedures use	
Yes No No N/A		Yes No No	1/A 🔀		Yes No	N/A 🔽
Basic Cause (and Contributory	Factors) E	XPLAIN FULLY U	NSAFE CONDIT	IONS		
- noné						
	• •					

Phase 2 Page 167 CFD-2013-00082

		·
Corrective Measures Taken and/or Recommended		· .
		•
- NONE		·
		. ا
Corrective Action Referred To:	Date To Be Completed By:/	
		· · · · · · · · · · · · · · · · · · ·
Additional Comments of Champing and Champing		
Additional Comments or Observations. Where applicable give details of etc., involved in this accident. (Use separate sheet if necessary)	f makes & models of machines, equipment, tools	i, structurės,
otor, involved in this accident. (Cas asparate affect it hoosassing		
N/A		
/*. / / ¹ /3		
Name(s) & occupations of person (s) who investigated accident:		•
Name(s) a occupations of person (s) with investigated accident.		
/Aminpo/Rospiana 1 C.O. 778452 2050	J. HARRIS 5002 778-4	49-2-50
		JA AU
FILITINATION & Occupation FILITING F	Print Name & Occupation Phone	a l
Ola 1 (2) L Juna /30/2010 1	1 Alannin Idean	03010
	J. Harris Gun	
Signature of Workers' Representative Date Signature	gnature of Employer Representative Date	a .
	<u>*</u>	
Nama(a) of Williams(a) (Institute whoma number)		
Name(s) of Witness(s) (include phone number)		
		•

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; &P(4)sec2alPAGED 64fice CFD-2013-00082

	•	<u> </u>
Ministry Tel.# HCFD 778-45J-2050	Location BYCS	Date of Report Jane 29/10
	1	
Last Name of Injured (or ill) Person	First Name	File No.
s.22		
Years of Service Time on	Occupation	Hours Worked in Previous 24 Hour Period
s.22	OPPRECTION OFFICER	16.5
Accident Location (Dept. or Area)	Date of Accident	Time
OUTSIDE FIAD	June 29/10	1426
Accident Category (check) Injury or	Equipment Motor Property Malfunction Vehicle Damage	Fire Other (specify)
Severity of Injury or Illness (check)	No Injury or First Ald Only Medical Treatment	Time Loss
Nature of Injury or Illness STRAIN	ED NECK (L) SIDE	
SCHAPE,		
SWOLLER	(R) KNEE	
Description of Accident or Employee's Account	of Occupational Disease (eg. RSI) (use separate she	et if necessary)
	D DURING A SOCI	EX GANG
	- AND RESIDENTS	4
	RAYING GOAL AT	
AND DID DIVE FO	LABALLAS PEL	HIS ATTICETIC
REACTION TO THE	SHOT PART OF BE SUPERVISOR.	ING A
Were Written Safe Work Procedures	Were they Adequate?	Were these Safe Work
Established and Available? Yes No N/A U	Yes No No N/A	Procedures used in Training?
16574 14011 14771		Yes No N/A
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDITIONS	
•		
		•
		•
· .		

**	, *
Corrective Measures Taken and/or Recommended	Province Garage
USE CAUTTON WHEN P	CAYING COAC
SWITCH OFF WITH O	MEXS WHEN A
SPARE IS AVAILABLE	
BS4	
Corrective Action Referred To:	Date To Be Completed By:/
Additional Comments or Observations. Where applicable give details	of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)	
MA	
Name(s) & occupations of person (s) who investigated accident:	11 St. of 1 mice 2006
Dave Dinhowe VISITS 778-452-2068	M. Weile + 18912-6019
Print Name & Occupation Phone	Print Name & Occupation Phone
10 M	1/1/10 July 1/00
Signature of Workers' Representative UDate	Signature of Employer Representative Date
Name(s) of Witness(s) (include nhone number)	
5.15, s.22 778 - 452 - 26	
TH - 42-0	-030
:	•

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry MINISTRY OF CHILDREN Tel.#				
AND FAMILIES	1900 FRASER PARK DRIVE. BASKETBALL COURT.		Date of Report	25
Last Name of Injured (or III) Person	First Name		File No.	
s.22				
Years of Service Time on Present Job	Occupation YOUTH SUPERVISOR	2	Hours Worked in Hour Period	n Previous 24
Accident Location (Dept. or Area)	Date of Accident		Time	
BASKETBALL COURT	2010-06-25		2040	
Accident Category Injury or	Equipment Motor Malfunction Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (check)	No Injury or First Aid Only	Medical Treatment	Time Loss	☐ Fatal *
Right ANKLE SPRAIN, SOUTH SWOLLEN. ICE WA	15 ADMINISTERED BY	HEALTH G	ARE.	
Description of Accident or Employee's Account of STAFF WAS PLAYING BASK BASKETBALL COURT. WHILL DOWN AND ROWED RAGHT	LETBALL WITH THE K	CESIDENTS (CH THE BAU	O THE C, STAFF	Pame Side
STAFF WAS PLAYING BASK	LETBALL WITH THE K	CESIDENTS (CH THE BAU	O THE C, STAFF	lame Side
STAFF WAS PLAYING BASK BASKETBALL COURT. WHILE DOWN AND ROLLED RIGHT OF BODY Were Written Safe Work Procedures	LETBALL WITH THE K	CESIDENTS (CH THE BAU	O THE C, STAFF	<i>SIDE</i> e Work
STAFF WAS PLAYING BASK BASKETBALL COURT. WHILL DOWN AND ROLLED RAGHT OF BODY	LETBALL WITH THE R LE JUMPING TO CATO T ANKLE, FALLING 1	CESIDENTS (CH THE BAU	O THE C, STAFF HANDS AND Were these Safe	SIDE e Work d in Training?

Corrective Measures Taken and/or Recommended	
n	
· ·	
Corrective Action Referred To:	Date To Be Completed By:/
	Sale 70 50 completed by
Additional Comments or Observations. Where applicable give	ive details of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necess	sary)
ulla	
PIF	
V	
Name(s) & occupations of person (s) who investigated accid	dent:
Dun Orden Middle Mario	326. MANGILL SALVEZ 2003
Dave Birchmore Visits Office 778-452	
Print Name & Occupation Phone	Print Name & Occupation Phone
$\langle (21) \rangle \langle (21) \rangle$	10 1 MS 1 Ch. 710
	10 / Cy 10
Signature of Workers' Representative Pate	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	
	·

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JOHA ACCIDENT INVESTIGATION FORM

PSC 38 Date of Report Tel.# Location Ministry File No. Las s.22 Hours Worked in Previous 24 Occupation Time on Years of Service YUTH SUPERVISOR Hour Period Present Job s.22 Time Date of Accident Accident Location (Dept. or Area) Other Fire Property __ Motor **Accident Category** Equipment Injury or (specify) Vehicle Damage (check) Malfunction Illness ☐ Fatal * Time Severity of Injury or Illness (check) t∕ledical No Injury or First Ald Only Loss Treatment Nature of Injury or Illness Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) allercation tovolving Were these Safe Work Were they Adequate? Were Written Safe Work Procedures Procedures used in Training? Established and Available? Yes No N/A Yeski Noll N/AL EXPLAIN FULLY UNSAFE CONDITIONS thee he came worse as day and on Basic Gause (and Contributory Factors)

Corrective Measures Taken and/or Recommended	·
N/A	
Corrective Action Referred To:	Date To Be Completed By:/
Concession / Conce	
Additional Comments or Observations. Where applicable give	details of makes & models of machines, equipment, tools, structures;
etc., involved in this accident. (Use separate sheet if necessar	vork aart dang
Now - Ketured to a	vove with any
, , ,	
Name(s) & occupations of person (s) who investigated accider	nt: / A1 .C1
11 1 1 1 1 1	M 81.1.1 770.482-78171
Vodvquez, Armando	Print Name & Occupation Phone
Print Name & Occupation Phone	74/200
	- Alle of the
Signature of Workers' Representative Date	Signature/of Employer Representative Date
Signature of Workers' Representative Date	
Olgridia o Cristia o Crist	
Signature of Workers' Representative Date Name(s) of Witness(s) (include phone number)	
Olgridia o Cristia o Crist	
Olgridia o Cristia o Crist	
Olgridia o Cristia o Crist	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

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Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office

Ministry of Children and family developmen	Location Bur	haby se	1004h	Date of Report 20/0 / 0	6/06
Last Name of Injured (or III) Person	First Name	1		File No.	
s.22			•		
Years of Service Time on Present Job	Occupation Youth	Superu	isor	Hours Worked I Hour Period	n Previous 24
Accident Location (Dept. or Area) Seperate Continement	Date of Accident 20/0/0	06/06		Tlme 1400	hrs
Accident Category	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (check)	☐ No Injury or I	First Aid Only	Medical Treatment	Time Loss	Fatal *
Nature of Injury or Illness ASSOW I + by res	dent				
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) STAFF WAS SNAT IN THE FACE					
Were Written Safe Work Procedures Established and Available?	Were they Adequ	· ·		Were these Saf Procedures use	· · · · · ·
Yes Mo N/A	Yes Mo No No	V/A!!		Yes No	N/A□
Basic Cause (and Contributory Factors)	EXPLAIN FULLY U	NSAFE CONDIT	TIONS		
•••	•				

<u> </u>				
Corrective Measures Taken and/or Recon				
SPIT @	GUANDS MOUNTARDS	SHAWLED	BE RE	-600 KEP.
	•	;		
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	•	•		
	[11.11		•	
Corrective Action Referred To:	e/fleath	Date To Be Comple	eted By 2010, 1	0.7
	7			
	·			
Additional Comments or Observations. Wetc., involved in this accident. (Use separ		ils of makes & models of	machines, equipm	ent, tools, structures,
	•			,
		•		•
		•		
•				
				· ·
Name(s) & occupations of person (s) who			. 1	
LES SOUDLY,	778 452 2051	MATT A.	WNAN_	178 452 2051
Print Name & Occupation	Phone	Print Name & Occupa	ition	Phone
	7784522051	> Moto	Im.	778482 7051
Signature of Workers' Representative	Date	Signature of Employer	Representative	Date
		· · · · · · · · · · · · · · · · · · ·		
Name(s) of Witness(s) (include phone nu	mber)		1	
		•		
		•		
				•

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JC...T ACCIDENT INVESTIGATION FORM

PSO:

			^	1. 1 0		
Ministry MCF	Tel.#		of tersor pe	we arme	Date of Report	
BYEC. 778-452 205	6	1234m			Mayaa	2010
Last Name of Injured (or iii) Pe	;	First Name			File No.	
	s.22					
Years of Service	Time on Present Joh s.22	Occupation PA	ograms s	Superinsor	Hours Worked in Hour Period 1	
Accident Location (Dept. or Ar	ea)	Date of Accident			Time	
67m	•	May 22 2	010		1430	
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (ch		☐ No Injury or I		Medical Treatment	Time Loss	Fatal*
Nature of Injury or Illness (Jett) The	my rupo	icted u	uich Kad	to ready	ve voti 1.
Description of Accident or Em	Supervis	519 You	WW C	2 game	of lod	sor Sor
Description of Accident or Em	Superioris Lap che Radio	of Occupational Display	WW C	2 game	of lod	sor So. inseco
Description of Accident or Em While achively s.22	Superioris Lap che Radio	519 You	WW C	2 game	of lod	sor Sor
Description of Accident or Employees white achive ly s.22 was s.22 by thombo	Supervis Lip Chy Radio	519 You	ya fello tan h	2 game	of lod	ingad
Description of Accident or Employees white active light s.22 was s.22 loft thomas or	Supervis Lip Chy Radio	eled be	ya fello tan h	2 game	of the dama	Work d in Training?
Description of Accident or Employers While achuely s.22 was s.22 who was something the safe Work Proceed to the safe Work	Superiors Lap Chy Radio s La edures	equents equents	ya fello tan h	of cause	Were these Safe Procedures used	Work d in Training?

	·				
orrective Measures Taken and/or Rec	commended				
	None	· ·			
		;			`. <i>;</i>
	•			•	• • • •
rective Action Referred To:		Date To Be Compl	eted Bv: /	•	
dditional Comments or Observations.	Where applicable give d	etails of makes & models of	machines, equipm	ient fools s	structures
c., involved in this accident. (Use ser			maarmicor ogaspi,	oriel coalel	
	•				
	\mathcal{N}_{ϵ}	re:			
		•			·
ame(s) & occupations of person (s) w	who investigated accidents		4		
	778-4522	j	Ania.	_	110: -
int Name & Occupation	7.70 7322 Phone	Print Name & Occupa	otton	798	-4/222
int Nathe & Occupation	riiotte	1 mil Name of Occupa	A .	/Phone	•
	50001/20	The last	//		11
LA	718 45222	- ////X/V / V	m	775	1822
gnature of Workers' Representative	778 452229 Date	Signature of Employer	Representative	77 <i>}</i> Date	1822
	Date	- ////X/V / V	Representative	775 Date	1822
	Date	- ////X/V / V	Representative	775 Date	4822
	Date	- ////X/V// / V	Representative	775 Date	4822
ignature of Workers' Representative ame(s) of Witness(s) (include phone i	Date	- ////X/V// / V	Representative	775 Date	4822

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

, do 00		
Ministry Tel.#	Location 7 Sco TRASSR PARK DRIVE	Date of Report
CHILDREN+ FRMILIES	HARRISON UNIT	MAY 17 10
Last Name of Injured (or ill) Person	First Name	File No.
s.22		
Years of Service Time on Present Job	Occupation	Hours Worked in Previous 24 Hour Period
r tasan sou	CORRECTIONS OFFICER	nodi Peliod
Accident Location (Dept. or Area)	Date of Accident	Time
HARRISON UNIT	MAY 10 10	13/5
Accident Category (check) Injury or Illness	Equipment Motor Property Malfunction Vehicle Damage	Fire Cother (specify)
Severity of Injury or Illness (check)	No Injury or First Aid Only Medical Treatment	Time Fatal *
Nature of Injury or Illness. OFFICER HAD TUST BEEST	N ASSAULTED AND PUNCHE	5D THE WALL
WFRUSTRATION		
Description of Accident or Employee's Account	of Occupational Disease (eg. RSI) (use separate shee	et if necessary)
AS BELOW, OFFICER	HAD BEEN ASSAULTED A	ND EXPRESSED
	Y PUNCHING THE WA	
Were Written Safe Work Procedures Established and Available?	Were they Adequate?	Were these Safe Work Procedures used in Training?
Yes No N/A N/A	Yes No No N/A	Yes No N/A
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDITIONS	
CAUSE WAS FRUSTAAT	700 AND ANGER TROM E	369NB
ASSAULTED.		

Corrective Measures Taken and/or Recommended	·
Corrective Inicasules Takert and/of Necontilliended	
,	
N/R	
Olamantina Author Defenda Tar	Data Ta Ba Completed By
Corrective Action Referred To:	Date To Be Completed By: /
Additional Comments or Observations. Where applicable give detail	c of makes 8 models of machines equipment tools structures
etc., involved in this accident. (Use separate sheet if necessary)	s of makes of models of machines, equipment, tools, structures,
	· .
N/A	
10/10	
Name(s) & occupations of person (s) who investigated accident:	
Arugupo Roman Z. 778452 2050	JAPQUIE HADDIS 778-459-9350
Print Name & Occupation / Phone	Print Name & Occupation Phone
	1/h 1/2 1/50 2053
Signature of Workers' Representative Date	Signature of Employer Representative Date
Signature of Workers' Representative Date	Justicia of Employer Representative Date
Name(s) of Witness(s) (include phone number)	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office Phase 2 Page 180 CFD-2013-00082

1 00 00		·
Ministry Children & Family Tel. #	Location Burnaby Youth Custody &M	thate of Report
Development 718-452-2050	1900- PRASER PARK DR.	MAY. 12/2010
Last Name of Injured (or III) Person	First Name	File No.
s.22		
Years of Service Time on Present Job	Varth Superison	Hours Worked in Previous 24 Hour Period
Accident Location (Dept. or Area) BYCS School Rotunda	Date of Accident - Hay 11 2010	1330 hrs
Accident Category Injury or Illness	Equipment	Fire Other (specify)
Severity of injury or lilness (check)	No Injury or First Aid Only Medical Treatment	Time Loss Fatal *
Nature of Injury or Illness While res	straining combative resider	rut, Resident
Description of Accident or Employee's Accoun	of Occupational Disease (eg. RSI) (use separate she	et if necessary)
Varth Keaches	l'aver a bit le	yr knee.
Were Written Safe Work Procedures	Were they Adequate?	Were these Safe Work Procedures used in Training?
Established and Available? Yes No N/A	Yes No No N/A	Yes No No N/A
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDITIONS	
ASSAULT		

Corrective Measures Taken and/or Recommended	
	•
N/A.	
Corrective Action Referred To:	Date To Do Completed Day
Corrective / Iction Presented To.	Date To Be Completed By:/
Additional Comments or Observations. Where applicable give details etc., involved in this accident. (Use separate sheet if necessary)	of makes & models of machines, equipment, tools, structures,
(222 3023110 31103111 110000011)	
Name(s) & occupations of person (s) who investigated accident: ARMADOS ROBRIGUEZ. 778 482 2050	Matthew Annun ADO 778-452-2017
Print Name & Occupation Phone	Print Name & Occupation Phone
Ladar h duly MAY/13/2010	MATERIAN New 13 /10
Signature of Workers' Representative Date	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

PSC 38				•	
Ministry Children & Family Tel. # Dovelownent 7842-2000	Location Burnaby Yours, Services, 7900 From	n Custody USEC PORTUDI	Date of Report	0 10se	
Last Name of Injured (or ill) Person	First Name	<u> </u>	File No.		
s.22					
Years of Service Time on Present Job	Occupation Covrections Vouth Supervisor		Hours Worked i Hour Period	n Previous 24	
Accident Location (Dept. or Area) BVCS School Roturdo	Date of Accident May II (2010)		Time 13-3-C)	
Accident Category Injury or Illness	Equipment	Property Damage	☐ Fire	ASSAUT Other (specify).	
Severity of Injury or Illness (check)	No Injury or First Aid Only	Medical Treatment	Time Loss	☐ Fatal *	
Nature of Injury or Illness SCRAPED Left Kneer S	ORE NECK & Thr	ost Are	A		
SCATCHES & Brusin	1 ON ARMS,				
Description of Accident or Employee's Accoun	t of Occupational Disease (eg. RSI)	(use separate shee	t if necessary)		
s.22 WQ	is assaulted	by Res	sident.	then	
l	in restraint	, ,	ident		
Resident was Dunching, Kneeing, biting and					
Spitting at the Officer and was combative					
Were Written Safe Work Procedures	Were they Adequate?	100000	Were these Safe		
Established and Available? Yes No N/A	Yes No N/A		Yes No 1		
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDIT	TONS	Yesi-I (VOI-II)	WALKI	
ASS AU					
		,			

Corrective Measures Taken and/or Recommended	
	; ;
N/A	
$\mathcal{N} / \mathcal{A}$	
Corrective Action Referred To:	Date To Be Completed By:/
Additional Comments or Observations. Where applicable give details etc., involved in this accident. (Use separate sheet if necessary)	or makes & models of machines, equipment, tools, structures,
Name(s) & occupations of person (s) who investigated accident:	
ARMANDO ROPRIOLIEZ 778452 2050/	Mattlew Annun A.ho 771-452-2077
Print Name & Occupation Phone	Print Name & Occupation Phone
Print Name & Occupation Finding	About 1
/ July / 13/2010/	////thelle /May 13/10
Signature of Workers' Representative Date	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committeepsa(4) 2 o real(2) OFD-2013-00082

SOINT ACCIDENT INVESTIGATION FOR A

PSC'38

Ministry					-y	
	Tel.#	Location			Date of Report	
MCF		BURNABY BC.		MAY 11,2010		
Last Name of Injured (or ill) D	Parenn	Firet Nama	1		File No.	
	s.22					
Years of Service /	Time on Present Job	Occupation	0H	-	Hours Worked in Previous 24 Hour Period	
Accident Location (Dept. or A	rea)	Date of Accident			Time	,
Secure Ro	MENDA	MAY O	1 2010)		
Accident Category (check)	Injury or	/ Equipment Malfunction	Motor Vehicle	Property Damage	Fire	Other (specify)
Severity of Injury or Illness (cl	heck)	☐ No Injury or I	First Aid Only	Medical Treatment	☐ Time Loss	☐ Fatal *
•	SWOWER SWOWEN SOKE (CUT /			KNEG	
THE THE	as or	71-30710			ſ	
Description of Accident or Em ELEACING HURT KNE	ES WHEA	V WE	WEST	70 THE	had	CERVER
Were Written Safe Work Processablished and Available?		Were they Adequ		70 THE	Were these Sat	/ \

· · · · · · · · · · · · · · · · · · ·			*
Corrective Measures Taken and/or Recomme	ended		
		•	
·		. ,	
Corrective Action Referred To:		Date To Be Completed By: /	
		etails of makes & models of machines, equipm	nent, tools, structures,
etc., involved in this accident. (Use separate	sheet if necessary)	
			*
Name(s) & occupations of person (s) who inv	restigated accident	;	
Driet Name 0 Oceannetter	Dhana	Drint Nama & Occupation	Dhono
Print Name & Occupation	Phone	Print Name & Occupation	Phone
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
Signature of vyorkers includes and the	Date	olginature of Employer Nepresentative	Date
Name(s) of Witness(s) (include phone numb	er)	<u>.</u>	
Teamician of wantsasian influence inforce fullip	778-4	12-2050	
s.15, s.22	7-78 -	457-2050	•
			•
•			

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

30 30						
Ministry	Tel.#	Location)		Date of Report	,
MIN CHILDKON	14 CAMILLY	Bycs		···	MAY 7	2010
Last Name of Injured (or ill) Po	erson	First Name		,	File No.	
	s.22	_				2 <u></u>
Years s.22	Time on Present Job	Occupation CORRECTO	—— ONS 07	FICER	Hours Worked Hour Period	in Previous 24
Accident Location (Dept. or A	rea)	Date of Accident		,	Time	,
SECURE LINI	۷.	MAY 7	2010	 	17:38	
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other Aspecify
Severity of Injury or Illness (ch	iećk)	No Injury or F	First Ald Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illness OFFICER CO	as spat	IN THE FA	KE BY	A RESID	ENT	
Description of Accident or Em	ployee's Account	of Occupational Dis	sease (eg. RSI)	(use separate shee	et if necessary)	
OPPICER WA	28 HOLDI.	NG OPER	JA DO	OR TO H	ELP IN	
TRANSPORT	ING A 1	RESIDEN	IT WHE	IN SHE	SPAT 1	N
HIS PACE.				· ·	1	
			· .			
Were Written Safe Work Proc Established and Available?	edures	Were they Adequ	ate?		Were these Sa	
Yes No No N/A			I/A 🖳		Yes No N/A	
Basic Cause (and Contributor	y Factors) E	I EXPLAIN FULLY UI	NSAFE CONDIT	rions	<u> </u>	
UNPREDICTA	HBLE BE	HAUKKU F	2 BV D	LESLIDENT	- BETNE	ា ទ
			/ '		10	
TRANSPORT	spat o	01 -				
	·					

Corrective Measures Taken and/or Recommended
SPIT GUARD ON CONER
Corrective Action Referred To: OCHLaHh Date To Be Completed By 010 1/144 7
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)
Name(s) & occupations of person (s) who investigated accident:
Print Name & Occupation Phone / Print Name & Occupation Phone /
Signature of Workers' Representative Date May 7 2010 Signature of Employer Representative Date Date Date
Name(s) of Witness(s) (include phone number)
s.15, s.22

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Junt accident investigation form.

Ministry	Tel. #	Location			Date of Report	,
MIN CHILDREN	+ FAMILIES	BYCS		,	May 7	7/2010
Last Name of Injured (or ill) Pe	^ / *	First Name			File No.	
	s.22			, .		
Years of Sandca	Time on Present Job	Occupation Corrects.	ond C	Pfice	Hours Worked Hour Period	in Previous 24
Accident Location/(Dept. or Ar	ea) .	Date of Accident			Time	
EMERALD UNI	T	Emerald	ant	,	17:15	5
Accident Category (check)	Injury or	Equipment Malfunction	☐ Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (ch	eck)	☐ No Injury or I	First Ald Only	Medical Treatment	Time Loss	Fatal *
Nature of Injury or Illness Assaulted Headache 1	by cli	ert or	unt.		:	
Description of Accident or Em	ployee's Account	of Occupational Di	sease (eg. RSI)	(use separate shee	et if necessary)	
Assav 140	ed by	chert,				
			•			,
Were Written Safe Work Proc Established and Available?	cedures	Were they Adequ			Were these Sa Procedures use	fe Work ed in Training?
Yes No N/A	÷	Yes No No No	N/ALL		Yes 14 No	N/A 🗆
Basic Cause (and Contributor	y Factors)	EXPLAIN FULLY U	INSAFE CONDI	TIONS		
STRUW.						· · · · · · · · · · · · · · · · · · ·
	•					
			r			

Corrective Measures Taken and/or Recommended
TESTING POT System in aveas throughout
building Daily Par 5/Sten. products/for prope
Setting s.
Corrective Action Referred To: OC/flex/th Court of Date To Be Completed By: 20/01 05 07
Corrective Action Referred To: / / / / / / / / Date To Be Completed By: / 6/0/ 05 0 /
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools; structures, etc., involved in this accident. (Use separate sheet if necessary) About of proper settings by Staff.
Name(s) & occupations of person (s) who investigated accident:
Print Name & Occupation Phone, Print Name & Occupation Phone
Print Name & Occupation Phone Print Name & Occupation Phone
Signature of Workers' Representative Date Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JOINT ACCIDENT INVESTIGATION FORM

Ministry	Tel.#	Location		,	Date of Report	
MCF 77	18-452-2050	BURNA	134 BC	<u> </u>	APRI	18,2010
Last Name of Injured (or ill) Pe	rson	First Name	1		File No.	
	s.22					·····
Years of Service	Time on	Occupation			Hours Worked I	in Previous 24
s.22	Present Inh s.22	Youth.	Super	VISOR	Hour Period	.58
Accident Location (Dept. or Ar	ea)	Date of Accident			Time	
SECURE ROTUNDA	4 STARS	APR.	17,20	10	13	30
Accident Category (check)	Injury or	☐ Equipment	☐-Motor	☐ Property	☐ Fire	Other
	/Illness	Malfunction	Vehicle	Damage		(specify)
Severity of Injury or Illness (ch		No Injury or F		Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illness S	SORE K	NEE(R),	CALF	MUSCLE	(4), EC	BOW(R),
Description of Accident of Em	nloveels Account	of Occupational Dis	ease (en RSI) i	luse senarate shee	ot if necessary)	
Fac on S						DE
RED						
		· Aug				
					· · · · · · · · · · · · · · · · · · ·	
Were Written Safe Work Proc Established and Available?	edures	Were they Adequi	ate?		Were these Saf Procedures use	
Yes No NA		Yes No N	/A□			
/					Yes XI NoLI	N/A 🗆
Basic Cause (and Contributor	y Factors) E	EXPLAIN FULLY UI	ISAFE CONDIT	TIONS .		
		* .				

	Corrective Measures Taken and/or Recommended
٠	TAKE MORE CAUTION WHEN USING THE STAIRS IN THE SECURE ROTUNDA.
	THE SECURE ROTUNDA.
.	
	Corrective Action Referred To: Date To Be Completed By:/
	Bate to be completed by.
-	
	Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)
	cto., another in this accident. (Use separate sheet in necessary)
	Name(s) & occupations of person (s) who investigated accident:
	500/AMESBURY 778-450-2050 TODD WATSON 778-457-2050
1	Print Name & Occupation Phone Print Name & Occupation Phone
	January 10/04/18 10/04/18
Ł	Signature of Workers' Representative Date Signature of Employer Representative Date
ļ	
-	Name(s) of Witness(s) (include phone number)
	775-452-2050 s.15, s.22 778-452-2050
	s.15, s.22 778 - 45J - 2050
L	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office Phase 2 Page 192 CFD-2013-00082

J. AT ACCIDENT INVESTIGATION FOR W

Accident Location (Dept. or Area Gymaus (cm Accident Category (check)	s.22 I lime on Present Joh s.22 a) Injury or Iliness	First Name Occupation Oct+(Date of Accident	Super Super Motor Vehicle	ERVICE VISOR	Date of Report 2000 / 2 File No. Hours Worked i Hour Period Time ((: < < <)	in Previous 24
Last Name of Injured (or ill) Personal Vears or Service s.22 Accident Location (Dept. or Area Cymaus cum Accident Category (check)	s.22 I lime on Present Joh s.22 a) Injury or Iliness	First Name Uccupation \(\lambda U + t' \) Date of Accident \(\lambda O \) \(\lambda \) Equipment	Super 104/13 12 Motor	.V(S0/~	File No. Hours Worked i Hour Period Time	in Previous 24
Accident Location (Dept. or Area Accident Category (check)	s.22 I lime on Present Joh s.22 a) Injury or Iliness	Occupation \(\lambda \text{OUT}(\) Date of Accident \(\lambda \text{O} \)	/04/13	Ž	Hours Worked i Hour Period Time	6.5
Accident Location (Dept. or Area Gymnascum Accident Category (check)	I ime on Present Johs.22 a) Injury or	Yout(Date of Accident Zo (O ☐ Equipment	/04/13	Ž	Hour Period Time	6.5
Accident Location (Dept. or Area Gymnascum Accident Category (check)	Present .loh s.22 a) Injury or liness	Yout(Date of Accident Zo (O ☐ Equipment	/04/13	Ž	Hour Period Time	6.5
Accident Location (Dept. or Area Gymaus cum Accident Category (check)	s.22 a) Injury or liness	Date of Accident 2000 Equipment	/04/13	Ž	Time	5 am
Accident Category (check)	Injury or liness	Zo (O	□ Motor	l	11:45	5 am
Accident Category (check)	liness	☐ Equipment	□ Motor	l		1
Accident Category (check)	liness	☐ Equipment	□ Motor	l	Fire	I —
Severity of Injury or Illness (chec	ck)			Damage		Other (specify)
,		No Injury or F	First Aid Only	Medical Treatment	Time	Fatal *
PLATING BA	•					
Were Written Safe Work Proced Established and Available? Yes No N/A	lures	Were they Adequate Yes No No No			Were these Safe Procedures used Yes No	d in Training?
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS						
No aus	AFC	CONDITION	us vo	TED>		
			, ·		·	

Corrective Measures Taken and/or Recommended	
	:
·	
Corrective Action Referred To:	Date To Be Completed By:/
Additional Comments or Observations. Where applicable give de	tails of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)	
,	
Name(s) & occupations of person (s) who investigated accident:	M. lathill com my some
	Mark Streile Scor 778.452.2679
Print Name & Occupation Phone	Print Name & Occupation Phone
	Amil 19/2010
Signature of Workers' Representative Date	Signature of Employer Representative Date
· · · · · · · · · · · · · · · · · · ·	LV
Name(s) of Witness(s) (include phone number)	V
	·
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*if fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

J....IT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location				
MIN. CHILDRON		1	1/ 1/0	2 - 0 - 2 /	Date of Report	
Last Name of Injured (or ill) P			YOUTH C	USIDOY	HARCH 1	8/2010
Educitating of Injured (of (ii) P		First Name	,	* .	File No.	/
	s.22		<u>.</u>	<u> </u>		
Years or Service	Time on Present Job	Occupation . You 174 Si	PRIVE	»ک	Hours Worked Hour Period	n Previous 24
Accident Location (Dept. or Ar		Date of Accident	, .		Time	
MANTEAP CONTROL	-	MAR 18/	2610		12-55	
Accident Category (check)	Injury or		Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (ch	eck)	No Injury or Fir	st Ald Only	Medical Treatment	Time	☐ Fatal *
Nature of Injury or Illness SOAE WALLS						
Description of Accident or Emp Door HIT WAS PUSITED DOOR CAUSIN	WRIST W	WHEN TRYI WHEN LAY	WG 70 PLOYER	CLOSE DO WAS THY	ok. Deo	
Were Written Safe Work Proced Established and Available? Yes ☑ No ☐ N/A ☐		Were they Adequate			Were these Safe Procedures used	in Training?
Basic Cause (and Contributory I	Factors) EX	(PLAIN FULLY UNS,	AFE CONDITION		Yes No N	/A L

Phase 2 Page 195 CFD-2013-00082

Corrective Measures Taken and/or Recom	mended		•	
			•	
	Nowe			
		1		
Corrective Action Referred To:		Date To Be Complete	d By:/	
Additional Comments or Observations. Whete, involved in this accident. (Use separa	nere applicable give detai ate sheet if necessary)	is of makes & models of m	achines, equipment, to	ols, structures,
471	<i>(</i>			,
\mathcal{N}	F	·		
·		•		
Name(s) & occupations of person (s) who	investigated accident:	•		
	778 412 2011	KM U A.	A.D.O. 77	2 4522051
LAS SOMORY,				· · · · · · · · · · · · · · · · · · ·
Print Name & Occupation	Phone	Print Name & Occupation		one /
	MARCH 18/20	CAMHHA AN	MILL HIS	1Ret 18/211
Signature of Workers' Representative	Date	Signature of Employer R		Date
Signature of Anothers Teblesetrative	Buto /	organization and ampropriate		
	•		· · · · · · · · · · · · · · · · · · ·	
Name(s) of Witness(s) (Include phone nur	mber)			
	s.15, s.22	778 45	2 2051	
	,		•	
				Topical and the second
			•	
	•			· i

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

if this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office Phase 2 Page 196 CFD-2013-00082

J... ACCIDENT INVESTIGATION FOR

Tel.#					
İ	Location Burnaly	Youth Custo	idy Service	Date of Report March 18	2010
erson s.22	First Name			File No.	
Time on Present Job	Occupation Youth	Supervisor		Hours Worked in Hour Period	n Previous 24
	Date of Accident	n 18 2010		Time / 700 /	hrs
Injury or	Equipment Malfunction	☐ Motor Vehicle	Property Damage	☐ Fire	Other (specify)
heck)	No Injury or F	First Ald Only	Medical Treatment	Time Loss	Fatal *
Wet floor					
Sep. Con are	ia. Floor L				polled
n the gro	in asea				
* .					
cedures	Were they Adequ			Were these Safe Procedures used	
cedures	Were they Adequ				d in Training?
	/	ı/A□	'IONS	Procedures used	d in Training?
1	Present Job Area) Injury or Illness heck) Wet Floor Inployee's Account Sep - Con Are	Present Job Area) Date of Accident March Injury or Illness heck) Date of Accident March Malfunction No Injury or F	Present Job Youth Suprvisor Area) Date of Accident March 18 2010 Plinjury or Equipment Motor Malfunction Motor Vehicle No Injury or First Ald Only Muth Floor Application Sep Con Area. Floor Wall Welt.	Present Job Youth Supruisor Area) Date of Accident March 18 2010 Property Illness Malfunction Medical Treatment Met Floor Sep - Con Area. Floor Wal Welt. She Stip	Present Job Youth Supervisor Time 1700 March 18 2010 Property Damage The Medical Treatment No Injury or First Ald Only Property Damage The Medical Treatment Noss Property Damage Fire No Injury or First Ald Only The Loss Property Damage Time Loss Property Damage Time Treatment Sep - Con Ala. Floor Wal Welt. She Stipped and

Corrective Measures Taken and/or Recommended	
They wer I four.	
Mop wet floor. Med Shower Cortain	
Corrective Action Referred To:	Date To Be Completed By: 64, 01 10
	To potify W.S. E
Additional Comments or Observations. Where applicable give detailetc., involved in this accident. (Use separate sheet if necessary)	ils of makes & models of machines, equipment, tools, structures,
N/A	
Name(s) & occupations of person (s) who investigated accident:	
US SONDAY/ 7184522050	
Print Name & Occupation Phone	Print Name & Occupation Phone
MAPet 10/10	March 18/10
Signature of Workers' Representative Date	Śignature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	
s.15, s.22	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

If this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy To: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee; & (4) Local WCB office Phase 2 Page 198

CFD-2013-00082

					<u> </u>	
Ministry MCFD 778	Tel.# 452-2050	Location B.Y 7900 FV Burn	i.C.S aser la aby v	WK Dr.	Date of Report Mawa	ch 16/10
Leat Nama af Internal Carolly C	s.22	Philipping 1	. /	:	File No.	
Years of Service s.22	Time on Present Inb s.22	Occupation YouTH	SUPER	VISOR	Hours Worked I Hour Period	in Previous 24
Accident, Location (Dept. or A	rea)	Date of Accident	H161	10	Time 1330	ohrs.
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (cl CALF STRA)		No Injury or I	 ,	Medical Treatment	Time Loss	☐ Fatal*
Nature of Injury or Illness STRAINE	•	T CAL			? 7	
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)						
Were Written Safe Work Proc Established and Available?	edures	Were they Adequ			Were these Safe Procedures used	Work In Training?
Yes No N/A		Yes No N	/AL4		Yes No DI	V/A[]
Basic Cause (and Contributor) ACCIDEN SPORTS PARTIC RESIDEN	T OR ACT IPATI	1UITY	RY DURI	DURIN VG WO	/	tours.
						31

Corrective Measures Taken and/or R	Recommended			
		. •		
NON	VE NEED	>ED		
		;	· · · · · · · · · · · · · · · · · · ·	
Corrective Action Referred To:		_ Date To Be Complete	d By:/	
Additional Comments or Observation etc., involved in this accident. (Use s		ils of makes & models of ma	achines, equipment,	fools, structures,
		•		
Name(s) & occupations of person (s)) who investigated accident: SUPER VISOR E 778 452-2050	(YOUTH SUPE	,	8.452.2050
Print Name & Occupation	MAR.16/10	Print Name & Occupation		1952.2050 Phone MAR 16/10
Signature of Workers' Representative		Signature of Employer Re		Date
Name(s) of Witness(s) (include phon				
s.15, s.22		52 2050	•	
J. 10, J.L.	- 778 · 45	52.2050	•	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

Ministry Tel.#	Location BYCS		Date of Report	5/2010
Last Name of			File No.	
s	.22			· · · · · · · · · · · · · · · · · · ·
Years of Service Time on s.22	Occupation for TH SUP	ERVINE	Hours Worked i Hour Period	n Previous 24
Accident Location (Dept. of Alea)	Date of Accident	/13	Time /3:	40
Accident Category (check) Injury or	Equipment Motor Malfunction Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (check)	☐ No Injury or First Ald Only	Medical Treatment	Time	☐ Fatal *
Nature of Injury or Illness Riff	AM KNEE 1	wwy		
Description of Accident or Employee's Account While playing in Collided with a	of Occupational Disease (eg. RSI) Lister Volley eus Two pla	(use separate shee hall h	et if necessary)	l
Were Written Safe Work Procedures Established and Avallable?	Were they Adequate?	•	Were these Safe Procedures use	
Yes No NA NA	Yes No NiA	•	Yes No No	N/A
Basic Cause (and Contributory, Factors) Recedental Olivery back	EXPLAIN FULLY UNSAFE CONDI	TIONS Repla	gjng	

Corrective Measures Taken and/or Recommended			
rel /ia	:		
NA			
	1		
		,	
			1.4
	<u>.</u>		· ·
Corrective Action Referred To:	Date To Be Compl	eted By:/	<u> </u>
Nove			•
Nove			
Nove			
Nove			
Name(s) & occupations of person (s) who investigated accide	ent:		
Name(s) & occupations of person (s) who investigated accide H. SHEWEL FIP 152.28	79 Shery/ A	hidsp12	778:452 707
Print Natrie & Occupation Phone	ent: Novy 4 Print Name & Occup	waspe/2_	778-457 767 Phone
M. STREEMER 798-45226	79 Shery/ A	waspe/2_	798.452.767 Phone 2010/02/15
Print Natrie & Occupation Phone	79 Shery/ A		1-1-
M. STICKION 718-152.26 Print Neltie & Occupation Phone 1010/02/15	Print Name & Occupa		2010/02/15
M. STICKION 718-152.26 Print Neltie & Occupation Phone 1010/02/15	Print Name & Occups Signature of Employer	Representative	2010/02/15
Print Nertice & Occupation Phone 100/02/15 Signature of Workers' Representative Date	Print Name & Occupa	Representative	2010/02/15
Print Nartie & Occupation Phone 1010 01 15 Signature of Workers' Representative Date Name(s) of Witness(s) (include phone number)	Print Name & Occups Signature of Employer	Representative	2010/02/15

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JC...T ACCIDENT INVESTIGATION FORM

1 00 00				
Ministry Tel	I.# Location		Date of Report	
CHILDLEN+FAMILIBS	7900 FASSER PARK	'DR.	FEB 25	(3
Last Name of injured (or ill) Person	First Name		File No.	
s.22				· · · · · · · · · · · · · · · · · · ·
Years of Service Time on	Occupation	e.	Hours Worked In	n Previous 24
s.22	CORRECTIONS OF	FICER	11001	
Accident Location (Dept. or Area)	Date of Accident		Time	
HARRISON CENT	FBB 25 10		1515	· · · · · ·
Accident Category (check) Illness	r Equipment Motor Malfunction Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (check)	No Injury or First Ald Only	Medical Treatment	Time Loss	☐ Fatal*
Nature of Injury or Illness STAPF MEMBER INJUR AGGRESSIUG YOUTH.	ED RIGHT WRIST DU	ering a R	LESTRAINT	-OF AN
Description of Accident or Employee's Acco				
OFFICER RESPONDED	TO A CODE AND PA	HYSICALLY	' RESTRAI	NBD
AN AGGRESSIVE YOU THIS RESULTED IN TO	eTH. BOTH PARTIES	PELL ON	UTO THE	STHKS.
Were Written Safe Work Procedures Established and Available?	Were they Adequate?		Were these Safe Procedures use	
Yes No No N/A Y	Yes No No N/A		Yes D. No D	N/ALT
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE COND	ITIONS		
OFFICER WAS ATTEN	LATING TO PREVEN	IT AN AG	GRESSIU	5
YouTH FROM HURT	ING ANOTHER YOU	TH IN AC	ORRECTIC	NAL
CONTER.				

Corrective Measures Taken and/or Recommended	
Confective triessures Takerrandroi Necontinonded	:
11.10	
NONE.	
·	
Corrective Action Referred To: V/A	Date To Be Completed By:/
Corrective / tollor Notice Bate 10 Be completed by	
Additional Comments or Observations. Where applicable give details	of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)	
NONE.	
70002.	
Name(s) & occupations of person (s) who investigated accident:	
11.00	Amoun 2 Ropot A of \$100 bours 200
JACQUIE HARRIS SYS 778-452-2050	1 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.
Print Name & Occupation Phone	Print Marrie & Occupation / Phone
	Man had h I-1/2-had
Simulation of Ward and Branch and State of State	19h July 125/2010
Signature of Workers' Representative Date	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	
s.15, s.22 -778-452-20 <i>5</i> 0	

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

. 00 00	•		· .	
Ministry Tel.#	Location DURNAS	1	Date of Report	2010
Last Na	I		File No.	•
s.22				
Years of Service S.22 Time on Present Job	Occupation SW	ERVISOR	Hours Worked in Hour Period	Previous 24
Accident Location (Dept. or Area)	Date of Accident FFB	3/2016	Time 09.60	
Accident Category (check) Injury or	Equipment Motor Malfunction Vehicle	Property Damage	☐ Fire	Other (specify)
Severity of injury or Illness (check)	☐ No Injury or First Aid Only	Medical Treatment	Time	☐ Fatal *
Nature of Injury or Illness : TWITE) A	ND SORE PUBLIT &	WEE; UP	PER UP A	MA
LEFT SIDE OFFIACE SW	ocens			
Description of Accident or Employee's Account While M Symhasivm What My Masivm What My My red m 1	the yorth after	upted & affempte	ud did of to onte	VVene
Were Written Safe Work Procedures	Were they Adequate?		Were these Safe	Work
Established and Available?	<i>P</i> /	:	Procedures used	
Yes No No N/A	Yes No No N/A		Ves□ No□ N	I/A□
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDIT	IONS		
Aggrenne york was	comprative.			

Corrective Measures Taken and/or Recommended When I Staff responded	appropriately
V	
Corrective Action Referred To:	Date To Be Completed By: N
etc., involved in this accident. (Use separate sheet if ne Nove Tight was Mitted to Mevveue	le give details of makes & models of machines, equipment, tools, structures, ecessary) s.22 alternated
Name(s) & occupations of person (s) who investigated a	M. Sheild. Superma 778.457.2079
Print Name & Occupation Phone Signature of Workers' Representative Date	JAM guest 1
Name(s) of Wijness(s) (include phone number) s.15, s.22	74-452-2057

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JUINT ACCIDENT INVESTIGATION FOR IM

		<u> </u>		
Ministry Tel.#	Location	Date of Report Jan 30/2010		
Last Name of Inlured (or ili) Person s.22	First Name	File No.		
Years of Service Time on	Occupation Youth Supervisor	Hours Worked in Previous 24 Hour Period		
Accident Location (Dept. or Area) ENELSO UNIT	Date of Accident San 30/2010	Time 02.00		
Accident Category Injury or	Equipment Motor Property Malfunction Vehicle Damage	Fire Cother (specify)		
Severity of injury or illness (check) Twisted back	No Injury or First Ald Only Medical Treatment	Time Loss		
Nature of Injury or Illness Sliped or Description of Accident or Employee's Account	of Occupational Disease (eg. RSI) (use separate sheet	of if necessary)		
Were Written Safe Work-Procedures Established and Available? Yes ☑ No ☑ N/A ☑	Were they Adequate?	Were these Safe Work Procedures used in Training?		
YesLI NoLI N/ALI		Yes No No N/A		
Basic Cause (and Contributory Factors) Steep Stairs Dark area	EXPLAIN FULLY UNSAFE CONDITIONS			

	`*
Corrective Measures Taken and/or Recommended	
22., Tour o House to Fangi allaroi Foodificitoriada	: ``
	· ·
Corrective Action Referred To:	Date To Be Completed By:
Additional Comments or Observations. Where applicable give detail etc., involved in this accident. (Use separate sheet if necessary)	ls of makes & models of machines, equipment, tools, structures,
Name(s) & occupations of person (s) who investigated accident:	
	0 / 0
TODO WATSON (STEWARD) 778-452-203	JILL GARDNEL 778-4522050
Print Name & Occupation Phone	Print Name & Occupation Phone
JAN 30/10	//N hidron Sonzolia
	Clausture of Francisco Bonnescontailing
Signature of Workers' Representative Date	Signature of Employer Representative Date
Name(s) of Witness(s) (include phone number)	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

	•					
Ministry Tel. # Children + Families	Location B. Y. C-J	Date of Report Jan 24 2010				
Last Name of Injured (or III) Person	First Name	File No.				
s.22	<u> </u>					
Years of Service Time on s.22	Occupation Yorth Supervilor	Hours Worked in Previous 24 Hour Period				
Accident Location (Dept. or Area) Artificial Marketine (Dept. or Area)	Date of Accident Jan - 24 2010	Time 1700 hrs				
Accident Category Injury or (check)	Equipment Motor Property Malfunction Vehicle Damage	Fire Cother (specify)				
Severity of Injury or Illness (check)	No Injury or First Ald Only Medical Treatment	Time				
Nature of Injury or Illness Right Anec	Nature of Injury or Illness Right Knee cup hit by table.					
•	of Occupational Disease (eg. RSI) (use separate sheety dining room table. At him had area.					
Were Written Safe Work Procedures Established and Available? Yes No No N/A	Were they Adequate? Yes No N/A	Were these Safe Work Procedures used in Training? Yes No N/A				
Basic Cause (and Contributory Factors) Arman Cror. (SYRUCK)	EXPLAIN FULLY UNSAFE CONDITIONS					
•		· · · .				

Corrective Measures Taken and/or Recommended	
·	•
•	
•	N/4
•	
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en e	
Corrective Action Referred To:	Date To Be Completed By:/
Additional Comments or Observations. Where applicable give detail	ils of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)	·.
i i i	
N/n	
J. / W	
i ·	
Name(s) & occupations of person (s) who investigated accident:	
	10 1111. 1 770 (1/2-205)
Jompy 1 /78-4(22251	Matthew Annan 778-452-2050
Print Name & Occupation Phone	Print Name & Occupation Phone
/ XX	Batt non 1 man
JAOK 24/10	///// Um 14 2010
Signature of Workers' Representative Date	Signature of Employer Representative Date
A CANTLE AND THE SHOPE MANAGED	
Name(s) of Witness(s) (include phone number)	
None	
pounc	
· · · · · · · · · · · · · · · · · · ·	

^{*}If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JUINT ACCIDENT INVESTIGATION FOR ...

1 00 00						
Ministry Children + Families	Tel. #	Location Ventore D	ay room		Date of Réport Jan 21	2010
Last Name of Injured (or ill) Po	erson	First Name			File No.	
	s.22					
Years of Service	Time on Present Job	Senior Youth	Sepervic	sor	Hours Worked in Hour Period	n Previous 24
Accident Location (Dept. or A	rea)	Date of Accident			Time	1
Venture		Jan. 21 2	2010		1915	NFS
Accident Category (check)	Injury or		Motor /ehicle	Property Damage	☐ Fire	Other (specify)
Severity of Injury or Illness (cl	neck)	No Injury or First A	id Only	Medical Treatment	Time Loss	☐ Fatal *
Nature of Injury or Illness Strain ย	l left po	ılm, middle an	d index	finger		
Description of Accident or En	morny K	le mon hould ed hij left	and m			
			•	•		
Were Written Safe Work Pro Established and Available?	cedures	Were they Adequate?			Were these Safe Work Procedures used in Training?	
Yes☑ No□ N/A□	•	Yes No No N/A	į		Yes☑ No□	N/A□
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS						
Mop hu	clerk was	not emptie	d .			•• .
						. •
	V.				. *	

Corrective Measures Taken and/or Recommended		
Put cleaning equipment an	my when not in use.	
Put cleaning equipment and Do not leave in Day,	(70).	
100 May pear M. May	wan	
	•	
		·
Corrective Action Referred To:	Date To Be Completed By:/	
	, , <u>, , , , , , , , , , , , , , , , , </u>	
Additional Comments or Observations. Where applicable give de etc., involved in this accident. (Use separate sheet if necessary)		ools, structures,
	·	٠.
		•
Name(s) & occupations-of person (s) who investigated accident:	10 A 1 A A A A A A A A A A A A A A A A A	
TODD WATSON STEWARD 776-457-2050	Matthew Annan 11.10 17	18-452-2050
Print Name & Occupation Phone	Print Name & Occupation Pl	none
Signature of Workers' Representative Date	Signature of Employer Representative	<u>m 2 2010 -</u> Date
Tall Tall Tall Tall Tall Tall Tall Tall	o.g	
Name(s) of Witness(s) (include phone number)		

*if fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

SINT ACCIDENT INVESTIGATION FOR.

Ministry Tel. #	Location	Date	of Report	
Children & family Development	Burnaby, BC	Jan	22 2010	
Last Name of Injured (or ill) Person	First Name	File N	lo.	
s.22				
Years of Service Time on s.22	Occupation Office,	Hour	s Worked in Previous 24 Period ***********************************	
Accident Location (Dept. or Area)	Date of Accident	Time		
GN/m	Jan 212010 - 1	3:30	13:30	
Accident Category (check) Injury or	Equipment Motor Vehicle	Property Damage	Fire Other (specify)	
Severity of Injury or Illness (check)	☐ No Injury or First Aid Only	Medical Treatment L	Time Fatal *	
Nature of Injury or Illness Twisfed lower back	K			
Made a quich turn twisted lower bac	n playing floor	nockey !	gym 4	
Were Written Safe Work Procedures Were they Adequate?			e these Safe Work edures used in Training?	
Yes No N/A	Yes No N/A V Yes No N/A V		Yes No N/A	
Basic Cause (and Contributory Factors)	EXPLAIN FULLY UNSAFE CONDITION	`,	•	
Twist during !	Sporting Event	interacting	e with	
	•			
·				

Corrective Measures Taken and/or Recommended
- STAFF AND CHENTS SHOULD BE ENCOURAGED
TO STRETCH BEFORE PARTICIPATING IN SPORTING
ACTIVITIES DE DECREASE POTENTIAL HARM.
- POSTERS AND REMINDERS TO STRETCH BEFORE INTERSETTAL
IN SBUTS.
Corrective Action Referred To: RASMIS, BILL Date To Be Completed By: 10 104 61
Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)
N/A
Name(s) & occupations of person (s) who investigated accident:
/
SHOKAR 7184522251 SOMOLUI 7784522251
Print Name & Occupation Phone Print Name & Occupation Phone
In Shop In 122/0 / Tow 22/00
Signature of Workers' Representative Date Signature of Employer Representative Date
Signature of vyorkers Representative Date / Signature Port Representative Date /
Name(s) of Witness(s) (include phone number)
s.15, s.22

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

JINT ACCIDENT INVESTIGATION FORM

F3C 30						
Ministry MCFO	Tel.#	Location BURNARY		Date of Report Zoto (or (Zo		
Last Name of Injured (or ill) Po	erson	First Name		•	File No.	
	s.22			•] ·	
Years of Service.	Time on ·	Occupation SENTOR:	GUTH SU	PERUISOR	Hours Worked i Hour Period (n Previous 24
Accident Location (Dept. or A	-	Date of Accident	1 1 4		Time /3:00 11785	
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	Fire	Other (specify)
Severity of Injury or Illness (character) INTURED BACK		No injury or	First Ald Only	Medical Treatment	Time Loss	Fatal *
Nature of Injury or Illness STRACNED BA	ce WH	IL UF	TING t	fockey (JE TS	
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) BENT OVER TO UFT HOUSE (IECS, FELT TWINSE) WWER BACK						
	· ·					
Established and Available?		Were they Adeq			Were these Sat Projectures use	
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS						
NONE - SIMPLY BENT OVER TO INSPECT HOCKEY NET						
-	,				•	
					•	
			•			

\$ ~	· · · · · · · · · · · · · · · · · · ·
Corrective Measures Taken and/or Recommended	
HONE	
·	
. '	
, .	
Corrective Action Referred To:	Date To Be Completed By:
, ,	
Additional Comments or Observations, Where applicable give do	tails of makes & models of machines, equipment, tools, structures,
etc., involved in this accident. (Use separate sheet if necessary)	ians of makes & models of machines, equipment, tools, sudctutes,
YONE	,
•	
Name(s) & occupations of person (s) who investigated accident: H-Sweller TH-162-76	19 A. SMAFFORD 778-452-2050
Print Name & Cocupation Phone	Print Name & Occupation Phone
Signature of Workers' Representative Date	Signature of Employer Representative Date
// · · · · · · · · · · · · · · · · · ·	00.
Name(s) of Witness(s) (include phone number)	
HOWE	
(- k	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

		<u>'</u>	,		·		
Ministry Tel.#		Location B. Y. C.S.			Date of Report - 2010 . 01 . 18		
Last Name of Injured (or ill) Person		First Name \(\tau \)			File No.		
Years of Service s.22	Time on Present Johy	Occupation UNASUPETUISÕT		Hours Worked in Previous 24 Hour Period			
Accident Location (Dept. or Area)		Date of Accident ZO(0.01,17.		Time 2030			
Accident Category (check)	Injury or	Equipment Malfunction	Motor Vehicle	Property Damage	Fire	Other (specify)	
Severity of Injury or Illness (cl	Severity of Injury or Illness (check)		First Aid Only	Medical Treatment	Time Loss	Fatal *	
Nature of Injury or Illness Sore Lower Back							
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) While playing Soccer with residents in the Oym, Lell and NO major Concerns at this time. A few hows Later developed pain in his Lower back.							
Were Written Safe Work Procedures Established and Available? Yes No No N/A		Were they Adequate? Yes ◯ No ◯ N/A ◯		Were these Safe Work Procedures used in Training? Yes No N/A			
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS UN QUOID able OCCUPTANCE. IN MAY OCCUPTED While COUTY NO ont his duties and participating will residents (playing SDOCET in the Organ). Everyday job hazzonol.							
		:				4	

None. Possibl	le re	alization) Yhat	we			
None. Possible realization that we are not as young and as Cit as we proce were (ie. in 1985).							
INP. DACE LIPET	P	ie. in 19	85		:		
0,000,000)				
		•	,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
		·	•				
Corrective Action Referred To:	· .	Date To Be Complete	d By: \\ \/	4.			

Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)							
Non	0				-		
Name(s) & occupations of person (s) who investigated ac	ccident:						
			• .		,		
Print Name & Occupation Phone	, , , , , , , , , , , , , , , , , , , 	Print Name & Occupation	n .	Phone			
					_		
Signature of Workers' Representative Date	S	ignature of Employer Re	presentative	Date			
Name(s) of Witness(s) (include phone number).	(47R	1452-205	50				
s.15, s.22) (i		
s.15, s.21, s.79 YCJA							
		,	·				

Corrective Measures Taken and/or Recommended

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency

UNIT ACCIDENT INVESTIGATION FOK...

Ministry Children + Family	Tel.# Dlvllopment	Location B. Y. C.	S		Date of Report Jan 16	2010
Last Na	s.22				File No.	
Years of Service	Time on Present Job	Occupation Youth Supervisor		Hours Worked in Previous 24 Hour Period		
Accident Location (Dept. or Area) Venture, Sep. Lon #1		Date of Accident Jan Vary 15 2010		Time 2115 hrs		
Accident Category (check)	Injury or Illness	Equipment Malfunction	Motor Vehicle	Property Damage	Fire	Other (specify)
Severity of Injury or Illness (check)		☐ No Injury or First Aid Only		Medical Treatment	Time Loss	Fatal *
Nature of Injury or Illness	ed Right	Shoulder.				
Description of Accident or Em					er ii nacessary)	
						_
Were Written Safe Work Procedures Established and Available? Yes☑ No☑ N/A☑		Were they Adequate? Yes ☑ No ☐ N/A ☐			Were these Safe Work Procedures used in Training? Yes No N/A	
Basic Cause (and Contributor	, ,	EXPLAIN FULLY U			L'enf	i.e.
· .						

		••
Corrective Measures Taken and/or Recommended		
None		
1.000		
		ţ.
		·
Corrective Action Referred To:	Date To Be Completed By:/	
Additional Comments or Observations. Where applicable give etc., involved in this accident. (Use separate sheet if necessa	e details of makes & models of machines, equipment, tools, ary)	structures,
Name(s) & occupations of person (s) who investigated accide	ent:	
Poter K. Murchy Co.	Mattlew Annun 604-45	7-2050
Print Name & Occupation Phone	Print Name & Occupation Phone	
Signature of Workers' Representative Date	Signature of Employer Representative Date	16/10
Name(s) of Witness(s) (include phone number)		
778-452 s.15, s.22	2-2050	

*If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, local BCGEU office and the Deputy Minister, BC Public Service Agency