BRITISH COLUMBIA | Ministry of Children and Family Development

Joint Incident Investigation Form

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TELEPHONE NUMBER	LOCATION	REPORT DATE (YYYY-MM-DD)
778-452-2350	7700 FRASER PARK 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'S OFFICER	17

INCIDENT LOCATION (DEPARTMENT OR AREA)	INCIDENT DATE (YYYY-MM-DD)	TIME
FITNESS/PROGRAMS OFFICE	2012.12.30	1700 ○ AM ☒ PM

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 ABOVE R. EYE NEEDING STITCHES

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

s.22 PULLED DOOR OPEN HARD INTO HEAD

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

s.22

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

NONE

CORRECTIVE ACTION REFERRED TO:	TO BE COMPLED BY (YYYY-MM-DD)
NONE	

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
Jacquie Harris	Senior corrections officer	778-452-2350

SIGNATURE OF WORKER'S REPRESENTATIVE	DATE (YYYY-MM-DD)	SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
J. Harris	2012.12.30		2012/12/30

NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER:

Name	Phone

...NT ACCIDENT INVESTIGATION FOR

PSC 38

Ministry	Tel. #	Location	Date of Report
MCFD		BYCS	Dec 26, 2012
Last Name of Injured (or ill) Person		First Name	File No.
s.22		s.22	
Years of Service	Time on Present Job	Occupation	Hours Worked in Previous 24 Hour Period
s.22	s.22	Corrections Officer Youth Supervisor	12
Accident Location (Dept. or Area)		Date of Accident Infection noted Dec 23/12 saw Doctor Dec 26/12	Time

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

Eye infection

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

s.22

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

s.22, s.79 YCJA

Corrective Measures Taken and/or Recommended

UNIVERSAL PRECAUTIONS.

Corrective Action Referred To: 545 @ WALLACE A/ADO WHITE

Date To Be Completed By: ONGOING

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Brandon Thistle	778 452-2050	Doug [signature] Manager	778-452-2055

Signature of Workers' Representative	Date	Signature of Employer Representative	Date
[signature]	Jan 10/13	Doug [signature]	Jan 10/13

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

N/A

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

.NT ACCIDENT INVESTIGATION FOR

PSC 38

Ministry MCFD Tel. #		Location BYCS				Date of Report DEC 24/12
Last Name of Injured (or ill) Person s.22		First Name				File No.
Years of Service s.22	Time on Present Job	Occupation C/O				Hours Worked in Previous 24 Hour Period 0630 -
Accident Location (Dept. or Area) ASPERITY		Date of Accident Dec 24, 2012				Time 0900
Accident Category (check)	☒ Injury or Illness	☐ Equipment Malfunction	☐ Motor Vehicle	☐ Property Damage	☐ Fire	☐ Other (specify)
Severity of Injury or Illness (check) SAW CENTRE NURSE.		☒ No Injury or First Aid Only		☐ Medical Treatment	☐ Time Loss	☐ Fatal *

Nature of Injury or Illness large bump on head -right side-, shoulder yarred against wall, neck but off now and s.22

s.22

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

slipped on wet floor going around corner and hit head on wall, and hit shoulder on wall and neck is aqravated

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

THE WET FLOOR HAD JUST BEEN MOPPED UNDER THE SUPERVISION OF s.22 WAS VERY AWARE BUT STILL HAD AN ACCIDENTAL SLIP.

Corrective Measures Taken and/or Recommended

CAREFUL DILIGENCE

Corrective Action Referred To: NONE AT THIS TIME 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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Brad Stewart Ys	778 452 2050	SYS D WALLACE SOUTH YOUTH SUPERVISOR	778 452 2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	12.12.24	SYS D Wallace	DEC 24 2012

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

BRITISH COLUMBIA | Ministry of Children and Family Development

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TELEPHONE NUMBER	LOCATION	REPORT DATE (YYYY-MM-DD)
7784522050	BYCS Fraser Park Drive Bby V5J 5H1	2013 01 02

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
s.22		Youth Supervisor	11.5

INCIDENT LOCATION (DEPARTMENT OR AREA)	INCIDENT DATE (YYYY-MM-DD)	TIME	
Harrison Unit	2012 12 18	3	○ AM ◉ PM

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

Assaulted by resident

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

Resident punched staff (L) side of jaw/face.

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

Violent Resident with no coping skills

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

staff to use caution when working.

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
Doug Carmichael	Manager	778 452 2055

SIGNATURE OF WORKER'S REPRESENTATIVE	DATE (YYYY-MM-DD)	SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
	2013/01/02		2013 01 02

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone
None	

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TELEPHONE NUMBER: 778-452-2050 | LOCATION: 7900 FRASER PARK DRIVE | REPORT DATE (YYYY-MM-DD): 2012/12/15

LAST NAME OF INJURED (OR ILL) PERSON: s.22 | FIRST NAME | FILE No.

YEARS OF SERVICE: s.22 | TIME ON PRESENT JOB | OCCUPATION: CORRECTION OFFICER | HOURS WORKED IN PREVIOUS 24-HOURS: 15 HRS

INCIDENT LOCATION (DEPARTMENT OR AREA): GYMNASIUM | INCIDENT DATE (YYYY-MM-DD): 2012/12/14 | TIME: 1940 ○ AM ○ PM

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: R 16 HT CALF

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

s.22 WAS BREAKING UP A PHYSICAL ALTERCATION

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 CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS

Responding to a youth altercation

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

Nothing to recommend. Injured while responding to Incident

CORRECTIVE ACTION REFERRED TO: N/A. | 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
Brenden Thistle	CO/OSH Rep.	778-452-2050

SIGNATURE OF WORKER'S REPRESENTATIVE | DATE (YYYY-MM-DD): Dec 15/12 | SIGNATURE OF EMPLOYER'S REPRESENTATIVE | DATE (YYYY-MM-DD): 2012/12/15

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone
s.15, s.22	778-452-2050

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TELEPHONE NUMBER: 778-452-2080 | LOCATION: BICS - ASPERITY UNIT | REPORT DATE (YYYY-MM-DD): 2012/12/13

LAST NAME: s.22 | FIRST NAME: | FILE No.:

YEARS OF SERVICE: s.22 | TIME ON PRESENT JOB: | OCCUPATION: YOUTH SUPERVISOR | HOURS WORKED IN PREVIOUS 24-HOURS: 11.5

INCIDENT LOCATION (DEPARTMENT OR AREA): ASPERITY UNIT - BICS | INCIDENT DATE (YYYY-MM-DD): 2012/12/13 | TIME: 0930 ☒ AM ☐ PM

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: TWISTED RIGHT KNEE

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI): MISSED STEP WALKING DOWN STAIRS AND TWISTED KNEE

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: s.22

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED: N/A

CORRECTIVE ACTION REFERRED TO: N/A | 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.: NONE

NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:

Name	Occupation	Phone
MARK [illegible]	Senior Youth Supervisor	778-452-2079

SIGNATURE OF WORKER'S REPRESENTATIVE | DATE (YYYY-MM-DD) | SIGNATURE OF EMPLOYER'S REPRESENTATIVE | DATE (YYYY-MM-DD)

NAME(S) OF WITNESS(ES) INCLUDE PHONE NUMBER:

Name	Phone

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TELEPHONE NUMBER: 778-452-2050

LOCATION: Byes Gym

REPORT DATE (YYYY-MM-DD): 2012-12-14

LAST NAME OF INJURED (OR ILL) PERSON: s.22

FIRST NAME:

FILE No.:

YEARS OF SERVICE:

TIME ON PRESENT JOB:

OCCUPATION: CORRECTIONS OFFICER

HOURS WORKED IN PREVIOUS 24-HOURS: 9.5HRS

INCIDENT LOCATION (DEPARTMENT OR AREA): GYMNASIUM

INCIDENT DATE (YYYY-MM-DD): 2012-12-14

TIME: 2300 ○ AM ◉ PM

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: Puncture on hand

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI): Tooth Puncture on hand (L)

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 CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS: Restraining a youth

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. INVOLVED IN THIS INCIDENT.

NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:

Name	Occupation	Phone
LES SOMPEL / JAQUE HARRIS	Youth Supervisor / Supervisor	778 452 2051

SIGNATURE OF WORKER'S REPRESENTATIVE: C [illegible] DATE (YYYY-MM-DD): Dec 14/2012

SIGNATURE OF EMPLOYER'S REPRESENTATIVE: DATE (YYYY-MM-DD): Dec 14/2012

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone

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TELEPHONE NUMBER: 778-452-2079

LOCATION: BURNABY YOUTH CUSTODY CENTRE s.22

REPORT DATE (YYYY-MM-DD): 2012/12/01

LAST NAME OF INJURED (OR ILL) PERSON: s.22

FIRST NAME:

FILE No.:

YEARS OF SERVICE / TIME ON PRESENT JOB: s.22

OCCUPATION: YOUTH SUPERVISOR

HOURS WORKED IN PREVIOUS 24-HOURS: 7.5

INCIDENT LOCATION (DEPARTMENT OR AREA): VENTURE DAY ROOM

INCIDENT DATE (YYYY-MM-DD): 12/12/06

TIME: 1445 ○ AM ○ PM

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

PRECAUTIONARY REPORT - HAD A DECK OF CARDS THROWN AT FACE

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

RESIDENT TAKEN DECK OF CARDS, THE STRUCK ON RIGHT SIDE OF FACE

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

HAPPENED OUT OF THE BLUE – NO INDICATION

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

N/A

CORRECTIVE ACTION REFERRED TO:

N/A

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.

NONE

NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:

Name	Occupation	Phone
MARK [illegible]	SENIOR YOUTH SUPERVISOR	778-452-2079

SIGNATURE OF WORKER'S REPRESENTATIVE: [signature] DATE (YYYY-MM-DD): 12/12/06

SIGNATURE OF EMPLOYER'S REPRESENTATIVE: [signature] DATE (YYYY-MM-DD):

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone

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TELEPHONE NUMBER	LOCATION	REPORT DATE (YYYY-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 WORKED 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 ○ AM ◉ PM

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

HIT HEAD, PUNCHED IN HEAD

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

LANDED AND RECEIVED PUNCH IN RIGHT S HEAD

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

FALLING HITTING HEAD. IMPACT FROM RESIDENT

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

N/A

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
LSOMMI / BILL SHORTER	S / YOUTH SUPV	778-452-2050

SIGNATURE OF WORKER'S REPRESENTATIVE	DATE (YYYY-MM-DD)	SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
	NOV. 12/12	B. Shorter	2012-11-12

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone

BRITISH COLUMBIA | Ministry of Children and Family Development

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TELEPHONE NUMBER: 778-452-2050

LOCATION: Burnaby Youth Custody Services

REPORT DATE (YYYY-MM-DD): 2012-11-12

LAST NAME OF INJURED (OR ILL) PERSON: s.22

FIRST NAME:

FILE No.:

YEARS OF SERVICE: s.22,

TIME ON PRESENT JOB:

OCCUPATION: Youth Supervisor

HOURS WORKED IN PREVIOUS 24-HOURS: 12 hrs

INCIDENT LOCATION (DEPARTMENT OR AREA): Healthcare Corridor

INCIDENT DATE (YYYY-MM-DD): 2012-11-12

TIME: 20:15 ○ AM ◉ PM

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

LOWER AND MIDDLE BACK TIGHT

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

RESTRAINING A RESIDENT DURING AN EMERGENCY

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

RESTRAINING A RESIDENT DURING AN EMERGENCY

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

N/A

CORRECTIVE ACTION REFERRED TO:

N/A

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
LEO SOMOGYI / BILL SHOLAR	YOUTH SUPERVISOR	778 452 2052

SIGNATURE OF WORKER'S REPRESENTATIVE: [signature] DATE (YYYY-MM-DD):

SIGNATURE OF EMPLOYER'S REPRESENTATIVE: B. Sholar DATE (YYYY-MM-DD): 2012-11-12

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone

BRITISH COLUMBIA | Ministry of Children and Family Development

Joint Incident Investigation Form

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TELEPHONE NUMBER: 778-452-2050

LOCATION: Burnaby Youth Custody Services

REPORT DATE (YYYY-MM-DD): 2012-11-12

LAST NAME: s.22

FILE No.:

YEARS OF S...: s.22

Youth Supervisor

HOURS WORKED IN PREVIOUS 24-HOURS: 12 hrs

INCIDENT LOCATION (DEPARTMENT OR AREA): Healthcare Corridor

INCIDENT DATE (YYYY-MM-DD): Nov 12-12

TIME: 20:15 ○ AM ☑ PM

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

Hamstring pull on Left Leg

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

Responding to emergency (Code Red) pulled hamstring.

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 CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS

Running very fast - responding to Code Red.

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

Unavoidable injury

CORRECTIVE ACTION REFERRED TO: N/A

TO BE COMPLED BY (YYYY-MM-DD): N/A

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
Lee Stomogyi / Bill Sholan	S / Youth Sup.	778-452-2050

SIGNATURE OF WORKER'S REPRESENTATIVE: [signature] DATE (YYYY-MM-DD): NOV. 11/12

SIGNATURE OF EMPLOYER'S REPRESENTATIVE: B. Sholan DATE (YYYY-MM-DD): 2012-11-12

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone

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TELEPHONE NUMBER	LOCATION	REPORT DATE (YYYY-MM-DD)
778-452-2050	Burnaby Youth Custody Services, 7900 Fraser Park Dr. Burnaby B.C. V5J-5H1	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 WORKED IN PREVIOUS 24-HOURS
s.22		Senior Youth Supervisor	12 hrs.

INCIDENT LOCATION (DEPARTMENT OR AREA)	INCIDENT DATE (YYYY-MM-DD)	TIME
7900 FRASER PARK DRIVE Burnaby BC. Elkhorn Unit	2012-10-30	07:15 (•) AM ( ) PM

INCIDENT CATEGORY (CHECK)

[x] Injury or Illness [ ] Equipment Malfunction [ ] Motor Vehicle [ ] Property Damage

[ ] Fire [ ] Other

SEVERITY OF INJURY OR ILLNESS (CHECK)

[x] No Injury or First Aid Only [ ] Medical Treatment [ ] Time Loss [ ] Fatal

NATURE OF INJURY OR ILLNESS

Left Knee swollen/Bloody/SCRAPED. Right neck & Shoulder stiff/sore. Pain below Left Eye. Hit head.

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

Attempted assault resulting in 2 staff take down restraint. Both staff & resident fell on top of officer. Injury to left Knee, Head, Neck, shoulder.

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

Resident Attempted to assault officer by punching. Take down restraint applied causing injury to knee, neck, shoulder, head, cheek. Due to combative resident & other staff & resident falling on offi

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

Staff USED Restraint procedures to deal with assaultive resident.

CORRECTIVE ACTION REFERRED TO:	TO BE COMPLED BY (YYYY-MM-DD)
Methods used to defend himself appropriate.	N/A

ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. INVOLVED IN THIS INCIDENT.

Restraint training provided Yearly. Occupation has Risk of Injuries Due to restraint application of Assaults from residents.

NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:		
PAMELA DREW	Assistant Director - Operations	2012-10-30

SIGNATURE OF WORKER'S REPRESENTATIVE	DATE (YYYY-MM-DD)	SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
	2012/10/30	Pamela Drew	2012-10-30

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:		
s.15, s.22	Name	Phone
		778-452-2050

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TELEPHONE NUMBER	LOCATION	REPORT DATE (YYYY-MM-DD)
778-452-2050	Burnaby Youth Custody Services 7900 Fraser Park Dr. Burnaby BC	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 WORKED IN PREVIOUS 24-HOURS
s.22		Youth Supervisor / Corrections Officer	8

INCIDENT LOCATION (DEPARTMENT OR AREA)	INCIDENT DATE (YYYY-MM-DD)	TIME
Elkhorn Unit - BYCS - DAY Room	2012-10-30	07:15 ☑ AM ☐ PM

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

(L) Neck (L) shoulder, Neck (Link) (R) Shoulder

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

Injured while conducting Take down restraint on Combative / Assaultive Resident

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

Youth Attempted to Assault Staff - Youth restrained by Two Youth Supervisors

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED Youth was resistant & Combative @ Take down required

None - Use of restraint training provided and was used appropriately

CORRECTIVE ACTION REFERRED TO:	TO BE COMPLED BY (YYYY-MM-DD)
N/A	N/A

ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. INVOLVED IN THIS INCIDENT.

Restraint Training provided Yearly / Occupation has risk of Injury due to use of restraint Application & Assaultive Youths'

NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:		
Pamela Drew	Assistant Director operations	778-452-2050

SIGNATURE OF WORKER'S REPRESENTATIVE	DATE (YYYY-MM-DD)	SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
	2012/10/30	Pamela Drew	2012-10-30

NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER:	Name	Phone
s.15, s.22		778-452-2050

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TELEPHONE NUMBER	LOCATION	REPORT DATE (YYYY-MM-DD)
778 452-2050	Burnaby Youth Custody Services 7900 FRASER PARK DR. Burnaby B.C.	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 WORKED IN PREVIOUS 24-HOURS
		Youth Supervisor / Correctional Officer	

INCIDENT LOCATION (DEPARTMENT OR AREA)	INCIDENT DATE (YYYY-MM-DD)	TIME
		○ AM ○ PM

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

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

Applied restraint on resident during an assault on another resident.

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

Hit on left side of head by combative Youth while trying to restrain her.

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

None- Restraint training provided and was used appropriately

CORRECTIVE ACTION REFERRED TO:	TO BE COMPLED BY (YYYY-MM-DD)
N/A	N/A

ADDITIONAL COMMENTS OR OBSERVATIONS. WHERE APPLICABLE GIVE DETAILS OF MAKES AND MODELS OF MACHINES, EQUIPMENT, TOOLS, STRUCTURES, ETC. INVOLVED IN THIS INCIDENT.

Restraint training Provided Yearly / Occupation has risk of Injury due to use of restraint application on Assaultive & Combative Youths.

NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:		
Pamela Drew	Assistant Director Operations	778-452-2077

SIGNATURE OF WORKER'S REPRESENTATIVE	DATE (YYYY-MM-DD)	SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
		Pamela Drew	2012-10-30

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:	
Name	**Phone**
	778-452-2050

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TELEPHONE NUMBER: 778 452-2050 | LOCATION: Burnaby Youth Custody Services | REPORT DATE (YYYY-MM-DD): 2012/10/26

LAST NAME OF INJURED (OR ILL) PERSON: s.22 | FIRST NAME: | FILE No.:

YEARS OF SERVICE: s.22 | TIME ON PRESENT JOB: | OCCUPATION: Youth Supervisor | HOURS WORKED IN PREVIOUS 24-HOURS: 8 hrs

INCIDENT LOCATION (DEPARTMENT OR AREA): B.Y.C.S - Asperity Unit | INCIDENT DATE (YYYY-MM-DD): 2012/10/24 | TIME: 2240 ○ AM ☒ PM

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 resident

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: 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: N/A | TO BE COMPLED BY (YYYY-MM-DD): N/A

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
TODD WATSON / MATT ANNAN	CORRECTIONS OFFICER / ACTING DIRECTOR OPERATIONS	778-452-2050

SIGNATURE OF WORKER'S REPRESENTATIVE | DATE (YYYY-MM-DD): 2012/10/26 | SIGNATURE OF EMPLOYER'S REPRESENTATIVE | DATE (YYYY-MM-DD): 2012/10/26

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

	Phone
s.15, s.22	778-452-2050

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TELEPHONE NUMBER	LOCATION	REPORT DATE (YYYY-MM-DD)
778 452-2050	Burnaby Youth Custody Services	2012/10/26

LAST NAME OF INJURED (OR ILL) PERSON	FIRST NAME	FILE No.
s.22	s.22	

	OCCUPATION	HOURS WORKED IN PREVIOUS 24-HOURS
s.22	Youth Supervisor	

INCIDENT LOCATION (DEPARTMENT OR AREA)	INCIDENT DATE (YYYY-MM-DD)	TIME
B.Y.C.S - Asperity Unit	2012/10/24	2210 ○ AM ● PM

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

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 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

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/A	N/A

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
Todd Watson / Matt Annan	Correction officer / A.D.O	778-452-2050

SIGNATURE OF WORKER'S REPRESENTATIVE	DATE (YYYY-MM-DD)	SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
	2012/10/26		2012/10/26

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone
s.15, s.22	778-452-2050

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TELEPHONE NUMBER	LOCATION	REPORT DATE (YYYY-MM-DD)
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	HOURS WORKED IN PREVIOUS 24-HOURS
s.22		CORRECTIONS OFFICER	7.5

INCIDENT LOCATION (DEPARTMENT OR AREA)	INCIDENT DATE (YYYY-MM-DD)	TIME
BYCS - ELKHORN UNIT	2012/10 22	1200 ○ AM ◉ PM

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

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 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

TWISTED BACK RESTRAINN YOUTH

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 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 / MATT ANNAN	CORRECTIONS OFFICER / ACTING DIRECTOR OPERATIONS	778-452-2050

SIGNATURE OF WORKER'S REPRESENTATIVE	DATE (YYYY-MM-DD)	SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
	2012/10/26		

NAME(S) OF WITNESS(ES) INCLUDE PHONE NUMBER:

Name	Phone

INT ACCIDENT INVESTIGATION FOR

PSC 38

Ministry / Tel. #	Location	Date of Report
MCFD 778-452-2052	Burnaby Youth Custody Services	Oct. 8/12
Last Name of Injured (or Ill) Person	**First Name**	**File No.**
s.22		
Years of S s.22	**Occupation** Youth Supervisor (presently program officer)	**Hours Worked in Previous 24 Hour Period** 19.
Accident Location (Dept. or Area) track / field	**Date of Accident** Oct 8/12	**Time** 1920

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

small cuts/punctures to both hands (palms) from climbing fence between basketball crt. and track & field

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

* Youth Jumped over fence from basketball court to track and field to assault another youth. This employee followed him up the fence. The top spikes of the fence ended up causing cuts on both hands. (3 on both hands)

s.22

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

Youth attempting to climb fence to assault youth on other side.

Corrective Measures Taken and/or Recommended

Will consult with programs to ensure no-contacts are not programmed next to each other.

Corrective Action Referred To: Programs Supervisors Date To Be Completed By: ASAP

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
Dean A. White ADO	778.452.2052	Twyla Sacilotto - Youth Supervisor	778.452.2052
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Oct 7/12		Oct 07/12

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

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TELEPHONE NUMBER: 778-452-2050

LOCATION: 7900 Fraser Park Drive Burnaby B.C.

REPORT DATE (YYYY-MM-DD):

LAST NAME OF INJURED (OR ILL) PERSON: s.22

FIRST NAME:

FILE No.:

YEARS OF SERVICE:

TIME ON PRESENT JOB:

OCCUPATION: Correctional officer Youth supervisor

HOURS WORKED IN PREVIOUS 24-HOURS: 8 hrs.

INCIDENT LOCATION (DEPARTMENT OR AREA): Burnaby Youth Custody Services Hallway near art room

INCIDENT DATE (YYYY-MM-DD): Sept. 25/2012

TIME: 13:27 ○ AM ● PM

INCIDENT CATEGORY (CHECK)

- [x] Injury or Illness
- [ ] Equipment Malfunction
- [ ] Motor Vehicle
- [ ] Property Damage
- [ ] Fire
- [x] Other Assaulted.

SEVERITY OF INJURY OR ILLNESS (CHECK)

- [ ] No Injury or First Aid Only
- [x] Medical Treatment
- [x] Time Loss
- [ ] Fatal

NATURE OF INJURY OR ILLNESS

Assaulted by resident, punched & stabbed in head area, kicked in stomach.

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

s.79 YCJA

I was punched in head x4 stabbed with pencil in ear area.. kicked in stomach.

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

s.79 YCJA

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

Enhance staffing,

s.79 YCJA

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

SIGNATURE OF WORKER'S REPRESENTATIVE

DATE (YYYY-MM-DD):

SIGNATURE OF EMPLOYER'S REPRESENTATIVE

DATE (YYYY-MM-DD):

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone

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TELEPHONE NUMBER

LOCATION

REPORT DATE (YYYY-MM-DD)

LAST NAME OF INJURED (OR ILL) PERSON: s.22

FIRST NAME

FILE No.

YEARS OF SERVICE: s.22

TIME ON PRESENT JOB

OCCUPATION: Correction officer

HOURS WORKED IN PREVIOUS 24-HOURS

INCIDENT LOCATION (DEPARTMENT OR AREA): A Security / Dining room

INCIDENT DATE (YYYY-MM-DD): 2012/09/03

TIME: 1604 ○ AM ◉ PM

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

(R) upper Arm / (R) Side / Back Shoulder stiffness / sore And lower back

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

see back

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

Youth

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

to respond when staff repeatedly hit the panic

CORRECTIVE ACTION REFERRED TO: OSH

TO BE COMPLED BY (YYYY-MM-DD): ASAP

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
Tayle Sackett	Corrections	

SIGNATURE OF WORKER'S REPRESENTATIVE

DATE (YYYY-MM-DD)

SIGNATURE OF EMPLOYER'S REPRESENTATIVE

DATE (YYYY-MM-DD)

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone

Y/S was watching movie with residents
and s.79 YCJA laying on kitchen counter
Y/S staff asked youth to please remember
Self from the counter
Youth ignored direction
Y/S call Supervisor + additional staff.
10 second later Y/S heard res s.79 YCJA
Yelling "No" Y/S staff glanced and
saw Youth charging towards me
and Youth struck my arm as
I put my arm up + protect my head
and face.

s.79 YCJA

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MCF	1900 Fraser Park	July 26/2012
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	Youth Supervisor	16
Accident Location (Dept. or Area)	**Date of Accident**	**Time**
Cypress Unit	July 26 2012	2010

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 *
Redness on knuckles	☐	☑	☐	☐

Nature of Injury or Illness: Swollen and redness on third and fourth knuckles of right hand

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Staff member intervened in a resident physical altercation. While separating youths the staff member and hit the floor

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

Youth involved in fight and needed to be stopped by staff.

Corrective Measures Taken and/or Recommended

N/A

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
YOUTH SUPERVISOR A. RODRIGUEZ	778-452-2050	BRENT ASSAD YOUTH SUPERVISOR	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	July 26/2012		July 26/2012

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

s.15, s.22 -778-452-2050

-778-452-2050

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 COLUMBIA | Ministry of Children and Family Development

Joint Incident Investigation Form

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TELEPHONE NUMBER: (778) 452-2050 | LOCATION: Burnaby Youth Custody Services | REPORT DATE (YYYY-MM-DD): 2012.07.17.

LAST NAME OF INJURED (OR ILL) PERSON: s.22 | FIRST NAME: | FILE No.:

YEARS OF SERVICE: s.22 | TIME ON PRESENT JOB: | OCCUPATION: Youth Supervisor | HOURS WORKED IN PREVIOUS 24-HOURS: 9.58

INCIDENT LOCATION (DEPARTMENT OR AREA): Basketball court | INCIDENT DATE (YYYY-MM-DD): 2012.07.17 | TIME: 8:15 ○ AM ● PM (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 ☑ Medical Treatment ☐ Time Loss ☐ Fatal

NATURE OF INJURY OR ILLNESS: Injured left shoulder, left thumb & neck

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI): Staff injured while attempting to break up a serious fight (altercation) between two (2) female residents

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): Cause of injuries to both staff members & residents was due to the physical altercation | EXPLAIN FULLY UNSAFE CONDITIONS:

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED: None, everyday job hazzard

CORRECTIVE ACTION REFERRED TO: None (at this time) | TO BE COMPLED BY (YYYY-MM-DD): N/A

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
Rosanna Z	Youth Supervisor / Programs Officer	(778) 452-2050

SIGNATURE OF WORKER'S REPRESENTATIVE | DATE (YYYY-MM-DD) | SIGNATURE OF EMPLOYER'S REPRESENTATIVE: Sus Mburnal Sus Murdoch | DATE (YYYY-MM-DD): 2012.07.17.

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone
s.15, s.22	(778) 452-2050

BRITISH COLUMBIA | Ministry of Children and Family Development

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TELEPHONE NUMBER: 778 452 2050 | LOCATION: BYCS | REPORT DATE (YYYY-MM-DD): JUNE 28/2012

LAST NAME OF INJURED (OR ILL) PERSON: s.22 | FIRST NAME: | FILE No.:

YEARS OF SERVICE: s.22 | TIME ON PRESENT JOB: | OCCUPATION: YOUTH SUPERVISOR | HOURS WORKED IN PREVIOUS 24-HOURS: 1 hr. 30 min.

INCIDENT LOCATION (DEPARTMENT OR AREA): FITNESS ROOM | INCIDENT DATE (YYYY-MM-DD): 2012/06/28 | TIME: 0950 ○ AM ○ PM

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

CUT OR ABRAISON ON FOREHEAD

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

Assisting to install a bar, in weight room, to stabilized weights

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

equipment malfunction.

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

Call weight room equipment repair to complete.

CORRECTIVE ACTION REFERRED TO: Occupational Health Committee | TO BE COMPLED BY (YYYY-MM-DD): by July 30/2012

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**

SIGNATURE OF WORKER'S REPRESENTATIVE | DATE (YYYY-MM-DD): 2012/06/28 | SIGNATURE OF EMPLOYER'S REPRESENTATIVE x | DATE (YYYY-MM-DD): 2012/06/28

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:	
Name	**Phone**
Home - Resident	

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TELEPHONE NUMBER	LOCATION	REPORT DATE (YYYY-MM-DD)
778 452 2050	BYCS 7900 Fraser Park Drive. Bby BC V5J 5H1	2012 07 01

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
s.22		Correctional Officer	9-5

INCIDENT LOCATION (DEPARTMENT OR AREA)	INCIDENT DATE (YYYY-MM-DD)	TIME
Gymnasium	2012 06 26	7:30 ○ AM ◉ PM

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

Sprained Left ~~Knee~~ Leg Knee.

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

landed awkwardly, knee buckled and bent backwards

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

Accidental sports injury

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

N/A

CORRECTIVE ACTION REFERRED TO:	TO BE COMPLED BY (YYYY-MM-DD)
N/A	

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
Brad Stewart	Correctional Officer	778 452 2050

SIGNATURE OF WORKER'S REPRESENTATIVE	DATE (YYYY-MM-DD)	SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
	20120701		2012 07 01

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone
s.15, s.22	778 452-2050

BRITISH COLUMBIA | Ministry of Children and Family Development

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TELEPHONE NUMBER	LOCATION	REPORT DATE (YYYY-MM-DD)
7784522050	BYCS	2012/06/28

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
s.22		YOUTH SUPERVISOR	9.5

INCIDENT LOCATION (DEPARTMENT OR AREA)	INCIDENT DATE (YYYY-MM-DD)	TIME
BYCS GYMNASIUM	2012/6/20	1930 ○ AM ● PM

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

INJURED KNEE WHILE PLAYING BASKETBALL W/ RESIDENTS. FELL ON KNEE

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

BODY CHECKED AFTER LEAVING HIS FEET. FELL TO FLOOR ONTO KNEE

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

ACCIDENTAL CONTACT WITH RESIDENT WHILE PLAYING BASKETBALL.

CORRECTIVE MEASURES TAKEN AND / OR RECOMMENDED

NONE

CORRECTIVE ACTION REFERRED TO:	TO BE COMPLED BY (YYYY-MM-DD)
N/A.	NOT SURE.

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
GRANT BUNKER	A/ SENIOR YOUTH SUPERVISOR	7784522050

SIGNATURE OF WORKER'S REPRESENTATIVE	DATE (YYYY-MM-DD)	SIGNATURE OF EMPLOYER'S REPRESENTATIVE	DATE (YYYY-MM-DD)
	2012/6/28		JUNE 29 12

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone
s.15, s.22	7784522050

BRITISH COLUMBIA | Ministry of Children and Family Development

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TELEPHONE NUMBER: 778·452·2050

LOCATION: Burnaby Youth Custody Services

REPORT DATE (YYYY-MM-DD): 12·06·16

LAST NAME OF INJURED (OR ILL) PERSON: s.22

FIRST NAME:

FILE No.:

YEARS OF SERVICE: s.22

TIME ON PRESENT JOB:

OCCUPATION: Youth Programs officer

HOURS WORKED IN PREVIOUS 24-HOURS: 9·58

INCIDENT LOCATION (DEPARTMENT OR AREA): Gymnasium

INCIDENT DATE (YYYY-MM-DD): 12·06·16

TIME: 1500 ○ AM ○ PM

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: Swelling left eyebrow area.

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI): Elbowed in left eyebrow area during basketball

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 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): N/A

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
Dean White	Acting Asst. Dir. of Ops.	778·452-2050

SIGNATURE OF WORKER'S REPRESENTATIVE: [signature] DATE (YYYY-MM-DD): 12·06·16

SIGNATURE OF EMPLOYER'S REPRESENTATIVE: [signature] DATE (YYYY-MM-DD): 12·06·16

NAME(S) OF WITNESS(ES), INCLUDE PHONE NUMBER:

Name	Phone
s.15, s.22	778·452·2050

JOINT ACCIDENT INVESTIGATION FOR...

PSC 38

Ministry	Tel. #	Location	Date of Report
MCF	778-452-2050	BYCS.	JUNE 2, 2012

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
s.22	s.22	YOUTH SUPERVISOR	8

Accident Location (Dept. or Area)	Date of Accident	Time
GLACIER	JUNE 2, 2012	0920

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

MINOR BRUISE TO LEFT CHEEK.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

s.22 RECEIVED AN ACCIDENTAL ELBOW TO HIS LEFT CHEEK BELOW HIS LEFT EYE, WHILE BREAKING UP A FIGHT BETWEEN TWO YOUTH RESIDENTS.

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

ACCIDENTAL IN THE COURSE OF DUTIES.

Corrective Measures Taken and/or Recommended

N/A.

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Armando Rodriguez C.O	7784522050	Darryl Wallace A/ADO	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	June 2/12		June 2/12

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

s.15, s.22 778-452-2050

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 COLUMBIA | Ministry of Children and Family Development

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TELEPHONE NUMBER: 778-452-2050

LOCATION: BURNABY YOUTH CUSTODY SERVICES

REPORT DATE (YYYY-MM-DD): 2012-05-17

LAST NAME OF INJURED (OR ILL) PERSON: s.22

FIRST NAME:

FILE No.:

YEARS OF SERVICE: s.22

TIME ON PRESENT JOB:

OCCUPATION: YOUTH SUPERVISOR

HOURS WORKED IN PREVIOUS 24-HOURS: NIL

INCIDENT LOCATION (DEPARTMENT OR AREA): BYCS MOSAIC ROOM.

INCIDENT DATE (YYYY-MM-DD): 2012-05-15

TIME: 0825 ◉ AM ○ PM

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 4 HRS MAY 16/12 ☐ Fatal

NATURE OF INJURY OR ILLNESS

L KNEE INJURY

DESCRIPTION OF INCIDENT OR EMPLOYEE'S ACCOUNT OF OCCUPATIONAL DISEASE (E.G. RSI)

RESPONDED TO A CODE YELLOW IN MOSAIC ROOM, WITH OTHER STAFF, RESTRAINED YOUTH AND TRIPPED IN THE PROCESS, MYSELF + COMBATANTS FELL TO FLOOR AGAINST WALL. ONE YOUTH FELL ON ME AS WELL.

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 CONTRIBUTORY FACTORS) EXPLAIN FULLY UNSAFE CONDITIONS

ACCIDENT, DURING RESTRAINT, COMBATANTS NFSD. CROWDED AREA

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 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 / PAM DREW	CORRECTIONS OFFICER / A.D.O	778-452-2050

SIGNATURE OF WORKER'S REPRESENTATIVE

DATE (YYYY-MM-DD): 2012-05-17

SIGNATURE OF EMPLOYER'S REPRESENTATIVE

DATE (YYYY-MM-DD): 2012

NAME(S) OF WITNESS(ES). INCLUDE PHONE NUMBER:

Name	Phone
s.15, s.22	778-452-2050

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCFD		Burnaby Youth Custody Services	2012-03-25

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
s.22		Youth Supervisor	11.5 hrs

Accident Location (Dept. or Area)	Date of Accident	Time
Link between Seamee and Open	2012.03.25	0910

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 possible probable	☐ Fatal *

Nature of Injury or Illness

Opened a Large metal door and injured his right bicep

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

While escorting a resident to Records s.22 opened a Large metal door injuring his right bicep

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

Unfortunate occurrence, accidental incident resulting in an injury.

Corrective Measures Taken and/or Recommended

NONE (N/A)

Corrective Action Referred To: N/A Date To Be Completed By: 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)

NONE

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Brandon Thistle (Senior Youth Supervisor)	(604)395-3362	M Burchak	(778)452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	March 25/12		2012.03.25

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

Only witness was a young offender (resident in custody).

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 ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MCFD	7900 FRASER PARK DRIVE	March 26/2012

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
s.22	s.22	CORRECTION OFFICER	8 hr.

Accident Location (Dept. or Area)	Date of Accident	Time
GYM	2012/02/19	12:00 pm

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 *
TENDER INJURY				

Nature of Injury or Illness

BALL JAMMED FINGER PLAYING BASKETBALL

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

OFFICER PLAYING BASKET BALL WITH RESIDENTS, BALL HIT FINGER AND JAMMED IT.

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

SPORT INJURY

Corrective Measures Taken and/or Recommended

N/A

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Vivieke Stromberg SJS	778-452-2051	[illegible]	778 452 2051
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
[signature]	March 26/12	[signature]	March 26/12

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 ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: MCFD Tel. #	Location: BURNABY		Date of Report: FEB 28/12
Last Name of Injured (or Ill) Person: s.22	First Name		File No.
Years of Service: s.22	Time on Present Job: s.22	Occupation: YOUTH SUPERVISOR	Hours Worked in Previous 24 Hour Period: 12
Accident Location (Dept. or Area): BYCS - GYM		Date of Accident: FEB 19/2012	Time: 12:30

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

LEFT MIDDLE BACK INJURY

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Was involved in the Restraint portion of Therapeutic Crisis Intervention training.

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

Back twisted while involved in a controlled training group.

Corrective Measures Taken and/or Recommended

None at this time

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
M. Strevell	778-452-2079	J HARRIS	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Feb 28/12		Feb 28/12

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

s.15, s.22

778-452-7052

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 ACCIDENT INVESTIGATION FORM

Istry / Tel. #	Location	Date of Report
CHILDREN & FAMILIES	7900 FRASER PARK DRIVE	FEB 12/12

Last Name of Injured (or Ill) Person	First Name	File No.
s.22	s.22	

Years of Service	Time on Present Job	Occupation	Hours Worked in Previous 24 Hour Period
s.22	s.22	CORRECTIONAL OFFICER	7.5

Accident Location (Dept. or Area)	Date of Accident	Time
GLACIER DAY ROOM	FEB 12/12	14:35

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: TWISTED & TORQUED LEFT KNEE

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

WHILE BREAKING UP A FIGHT BETWEEN TWO RESIDENTS AND RESTRAINING ONE OF THEM TWISTED & TORQUED LEFT KNEE.

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

Injury Caused during resident Restraint. Part of Regular Duties.

Corrective Measures Taken and/or Recommended

No Recommendation at this time.

N/A

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
JILL GARDNER AADO	778 452-2077	GRANT BUNKER SYS	778-452-2077
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
J Gardner	Feb 12/12	G. BUNKER	FEB. 12/12

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 ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
BMCS	778-452-2050	Burnaby	Feb 10/2012

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
s.22	s.22	Shift Supervisor	9.58 hours

Accident Location (Dept. or Area)	Date of Accident	Time
Parking lot	Feb 9/2012	0650

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 *
(L) Knee				

Nature of Injury or Illness

(L) Knee / step into tire rut and twisted knee

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

While stepping out of my vehicle, I stepped in a tire rut and twisted knee

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

Tire rut in gravel

Corrective Measures Taken and/or Recommended

Vehicle that left tire rut should not have parked at opening of parking lot – Email to all staff re parking restrictions. WSI NOTIFIED TO Fill hole – Signage to be posted – NO PARKING

Corrective Action Referred To: Director. Date To Be Completed By: Feb. 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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
T. Sacalo H	778-452-2080	Pamela Drew Assistant Director OPERATIONS	778-452-2077
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Feb 10/2012	Pamela Drew	Feb. 10/2012.

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 ACCIDENT INVESTIGATION FORM

PSC 38

Ministry Children & Family Development Tel. #		Location Burnaby Youth Custody Services, 7900 FRASER PARK DR. Burnaby B.C.				Date of Report Feb. 10/2012.
Last Name of Injured (or Ill) Person s.22		First Name				File No.
Years of Service s.22	Time on Present Job s.22	Occupation Program Officer Youth Supervisor.				Hours Worked In Previous 24 Hour Period 9.58
Accident Location (Dept. or Area) Gym at Burnaby Youth Custody.		Date of Accident Feb. 09/2012				Time 20:00hrs.
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: Dislocated Ring Finger on Right Hand may be broken. / NOT BROKEN / Dislocated Reset by Doctor.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

In Gym playing Basketball; Ball Hit Ring Finger Directly.
Dislocated Ring Finger on Right Hand, May be Broken.

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

Accidental injury while playing Basketball in Gym.

Corrective Measures Taken and/or Recommended

N/A

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
T Sawchuk	778-452-0205	Pamela Drew Assistant Director Operations	778-452-2077
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
N/A	Feb 10/2012	Pamela Drew	Feb 10/2012

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

s.15, s.22 Youth Supervisor

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 ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCFD		BYCS	JAN 27/12

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
s.22		Senior Youth Supervisor	

Accident Location (Dept. or Area)	Date of Accident	Time
	JAN. 26/2012	17:40

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 7	☐ Fatal *

Nature of Injury or Illness

Neck and shoulder pain

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Was involved in separating two Residents that were fighting.

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

Staff member was injured while separating two Residents that were fighting

Corrective Measures Taken and/or Recommended

N/A

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
M. Stanley	778-452-2019	Sheryl Hudspeth ADO	778-452-2077
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Jan 27/12	S Hudspeth	Jan 27/12

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

Revised July 2004

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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.

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JOINT ACCIDENT INVESTIGATION FORM

Employer: Children & Family Development-BYCS Tel. #	Location: 7900 Fraser Park Dr Burnaby B.C. BYCS 778-452-2050	Date of Report: Jan 25/2012
Last Name of Injured (or Ill) Person: s.22	First Name	File No.
Years of Service	Time on Present Job	Occupation: Youth Supervisor.
Hours Worked in Previous 24 Hour Period		
Accident Location (Dept. or Area): Programs, Gym	Date of Accident: Jan. 25/2012	Time: 16:30 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: During Basketball program in Gym was hit by Ball or Elbow, to the face, caused glasses to cut nose. Accidental. Cut on bridge of nose.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Please see above Description.

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

Accidental, was hit in face during Basketball game by Ball or Elbow which caused glasses to cut the bridge of my nose.

Corrective Measures Taken and/or Recommended

Accidental 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)

N/A

Name(s) & occupations of person (s) who investigated accident:

[illegible]	778 452-2050	Pamela Drew	Assistant Director of Operations BVCS	778-452-2077
Print Name & Occupation	Phone	Print Name & Occupation		Phone
[signature]	Jan 25/2012	Pamela Drew		Jan 25/2012
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 ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
Children & Family	7900 Fraser Park Drive. Burnaby, BC	Jan 20 2012

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
s.22	s.22	Youth Supervisor	8 hrs

Accident Location (Dept. or Area)	Date of Accident	Time
Fitness Room - Burnaby Youth Custody Service	Jan 20 2012	16:00 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 *
Cut to left Thumb				

Nature of Injury or Illness

Cut to left thumb.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Staff member was demonstrating a piece of fitness equipment to a youth. As staff member grabbed the piece of equipment ~~a loos~~ a loose splinter cut into his left thumb.

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 splinter of metal caused cut to thumb.

Corrective Measures Taken and/or Recommended

REPAIR & OR REPLACE PULL DOWN BAR.

Corrective Action Referred To: PROGRAMS SUPERVISOR Date To Be Completed By: AS SOON AS POSSIBLE

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)

- Piece of Fitness equipment
- Metal bar used for pulling weight.

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
T. WATSON	778-452-2050	B. SHOKAR	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	JAN 20/12	B. Shokar	Jan 20/2012

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

No witnesses. Might be visible on DVR.

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 Union Office

JOINT ACCIDENT INVESTIGATION FO...d

PSC 38

Ministry	Tel. #	Location	Date of Report
			January 3 2012

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
s.22		Youth Supervisor	

Accident Location (Dept. or Area)	Date of Accident	Time
Elkhorn Unit	January 2 2011	1100 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

Fell on Right knee

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 knee

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

Slip on floor while restraining a youth.

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, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)

None

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Les Samoiloff	452-2051	Matthew Annan A.D.O	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	June 3/2012		778-452-2050

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

s.15, s.22 778 452 2051

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 ACCIDENT INVESTIGATION FORM

SC 38

Ministry	Tel. #	Location	Date of Report
		BYCS - EMERALD.	JAN 1/12

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
s.22	s.22	SENIOR YOUTH SUPERVISOR.	12

Accident Location (Dept. or Area)	Date of Accident	Time
EMERALD UNIT	JAN 1/12	1950

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

SMALL SCRATCH TO LEFT THUMB

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

DURING RESTRAINT OF A RESIDENT - RESIDENT USED FINGERNAIL TO SCRATCH STAFF THUMB.

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

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, 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
Thompson Rivers Univ.	778 452 2050	Matthew Annan	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Jan 11/12.		Jan 11/12

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 ACCIDENT INVESTIGATION FORM

PSC 38

Ministry Tel. #		Location BYCS			Date of Report DEC 30 2011	
Last Name of Injured (or ill) Person s.22		First Name			File No.	
Years of Service s.22	Time on Present Job s.22	Occupation YOUTH SUPERVISOR			Hours Worked in Previous 24 Hour Period 7.5 DEC 29/11	
Accident Location (Dept. or Area) BYCS ROTUNDA STAIRS.		Date of Accident DEC 30, 2011			Time 1900 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 LEFT KNEE BUCKLED & REMAINS UNSTABLE. SAW CGWRG NURSE s.22						
Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary) WHILE WALKING A FLIGHT OF STAIRS IN THE BYCS ROTUNDA THE LEFT KNEE BUCKLED & REMAINED UNSTABLE.						
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 Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS						

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, 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
SPENCER LOEN YOSH SUPERVISOR	778-452-2050	A/ADO DARRYL WALLACE	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	DEC 30/11		DEC 30/11

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

s.15, s.22 778-452 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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: MCFD Tel. #		Location: BYCS	Date of Report: DEC 4/2011
La s.22			File No.
Years of Service: s.22	Time on Present Job	Occupation: YOUTH SUPERVISOR	Hours Worked in Previous 24 Hour Period: 9.58
Accident Location (Dept. or Area): BYCS - GYM		Date of Accident: NOV 23/11	Time: 2100

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

LEFT ACHILES TENDON STRAIN

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

AFTER SUPERVISING GYM PROGRAM, LEFT ACHILES WAS SORE

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 Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS

PARTICIPATING IN GYM PROGRAM

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, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)

None

Name(s) & occupations of person (s) who investigated accident:

M. Shrubb	778.452.2049	PAUL TIGHE	778.452.2080
Print Name & Occupation	Phone	Print Name & Occupation	Phone
	Dec 4/11		Dec 4/11
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

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
Min Children Fam / (25)	BYCS	Nov. 19 / 2011

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
s.22		C.O.	

Accident Location (Dept. or Area)	Date of Accident	Time
	Nov. 19 / 2011	12:45

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

Knee

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

TWIST LEFT KNEE
WHEN RESPONDING TO CODE

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

TWIST

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, 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
Les Somoski	778 452 2051	Matthew Annan	778-452-2051
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Nov. 19/2011		Nov 19/11

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

s.15, s.22

778 452 2051

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
Min Children Families	BYCS	Nov. 19/2011

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
s.22		C.O.	

Accident Location (Dept. or Area)	Date of Accident	Time
	Nov. 19/2011	12:45

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

Back

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Responding to code

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

Twist

Corrective Measures Taken and/or Recommended

Ab None

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:

LES SOUVORY	W 778 952 2205	Matthew Annan	778-452-2051
Print Name & Occupation	Phone	Print Name & Occupation	Phone
[signature]	Nov. 19/2011	[signature]	Nov/19/11
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

s.15, s.22

778 452 2051

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry CHILDREN + FAMILIES	Tel. # 778-452-2650	Location 7900 FRASER PARK DRIVE			Date of Report 2011.11.18	
Last Name of Injured (or Ill) Person s.22		First Name			File No.	
Years of Service s.22	Time on Present Job	Occupation CORRECTIONS OFFICER			Hours Worked in Previous 24 Hour Period 11.5	
Accident Location (Dept. or Area) COURTYARD 2		Date of Accident 2011.11.18			Time 1930	
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
PULLED LOWER BACK SEPARATING 3 YOUTHS FIGHTING

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)
STAFF MEMBER CALLED FOR BACK UP BUT HAD TO ATTEMPT TO BREAK UP 2 YOUTHS ASSAULTING A THIRD.

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

~~TWISTED~~

PULLING 2 FIGHTING YOUTHS OFF A THIRD.

Corrective Measures Taken and/or Recommended

None

Corrective Action Referred To: N/A 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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
L.S. [illegible]	778 452 2051	J. HARRIS	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Nov. 18/2011	J. Harris	778-452-2050

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

DVD recorded.

Revised July 2004

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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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry MCFD Tel. #		Location BYCS			Date of Report 11/11/17	
La s.22					File No.	
Years of S s.22	Time on Present Job s.22	Occupation YOUTH SUPERVISOR			Hours Worked in Previous 24 Hour Period 0630 - 1830	
Accident Location (Dept. or Area) MPR 2		Date of Accident 11/11/16			Time 1505	
Accident Category (check)	☑ Injury or Illness	☐ Equipment Malfunction	☐ Motor Vehicle	☐ Property Damage	☐ Fire	☐ Other (specify)
Severity of Injury or Illness (check) SLIGHT		☑ No Injury or First Aid Only		☐ Medical Treatment	☐ Time Loss	☐ Fatal *

Nature of Injury or Illness

JAMMED (R) THUMB

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

While separating a fight in MPR 2 s.22 jammed his thumb (R).

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

by c/o s.22 intervening to separate 2 residents while fighting caused the injury.

Corrective Measures Taken and/or Recommended

As discussed & viewed by both

s.22

it was recommended that intervention should not occur until back-up responders arrive. s.22 acknowledged this after viewing the DVRs s.22

Corrective Action Referred To: _____ Date To Be Completed By: ___/___/___

(As above).

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)

SA

Name(s) & occupations of person (s) who investigated accident:

A STAFFORD	778-452-2050	S.B. Scott-Davies	778-452-2050
Print Name & Occupation	Phone	Print Name & Occupation	Phone
		A. Stafford	11/1/17
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

Name(s) of Witness(s) (include phone number) None.

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
CHILDREN & FAMILY DEVELOPMENT	BYCS BURNABY B.C.	2011/11/03.

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
s.22	s.22	PROGRAM OFFICER	12

Accident Location (Dept. or Area)	Date of Accident	Time
ROTUNDA	2011/11/03	1350:

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

SOAR LEFT HEAL - SHARP PAIN WHEN TURNED.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

RUNNING UP STAIRS RESPONDING TO CODE YELLOW - HIT HEAL ON STAIR.

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

ACCIDENTAL.

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
PAUL TIFFEN	778/452/2020	M. Strale	778.452.2079
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	NOV 3/11		Nov 3/11

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

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry MCFD Tel. #		Location BURNABY YOUTH			Date of Report NOV 7/11	
Last Name of Injured (or Ill) Person s.22		First Name			File No.	
Years of Service s.22	Time on Present Job	Occupation YOUTH SUPERVISOR			Hours Worked in Previous 24 Hour Period	
Accident Location (Dept. or Area)		Date of Accident			Time	
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 TWISTED RIGHT KNEE

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)
while exiting FENNIE UNIT, pulled door, twisted knee and "locked" up and pain was instant in right knee

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
Twisted while opening door and the pain occured @ that time

Corrective Measures Taken and/or Recommended

N/A

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)

None

Name(s) & occupations of person (s) who investigated accident:

M. Streifel 778.452.2079

Print Name & Occupation | Phone | Print Name & Occupation | Phone

Signature of Workers' Representative | Nov 7/11 Date | Signature of Employer Representative | Nov 7/11 Date

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

s.15, s.22

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry MCF Tel. # 778-452-2050		Location Burnaby			Date of Report	
Last Name of Injured (or ill) Person s.22		First Name			File No.	
Years of Service s.22	Time on Present Job s.22	Occupation Correction officer.			Hours Worked in Previous 24 Hour Period 7.5	
Accident Location (Dept. or Area) Gym		Date of Accident Oct 4/2021			Time 1920	
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
Playing Basketball Jammed (L) Pinky.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)
While playing basketball in the gym, the ball Jammed my left Pinky finger

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

Ball hitting my finger

Corrective Measures Taken and/or Recommended

N/A

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
T Sacco H	778-452-2050		
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Oct 4/2011		Oct 5/11

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

Revised July 2004

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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

JOINT ACCIDENT INVESTIGATION FOR...

PSC 38

Ministry / Tel. #	Location	Date of Report
MCF 778-452-2000	Burnaby	OCT 4/2011

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
s.22	s.22	Correcton officer	Ø

Accident Location (Dept. or Area)	Date of Accident	Time
Gym	OCT 3/2011	1600

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

Gash across nose / (R) eye Impacted by Soccor ball

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Blocking a shot / Goalie. ball hit the side of his head

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

Ball hitting s.22 in the head

Corrective Measures Taken and/or Recommended

N/A

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

T Sacco	778-452-2050		
Print Name & Occupation	Phone	Print Name & Occupation	Phone
	Oct 4/2011		Oct 5/11
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

s.15, s.22

Revised July 2004

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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.

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry MCFD Tel. #		Location BURNABY YOUTH CUSTODY SERVICES			Date of Report SEPT 30/11	
Last Name of Injured (or ill) Person s.22		First Name s.22			File No.	
Years of Service s.22	Time on Present Job s.22	Occupation OA2			Hours Worked In Previous 24 Hour Period 7.78	
Accident Location (Dept. or Area) BYCS OUTER PARKING LOT		Date of Accident SEPT 29/11			Time 1240	
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	INJURED Ⓡ KNEE, Ⓡ ANKLE, Ⓡ HIP/GLUTEOUS SORENESS IN MID BACK AREA					

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

WALKING THROUGH PARKING STALL, STEPPED UP TO CURB/GRASS AREA WITH Ⓡ FOOT, SLIPPED ON WET GRASS AND FELL ON KNEE Ⓡ & Ⓡ HIP AREA. SORE HAND AS WELL FROM BREAKING MY FALL.

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

WET GRASS, SLIPPERY

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: N/A 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)

N/A

Name(s) & occupations of person (s) who investigated accident:

TODD WATSON	~~604~~ 778-452-2050	CARLA DEVITA	778-452-2058
Print Name & Occupation	Phone	Print Name & Occupation	Phone
[signature]	SEPT 30/11	[signature]	Sept/30/11
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
Children & Families		Sept. 24, 2011
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
		Youth Supervisor	

Accident Location (Dept. or Area)	Date of Accident	Time

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

Strained Right Shoulder

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Hurt Right Shoulder trying to restrain a youth involved in a physical altercation.

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

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, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)

Name(s) & occupations of person (s) who investigated accident:

Matthew Annan	778-452-20[illegible]	[signature]	
Print Name & Occupation	Phone	Print Name & Occupation	Phone
[signature]	Sept 24/11		
Signature of Worker's Representative	Date	Signature of Employer Representative	Date

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry MCF - Tel. # 778-452-2050		Location 7900 FRASER PARK DRIVE BURNABY B.C. V5J-5H1				Date of Report Sept 21/2011
Last Name of Injured (or ill) Person s.22		First Name				File No.
Years of Service s.22	Time on Present Job	Occupation Youth Supervisor				Hours Worked in Previous 24 Hour Period 7.5
Accident Location (Dept. or Area) Gym		Date of Accident Sept 21/2011				Time 10:00 am.
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 - BACK (LOWER)

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

STRAINED LOWER BACK During TRAINING

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

s.22 over exertion during Physical Restraint training class. Uncomfortable movements, twistings, take downs caused back to become tight & sore.

Corrective Measures Taken and/or Recommended

N/A

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)

Staff seen by Healthcare and healthcare recommended stuff, to go home and ice & heat & Ibprofen taken. Rest.

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
		Pamela Drew ADO	Sept. 21/2011
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
		Pamela Drew	Sept. 21/2011

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

s.15, s.22

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCF		Burnaby	Sept 17/2011

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
s.22	s.22	Correctional officer	0

Accident Location (Dept. or Area)	Date of Accident	Time
Glacier Unit / BYCS	Sept 17/2011	0843

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

Small cut under chin 1 inch / Neck back

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

While directing a youth to his room another youth threw a bowl of cereal at s.22 and struck him on the chin

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

The other youth stuck his nose in an incident that didn't involve him

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, 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
T. Sacco H	778 452 0-2050		

Signature of Workers' Representative	Date	Signature of Employer Representative	Date
			Sept 17/2011

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

Camera in Glacier

Revised July 2004

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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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCF BVCS	778 452-2050	Burnaby	Sept 19/2011
Last Name: s.22			File No.
Years of Service: s.22	Time on Present Job: s.22	Occupation: Shift superv	Hours Worked in Previous 24 Hour Period: 0
Accident Location (Dept. or Area)		Date of Accident: Sept 19/2011	Time: 2011

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

(R) knee / (R) shoulder (R) side of neck

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

During a escort / take down. Youth was be restrained to the floor. During which RO s.22 still had a hold of youth. While youth was being placed to the floor s.22 went down with youth and struck his knee to the ground and pulled shoulder and neck

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

Youth made a motion which was interpeted as aggressive, s.22 quick action ~~struck~~ by the a resulted in falling & his knee and pulling his shoulder and neck as well

Corrective Measures Taken and/or Recommended

Practice physical restraints and 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)

Name(s) & occupations of person (s) who investigated accident:

T Sacht	778-452-2050	Studspeth ADO	778-452-2050
Print Name & Occupation	Phone	Print Name & Occupation	Phone
	Sept 19/2011	Studspeth ADO	Sept 19/2011
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

s.15, s.22

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
Ministry of Children & Families		Burnaby	Aug 29/2011

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
s.21	s.22	YOUTH SUPERVISOR	9-17

Accident Location (Dept. or Area)	Date of Accident	Time
WHILE ON ISSP - COMMUNITY	August 28, 2011	1500

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

PULLED TENDON on Bottom of Right Foot, on A R/L C A RESIDENT

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Went to GET on Bike, SLIPPED of Peddle Bending TOES on Right FOOT BACKWARDS. RECEIVED LACERATION on Left Shin.

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

BIKE MISHAP. NO UNSAFE CONDITIONS

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, 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
VIBEKE STRØMGREN SJØ	778-452-2050	JACQUIE HARRIS	778-452-2350
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	778-452-2050		778-452-2350

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

s.15, s.22, s.79

Revised July 2004

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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.

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

...INT ACCIDENT INVESTIGATION FOR...

PSC 38

Ministry C&F Development Tel. # 778-452-2050		Location Burnaby Youth Custody 7900 FRASER PARK DRIVE Burnaby B.C. V5J-5H1	Date of Report August. 27/2011
Last Name of Injured (or ill) Person s.22		First Name	File No.
Years of Service s.22	Time on Present Job s.22	Occupation Youth Supervisor.	Hours Worked in Previous 24 Hour Period 9.58
Accident Location (Dept. or Area) BYCS, Aspenty Unit Open Custody		Date of Accident August. 27/2011	Time 15:31 pm

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 SP strained middle lower back while Restraining Combative Youth.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

strained middle lower back while restraining and lifting a combative youth.

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 Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS

Restraining Volatile and Combative youth. Strained middle Lower back while lifting resident to her room.

Corrective Measures Taken and/or Recommended

N/A. Officer has completed restraint training and followed proper procedures. Due to nature of Duties Injuries do occur.

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Fernando Rodriguez	778 452 2010	Pamela Drew Assistant Director operation	778-452-2077

Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Aug/27/11	Pamela Drew	Aug. 27/2011

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

s.15, s.22

778-452-2050
BYCS

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MCFD	BARRIERE	AUG 14/2011
Last Name of Injured (or Ill) Person: s.22	First Name	File No.
Years of Service / Time on: s.22	Occupation: YOUTH SUPERVISOR	Hours Worked in Previous 24 Hour Period: 2
Accident Location (Dept. or Area): STAIRWELL LEADING TO OPEN ASSEMBLY	Date of Accident: AUG 14/2011	Time: 09:17

Accident Category (check)	Severity of Injury or Illness (check)
☒ Injury or Illness	☐ No Injury or First Aid Only
☐ Equipment Malfunction	
☐ Motor Vehicle	
☐ Property Damage	☒ Medical Treatment
☐ Fire	☐ Time Loss
☐ Other (specify)	☐ Fatal *

Nature of Injury or Illness

SORE LOWER LEFT BACK

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Went to open the door leading from Healthcare Hallway up to open activity and heard back crack

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

Unsure, pushed door open, heard back crack

Corrective Measures Taken and/or Recommended

N/A -

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Mark Streit	778-452-2079	Mellie Annan A.D.O	778-452-2058
Print Name & Occupation	Phone	Print Name & Occupation	Phone
	Aug 14/11		
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

None

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry MCFD Tel. #	Location BURNABY	Date of Report Aug 8/2011
Last Name of Injured (or Ill) Person s.22	First Name	File No.
Years of Service s.22 / Time on	Occupation YOUTH SUPERVISOR	Hours Worked in Previous 24 Hour Period 11-5
Accident Location (Dept. or Area) GLACIER UNIT	Date of Accident 2011/08/07	Time 1300 APPROX

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 TWISTED AND FELL ON RIGHT KNEE; RIGHT SIDE OF NECK SORE; RIGHT WRIST SORE.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

THREE RESIDENTS FIGHTING, STAFF INTERVENED TO SEPERATE COMBATIVE YOUTH. WHILE DOING SO TWISTED AND FELL ON RIGHT KNEE. RIGHT WRIST WHILE BRACING FOR FALL

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

NO UNSAFE CONDITIONS — RESIDENTS INVOLVED IN FIGHT

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, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
M. Strickel SAS	778-452-2049	D. WALLACE	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Aug 8/11		Aug 8/11

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

s.15, s.22 778-452-2050

Revised July 2004

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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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry MCF Tel. #		Location BYCS 7900 FRASER PARK DR. BURNABY BC				Date of Report 2011 08 08
Last Name of Injured (or Ill) Person s.22		First Name				File No.
Years of Service s.22	Time on Present Job s.22	Occupation YOUTH SUPERVISOR				Hours Worked In Previous 24 Hour Period
Accident Location (Dept. or Area) GLACIER UNIT DAYROOM LOWER TIER.		Date of Accident 2011 08 07				Time 1258
Accident Category (check)	☑ Injury or Illness	☐ Equipment Malfunction	☐ Motor Vehicle	☐ Property Damage	☐ Fire	☐ Other (specify)
Severity of Injury or Illness (check) RIGHT SHOULDER PAINFUL NO MOBILITY		☐ No Injury or First Aid Only		☐ Medical Treatment	☐ Time Loss	☐ Fatal*

Nature of Injury or Illness

PAINFUL RIGHT SHOULDER NO MOBILITY

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

THREE RESIDENT YOUTHS INVOLVED IN PHYSICAL ALTERCATION REQUIRED STAFF TO PHYSICALLY SEPARATE THE THREE BOYS AND RESTRAIN THEM. ACTING/SENIOR YOUTH SUPERVISOR WHITESIDE WAS THE FIRST RESPONDER TO A CODE CALL BY THE UNIT STAFF TO RESTRAIN ONE OF THE BOYS. SHE HAD PHYSICAL PULL HIM AWAY FROM THE FIGHT. THIS INVOLVED DUE EXTENSION, TWISTING AND FALLING WITH THE YOUTH DURING THE RESTRAINT. DISCOMFORT WAS MINIMAL UNTIL WAKING UP THIS MORNING UNABLE TO USE R. ARM WITH PAIN.

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

N/A

Corrective Measures Taken and/or Recommended

N/K

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)

None

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
M. Shrubb SHS	778-452-2049	O Wallace	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Aug 8/11		Aug 8/11

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

s.15, s.22 778 452 2050

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry M.C.F.D. Tel. #		Location Burnaby Youth Custody Services			Date of Report June 19/11.	
Last Na s.22					File No.	
Years of Service	Time on Present Job	Occupation Health Care Nurse			Hours Worked in Previous 24 Hour Period 0	
Accident Location (Dept. or Area) Health Care Office		Date of Accident June 19/11.			Time 0945	
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

needlestick injury s.79 YCJA

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Removing cancet from device, poked Rt index finger c used cancet.

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

accidental occurance. s.79 YCJA

s.79 YCJA

Corrective Measures Taken and/or Recommended

s.79 YCJA

Looking at updating equipment

Corrective Action Referred To: C. Turnley Date To Be Completed By: July 31/11

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
C Turnley RPN	778 452-2116	SUS Mykurchak	(778) 452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
C.	June 21/11	SUS Mykurchak	(778) 452-2050

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

None

Revised July 2004

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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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: MCFD	Tel. #	Location: Burnaby Youth Custody Services.			Date of Report: June. 13/2011	
Last Name of Injured (or Ill) Person: s.22		First Name			File No.	
Years of Service: s.22	Time on Present Job	Occupation: Youth Supervisor/ Correctional Officer			Hours Worked in Previous 24 Hour Period: 5½ hrs	
Accident Location (Dept. or Area): BYCS, open custody stairwell/ Health care Entrance.		Date of Accident: June. 13/2011			Time: 11:00 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

LEFT ANKLE SPRAIN (SWOLLEN)

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

WENT OVER ON LEFT ANKLE while going up stairs to open custody.

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

N/A

Corrective Measures Taken and/or Recommended

To be more careful when going up stairs.

No physical Corrective Measures Required.

N/A

Corrective Action Referred To s.12 Date To Be Completed By: ongoing

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
C/O Armando Rodrigues	778 452 2050		
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	June/14/11.		

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

Revised July 2004

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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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCFD		BYCS 7900 CHASER PARK DR. BURNABY BC.	MAY 14/11

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
s.22	s.22	YOUTH SUPERVISOR	9.5 MAY 13/11

Accident Location (Dept. or Area)	Date of Accident	Time
GYM	MAY 14/11	1330

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

- HEAD ACHE, SMALL SCRATCH/NICK ABOVE LEFT EYE, SORE LEFT EYE SOCKET. NAUSEA

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

WHILE INVOLVED IN BASKETBALL GAME WITH RESIDENTS I RECEIVED AN ACCIDENTAL ELBOW TO THE LEFT TEMPLE FROM s.79 YCJA

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

ACCIDENTAL INJURY DURING NORMAL/ROUTINE JOB REQUIREMENT

Corrective Measures Taken and/or Recommended

N/A

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

T. SACCOTTO	778-452-2050	D WALLACE	778 452 2050
Print Name & Occupation	Phone	Print Name & Occupation	Phone
	MAY 14/11		MAY 14/11
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

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 ACCIDENT INVESTIGATION FOR...

PSC 38

Ministry / Tel. #	Location	Date of Report
MCFD.	BYCS	MAY 14/11
Last Nar s.22		**File No.**
Years of Service / **Time on Present Job** s.22	**Occupation** YOUTH SUPERVISOR	**Hours Worked in Previous 24 Hour Period** 6 MAY 12/11
Accident Location (Dept. or Area) BYCS GYM	**Date of Accident** MAY 13/11	**Time** 1545.

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
HYPER-EXTENDED LEFT KNEE.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)
PLAYING BASKETBALL WITH RESIDENTS WENT UP FOR LAY UP. RECEIVED A HARD FOUL FROM BEHIND. HYPER-EXTENDED MY LEFT KNEE AS I WENT UP.

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

ACCIDENTAL INJURY DURING NORMAL/ROUTINE JOB REQUIREMENTS

Corrective Measures Taken and/or Recommended

N / A

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)

N / A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
T. SACYOTTO	778-452-2050	D WALLACE SYS.	778-452 2050
Signature of Workers' Representative	May 14/11 Date	Signature of Employer Representative	May 14/11 Date

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

s.15, s.22

778-452-2050

778 452 2050

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MIN. CHILDREN & FAMILY	BURNABY	May 8 / 2011
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
		S. C. O	

Accident Location (Dept. or Area)	Date of Accident	Time
	May 7	13:00

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: CRUSHED HAND

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

HAND IN DOOR CRUSHED

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

CRUSH

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, 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
Les Somogyi	778 452 2051	M. Annan	778-452-2051
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	May 8.		May 8

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

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MIN CHILDREN & FAMILIES	BONNAB 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**	**Hours Worked in Previous 24 Hour Period**
	Correction Offic	12
Accident Location (Dept. or Area)	**Date of Accident**	**Time**
BYCS	May 6	17:40

Accident Category (check)	☑ Injury or Illness	☐ Equipment Malfunction	☐ Motor Vehicle	☐ Property Damage	☐ Fire	☐ Other (specify)
Severity of Injury or Illness (check) SPRAINED RIGHT THUMB		☐ No Injury or First Aid Only		☐ Medical Treatment	☐ Time Loss	☐ Fatal *

Nature of Injury or Illness
SPRAINED RIGHT THUMB - HYPER EXTENDED.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)
THREE STAFF INVOLVED IN RESTRAINING A FEMALE RESIDENT & PLACING HER IN HER ROOM; s.22 & MYSELF HAD WITHDRAWN TOWARDS THE DOOR. AS s.22 ATTEMPTED TO EXIT, THE RESIDENT RAN AT HER. THIS OFFICER GRABBED THE RESIDENT TO RESTRAIN HER; DURING THE STRUGGLE TO RESTRAIN MY RIGHT THUMB WAS HYPER EXTENDED BACKWARD.

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

ACCIDENTAL INJURY DURING COURSE OF REGULAR DUTIES.

Corrective 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. WALLACE SENIOR TRADE SUPERVISOR	778-4522050	Armando Rodrigues	778 452 2050
Print Name & Occupation	Phone	Print Name & Occupation	Phone
	MAY/12/11	D Wallace	MAY 12/11
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

778-452 2050

s.15, s.22 778 452 2050

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
Children & Family		Burnaby	April 17/2011
Last Name of Injured (or Ill) Person		First Name	File No.
s.22			
s.22	Time on Present Job s.22	Occupation: Youth Supervisor	Hours Worked in Previous 24 Hour Period: 8hrs
Accident Location (Dept. or Area): Track & Field		Date of Accident: April 17/2011	Time: 16:00

Accident Category (check)	☐ Injury or Illness	☐ Equipment Malfunction	☐ Motor Vehicle	☐ Property Damage	☐ Fire	☑ Other (specify)
Playing Sports with Residents						
Severity of Injury or Illness (check)		☑ No Injury or First Aid Only		☐ Medical Treatment	☐ Time Loss	☐ Fatal *

Nature of Injury or Illness
Injury to Right Foot

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)
Staff Member was playing soccer with residents in Track & Field. Staff Member sustained injury kicking soccer ball.

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

Kicking motion while striking soccer ball.

Corrective Measures Taken and/or Recommended

None at this time.

Corrective Action Referred To: N/A 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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
LES GOMOCAK	7784522051	Bill SHOKAR/Supervisor	(778) 452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	April 17/11	B. Shokar	April 17/2011

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

Just residents in Staff member's Care.

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: Children & Family Development Tel. #:	Location: Burnaby Youth Custody Services 7900 Fraser Park Dr Burnaby. BC V5J-5H1	Date of Report: 2011-03-28
Last Name of Injured (or ill) Person: s.22	First Name:	File No.:
Years of Service: s.22 / Time on Present Job: s.22	Occupation: Senior Correctional Officer	Hours Worked in Previous 24 Hour Period: 8 hrs.
Accident Location (Dept. or Area): BYCS, Emerald Unit DAYROOM	Date of Accident: 2011-03-28	Time: 20:05

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: Turned over on left ankle causing pain & swelling.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Responding to Code Yellow Called. Separating 2 Girls involved in fight. While pulling off one girl fell back on bent leg and turned left ankle with Youths weight on top.

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

Due to the nature of our work. Physical Restraints are necessary to keep the Youth Safe. This was a unfortunate circumstance where I fell back due to being off Balance and landed on leg and turned ankle with weight of Youth on Top.

Corrective Measures Taken and/or Recommended

officer has been trained recently in restraint procedures and this was just unfortunate outcome. 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)

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Tayla Gaelsh	778 452-2050	Pamela Drew Assistant Director operations	778-452-2077
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Mar 28/11	Pamela Drew	March 28/2011

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

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: MCFD Tel. #: (778)452 0050	Location: B4CS Science Class.		Date of Report: March 24/2011
Last Name of Injured (or ill) Person: s.22	First Name		File No.
Years of Service: s.22	Time on Present Job: s.22	Occupation: Youth Supervisor	Hours Worked in Previous 24 Hour Period: 12 hrs.
Accident Location (Dept. or Area): Science Class		Date of Accident: March 24/2011	Time: 1050 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

cut left thumb - 1 inch length ¼ inch width

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

cut left thumb on a broken coffee mug in the Science class.

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

accidentin grabbing a broken coffee mug to throw out.

Corrective Measures Taken and/or Recommended

N/A.

Corrective Action Referred To: N/A 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)

N/A.

Name(s) & occupations of person (s) who investigated accident:

M. Streifel S45	778.452.2079	PAUL TIFFIN	778.452.2050
Print Name & Occupation	Phone	Print Name & Occupation	Phone
Signature of Workers' Representative	March 24/11 Date	Signature of Employer Representative	MAR 24/11 Date

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

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
CHILDREN + FAMILIES	778-452-2552	BYCS GYM	MARCH 23 11

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
		CORRECTIONS OFFICER	19.50

Accident Location (Dept. or Area)	Date of Accident	Time
BYCS	MARCH 23 11	2040

Accident Category (check)	☑ Injury or Illness	☐ Equipment Malfunction	☐ Motor Vehicle	☐ Property Damage	☐ Fire	☑ Other (specify) SPORTS INJURY

Severity of Injury or Illness (check)	☑ No Injury or First Aid Only	☐ Medical Treatment	☐ Time Loss	☐ Fatal *

Nature of Injury or Illness

HIT R. HAND ON VOLLYBALL POST DURING A GAME WITH KIDS.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Staff member struck his hand on volleyball post during a game. No safety measures to be employed!

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

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, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
J. HARRIS SCO2	778-452-2052	L Samoj -5	778-452-2051
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
J. Harris	March 23/11		March 23/11

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

None

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCFD	778-452 2050	BYCS	MAR 19/11

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
s.22		YOUTH SUPERVISOR	7 HRS.

Accident Location (Dept. or Area)	Date of Accident	Time
DRIVING FLEET VEHICLE	2011 | 01 | 04	1100

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: SORE RIGHT SHOULDER

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

s.22 WAS DRIVING ONE OF THE FLEET VEHICLES DURING HIS SHIFT AS ISSP WORKER. WHILE STEERING VEHICLE HE FELT A SHARP PAIN IN SHOULDER AREA.

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

NONE NOTED OR OBSERVED

Corrective Measures Taken and/or Recommended

NONE REQUIRED

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:

TODD WATSON	778-452-2050	Pamela Drew - ADO	778-452-2077
Print Name & Occupation	Phone	Print Name & Occupation	Phone
	MAR 19/11		Mar 19/11
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: MCFD Tel. #		Location: Burnaby Youth Custody Services				Date of Report: Mar. 15/11
Last Name of Injured/Ill Person: s.22		First Name				File No.
Years of Service: s.22	Time on Present Job: s.22	Occupation: Youth Supervisor				Hours Worked in Previous 24 Hour Period: 7.5
Accident Location (Dept. or Area): Gymnasium		Date of Accident: Feb. 14/11.				Time: 1230 ish
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: Inflamation of left shoulder tendon "impizement syndrome"

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

tweaked left shoulder during restraint (NVCPI) training

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

Accidental occurrance that could have happened during staff training, on job work etc.

Corrective Measures Taken and/or Recommended

None

Corrective Action Referred To: N/A Date To Be Completed By: 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)

None

Name(s) & occupations of person (s) who investigated accident:

Brandon Thistle JOSH steward	(778) 452-2050	M Burchak (SO02)	(778) 452-2050
Print Name & Occupation	Phone	Print Name & Occupation	Phone
[signature]	Mar 15/11.	[signature] (SO02)	Mar 15/11.
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

s.15, s.22

(778) 452-7050

Revised July 2004

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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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
CHILDREN + FAMILIES	BURNABY 7100 FRASER PARK DR.	MARCH 6 11

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
s.22		CORRECTIONS OFFICER	19 HRS.

Accident Location (Dept. or Area)	Date of Accident	Time
ELKHORN UNIT	MARCH 6 2011	17:18

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

SORE LOWER BACK

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

BROKE UP A PHYSICAL ALTERCATION BETWEEN TWO YOUTHS

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

STAFF MEMBER BROKE UP A FIGHT BETWEEN TWO YOUTHS.

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, tools, 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 SSOII	778-452-2052
Print Name & Occupation	Phone	Print Name & Occupation	Phone
[signature]	MAR 6/11	[signature]	March 6'11
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

Recorded on DVD.

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MCF 778-452-2056	Burnaby	Mar 4/2011

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
s.22	s.22	Correctional officer	8 hours

Accident Location (Dept. or Area)	Date of Accident	Time
Hollyburn landing T/Room	March 4/2011	10.45 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 *
(R) elbow				

Nature of Injury or Illness

(R) elbow

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

While restraining youth, (R) elbow might have hit ground / or wall / object

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

Youth acting up and destroyed property eg. Cabinet handles and youth need to be restrained

Corrective Measures Taken and/or Recommended

N/A

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:

T. SACILOTTO	778-452-2050	S Hudspeth ADO	
Print Name & Occupation	Phone	Print Name & Occupation	Phone
Signature of Workers' Representative	Date	Signature of Employer Representative	Date: Mar 3/11

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

s.15, s.22

- Camera

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 ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCFD		Burnaby Youth Custody Services	Feb. 28/11
Last Name	First Name		File No.
s.22			
Years of Service	Time on	Occupation	Hours Worked in Previous 24 Hour Period
s.22	s.22	Youth Supervisor (Correctional Officer)	11.5
Accident Location (Dept. or Area)		Date of Accident	Time
Staff Parking Lot		Feb. 28/11	0615 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

Wrenched back (as a result of the fall)

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

s.22 was walking to the main building (prior to the start of his shift) when he slipped on the ice (pavement). He landed on his buttocks wrenching his back.

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

The main cause was the ice that was built up on the pavement. The "salt/sand" truck did NOT provide the service through the night (or early hours of the morning).

Corrective Measures Taken and/or Recommended

To ensure the salt & sand truck makes it's rounds on any potential "freezing or icy" nights. All staff members should be mindful of icy conditions whenever entering or exiting the building.

Corrective Action Referred To: WSI John Tyler Date To Be Completed By: asap

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
Corrections Officer Brandon Thistle	(778) 452-2050	M Burdak (SCO)	(778) 452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
(Thistle)	Feb. 28/11	M Burdak (SCO)	Feb. 28/11

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

s.15, s.22 (778) 452-2050

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
			2011/02/18
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
s.22	s.22	SCO	10
Accident Location (Dept. or Area)		Date of Accident	Time
GYMNASIUM		2011/02/18	1100

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
STRAINED (R) SHOULDER AND JOLTED IT BUMPING INTO ANOTHER STAFF MEMBER

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)
WHILE DOING NCVPI TRAINING I BUMPED INTO ANOTHER STAFF MEMBER JOLTING MY (R) SHOULDER. THROUGHOUT THE REST OF THE DAY THE SHOULDER WORSENED CAUSING PAIN DURING CERTAIN MOVEMENTS.

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

Review stretching and expectations when interacting.

Corrective Measures Taken and/or Recommended

Review of techniques when training

Corrective Action Referred To: Supervisor 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:

LB Supervisor	FEB 28/11	778 452 2051	ADO Matt Annan	778 452 2051	
Print Name & Occupation		Phone	Print Name & Occupation	Phone	
Signature of Workers' Representative	FEB 28/11		Signature of Employer Representative	FEB 28/11	
	Date			Date	

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

N/A

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.

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MIN. CHILDREN & FAM	BURNABY YOUTH CUSTODY	FEB. 16 / 2011

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
		YOUTH SUPERVISOR	

Accident Location (Dept. or Area)	Date of Accident	Time
HARRISSON	FEB 14 / 2011	10 30

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

RIGHT SHOULDER INJURY DURING YOUTH TAKE DOWN IN HARRISSON

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

YOUTH SUPERVISOR HAD TO BE PHYSICALLY TAKE DOWN A YOUTH THAT WAS AGGRESIVELY APPROACHING ANOTHER RESIDENT -

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

FALL ON RIGHT SHOULDER.

Corrective Measures Taken and/or Recommended

TRAINING IN PHYSICAL INTERVENTION

Corrective Action Referred To: ONGOING 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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
SOMOGYI	778 452 2051	HUDSPETH	778 452 2052
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	FEB 16/2011		FEB 16/2011

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

s.15, s.22

778 452 2051

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: MCF Tel. #	Location: B.Y.C.S				Date of Report: January	
Last Name of Injured (or Ill) Person: s.22	First Name				File No.	
Years of Service: s.22	Time on Present Job	Occupation: Youth Supervisor			Hours Worked in Previous 24 Hour Period: 2	
Accident Location (Dept. or Area): Fairweather Unit		Date of Accident: January 9 2011			Time: 1630 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

Punched in the face by an angry resident

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Broken Nose, Damage to Left eye DUE TO ASSAULT BY RESIDENT ##

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

N/A

Corrective Measures Taken and/or Recommended

NONE AT THIS TIME

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:

TODD WATSON	778-452-2050	Matthew Annan A.D.O	778-452-2050
Print Name & Occupation	Phone	Print Name & Occupation	Phone
[signature]	2011/01/09.	[signature]	Jan 11/09
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

s.15, s.22

Revised July 2004

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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.

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCFD		Burnaby Youth Custody Services	JAN 13/11
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
s.22		Youth Supervisor	7.5 hrs
Accident Location (Dept. or Area)		Date of Accident	Time
Open Stairwell		JAN 6/11	0930

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

Lower Left (side) back pain

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Tweaked back while opening metal doors (@ Open)

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

Accidental occurrance while doing / conducting basic work duties

Corrective Measures Taken and/or Recommended

None, only thing is to possibly slow down a bit when opening numerous metal doors.

Corrective Action Referred To: N/A Date To Be Completed By: 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)

None

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
[illegible]		M Burchat (AHSO)	(778) 452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
[illegible]	JAN 13/11	[illegible] (AHSO)	JAN 13/11

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

None. (IF needed a review of SIR this date to confirm number of doors accessed that day).

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCFD	778.452.0089	Burnaby	Jan 5, 2011

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
s.22		Food Service Worker	1.5

Accident Location (Dept. or Area)	Date of Accident	Time
Open Custody	December 25, 2010	11:20 am

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
Right hand baby finger

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)
Pushed one wagon through door then went to get second wagon and door closed on finger.

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
Heavy doors that close automatically.

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: 2011/01/05

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
Catherine Hubbard (Supervisor)	778-452-2089		
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
Jerold Hodges	Jan 5		

Name(s) of Witness(s) (include phone number) s.15, s.22 778-452-2089

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry ~~Burnaby Yo~~ Children & Family Develpmt	Tel. #	Location Burnaby Youth Custody Services				Date of Report 2010-12-17
Last Name of Injured (or ill) Person s.22		First Name				File No.
Years of Service s.22	Time on Present Job s.22	Occupation Youth Supervisor.				Hours Worked in Previous 24 Hour Period 6 hr.
Accident Location (Dept. or Area) gymnasium		Date of Accident Dec 17/10				Time 19:45
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 Rt Left hand swollen.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

s.22 had to break up an altercation between two residents.

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

Staff was restraining a youth during an incident. and hurt his hand

Corrective Measures Taken and/or Recommended

N/A

Corrective Action Referred To: N/A Date To Be Completed By: 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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
S. Smith Acting Youth Supervisor	778-452-2050		
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
Armando Rodrigues	Dec/17/10		

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

s.15, s.22 778-452-2050

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

C 38

Ministry	Tel. #	Location	Date of Report
M.C.F.	778-452-2050	7900 FRASER PARK DR. BURNABY V5J 5H1 B.C.	DEC. 14/10

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
s.22	s.22	YOUTH SUPERVISOR	9.58

Accident Location (Dept. or Area)	Date of Accident	Time
GYMNASIUM	DEC. 13, 2010	1530 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 SEVERE CHARLIE HORSE

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

RECEIVED A KNEE TO HIS LEG (AROUND THE THIGH) JUST ABOVE THE KNEE ON THE (R) LEG

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

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, 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	Signature of Employer Representative	Date

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

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
Children + Families	Burnaby Youth Custody	Nov 30 /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**
	Youth Supervisor	8
Accident Location (Dept. or Area)	**Date of Accident**	**Time**
	Nov 29 2010	1930

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

PAIN IN LOWER RIGHT BACK AREA

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

PLAYING BASKETBALL STRETCHED TO RETRIEVE BALL FELT PAIN IN BACK AREA

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

PHYSICAL EXURSION DURING SPORTS.
NO UNSAFE CONDITIONS

Corrective Measures Taken and/or Recommended

MEMBER TO STRETCH MORE

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
TODD WATSON	778-452-2050		
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	NOV 30/10	SAS	NOV 30/2010

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

s.15, s.22, s.79 YCJA

Revised July 2004

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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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry Children & Family DEV Tel. #		Location BYCS 7900 FRASER PARK DR. Burnaby B.C V5J-5H1			Date of Report NOV.26/2010	
Last Name of Injured (or Ill) Person s.22		First Name			File No.	
Years of Service s.22	Time on Present Job s.22	Occupation Senior Youth Supervisor			Hours Worked in Previous 24 Hour Period 11.5	
Accident Location (Dept. or Area) Hollyburn		Date of Accident Nov 26/10			Time 16.14	
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

Pain in right knee to both sides as well as back of knee.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Responded to Code Yellow on Hollyburn Unit. 2 youth involved in Physical Altercation. Attempting to separate Youth and stop fight. Fell & Twisted right knee while restraining combative 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 ☐ N/A ☑

Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS

Restraining Combative Youth. Intervened to stop two youth from fighting. Knee was hurt during breaking up Physical Altercation.

Anytime your involved in using Physical Force it is high risk for injury. This is part of our Job requirements. WE ARE Trained in Physical Restraint and proper procedure but injury can occur at any time due to circumstances.

Corrective Measures Taken and/or Recommended

N/A – STAFF ARE TRAINED IN Physical Restraint and use of force regularly. Part of our duties to respond to codes and use force when necessary. No corrective measures or Recommendation.

Corrective Action Referred To: N/A 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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Peter K. Murphy Steward		Pamela Drew BYCS ADO	778-452-2077
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Nov 26/10		Nov. 26/2010

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

s.15, s.22

778-452-2050

DVR BYCS caught incident on Camera.

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 ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCF		BYCS 7900 FRASER PARK DR Burnaby BC	NOV 18/10

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
s.22	s.22	YOUTH SUPERVISOR.	12

Accident Location (Dept. or Area)	Date of Accident	Time
HARRISON	NOV 18/10	0722

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

SHOULDER & BACK STARTED HURTING AT ABOUT 2:30 P.M.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

WHILE BREAKING UP A FIGHT BETWEEN 3 RESIDENTS, ATTEMPTED TO RESTRAIN THE AGGRESSOR, WE BOTH FELL BACK AND THE RESIDENT LANDED ON TOP OF ME AS WE BOTH LANDED ON THE TOP OF A SET OF STAIRS.

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

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, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)

Name(s) & occupations of person (s) who investigated accident:

		D WALLACE Senior Youth Supervisor	778-452 2050
Print Name & Occupation	Phone	Print Name & Occupation	Phone
		D Wall	NOV 18/10
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

Revised July 2004

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...NT ACCIDENT INVESTIGATION FOR...

PSC 38

Ministry / Tel. #	Location	Date of Report
MIN CHILDREN + FAMILIES	BYCS	Sept 27 / 2010
Last Name of Injured (or ill) Person	**First Name**	**File No.**
s.22		
Years of Service / **Time on Present**	**Occupation**	**Hours Worked in Previous 24 Hour Period**
s.22 / s.22	YOUTH SUPERVISOR	10 hours.
Accident Location (Dept. or Area)	**Date of Accident**	**Time**
Delta	Sept 27 / 2010	8:30

Accident Category (check)	Severity of Injury or Illness (check)
☑ Injury or Illness	☐ No Injury or First Aid Only
☐ Equipment Malfunction	☐ Medical Treatment
☐ Motor Vehicle	☑ Time Loss
☐ Property Damage	☐ Fatal *
☐ Fire	
☐ Other (specify)	

Nature of Injury or Illness

LEFT ANKLE + RIGHT ELBOW

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

DURING CLEANING TIME IN DELTA FORM EMPLOYEE SLIPPED ON WET FLOOR LANDING ON RIGHT ELBOW AND TWISTED LEFT ANKLE.

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

FALL AND TWIST

Corrective Measures Taken and/or Recommended

FLOOR WAS VERY WET. SIGNS NOT BEING USED AND MOP SHOULD HAVE BEEN SQUEEZED MORE FOR LESS WATER USE. USE OF DRY MOP MOPING STYLE.

Corrective Action Referred To: OC / HEALTH 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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
[redacted]	778 452 2051	[redacted]	778 452 2051
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	SEPT 27/2010	SVS	SEPT 27/2010

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

s.15, s.22

- 778 452 2051
- 778 452 2051

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.

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: MCFD. Tel. #		Location: Burnaby Youth Custody Services 7900 Fraser Park Dr. Bby B.C.			Date of Report: Sept. 22/2010	
Last Name of Injured (or ill) Person: s.22		First Name			File No.	
s.22	Time on Present Job: s.22	Occupation: Youth Supervisor			Hours Worked in Previous 24 Hour Period: 12 hrs.	
Accident Location (Dept. or Area): Gym.		Date of Accident: Sept. 22/2010			Time: 08:30 am.	
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: Right cheek swollen. due to being hit in face w/ Volleyball.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Playing volleyball in Gym. Resident kicked Volleyball and it hit the right cheek causing bruising & swelling. Also Broke my glasses frame.

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

Injury was due to ball hitting staff in face accidently while playing volleyball. Resident kicked ball playfully and Accidental Injury occurred.

Corrective Measures Taken and/or Recommended

Accidental injury while playing volleyball. Instruct Residents not to kick balls when playing.

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Pamela Drew ADO.	778 452-2017		
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
Peter K. Murphy	Sept 23/10	Pamela Drew	Sept 23/10

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

Revised July 2004

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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.

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: Children + Families	Tel. #:	Location: B.Y.C.S			Date of Report: Sept. 21 2010	
Last Name of Injured (or Ill) Person: s.22		First Name			File No.	
Years of Service: s.22	Time on Present Job: s.22	Occupation: Youth Supervisor			Hours Worked In Previous 24 Hour Period: 8	
Accident Location (Dept. or Area): Control Room		Date of Accident: Sept 21 2010			Time: 1510 hrs.	
Accident Category (check)	☑ Injury or Illness	☐ Equipment Malfunction	☐ Motor Vehicle	☐ Property Damage	☐ Fire	☐ Other (specify)
Severity of Injury or Illness (check): Swollen Right Knee		☐ No Injury or First Aid Only		☑ Medical Treatment	☑ Time Loss	☐ Fatal *

Nature of Injury or Illness: Twisted knee walking down stairs

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Took a step down and felt my knee buckle

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

N/A

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, 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
[illegible]	778-452-2050	Matthew Arnan A.D.O	778-452-2077
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
			Sept 21/10

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

None

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
CHILDREN + FAMILIES		BYCS BBY	AUG 28 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
s.22	s.22	CORRECTIONS OFFICER	32
Accident Location (Dept. or Area)		Date of Accident	Time
EMERALD		AUG 28 10	1905

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 (X-RAY)	☐ Time Loss	☐ Fatal *
		☑		

Nature of Injury or Illness

BRUISING + SWELLING OF R. SHOULDER

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

OFFICER WAS INVOLVED WITH OTHER STAFF IN THE TAKE 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 ☐ N/A ☑

Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS

Escalated youth needed restraining.

Corrective Measures Taken and/or Recommended

Officers are trained in these matters but situations have varying outcomes. No corrective measures to be applied

Corrective Action Referred To:_____ Date To Be Completed By:____/____/____ 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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
JACQUIE HARRIS SCO2	778-452-2052	Armando Rodriguez C.O.	778 452 2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
Jacquie Harris	Aug. 28 '10		08/28/10

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

s.15, s.22 778-452-2052

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
CHILDREN + FAMILIES	778 452-2056	BURNABY	AUG 19 '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
s.22	s.22	CORRECTIONS OFFICER	12

Accident Location (Dept. or Area)	Date of Accident	Time
GLACIER UNIT	AUG 18 '10	2030

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 (X-RAY)	☐ Time Loss	☐ Fatal *
SOFT TISSUE INJURY				

Nature of Injury or Illness

injury and swelling of right hand.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

s.22 was involved in a take down with a youth during his working hours. This resulted in an injury to his right hand.

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

N/A.

Corrective Measures Taken and/or Recommended

N/A. Accidental Occurrence.

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
JACQUIE HARRIS SCO2	778-452-2050	ARMANDO RODRIGUEZ C.O.	778 452 2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
Jacquie Harris	Aug 19/10		Aug/19/2010

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

s.15, s.22 778-452-2050

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MIN. CHILDREN + FAMILIES	BYCS	JULY 30 / 2010
Last Name of Injured (or ill) Person	**First Name**	**File No.**
s.22		
Years of Service	**Time on Present Job**	**Occupation**
s.22		YOUTH SUPERVISOR
Hours Worked in Previous 24 Hour Period		
9		
Accident Location (Dept. or Area)	**Date of Accident**	**Time**
SELKIRK LIBERTY	JULY 30 / 2010	1400

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

LEFT KNEE, SORE FROM AROUND RIGHT SHOULDER, SORE FROM CHAIR.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

RESPONDING TO A PHYSICAL ALTERCATION BETWEEN TWO RESIDENTS. WENT TO THE GROUND (LEFT KNEE HURT) WHILE ON THE GROUND, THIS STAFF WAS HIT IN RIGHT SHOULDER BY A CHAIR

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

STRUCK BY CHAIR.

Corrective Measures Taken and/or Recommended

CHAIR REVIEW. ARE CHAIRS TO LIGHT THUS CAN BE EASILY THROWN?

Corrective Action Referred To: OC HEALTH Date To Be Completed By: DEC 11

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
LES SOMOGYI	778 452-2051	BILL STROAK.	778 452 2051
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	Sept 3/2010 778 452/2051		Sept 3/2010

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MIN. CHILDREN + FAMILIES.	BYCS	JULY 30 /2010
Last Name of Injured (or ill) Person s.22	**First Name**	**File No.**
Years of Service / **Time on Present Job**	**Occupation** YOUTH SUPERVISOR	**Hours Worked in Previous 24 Hour Period**
Accident Location (Dept. or Area) GYM	**Date of Accident** JULY 30 /2010	**Time** 15:45

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

RIGHT SIDE OF RIGHT ANKLE STRAINED.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

PLAYING FLOOR HOCKEY IN THE GYM AND TRIED TO STRIKE AFTER THE BALL AND INJURED MY RIGHT FOOT.

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

ACCIDENT

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, 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
LES SOMOGYI	778 452 2051	B. SHOKAR	778 452 2051
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	SEPT 3/2010		SEPT 3/2010

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MIN. CHILDREN FAMILIES	HOLLYBURN (BYCS)	JULY 30 / 2010
Last Name of Injured (or ill) Person s.22	**First Name**	**File No.**
Years of Service s.22 / **Time on Present Job**	**Occupation** YOUTH SUPERVISOR	**Hours Worked in Previous 24 Hour Period** Y
Accident Location (Dept. or Area) HOLLYBURN	**Date of Accident** JULY 30 / 2010	**Time** 21:25

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

Left elbow injury.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

HIT ELBOW (R) ON CONCRETE FLOOR RESTRAINING AN AGGRESSIVE + COMBATIVE YOUTH. ALSO CUT ELBOW ON MECHANICAL RESTRAINT WHILE YOUTH WAS NOT COMPLYING.

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

VOLITICE YOUTH

Corrective Measures Taken and/or Recommended

REFRESHER TRAINING FOR RESTRAINT NON COMPLIANT YOUTH

Corrective Action Referred To: DC. HEALTH Date To Be Completed By: DEC 11

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
LES SOMOGYI	778 452 2051	B. SHOKAR	778 452 2051
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	SEPT 3/2010		SEPT 3/2010

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: CHILDREN/FAMILY DEV. Tel. #: 778 452 4050		Location: BURNABY YOUTH CUST. SERV. 7900 FRASER PARK DR. BURNABY BC			Date of Report: 2010.07.19	
Last Name of Injured (or Ill) Person: s.22		First Name			File No.	
Years of Service	Time on Present Job	Occupation: YOUTH SUPERVISOR			Hours Worked In Previous 24 Hour Period	
Accident Location (Dept. or Area): OUTSIDE OF ADMINISTRATION OFFICE PATIO		Date of Accident: 2010.07.19			Time	
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

BURN TO 3 FINGERS ON LEFT HAND

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

s.22 PLACED HIS LEFT HAND ON THE EXHAUST BOX ON A GAS POWERED PRESSURE WASHER. BURNS WERE SUSTAINED AS A RESULT.

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

BLACK BOX AROUND EXHAUST UNIT UNMARKED AND GETS VERY HOT FROM ENGINE EXHAUST. HAND PLACED ON METAL SURROUND IN ORDER TO STABALIZE STARTING OF MACHINE.

Corrective Measures Taken and/or Recommended

- BETTER LABELING ON DANGER ZONES OF MACHINE
- WORK SAFE SAFETY SHEET ESTABLISHED

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
GRANT BUNKER A/SYS	778 452 2052	B. Thistle	778 452 2052

Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	2010/7/20		July 20/2010

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
CHILDREN & FAMILIES	BYCS	July 7/10
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**
	YOUTH SUPERVISOR	
Accident Location (Dept. or Area)	**Date of Accident**	**Time**
SCIENCE CLASSROOM	July 7 / 2010	11:00 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: RIGHT LEG INJURY.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

INVOLVED IN BREAKING UP A FIGHT (CODE YELLOW) IN SCIENCE CLASSROOM. CAUGHT BETWEEN DESK & STAFF & RESIDENTS LANDING ON HIS BODY.

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

RESIDENT FIGHT

Corrective Measures Taken and/or Recommended

NONE AT THIS TIME

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

CAROL A. MILLER	7784522050	SENIOR YOUTH SUPERVISOR	
Print Name & Occupation	Phone	Print Name & Occupation	Phone
BRANDON THISTLE	7784522050	YOUTH SUPERVISOR OSH + UNION REP.	
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

s.15, s.22

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 ACCIDENT INVESTIGATION FORM

PSC 38

Ministry CHILDREN + FAMILIES 778-452-2350 Tel. #		Location			Date of Report JUNE 30 / 10	
Last Name of Injured (or Ill) Person s.22		First Name			File No.	
Years of Service s.22	Time on Present Job s.22	Occupation CORRECTIONS OFFICER			Hours Worked in Previous 24 Hour Period 5	
Accident Location (Dept. or Area) GYM		Date of Accident JUNE 30 10			Time 11:40 am	
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		☐ POSSIBLE Medical Treatment	☐ Time Loss	☐ Fatal *

Nature of Injury or Illness
TWISTED R. KNEE PLAYING VOLLEYBALL

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)
TURNED TO GET BALL, KNEE DID NOT FOLLOW

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

— NONE

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, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Francisco Rodriguez / C.O.	778 452 2050	J. HARRIS SCO2	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	June/30/2010	J. Harris	June 30 10

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.

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MCFD 778-452-2050	BYCS	JUNE 29/10
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	CORRECTION OFFICER	16.5
Accident Location (Dept. or Area)	**Date of Accident**	**Time**
OUTSIDE FIELD	JUNE 29/10	1426

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: STRAINED NECK (L) SIDE
SCRAPED (R) ELBOW
SWOLLEN (R) KNEE

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

INJURY OCCURED DURING A SOCCER GAME BETWEEN STAFF AND RESIDENTS
s.22 WAS PLAYING GOAL AT THE TIME AND DID DIVE FOR A BALL AS PER HIS ATHLETIC REACTION TO THE SHOT. PART OF BEING A PROGRAM YOUTH SUPERVISOR.

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

Corrective Measures Taken and/or Recommended

USE CAUTION WHEN PLAYING GOAL
SWITCH OFF WITH OTHERS WHEN A
SPARE IS AVAILABLE.

Corrective Action Referred To: OSH 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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Dave Birchmore Visits office.	778-452-2068	M. Sveistrup	778-452-2079
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	July 7/10		July 7/10

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

778-452-2050

s.15, s.22 778-452-2050

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry MINISTRY OF CHILDREN AND FAMILIES Tel. #		Location BURNABY YOUTH CUSTODY SERVICES 7900 FRASER PARK DRIVE. BASKETBALL COURT.			Date of Report 2010.06.25	
Last Name of Injured (or Ill) Person s.22		First Name			File No.	
Years of Service	Time on Present Job	Occupation YOUTH SUPERVISOR			Hours Worked in Previous 24 Hour Period	
Accident Location (Dept. or Area) BASKETBALL COURT		Date of Accident 2010.06.25			Time 2040	
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

RIGHT ANKLE SPRAIN, STRAINED INDEX FINGER. ANKLE APPEARS QUITE SWOLLEN. ICE WAS ADMINISTERED BY HEALTH CARE.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

STAFF WAS PLAYING BASKETBALL WITH THE RESIDENTS @ THE BASKETBALL COURT. WHILE JUMPING TO CATCH THE BALL, STAFF CAME DOWN AND ROLLED ~~RIGHT~~ ANKLE, FALLING DOWN ON HANDS AND SIDE OF BODY

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

N/A

Corrective Measures Taken and/or Recommended

N/A

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Dave Birchmore Visits Office	778-452-2068	M. Strickell	778.452.2079
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	July 7/10		July 7/10

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: MCFD	Tel. #:	Location: RYCS	Date of Report: JUNE 24/2010
Last Name: s.22			File No.
Years of Service: s.22	Time on Present Job:	Occupation: YOUTH SUPERVISOR	Hours Worked in Previous 24 Hour Period
Accident Location (Dept. or Area): School Rotunda		Date of Accident: June 23/2010	Time: 0935

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: Feeling of instability, swelling on knee

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Responded to altercation involving two residents.

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

Unsure, knee became worse as day went on

Corrective Measures Taken and/or Recommended

N/A

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)

None - Returned to work next day

Name(s) & occupations of person (s) who investigated accident:

Rodriguez, Armando		M. Strickel	778-452-2079
Print Name & Occupation	Phone	Print Name & Occupation	Phone
			June 24/2010
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 ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
Ministry of Children and Family development	Burnaby youth custody services	2010/06/06

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
s.22		Youth Supervisor	0

Accident Location (Dept. or Area)	Date of Accident	Time
Seperate Confinement	2010/06/06	1400 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

Assault by resident

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

STAFF WAS SPAT IN THE FACE

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

Volitale youth.

Corrective Measures Taken and/or Recommended

SPIT GUARDS SHOULD BE RE-LOOKED.

Corrective Action Referred To: OC/Heath Date To Be Completed By: 2010, 07

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
LES SOOCHAN	778 452 2051	MATT ANNAN	778 452 2051

Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	778 452 2051		778 452 2051

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

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC:

Ministry MCF BYCC. 778-452 2050 Tel. #		Location 7900 Fraser park drive in gym	Date of Report May 22 2010
Last Name of Injured (or Ill) Person s.22		First Name	File No.
Years of Service	Time on Present Job s.22	Occupation Programs Supervisor Youth Supervisor	Hours Worked in Previous 24 Hour Period 12 – 2200 may 2 12 –
Accident Location (Dept. or Area) Gym		Date of Accident May 22 2010	Time 1430

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 Hospital	☐ Time Loss	☐ Fatal *

Nature of Injury or Illness (left) Thumb impacted with Radio equipment from another staff.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

While actively supervising Youth in a game of indoor Soccer s.22 was hip checked by a fellow staff. The impact of s.22 Radio equipment on hip caused damage to left thumb area.

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 Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS

Accident

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, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)

None.

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
LES Sowden	778-4522251	Matt Arnew	778-4522251
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	778 4522251		778 4522251

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
CHILDREN + FAMILIES		7900 FRASER PARK DRIVE 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
		CORRECTIONS OFFICER	

Accident Location (Dept. or Area)	Date of Accident	Time
HARRISON UNIT	MAY 16 '10	1515

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.

OFFICER HAD JUST BEEN ASSAULTED AND PUNCHED THE WALL IN FRUSTRATION

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

AS BELOW, OFFICER HAD BEEN ASSAULTED AND EXPRESSED HIS FRUSTRATION BY PUNCHING THE WALL.

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

CAUSE WAS FRUSTRATION AND ANGER FROM BEING ASSAULTED.

Corrective Measures Taken and/or Recommended

N/A.

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)

N/A.

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
C-07 Armando Rodriguez.	778 452 2050	JACQUIE HARRIS	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	04/16/2010	J. Harris	778-452-2050

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry Children & Family Development Tel. # 778-452-2050		Location Burnaby Youth Custody Services 7900- FRASER PARK DR. Burnaby B.C. V5J- 5H1	Date of Report MAY. 12/2010
Last Name of Injured (or Ill) Person s.22		First Name	File No.
Years of Service	Time on Present Job	Occupation Correctional Officer Youth Supervisor	Hours Worked In Previous 24 Hour Period
Accident Location (Dept. or Area) BYCS School Rotunda		Date of Accident May. 11 /2010	Time 1330 hrs

Accident Category (check)	☑ Injury or Illness	☐ Equipment Malfunction	☐ Motor Vehicle	☐ Property Damage	☐ Fire	☑ Other (specify) Assault/Restrai
Severity of Injury or Illness (check)		☐ No Injury or First Aid Only		☐ Medical Treatment	☐ Time Loss	☐ Fatal *

Nature of Injury or Illness While restraining Combative Resident, Resident bit ~~[illegible]~~ left knee causing pain & bruising

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

While conducting a Restraint on Combative Youth, Youth Reached over a bit left knee.

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

ASSAULT

Corrective Measures Taken and/or Recommended

N/A.

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Armando Rodriguez	778 452 2050	Matthew Annum A.D.O	778-452-2077

Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	MAY/13/2010		May 13/10

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry Children & Family Development. 778-452-2050 Tel. #		Location Burnaby Youth Custody Services. 7900 Fraser Park Dr Burnaby B.C. V5J 5H1			Date of Report May. 12/2010	
Last Name of Injured (or ill) Person s.22		First Name			File No.	
Years of Service	Time on Present Job	Occupation Correctional Officer Youth Supervisor.			Hours Worked in Previous 24 Hour Period	
Accident Location (Dept. or Area) BYCS School Rotunda		Date of Accident May. 11/2010			Time 1330	
Accident Category (check)	☑ Injury or Illness	☐ Equipment Malfunction	☐ Motor Vehicle	☐ Property Damage	☐ Fire	☑ Other (specify) ASSAULTED.
Severity of Injury or Illness (check)		☑ No Injury or First Aid Only		☐ Medical Treatment	☐ Time Loss	☐ Fatal *

Nature of Injury or Illness

SCRAPED Left Knee, SORE NECK & Throat AREA, SCRATCHES & Bruising on ARMS.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

s.22 was assaulted by Resident then had to assist in restraint of resident. Resident was Punching, Kneeing, biting and Spitting at the officer and was Combative until Mechanically Restraint Applied.

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

ASSAULT.

Corrective Measures Taken and/or Recommended

N/A

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Alejandro Rodriguez	778 452 2050	Matthew Annan A.HO	778-452-2077
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	May 13/2010		May 13/10

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 ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCF		BURNABY BC	MAY 11, 2010
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
s.22		SCOII	0
Accident Location (Dept. or Area)		Date of Accident	Time
SECURE ROTUNDA		MAY 11, 2010	

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: SWOLLEN SORE (L) KNEE
SWOLLEN CUT/ABRASION (R) KNEE
SORE (R) INDEX FINGER

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

BREAKING UP AN ASSAULT ON STAFF
HURT KNEES WHEN WE WENT TO THE FLOOR (CEMENT)

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

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, 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	Signature of Employer Representative	Date

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

s.15, s.22 778-452-2050

778-452-2050

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

JOINT ACCIDENT INVESTIGATION FORM

SC 38

Ministry	Tel. #	Location	Date of Report
MIN CHILDREN & FAMILIES.		BYCS	MAY 7 '2010

Last Name of Injured (or ill) Person	First Name	File No.
s.22		

Years	Time on Present Job	Occupation	Hours Worked in Previous 24 Hour Period
s.22		CORRECTIONS OFFICER	

Accident Location (Dept. or Area)	Date of Accident	Time
SECURE LINK	MAY 7 '2010	17:38

Accident Category (check)	☐ Injury or Illness	☐ Equipment Malfunction	☐ Motor Vehicle	☐ Property Damage	☐ Fire	☑ Other (specify) ASSAULT
Severity of Injury or Illness (check)		☑ No Injury or First Aid Only		☑ Medical Treatment	☐ Time Loss	☐ Fatal *

Nature of Injury or Illness

OFFICER WAS SPAT IN THE FACE BY A RESIDENT

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

OFFICER WAS HOLDING OPEN A DOOR TO HELP IN TRANSPORTING A RESIDENT WHEN SHE SPAT IN HIS FACE.

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

UNPREDICTABLE BEHAVIOUR BY RESIDENT BEING TRANSPORTED.

other, spat on.

Corrective Measures Taken and/or Recommended

SPIT GUARD ON COVER

Corrective Action Referred To: QC / Health Date To Be Completed By: 2010 MAY 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
LES SOMOGY,	778 452 2050	JACQUIE HARRIS	778-452-2050

Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	MAY 7/2010	Jacquie Harris	MAY 7/2010

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

s.15, s.22

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MIN CHILDREN + FAMILIES	BYCS	May 7/2010
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
s.22		Correctional Officer	

Accident Location (Dept. or Area)	Date of Accident	Time
EMERALD UNIT	~~Enacted~~ MAY 7 2010 ~~Unit~~	17:15

Accident Category (check)	☐ Injury or Illness	☐ Equipment Malfunction	☐ Motor Vehicle	☐ Property Damage	☐ Fire	☑ Other (specify) ASSAULT
Severity of Injury or Illness (check)		☐ No Injury or First Aid Only		☐ Medical Treatment	☐ Time Loss	☐ Fatal *

Nature of Injury or Illness

Assaulted by client or unit.
Headache + cut on hand.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Assaulted by client,

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

STRUCK.

Corrective Measures Taken and/or Recommended

TESTING PAT system in areas throughout building. Daily PAT system products for proper settings.

Corrective Action Referred To: OC/Health Committee Date To Be Completed By: 2010 05 07

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)

Re Weekly pat checks for battery change and Check of proper settings by staff.

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
LES SOMOGY,	7784522050	X Jacquie Harris	778-452-2350
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	MAY 7/2010	J. HARRIS	MAY 7/2010

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCF	778-452-2050	BURNABY BC	APR 18, 2010

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
s.22	s.22	YOUTH SUPERVISOR	9.58

Accident Location (Dept. or Area)	Date of Accident	Time
SECURE ROTUNDA STAIRS	APR. 17, 2010	1830

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 SORE KNEE (R), CALF MUSCLE (L), ELBOW (R), HIP (R), HAND (L),

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

FELL ON STAIRS WHILE RESPONDING TO A CODE RED.

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

Corrective Measures Taken and/or Recommended

TAKE MORE CAUTION WHEN USING THE STAIRS IN THE SECURE ROTUNDA.

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
SCO/AMESBURY	778-452-2050	TODD WATSON STEWARD	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	10/04/18		10/04/18

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

s.15, s.22

778-452-2050

778-452-2050

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MCFD	BURNABY YOUTH CUSTODY SERVICE	2010/04/13

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
s.22	s.22	YOUTH SUPERVISOR	6.5

Accident Location (Dept. or Area)	Date of Accident	Time
Gymnasium	2010/04/13	11:45 am

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: PULLED MUSCLE IN RIGHT SIDE MID BACK

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

PLAYING BASKETBALL IN GYM. JUMPED FOR REBOUND, PULLED MUSCLE.

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

NO UNSAFE CONDITIONS NOTED.

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, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)

Name(s) & occupations of person (s) who investigated accident:

		Mark Streifel SAO2	778-452-2079
Print Name & Occupation	Phone	Print Name & Occupation	Phone
			April 19/2010
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MIN. CHILDREN + FAMILIES	BURNABY YOUTH CUSTODY	MARCH 18/2010
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**
s.22	YOUTH SUPERVISOR	8 hrs.
Accident Location (Dept. or Area)	**Date of Accident**	**Time**
MANTRAP CONTROL	MAR 18/2010	12:55

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

SORE WRIST

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

DOOR HIT WRIST WHEN TRYING TO CLOSE DOOR. DOOR WAS PUSHED OPEN WHEN EMPLOYEE WAS TRYING TO CLOSE DOOR CAUSING PAIN IN LEFT HAND.

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

CRUSH

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, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)

N/A

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
Les Somogyi	778 452 2051	Matt Annan A.D.O.	778 452 2051
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	MARCH 18/2010		MARCH 18/2010

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

s.15, s.22 778 452 2051

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
Children + Families	Burnaby Youth Custody Service	March 18 2010

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
s.22		Youth Supervisor	

Accident Location (Dept. or Area)	Date of Accident	Time
Seperate Confinement	March 18 2010	1700 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

Slipped on wet floor

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Employee in Sep. Con area. Floor was wet. She slipped and pulled a muscle in the groin area

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

Wet floor

Corrective Measures Taken and/or Recommended

Mop wet floor.

Need Shower Curtain.

Corrective Action Referred To:_____ Date To Be Completed By: 04/01/10

To notify W.S.E

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
LES SORBY	7784522050	Matt Annan A.DO	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	MARCH 18/10		March 18/10

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

s.15, s.22

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
MCFD	778.452.2050	B.Y.C.S 7900 Fraser Park Dr. Burnaby V5J 5H1	March 16/10
Last Name of Injured (or Ill) Person: s.22		First Name:	File No.
Years of Service: s.22	Time on Present Job: s.22	Occupation: YOUTH SUPERVISOR	Hours Worked in Previous 24 Hour Period: 6
Accident Location (Dept. or Area): GYM		Date of Accident: MARCH 16/10	Time: 1330 hrs.

Accident Category (check)	☑ Injury or Illness	☐ Equipment Malfunction	☐ Motor Vehicle	☐ Property Damage	☐ Fire	☐ Other (specify)
Severity of Injury or Illness (check): CALF STRAIN		☑ No Injury or First Aid Only: ICE		☐ Medical Treatment	☐ Time Loss	☐ Fatal *

Nature of Injury or Illness

STRAINED LEFT CALF PLAYING VOLLEY BALL

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

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

ACCIDENT OR INJURY DURING SPORTS ACTIVITY DURING WORK HOURS. PARTICIPATING WITH UNIT OF RESIDENTS.

Corrective Measures Taken and/or Recommended

NONE NEEDED

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
(SENIOR YOUTH SUPERVISOR) DEANA WHITE	778.452.2050	(YOUTH SUPERVISOR) TODD WATSON	778.452.2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	MAR.16/10		MAR.16/10

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

s.15, s.22

- ~~778.452.2050~~
- ~~778.452.2050~~
- ~~778.452.2050~~

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry MCF Tel. #	Location BYCS	Date of Report FEB 15/2010
Last Name of s.22		File No.
Years of Service s.22 Time on	Occupation YOUTH SUPERVISOR	Hours Worked in Previous 24 Hour Period 7.5
Accident Location (Dept. or Area) BYCS - GYM	Date of Accident 2010/02/13	Time 13:40

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: RIGHT KNEE INJURY

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

while playing ~~basketball~~ volleyball my knee collided with another player

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

Accidental. Occurred while playing volleyball

Corrective Measures Taken and/or Recommended

N/A

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)

None

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
M. STEELE	778.452.2879	Sheryl Hardspell	778.452.2077
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	2010/02/15		2010/02/15

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

s.15, s.22 — 778.452-2050

Revised July 2004

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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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry	Tel. #	Location	Date of Report
CHILDREN + FAMILIES	778-452-2655	7900 FRASER PARK DR.	FEB 25 '10
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		CORRECTIONS OFFICER	
Accident Location (Dept. or Area)		Date of Accident	Time
HARRISON UNIT		FEB 25 '10	1515

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

STAFF MEMBER INJURED RIGHT WRIST DURING A RESTRAINT OF AN AGGRESSIVE YOUTH.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

OFFICER RESPONDED TO A CODE AND PHYSICALLY RESTRAINED AN AGGRESSIVE YOUTH. BOTH PARTIES FELL ONTO THE STAIRS. THIS RESULTED IN THE OFFICER INJURING HIS WRIST.

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

OFFICER WAS ATTEMPTING TO PREVENT AN AGGRESSIVE YOUTH FROM HURTING ANOTHER YOUTH IN A CORRECTIONAL CENTER.

Corrective Measures Taken and/or Recommended

NONE.

Corrective Action Referred To: N/A 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)

NONE.

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
JACQUIE HARRIS SYS	778-452-2050	Armando Rodriguez / C.O	6045833829
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
			Feb/25/2010

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

s.15, s.22 -778-452-2050

Revised July 2004

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry MCFD Tel. #	Location BURNABY		Date of Report FEB 3/2010
Last Na s.22			File No.
Years of Service s.22 / Time on Present Job	Occupation YOUTH SUPERVISOR		Hours Worked in Previous 24 Hour Period 7.5
Accident Location (Dept. or Area) BYCS 6401	Date of Accident FEB 3/2010		Time 0900

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: TWISTED AND SORE RIGHT KNEE; UPPER LIP AND LEFT SIDE OF FACE SWOLLEN

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

While in gymnasium, one youth attempted and did assault another resident. s.22 attempted to intervene and was injured in the process

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

Aggressive youth was combative

Corrective Measures Taken and/or Recommended

None / Staff responded appropriately

Corrective Action Referred To: N/A Date To Be Completed By: 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)

None / Fight was not planned. s.22 attempted to intervene

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
MILLER 06625		M. Shrifel. Supervisor	778-452-2079

Signature of Workers' Representative	Date	Signature of Employer Representative	Date
			Feb 3/2010

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

s.15, s.22 - 778-452-2057

Revised July 2004

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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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MCFD		JAN 30/2010
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	Youth Supervisor	12
Accident Location (Dept. or Area)	**Date of Accident**	**Time**
EMERALD UNIT	Jan 30/2010	02:00

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 *
Twisted back				

Nature of Injury or Illness: slipped on stairs

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

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

Steep Stairs
Dark area

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, 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
TODD WATSON (STEWARD)	778-452-2050	JILL GARDNER	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	JAN 30/10		Jan 30/10

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

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: Children + Families — Tel. #	Location: B.Y.C.S				Date of Report: Jan 24 2010	
Last Name of Injured (or ill) Person: s.22	First Name				File No.	
Years of Service	Time on: s.22	Occupation: Youth Supervisor			Hours Worked In Previous 24 Hour Period: 11.5	
Accident Location (Dept. or Area): Hollyburn Unit		Date of Accident: Jan. 24 2010			Time: 1700 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: Right knee cap hit by table.

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Resident was moving dining room table. As he pulled it the table hit s.22 in the right knee area.

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

~~Human Error~~ &

(Struck)

Corrective Measures Taken and/or Recommended

N/A

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)

N/A

Name(s) & occupations of person (s) who investigated accident:

Sompoy	778-452-2251	Matthew Annan	778-452-2050
Print Name & Occupation	Phone	Print Name & Occupation	Phone
Signature of Workers' Representative	Jan 24/10 Date	Signature of Employer Representative	Jan 24 2010 Date

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

None

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FORM

PSC 30

Ministry	Tel. #	Location	Date of Report
Children + Families		Venture Day room	Jan 21 2010

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
s.22		Senior Youth Supervisor	

Accident Location (Dept. or Area)	Date of Accident	Time
Venture	Jan. 21 2010	1915 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

Strained left palm, middle and index finger

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

s.22 was moving the mop bucket and mop out of the dayroom. He strained his left hand

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

Mop bucket was not emptied

Corrective Measures Taken and/or Recommended

Put cleaning equipment away when not in use.
Do not leave in Dayroom

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
TODD WATSON STEWARD	778-452-2050	Matthew Annen A.D.O	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	JAN 21/10		Jan 21 2010

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

Revised July 2004

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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.

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JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
Children & Family Development	Burnaby, BC	Jan 22 2010
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	Correctional Officer	8 ~~hrs~~ hrs
Accident Location (Dept. or Area)	**Date of Accident**	**Time**
Gym	Jan 21 2010 - 13:30	13:30

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

Twisted lower back

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

Made a quick turn playing floor hockey in gym & twisted lower back.

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

Twist during Sporting Event interacting with clients.

Corrective Measures Taken and/or Recommended

- STAFF AND CLIENTS SHOULD BE ENCOURAGED TO STRETCH BEFORE PARTICIPATING IN SPORTING ACTIVITIES TO DECREASE POTENTIAL HARM.

- POSTERS AND REMINDERS TO STRETCH BEFORE INTERACTING IN SPORTS.

Corrective Action Referred To: RABBITS, BILL Date To Be Completed By: 10/04/01

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:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
SHOKAR	778 452 2251	SOMOGYI	778 452 2251
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	JAN 22/01		JAN 22/01

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

s.15, s.22

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry / Tel. #	Location	Date of Report
MCFD	BURNABY	2010 | 01 | 20
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 b	SENIOR YOUTH SUPERVISOR	9.58
Accident Location (Dept. or Area)	**Date of Accident**	**Time**
BYCS - GYM STORAGE	2010 | 01 | 19	13:00 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

STRAINED BACK WHILE LIFTING HOCKEY NETS

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

BENT OVER TO LIFT HOCKEY NETS, FELT TWINGE IN LOWER BACK

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

NONE - SIMPLY BENT OVER TO INSPECT HOCKEY NETS

Corrective Measures Taken and/or Recommended

NONE

Corrective Action Referred To: N/A 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)

NONE

Name(s) & occupations of person (s) who investigated accident:

Print Name & Occupation	Phone	Print Name & Occupation	Phone
M. Streifel	778.462.7079	A. STAFFORD	778-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	2010/01/20		10/01/20

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

NONE.

Revised July 2004

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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.

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

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry: M.C.F.D. Tel. #		Location: B.Y.C.S.			Date of Report: 2010.01.18	
Last Name of Injured (or ill) Person: s.22		First Name:			File No.	
Years of Service: s.22	Time on Present Job: s.22	Occupation: Youth Supervisor			Hours Worked in Previous 24 Hour Period: 12 hrs.	
Accident Location (Dept. or Area): Gymnasium		Date of Accident: 2010.01.17.			Time: 2030	
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

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 Gym, fell and no major concerns at this time. A few hours later developed pain in his lower back.

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

Unavoidable occurrance. Injury occurred while carrying out his duties and participating w/ residents (playing soccer in the Gym). Everyday job hazzard.

Corrective Measures Taken and/or Recommended

None. Possible realization that we are not as young and as fit as we once were (ie. in 1985).

Corrective Action Referred To: N/A Date To Be Completed By: 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)

None

Name(s) & occupations of person (s) who investigated accident:

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) 452-7050

s.15, s.21, s.79 YCJA

Revised July 2004

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JOINT ACCIDENT INVESTIGATION FOR...

PSC 38

Ministry Tel. # Children + Family Development		Location B.Y.C.S			Date of Report Jan 16 2010	
Last Na s.22					File No.	
Years of Service s.22	Time on Present Job	Occupation Youth Supervisor			Hours Worked in Previous 24 Hour Period 8	
Accident Location (Dept. or Area) Venture, Section #1		Date of Accident January 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

Injured Right Shoulder

Description of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)

While restraining a resident hurt right shoulder

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

Overexertion while trying to restrain a client

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, 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
Peter K Murphy C.O.		Matthew Annan	604-452-2050
Signature of Workers' Representative	Date	Signature of Employer Representative	Date
	JAN 16/10		Jan 16/10

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

778-452-2050

s.15, s.22

Revised July 2004

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