

JOINT UNION-MANAGEMENT ACCIDENT INVESTIGATION REPORT

Ministry of Children and Family Development, Prince George Youth Custody Services,
1211 Gunn Road, Prince George.

1. Worker's name: s.22

Address: s.22

Prince George BC

Postal Code: s.22

Telephone: s.22

Classification: Youth Supervisor Employee No.

2. Location and address where accident occurred: PGYCS 1211 Gunn Road, Prince George, BC
V2N 4P2 Perimeter sliding gate #3

Accident/Incident date: 2011 05 12 Time: 2350 pm ☐ am ☐
Year Month Day

3. Notification of accident/incident: 2011 05 12 Time: 2350 pm ☐ am ☐
Year Month Day

4. Names, addresses and telephone numbers of witnesses:

(a) None

(b)

(c)

5. **Brief description of the accident/incident:** At approximately 2350 hours on May 12, 2011 s.22
s.22 was briefly pinned by sliding gate 3 s.22 was doing a security patrol on foot checking
the perimeter fences. At sliding gate 3 the control officer advised s.22 that there had been a
recent bear sighting in the vicinity and advised s.22 not to go through gate 3. The Control
Officer opened gate 3 approximately 12 inches to ensure the gate was functioning. s.22 walked
partway through the open gate to observe the ball field fence from a distance to check for any obvious
breaches in the fence. The Control Officer closed the gate unaware that s.22 was in the gates
path. s.22 was briefly pinned by the gate, and was able to communicate by radio to control to
open the gate.

6. Injury analysis:

<input type="checkbox"/> Head	<input type="checkbox"/> Legs	<input type="checkbox"/> Wounds	<input type="checkbox"/> Burns	<input type="checkbox"/> Eyes
<input type="checkbox"/> Strain/sprain	<input type="checkbox"/> Hands	<input type="checkbox"/> Foreign body	<input type="checkbox"/> Trunk	<input type="checkbox"/> Feet
<input type="checkbox"/> Hernia	<input type="checkbox"/> Fracture	<input type="checkbox"/> Arms	<input type="checkbox"/> Internal	<input type="checkbox"/> Other

Describe if other: Left shoulder, left arm, back, neck

7. Sequence of events which preceded the accident/incident:

As described above

8. After reviewing accident/incident investigation worksheets, list:

(i) The essential links: Unclear communication between s.22 and the Control Officer

(ii) The contributing factors: Perimeter camera used to view gate 3 was obscured with condensation and s.22 was not visible to the Control Officer

9. Recommend corrective action (s) to prevent similar accidents/incidents. (If investigators cannot reach a consensus, please report separate recommendations.)

1. Install signage on both sides of the three sliding gates indicating "caution, remotely operated motorized gate stand back 10 feet. Foot traffic use man gate".
2. Implement policy that staff on foot will use man gates for transition through fences. Sliding gates will be used for vehicle traffic only.
3. Email reminding staff to report all security equipment deficiencies immediately.

10. Date report completed: 2011 06 07
Year Month day

OCCUPATIONAL HEALTH & SAFETY COMMITTEE INVESTIGATORS

Employer Committee Representative

B.C.G.E.U. Committee Representative

signature

signature

Name: Roy Blake

Name: Jim Arnold

Classification: BCGEU Youth Supervisor

Classification: Employer ML4

Discuss report at next Occupational Health & Safety Committee meeting.

KEEP ORIGINAL AND FORWARD COPY TO: Ministry Designate, B.C.G.E.U. Office, WCB

JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence SEPT. 21	Date Reported SEPT. 21
Exact Location of Incident COURTYARD		Time 1030 (select)	Reported to: (name) HELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 1) s.22 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.)		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT SHOULDER	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) () 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	s.22 while playing football with the youth, Youth Supervisor strained his right shoulder.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) <i>chewing a football</i> 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) <i>stretching, warming up</i> 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) <i>proper stretching and warming up prior to engaging in physical activities with the youth.</i> 2) 3) 4) 5) 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: <i>MELANIE SAUVE</i>	Phone #: <i>250-708-2202</i>	Occupation: <i>SUPERVISOR OF STAFFING</i>
	Investigated By: <i>CHRISTIAN HANER</i>	Phone #: <i>250 708 2224</i>	Occupation: <i>C.O.</i>
	Signature of Workers' Representative <i>C. Haner</i>	Signature of Employer Representative <i>Melanie Sauve</i>	Date: <i>04/10/2010</i>
	Reviewed By:	Date: <i>2010-10-01</i>	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence July 07 TH	Date Reported July 07 TH
Exact Location of Incident ADMISSIONS, 94 TALCOTT RD.		Time 1620 (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 1) s.22 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 3 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) STRAIN		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) LOWER BACK	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) 1) ON CAMERA 2) 3)	Phone # () () ()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	Youth Supervisor walked on freshly mopped floor and slipped. Youth Supervisor fell and injured his lower back and elbow.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) wet floor 2) 3)											
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)											
PREVENTION	1) Youth Supervisor was aware that the floor was just mopped. 2) Signage was posted and janitor was present. 3) 4) 5)											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 55%; padding: 5px;">Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):</th> <th style="width: 20%; padding: 5px;">Action By:</th> <th style="width: 25%; padding: 5px;">Date to be Completed By:</th> </tr> <tr> <td style="padding: 5px;"> 1) Remind staff to be cautious on wet floors 2) 3) 4) 5) 6) </td> <td style="padding: 5px; vertical-align: top;"> OFA Phone # (for First Aids) </td> <td style="padding: 5px;"> 1) 2) 3) 4) 5) 6) </td> </tr> </table>			Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):	Action By:	Date to be Completed By:	1) Remind staff to be cautious on wet floors 2) 3) 4) 5) 6)	OFA Phone # (for First Aids)	1) 2) 3) 4) 5) 6)			
Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):	Action By:	Date to be Completed By:										
1) Remind staff to be cautious on wet floors 2) 3) 4) 5) 6)	OFA Phone # (for First Aids)	1) 2) 3) 4) 5) 6)										
Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.												
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px;">Investigated By: <u>HELANIE SAUVE</u></td> <td style="width: 30%; padding: 5px;">Phone #: _____</td> <td style="width: 40%; padding: 5px;">Occupation: <u>SUPERVISOR OF STAFFING</u></td> </tr> <tr> <td style="padding: 5px;">Investigated By: <u>CHRISTIAN HALLIER</u></td> <td style="padding: 5px;">Phone #: <u>250-708 2224</u></td> <td style="padding: 5px;">Occupation: <u>C.O.</u></td> </tr> <tr> <td style="padding: 5px;">Signature of Workers' Representative: <u>C. Hallier</u></td> <td style="padding: 5px;">Signature of Employer Representative: <u>Melanie Sauve</u></td> <td style="padding: 5px;">Date: <u>01.09.2010</u></td> </tr> </table>				Investigated By: <u>HELANIE SAUVE</u>	Phone #: _____	Occupation: <u>SUPERVISOR OF STAFFING</u>	Investigated By: <u>CHRISTIAN HALLIER</u>	Phone #: <u>250-708 2224</u>	Occupation: <u>C.O.</u>	Signature of Workers' Representative: <u>C. Hallier</u>	Signature of Employer Representative: <u>Melanie Sauve</u>	Date: <u>01.09.2010</u>
Investigated By: <u>HELANIE SAUVE</u>	Phone #: _____	Occupation: <u>SUPERVISOR OF STAFFING</u>										
Investigated By: <u>CHRISTIAN HALLIER</u>	Phone #: <u>250-708 2224</u>	Occupation: <u>C.O.</u>										
Signature of Workers' Representative: <u>C. Hallier</u>	Signature of Employer Representative: <u>Melanie Sauve</u>	Date: <u>01.09.2010</u>										
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px;">Reviewed By: _____</td> <td style="width: 30%; padding: 5px;">Date: _____</td> <td style="width: 40%; padding: 5px;">Comments: _____</td> </tr> </table>				Reviewed By: _____	Date: _____	Comments: _____						
Reviewed By: _____	Date: _____	Comments: _____										

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

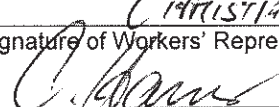
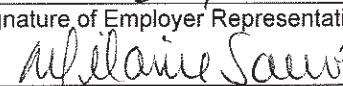
Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!

JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence August 14 TH	Date Reported August 14 TH
Exact Location of Incident TRANSPORT IN VEHICLE		Time (select)	Reported to: (name)
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22	1) s.22	1) YOUTH SUPERVISOR	1) s.22
2)	2)	2) YOUTH SUPERVISOR	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) EXPOSURE / DISEASE		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.)	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	Both Youth Supervisors escorted the refugees to another Centre. Youth Supervisors were confined in a small space; vehicle for a 4 hour transport. Refugees were very ill and Youth Supervisors were not equipped with masks. In addition, Youth Supervisors did not have adequate supplies such as water, cups for everyone and food.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) confined in an enclosed area with "refugees" 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist — e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) lack of protective equipment for transporting officers 2) lack of resources such as: water, cups (which could have contributed to dehydration) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) clear, provincial policy and processes for the detainment and transport of refugees. 2) health care professional to accompany the transport 3) interpreter to accompany the transport	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: MELANIE SAUVE	Phone #: 250-708-2202	Occupation: YOUTH SUPERVISOR
	Investigated By: CHRISTIAN HALLER	Phone #: 250-708-2224	Occupation:
	Signature of Workers' Representative 	Signature of Employer Representative 	Date: 15/09/2010
	Reviewed By:	Date:	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</p>			

ANALYSIS	1) <i>physical restraint</i> 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) <i>no contributing factors</i> 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) <i>no recommendations</i> 2) 3) 4) 5) 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: <i>MELANIE SAUVE</i>	Phone #: <i>250-708-2202</i>	Occupation: <i>SUPERVISOR OF STAFFING</i>
	Investigated By: <i>CHRISTIAN HUBER</i>	Phone #: <i>250-708-2224</i>	Occupation:
	Signature of Workers' Representative <i>[Signature]</i>	Signature of Employer Representative <i>[Signature]</i>	Date: <i>15/09/2010</i>
	Reviewed By:	Date: <i>Sept. 14.10</i>	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT


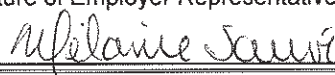
This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence SEPT. 11	Date Reported SEPT. 11
Exact Location of Incident COURTYARD		Time 1730 (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 4/ 3/ 4/ 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # s.22 1) 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input checked="" type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 3 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) BRUISE		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) LEFT KNEE	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	While physically restraining a young person, Youth Supervisor s.22 tripped over another Youth Supervisor's leg s.22 feel on the courtyard gravel injuring his knee.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence <i>Aug. 31</i>	Date Reported <i>Sept. 01</i>
Exact Location of Incident <i>UNIT 1</i>		Time (select)	Reported to: (name)
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) <i>s.22</i>		1) <i>YOUTH SUPERVISOR</i>	1) <i>s.22</i>
2)	<i>4)</i>	2)	2)
3)	<i>3)</i>	3)	3)
4)	<i>4)</i>	4)	4)
5)	<i>5)</i>	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input checked="" type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) <i>NECK STRAIN</i>		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) <i>NECK</i>	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) <i>s.15, s.22</i> 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	<i>While physically restraining two young people who were engaged in a physical altercation, Youth Supervision ^{s.22} strained his neck.</i>		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) physical altercation between two young people. 2) 3) Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.) 1) no underlying cause and contributing factors 2) 3) 4) 5)		
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident): 1) no recommendations 2) 3) 4) 5) 6)		Action By: OFA Phone # (for First Aids)
	Date to be Completed By: 1) 2) 3) 4) 5) 6)		
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: MELANIE SAUVE	Phone #: 250-708-2202	Occupation: SUPERVISOR OF STAFFING
	Investigated By: CHRISTIAN HAUER	Phone #: 708 2224	Occupation: C.O.
	Signature of Workers' Representative 	Signature of Employer Representative 	Date: 01/09/2010
	Reviewed By:	Date:	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence AUG.15	Date Reported AUG.15
Exact Location of Incident UNIT 4		Time 1204 (select)	Reported to: (name) MIKE MACPHEE
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) YOUTH SUPERVISOR	1) s.22
2)	2)	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 6 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) SPRAINED ANKLE, EMOTIONAL DISTRESS		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT ANKLE	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc) While physically restraining a young person, Youth Supervisor s.22 had to deflect two foot kicks from another young person. The kicks were directed at the young person being restrained, however Youth Supervisor s.22 was grazed by one foot strike. Youth Supervisor s.22 proceeded to physically restrain the kicking young person.		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

ANALYSIS	1) physical altercation and provocation from the young people 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) debriefing to occur immediately 2) after incidents. 3) Remind shift supervisors to check if all staff are OK 4) 5) 6)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)	
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: MELANIE SAUVE	Phone #: 250-708-2202	Occupation: SUPERVISOR OF STAFFING
	Investigated By: CHRISTIAN HAUER	Phone #: 250-708-2224	Occupation: C.O.
	Signature of Workers' Representative <i>C. Hauer</i>	Signature of Employer Representative <i>Melanie Sauve</i>	Date: 01/09/2010
	Reviewed By:	Date:	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence 2010/08/03	Date Reported AUG. 03 - 2010
Exact Location of Incident Outside of Stores by caged area		Time (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) s.22	1) s.22
2)	2)	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) strained back (right lat)		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) back	
Object/equipment/substance inflicting injury or damage filing cabinet / dolly		Witnesses (Attach statements if applicable)	Phone #
		1)	()
		2)	()
		3)	()
Description of Incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)			
DESCRIPTION	At approximately 08:00 A.M. I was trying to load a filing cabinet onto a dolly. I was pushing the dolly underneath the filing cabinet and attempting to pull the cabinet toward me with my right arm. I felt a tearing / pulling sensation in my right lat. This was fairly painful and it even hurt to take a deep breath. It feels better now and it is 11:30 hrs.		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

ANALYSIS	1)			
	2)			
	3)			
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)			
	1)	Working alone. Should have got ^{s.22} to load it for me.		
2)				
3)				
4)				
5)				
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:	Date to be Completed By:
	1) Ask for help when carrying/loading 2) heavy items.		OFA Phone # (for First Aids)	1)
				2)
				3)
				4)
			5)	
		6)		
Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.				
Investigated By: MELANIE SAUVE		Phone #: 250-708-2202	Occupation: SUPERVISOR OF STAFFING	
Investigated By: CHRISTIAN HAMER		Phone #: 708-2224	Occupation: C.O.	
Signature of Workers' Representative <i>C. Hamer</i>		Signature of Employer Representative <i>Melanie Sauve</i>	Date: AUG.03-2010 / Sep. 01 2010	
Reviewed By:		Date:	Comments:	
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</p>				

JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence JUNE 25	Date Reported JUNE 25
Exact Location of Incident UNIT 1, 94 TALCOTT RD., VICTORIA		Time (select) 1415	Reported to: (name) MIKE YAGER
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) YOUTH SUPERVISOR	1) s.22
2)	2)	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input checked="" type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.)		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.)	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable)	Phone #
		1) s.15, s.22	
		2)	()
		3)	()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	The above mentioned Youth Supervisor found notes dispersed in the living unit. The notes were written by a client and depicted how the client would "capture" the Youth Supervisor and "torture him". The Youth Supervisor reported these threats to the Senior Youth Supervisor and Director. s.79 YCJA		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) work environment, working with challenged, violent young 2) offenders. 3)											
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)											
PREVENTION	1) inadequate consequences for challenging behaviours. 2) adequate ^{or} 3) 4) 5)											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 55%; font-size: small;"> Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident): s.15, s.79 YCJA </td> <td style="width: 25%; font-size: small;"> Action By: MIKE MACPHEE OFA Phone # (for First Aids) </td> <td style="width: 20%; font-size: small;"> Date to be Completed By: 1) June 27 2) 3) 4) 5) 6) </td> </tr> </table>			Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident): s.15, s.79 YCJA	Action By: MIKE MACPHEE OFA Phone # (for First Aids)	Date to be Completed By: 1) June 27 2) 3) 4) 5) 6)						
Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident): s.15, s.79 YCJA	Action By: MIKE MACPHEE OFA Phone # (for First Aids)	Date to be Completed By: 1) June 27 2) 3) 4) 5) 6)										
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; font-size: small;"> Investigated By: MELANIE SAUVE </td> <td style="width: 30%; font-size: small;"> Phone #: 250-708-2202 </td> <td style="width: 40%; font-size: small;"> Occupation: YOUTH SUPERVISOR </td> </tr> <tr> <td style="font-size: small;"> Investigated By: CHRISTIAN BAKER </td> <td style="font-size: small;"> Phone #: 250-708-2224 </td> <td style="font-size: small;"> Occupation: </td> </tr> <tr> <td style="font-size: small;"> Signature of Workers' Representative <i>[Signature]</i> </td> <td style="font-size: small;"> Signature of Employer Representative melanie Sauve </td> <td style="font-size: small;"> Date: 15/09/2010 </td> </tr> </table>			Investigated By: MELANIE SAUVE	Phone #: 250-708-2202	Occupation: YOUTH SUPERVISOR	Investigated By: CHRISTIAN BAKER	Phone #: 250-708-2224	Occupation:	Signature of Workers' Representative <i>[Signature]</i>	Signature of Employer Representative melanie Sauve	Date: 15/09/2010
Investigated By: MELANIE SAUVE	Phone #: 250-708-2202	Occupation: YOUTH SUPERVISOR										
Investigated By: CHRISTIAN BAKER	Phone #: 250-708-2224	Occupation:										
Signature of Workers' Representative <i>[Signature]</i>	Signature of Employer Representative melanie Sauve	Date: 15/09/2010										
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; font-size: small;"> Reviewed By: </td> <td style="width: 30%; font-size: small;"> Date: July 19th, 2010 </td> <td style="width: 40%; font-size: small;"> Comments: </td> </tr> </table>			Reviewed By:	Date: July 19 th , 2010	Comments:						
Reviewed By:	Date: July 19 th , 2010	Comments:										

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

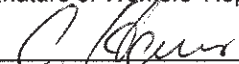
This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence AUG. 01 2010	Date Reported 2010-08-01
Exact Location of Incident UNIT 4		Time (select) 2020	Reported to: (name) RICK MARCHESE
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) YOUTH SUPERVISOR	1) s.22
2)	2)	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost: \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); # of days loss UNKNOWN AT THIS TIME			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) TORN LIGAMENT		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT BICEP	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc) While physically restraining a young person. Youth Supervisor s.22 injured his right arm. s.22		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

ANALYSIS	1) two youth were involved in a physical altercation 2) 3) Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.) 1) there were no underlying causes or factors 2) 3) 4) 5)			
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident): 1) no recommendations 2) 3) 4) 5) 6)		Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.			
	Investigated By: MELANIE SAUVE	Phone #: 250-708-2202	Occupation: SUPERVISOR OF STAFFING	
	Investigated By: CHRISTIAN BUEHLER	Phone #: 250-708-2224	Occupation:	
	Signature of Workers' Representative 	Signature of Employer Representative Melanie Sauve	Date: 15 09 2010	
Reviewed By:	Date: AUG. 03, 2010	Comments:		

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence SEPT. 02, 2010	Date Reported SEPT. 02, 2010
Exact Location of Incident COURTYARD		Time (select) 1130	Reported to: (name) HELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 4) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 1 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) STRAIN WRIST		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT WRIST	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) 1) s.15, s.22 2) 3)	Phone # () ()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc) While physically restraining a young person, Youth Supervisor s.22 strained his right wrist.		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

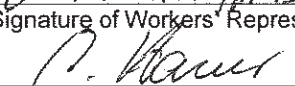
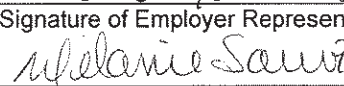
ANALYSIS	1) young person assaulting another young person 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist -- e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) no contributing factors or underlying cause 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) no recommendations 2) 3) 4) 5) 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: MELANIE SAUVE	Phone #: 250-708-2202	Occupation: SUPERVISOR OF STAFFING
	Investigated By: CHRISTIAN HAUER	Phone #: 250 708 2224	Occupation: C.O.
	Signature of Workers' Representative: <i>C. Hauer</i>	Signature of Employer Representative: <i>Melanie Sauve</i>	Date: 15.09.2010
	Reviewed By:	Date: SEPT. 03. 2010	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence July 13 TH	Date Reported July 13 TH
Exact Location of Incident SCHOOL, 94 TALLOTT RD.		Time 0945 (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input checked="" type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) LIGHT ABRASION TO THE RIGHT KNEE		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT KNEE	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) 1) s.15, s.22 2) 3)	Phone # () ()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc) While trying to separate two clients engaged in a physical altercation, the above mentioned Youth Supervisor scraped her knee on the carpet.		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

ANALYSIS	1) physical altercation between two youth 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) none of the above. Clients engaged in an unplanned 2) physical altercation. 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):	Action By:	Date to be Completed By:
	1) no recommendations 2) 3) 4) 5) 6)	OFA Phone # (for First Aids)	1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: MELANIE SAUVE	Phone #: 250-708-2202	Occupation: SUPERVISOR OF STAFFING
	Investigated By: CHRISTIAN HAUET	Phone #: 250-708-2224	Occupation: Occupation:
Signature of Workers Representative 	Signature of Employer Representative 	Date: 14.07.2010	
Reviewed By:	Date: July 13, 2010	Comments:	
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence June 12	Date Reported June 12
Exact Location of Incident UNIT 1		Time (select) 1850	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 4/ 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) 2) 3) 4) 5)
Incident: <input type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input checked="" type="checkbox"/> Other (describe): STAND-OFF			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.)		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.)	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc) s.79 YCJA		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

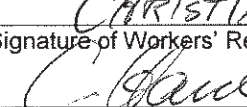
ANALYSIS	1			
	2			
	3			
	Underlying Cause and Contributing Factors: (what allowed the trigger to exist – e.g. inadequate training; supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)			
	1) <i>no underlying cause or contributing factors</i>			
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:	Date to be Completed By:
	1) <i>limit courtyard sharing between</i>		OFA Phone # (for First Aids)	1)
	2) <i>girls and boys unit</i>			2)
	3)			3)
	4)			4)
	5)			5)
6)		6)		
Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.				
Investigated By: <i>HELANIE SAUVE</i>		Phone #: <i>250-708-2202</i>	Occupation: <i>SUPERVISOR OF STAFFING</i>	
Investigated By: <i>CHRISTIAN RAYET</i>		Phone #: <i>250-708-2224</i>	Occupation: <i>C.O.</i>	
Signature of Workers' Representative: <i>C. Rayet</i>		Signature of Employer Representative: <i>Helanie Sauve</i>	Date: <i>21-06-10</i>	
Reviewed By:		Date: <i>June 21, 2010</i>	Comments:	
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>				



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence JUNE 07	Date Reported JUNE 08, 2010
Exact Location of Incident UNIT 4		Time (select) 1220	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # s.22 2) 3) 4) 5)
Incident: <input type="checkbox"/> Injury or Illness; <input checked="" type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) lower back pain		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) lower back	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	While supervising the unit, two youth engaged in a physical altercation. The above mentioned employee responded by physically restraining one of the young people.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) spontaneous altercation between two youth 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
	1) there are no underlying contributing factors. 2) 3) 4) 5)		
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:
	1) no recommendations 2) 3) 4) 5) 6)		Date to be Completed By:
			1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By:	Phone #:	Occupation:
	MELANIE SAUVE	250-708-2202	SUPERVISOR OF STAFFING
	Investigated By:	Phone #:	Occupation:
	CHRISTIAN	250-708-2224	C.O.
	Signature of Workers' Representative	Signature of Employer Representative	Date:
		M. Sauve	JUNE 08, 2010
	Reviewed By:	Date:	Comments:
		JUNE 08, 2010	
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			

JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

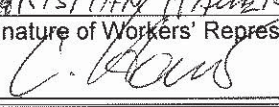
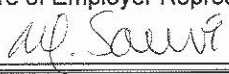
Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence MAY 19, 2010	Date Reported MAY 19, 2010
Exact Location of Incident LIFESKILLS ROOM		Time 1040 (select)	Reported to: (name) MEL SAUVE
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) s.22	
2)	2)	2)	4)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input checked="" type="checkbox"/> First Aid only (OFA phone # -); KAREN CHRISTENSEN <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut) bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.)		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) MIDDLE FINGER	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable)	Phone #
		1) s.15, s.22	()
		2)	()
		3)	()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	During sewing program, a client was holding a rotary cutter. Unadvisedly the employee brushed her hand across the blade cutting her finger.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1)			
	2)			
	3)			
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)			
	1)	Lack of instruction for the youth re: use of equipment		
2)				
3)				
4)				
5)				
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:	Date to be Completed By:
	1)	Instructor will review safety	s.22	1) IMMEDIATELY
	2)	before the start of program	OFA Phone # (for First Aids)	2)
	3)			3)
	4)			4)
5)			5)	
6)			6)	
Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident. ROTARY CUTTER				
Investigated By: MELANIE SAUVE		Phone #: 250-708-2202	Occupation: SUPERVISOR OF STAFFING	
Investigated By: CHRISTIAN HANER		Phone #: 250 708 2224	Occupation:	
Signature of Workers' Representative <i>C. Haner</i>		Signature of Employer Representative <i>Melanie Sauve</i>	Date: 19/10/2010	
Reviewed By:		Date: MAY 19, 2010	Comments:	
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</p>				

JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence MARCH 16	Date Reported MARCH 16
Exact Location of Incident UNIT 3 94 TALCOTT RD.		Time (select) 11:10	Reported to: (name) CHRISTIAN HAUER
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) YOUTH SUPERVISOR	1) s.22
2)		2) YOUTH SUPERVISOR	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input checked="" type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.)		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.)	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc) s.22 was supervising a group of youth in the games room. A resident requested to go to the bathroom. Youth Supervision s.22 made a radio call to available staff to assist with the bathroom request. Youth became agitated upon having to wait. Youth began to verbally threaten Youth Supervision s.22. Youth Supervision arrived to escort the resident. The young person directed the threats towards Youth Supervision s.22. The threats verbalized were violent in content.		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

ANALYSIS	1) young person became agitated / impatient 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
	1) working alone, another Youth Supervisor would have 2) been able to escort the young person to the bathroom 3) 4) 5)		
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:
	1) s.15, s.79 YCJA 2) 3) 4) 5) 6)		OFA Phone # (for First Aids)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, s.79 YCJA		Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Investigated By: MELANIE SAUVE	Phone #: 250-708 2202	Occupation: SUPERVISOR OF STAFFING
	Investigated By: CHRISTIAN HAUER	Phone #: 250-708 2224	Occupation: C.O.
Signature of Workers' Representative 	Signature of Employer Representative 	Date: 05.05.2010	
Reviewed By:	Date:	Comments:	
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence MARCH 09, 2010	Date Reported MARCH 10, 2010
Exact Location of Incident UNIT 4 94 TALCOTT RD		Time 1330 (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 2 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) STRAIN		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) UPPER BACK	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	Employee separated two agitated youth. In the process of holding a youth stationary, employee strained a muscle in his upper back.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1)																		
	2)																		
	3)																		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)																		
	1) <i>no underlying cause or contributing factors</i>																		
	2)																		
PREVENTION	3)																		
	4)																		
	5)																		
	6)																		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 55%;">Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):</th> <th style="width: 25%;">Action By:</th> <th style="width: 20%;">Date to be Completed By:</th> </tr> <tr> <td>1) <i>no recommendations</i></td> <td rowspan="6" style="text-align: center; vertical-align: middle;">OFA Phone # (for First Aids)</td> <td>1)</td> </tr> <tr> <td>2)</td> <td>2)</td> </tr> <tr> <td>3)</td> <td>3)</td> </tr> <tr> <td>4)</td> <td>4)</td> </tr> <tr> <td>5)</td> <td>5)</td> </tr> <tr> <td>6)</td> <td>6)</td> </tr> </table>			Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):	Action By:	Date to be Completed By:	1) <i>no recommendations</i>	OFA Phone # (for First Aids)	1)	2)	2)	3)	3)	4)	4)	5)	5)	6)	6)
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):	Action By:	Date to be Completed By:																
	1) <i>no recommendations</i>	OFA Phone # (for First Aids)	1)																
	2)		2)																
	3)		3)																
	4)		4)																
5)	5)																		
6)	6)																		
Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.																			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Investigated By: <i>MELANIE SAUVE</i></td> <td style="width: 33%;">Phone #: <i>250-708-2202</i></td> <td style="width: 34%;">Occupation: <i>SUPERVISOR OF STAFFING</i></td> </tr> <tr> <td>Investigated By: <i>CHRISTIAN HAUER</i></td> <td>Phone #: <i>250 708 2224</i></td> <td>Occupation:</td> </tr> <tr> <td>Signature of Workers' Representative <i>C. Hauer</i></td> <td>Signature of Employer Representative <i>Melanie Sauve</i></td> <td>Date: <i>MARCH 17, 2010</i></td> </tr> </table>			Investigated By: <i>MELANIE SAUVE</i>	Phone #: <i>250-708-2202</i>	Occupation: <i>SUPERVISOR OF STAFFING</i>	Investigated By: <i>CHRISTIAN HAUER</i>	Phone #: <i>250 708 2224</i>	Occupation:	Signature of Workers' Representative <i>C. Hauer</i>	Signature of Employer Representative <i>Melanie Sauve</i>	Date: <i>MARCH 17, 2010</i>								
Investigated By: <i>MELANIE SAUVE</i>	Phone #: <i>250-708-2202</i>	Occupation: <i>SUPERVISOR OF STAFFING</i>																	
Investigated By: <i>CHRISTIAN HAUER</i>	Phone #: <i>250 708 2224</i>	Occupation:																	
Signature of Workers' Representative <i>C. Hauer</i>	Signature of Employer Representative <i>Melanie Sauve</i>	Date: <i>MARCH 17, 2010</i>																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Reviewed By:</td> <td style="width: 33%;">Date:</td> <td style="width: 34%;">Comments:</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>			Reviewed By:	Date:	Comments:														
Reviewed By:	Date:	Comments:																	

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence JAN. 25, 2010	Date Reported JAN. 25, 2010
Exact Location of Incident 94 TALCOTT RD. UNIT 1		Time (select) 1950	Reported to: (name) MIKE MACPHEE
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) SENIOR YOUTH SUPERVISOR	1) s.22
2)		2)	2)
3)		3)	3)
4)		4)	4)
5)		5)	5)
Incident: <input type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost: \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.)		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.)	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable)	Phone #
		1) s.15, s.22	()
		2)	()
		3)	()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc) s.79 YCJA		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

ANALYSIS	1		
	2		
	3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
	1) NONE OF THE ABOVE 2) uncontrollable reaction from a resident, couldn't predict the incident 3) incident 4) 5)		
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident): 1) recommend cutlery in dishwasher 2) and drawers be locked at all times 3) recommend care plan for youth 4) investigator 5) 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) completed 2) 3) completed 4) and updated 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident. - lock has been installed on unit dishwasher. - operational review completed with recommendation		
	Investigated By: MELANIE SAUVE	Phone #: 250-708-2202	Occupation:
	Investigated By: CHRISTIAN HAUER	Phone #: 250 708 2224	Occupation: C.O.
	Signature of Workers' Representative C. Hauer	Signature of Employer Representative	Date: Mar 02, 2010
Reviewed By:	Date:	Comments:	
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</p>			

JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence MARCH 01. 2010	Date Reported MARCH 01. 2010
Exact Location of Incident 94 TALCOTT RD. COURTYARD		Time (select)	Reported to: (name)
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) PROGRAM COORDINATOR	1) s.22
2)		2) PROGRAM COORDINATOR	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input checked="" type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost: \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.)		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.)	
Object/equipment/substance inflicting injury or damage PROPANE KILN (ROCK HEATER)		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) 3)	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	Employee s.22 bend over to light the rock heater kiln with a barbecue lighter. In order to light the kiln, the propane tank must be turned open. The valve leading to the kiln was in the open position for 10 sec. Employee s.22 attempted to light the kiln with a few strikes unsuccessfully. With a final attempt, a large fireball erupted from the kiln.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) equipment malfunction 2) poor design (fatality) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) defective equipment 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) area is out of bounds until safer 2) equipment and measures are put 3) in place 4) quicker access to tank valves and line 5) shut off valves that are not in proximity to the burner 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: <u>MELANIE SAUVE</u>	Phone #: <u>250-708-2202</u>	Occupation: <u>SUPERVISOR OF STAFFING</u>
	Investigated By: <u>CHRISTIAN HANER</u>	Phone #: <u>250-708-2224</u>	Occupation: <u>C.O.</u>
	Signature of Workers' Representative <u>C. Haner</u>	Signature of Employer Representative <u>Melanie Sauve</u>	Date: <u>MARCH 02</u>
	Reviewed By:	Date:	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence FEB.05 TH 2010	Date Reported FEB.05 TH 2010
Exact Location of Incident 94 TALCOTT RD. UNIT 4		Time 2000 (select)	Reported to: (name) RICK MARCHESE
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) YOUTH SUPERVISOR	1) s.22
2)	2)	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) STRAIN/SPRAIN		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT KNEE	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable)	Phone #
		1) NO WITNESSES	()
		2)	()
		3)	()
Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)			
DESCRIPTION	While escorting a youth to his room, youth turned around quickly facing the escorting Youth Supervisor. Youth pushed the Youth Supervisor. Youth Supervisor physically restrained the youth. During the restraint the Youth Supervisor injured his right knee.		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

ANALYSIS	1) - Restraining acting out resident. 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) Appropriate action was taken by Youth Supervisor Note by. 2) Proper procedures were followed regarding the legal 3) authority to initiate physical intervention. 4) Employee agrees that distraction on his part was 5) a contributing factor, increasing personal distance could have provided more intervention options.		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident): 1) - Staff should consider 2) allowing more personal 3) space between himself 4) and the resident during 5) escalating incidents. 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident. <div style="text-align: center; font-size: 1.2em;">None</div>			
Investigated By: <u>CHRISTIAN HAUER</u>		Phone #: <u>250 708 2224</u>	Occupation: <u>C.O.</u>
Investigated By: <u>M MacPhee</u>		Phone #: <u>250 782 2225</u>	Occupation: <u>Dir of OPS</u>
Signature of Workers' Representative <u>C. Hauer</u>		Signature of Employer Representative <u>M MacPhee</u>	
Reviewed By:		Date:	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence OCT. 28	Date Reported OCT. 28
Exact Location of Incident COURTYARD		Time (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input type="checkbox"/> Injury or Illness; <input checked="" type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost: \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.)		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) EYE	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable)	Phone #
		1)	()
		2)	()
		3)	()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc) while supervising the courtyard activity, Youth Supervisor s.22 was struck in the eye with a basketball.		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

ANALYSIS	1) <i>no immediate cause</i> 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
	1) <i>no underlying cause or contributing factors</i> 2) 3) 4) 5)		
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:
	1) <i>no recommendations</i> 2) 3) 4) 5) 6)		OFA Phone # (for First Aids)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		Date to be Completed By:
	Investigated By: <i>MELANIE SAUVE</i>		Phone #: <i>250-708-2202</i>
	Investigated By: <i>Tony Amato</i>		Phone #:
	Signature of Workers' Representative <i>[Signature]</i> <i>FEB 3/12</i>		Signature of Employer Representative <i>[Signature]</i>
	Reviewed By:		Date: <i>FEB. 01</i>
Comments:			

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

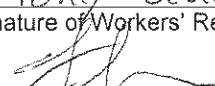

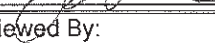
Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence NOV. 27	Date Reported NOV. 28
Exact Location of Incident VICS CONTROL		Time 0725 (select)	Reported to: (name) KELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 4 3 4 5	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input type="checkbox"/> Injury or Illness; <input checked="" type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost: \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) strain		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) right knee	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc) s.22 While entering the control room, Youth Supervisor caught the edge of the carpet with his right foot and stumbled forward. The Youth Supervisor experienced pain in his right knee.		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

ANALYSIS	1)	area carpet which was not flush to the floor		
	2)			
	3)			
		Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
	1)	there were no underlying cause and/or contributing factors		
	2)			
	3)			
	4)			
	5)			
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:	Date to be Completed By:
	1)	no recommendations		1)
	2)			2)
	3)			3)
	4)			4)
	5)			5)
	6)			6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.			
	Investigated By: MELANIE SAUVE		Phone #:	Occupation:
	Investigated By: Tony Guarascio		Phone #:	Occupation:
Signature of Workers' Representative <i>[Signature]</i> Feb 3/12		Signature of Employer Representative <i>Melanie Sauve</i>		
		Date:		
Reviewed By: <i>[Signature]</i>		Date: DEC. 01	Comments:	
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>				

JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence SEPT. 24	Date Reported SEPT. 24
Exact Location of Incident VYCS UNIT 4		Time (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) YOUTH SUPERVISOR	1) s.22
2)	-	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 2 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) STRAIN		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) KNEE STRAIN	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable)	Phone #
		1) NO WITNESSES	()
		2)	()
		3)	()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	The youth in the living unit had finished mopping the kitchen floor. Youth Supervisor s.22 jarred his knee while walking across the floor.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) WET FLOOR 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) there were no underlying causes 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) no recommendations 2) 3) 4) 5) 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: MELANIE SAUVE Investigated By: Tony Anarascio Signature of Workers' Representative:  Feb 3/12	Phone #: 250-708-2202 Phone #: 250 708 2224 Signature of Employer Representative: 	Occupation: SUPERVISOR OF STAFFING Occupation: Date:
	Reviewed By: 	Date: DEC. 01 / 11	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence Aug. 12 / 11	Date Reported Aug. 13 / 11
Exact Location of Incident Courtyard		Time (select)	Reported to: (name) HELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 1 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) sprain in		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) finger	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	while playing basketball in the courtyard, Youth Supervisor injured his finger.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) <u>Sprain</u> 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) <u>no underlying cause or contributing factors</u> 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) <u>exercise caution when playing</u> 2) <u>sports with youth</u> 3) 4) 5) 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: <u>HELANIE SAUVE</u>	Phone #: <u>250-708-2202</u>	Occupation: <u>SUPERVISOR OF STAFFING</u>
	Investigated By:	Phone #:	Occupation:
	Signature of Workers' Representative	Signature of Employer Representative <u>Melanie Sauve</u>	Date:
	Reviewed By:	Date: <u>AUG. 18TH / 2011</u>	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence AUG. 20 TH	Date Reported AUG. 20 TH
Exact Location of Incident GYMNASIUM		Time (select) 1830	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # -/ 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) SPRAIN		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT ANKLE	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) s.15, s.22	Phone # () ()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	While playing floor hockey in the gymnasium with the clients, Youth Supervisor s.22 sprained his right ankle.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) <u>Sprain</u> 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
	1) <u>no underlying cause or contributing factors</u> 2) 3) 4) 5)		
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:
	1) <u>exercise caution when playing</u> 2) <u>sports with youth.</u> 3) 4) 5) 6)		OFA Phone # (for First Aids)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		Date to be Completed By:
	Investigated By: <u>MELANIE SAUVE</u>		Phone #: <u>250-708-2202</u>
	Investigated By:		Phone #:
	Signature of Workers' Representative		Signature of Employer Representative <u>Melanie Sauve</u>
	Reviewed By:		Date: <u>AUG. 23rd / 2011</u>
Comments:			
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence JULY 26	Date Reported JULY 27
Exact Location of Incident STORES		Time AFTERNOON (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # -/ 3) 4) 5)	Position (e.g. Social Worker. etc.) 1) s.22 2) 3) 4) 5)	Phone # -/ 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury);			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) SPRAIN		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT ROTATOR CUFF	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) 1) N/A 2) 3)	Phone # () () ()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	While breaking down a box, the above mentioned employee hurt her shoulder pulling the staples out.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1)			
	2)			
	3)			
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)			
	1)	there were no underlying causes or contributing factors		
	2)			
	3)			
	4)			
	5)			
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:	Date to be Completed By:
	1)	careful procedures and movements when performing physical duties.	OFA Phone # (for First Aids)	1)
	2)			2)
	3)			3)
	4)			4)
	5)			5)
	6)			6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.			
	Investigated By: MELANIE SAUVE		Phone #: 250-708-2202	Occupation: SUPERVISOR OF STAFFING
	Investigated By:		Phone #:	Occupation:
Signature of Workers' Representative		Signature of Employer Representative Melanie Sauve	Date: July 27.11	
Reviewed By:		Date:	Comments:	

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence JULY 07.11	Date Reported JULY 07.11
Exact Location of Incident UNIT 2		Time (select) 0840	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) YOUTH SUPERVISOR 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input checked="" type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input checked="" type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.)		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT FACIAL AREA , LEFT FACIAL AREA	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) 1) 2) 3)	Phone # () () ()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	Both mentioned Youth Supervisors were struck with an unknown liquid substance from a youth's water bottle.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			


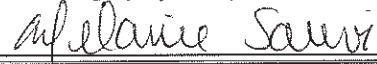
ANALYSIS	1) reactive youth 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) youth had in her possession a water bottle which is not an approved item 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) no recommendations 2) 3) 4) 5) 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: MELANIE SAUVE	Phone #: 250-708-2202	Occupation: SUPERVISOR OF STAFFING. Occupation:
	Investigated By:	Phone #:	Date:
	Signature of Workers' Representative	Signature of Employer Representative Melanie Sauve	Date:
	Reviewed By:	Date: July 07.11	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence 2011-04-11	Date Reported 2011-04-12
Exact Location of Incident CONTROL ROOM		Time (select) 1700	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input checked="" type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) SHOULDER STRAIN		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT SHOULDER	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) 1) N/A 2) 3)	Phone # () () ()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc.) While sliding out of a chair with wheels, Youth Supervisor slipped and hurt his shoulder when trying to regain his balance.		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

ANALYSIS	1) <u>slip from chair</u> 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) <u>there are no underlying causes</u> 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) <u>NO RECOMMENDATIONS</u> 2) 3) 4) 5) 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: <u>MELANIE SAUVE</u>	Phone #: <u>250-708-2202</u>	Occupation: <u>SUPERVISOR OF STAFFING</u>
	Investigated By: <u>Tony Guarascio</u>	Phone #: <u>250-708-2224</u>	Occupation: <u>Correctional Officer</u>
	Signature of Workers' Representative 	Signature of Employer Representative 	Date: <u>APRIL 12TH, 2011</u>
	Reviewed By:	Date:	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence APRIL 28 TH .11	Date Reported APRIL 28 TH .11
Exact Location of Incident COURTYARD		Time (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1 s.22	Employee ID #	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR	Phone # 1) s.22
2)	2)	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 4 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) STRAIN		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT HAMSTRING	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) 1) NONE 2) 3)	Phone # () () ()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	While responding to a code, Youth Supervisor strained her right hamstring. The strain occurred while running.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) <u>running</u> 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
	1) <u>no underlying cause and contributing factors</u> 2) 3) 4) 5)		
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:
	1) <u>Stop running when requested</u> 2) <u>to 'stand down':</u> 3) 4) 5) 6)		OFA Phone # (for First Aids)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		Date to be Completed By: 1) <u>ongoing</u> 2) 3) 4) 5) 6)
	Investigated By: <u>MELANIE SAUVE</u> Phone #: <u>250-708-2202</u> Occupation: <u>SUPERVISOR OF STAFFING</u> Investigated By: <u>Tony Amarasio</u> Phone #: <u>250-708-2221</u> Occupation: <u>Youth Supervisor</u> Signature of Workers' Representative: <u>[Signature]</u> Signature of Employer Representative: <u>Melanie Sauve</u> Date: <u>MAY 18TH.11</u>		
	Reviewed By:	Date:	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence MAY 07 TH	Date Reported MAY 07 TH
Exact Location of Incident MARY'S FARM		Time (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) YOUTH SUPERVISOR	1) s.22
2)	2)	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) STRAIN		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT SHOULDER	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable)	Phone #
		1) NONE; YOUTH IN CARE	()
		2)	()
		3)	()
Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)			
Youth Supervisor strained his right shoulder while lifting a log and throwing it.			
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) <i>throwing a heavy object</i> 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) <i>work procedures</i> 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) <i>Utilisation of proper lifting techniques</i> 2) <i>More time stretching and warming up prior</i> 3) <i>to engaging in strenuous physical activity</i> 4) 5) 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By:	Phone #:	Occupation:
	<i>Tony Anarascio</i>	<i>250-477-4219</i>	<i>Youth Supervisor</i>
	Investigated By:	Phone #:	Occupation:
	<i>MELANIE SAUVE</i>	<i>250-708-2202</i>	<i>SUPERVISOR OF STAFFING</i>
	Signature of Workers' Representative	Signature of Employer Representative	Date:
	<i>[Signature]</i>	<i>Melanie Sauve</i>	<i>May 23 2011</i>
	Reviewed By:	Date:	Comments:
	<i>[Signature]</i>		

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence MARCH 14 TH	Date Reported MARCH 14 TH
Exact Location of Incident COURTYARD		Time 1935 (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost: \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) strain in back		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) back	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) 1) s.15, s.22 2) 3)	Phone # () ()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc) While responding to a code, Youth Supervisor s.22 slipped on the grass in the courtyard and tweaked his back.		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

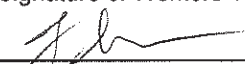
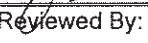
ANALYSIS	1) <i>slip</i>		
	2)		
	3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) <i>no contributing factors</i>		
	2)		
	3)		
	4)		
	5)		
	6)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):	Action By:	Date to be Completed By:
	1) <i>no recommendations</i> 2) 3) 4) 5) 6)	OFA Phone # (for First Aids)	1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident. <i>grass was wet causing the employee to lose his footing.</i>		
	Investigated By: <i>MELANIE SAUVE</i>	Phone #: <i>708-2202</i>	Occupation: <i>YOUTH SUPERVISOR</i>
	Investigated By: <i>Tony Anarascio</i>	Phone #: <i>708-2224</i>	Occupation: <i>Youth Supervisor</i>
	Signature of Workers' Representative <i>[Signature]</i>	Signature of Employer Representative <i>Melanie Sauve</i>	Date: <i>March 29 2011</i>
	Reviewed By:	Date: <i>MARCH 15, 2011</i>	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence MARCH 05 TH	Date Reported MARCH 05 TH
Exact Location of Incident 94 TALCOTT RD. PARKING LOT		Time 0645 (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 4) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost: \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 2 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) SENSITIVITY		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) TAILBONE, LOWER SPINE, HEAD	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	While exiting his vehicle, prior to the start of his shift; Youth Supervisor s.22 slipped on icy parking lot. Youth Supervisor fell and injured his tailbone and head.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) fell on icy parking lot 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) inadequate salt in parking lot 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) Salting occurs in the parking lot. 2) however, recommend salting 3) prior to the 0700 hours shift 4) start (i.e. 0600) 5) 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By:	Phone #:	Occupation:
	MELANIE SAUVE	250-708-2202	SUPERVISOR OF STAFFING
	Investigated By:	Phone #:	Occupation:
	Tony Anurascio	708 2224	Youth Supervisor
	Signature of Workers' Representative	Signature of Employer Representative	Date:
		M. Sauve	March 29, 2011
	Reviewed By:	Date:	Comments:
		MARCH 07 TH , 2011	

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.


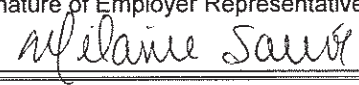
This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence JAN. 16 TH	Date Reported JAN. 16 TH
Exact Location of Incident COURTYARD		Time (select)	Reported to: (name) KELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input checked="" type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) STRAINED ABDOMINAL MUSCLE		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) STOMACH	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) 1) () 2) () 3) ()	Phone # () () ()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	While responding to a call for staff assistance, above mentioned Youth Supervisor pulled an abdominal muscle.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) sudden exertion. stationary to quick sprint 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) pre-existing injury 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):	Action By:	Date to be Completed By:
	1) no recommendations 2) 3) 4) 5) 6)	OFA Phone # (for First Aids)	1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: MELANIE SAUVE	Phone #: 250-708-2202	Occupation: YOUTH SUPERVISOR
	Investigated By: Tony Guarascio	Phone #: 250-708-2224	Occupation: Youth supervisor
Signature of Workers' Representative 	Signature of Employer Representative 	Date: Feb 17/2011	
Reviewed By:	Date: JAN. 24 th	Comments:	

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence FEB. 09 2011	Date Reported FEB. 09 2011
Exact Location of Incident UNIT 3		Time 1500 (select)	Reported to: (name) MIKE MACPHEE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); # of days loss ?			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) BRUISE		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIBS	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) 1) NONE 2) 3)	Phone # () () ()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	Youth Supervisor fell out of an old office chair bruising his ribs.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) <i>fall from chair</i> 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) <i>broken, old chain on the unit</i> 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) <i>The old chain was not removed from</i> 2) <i>the unit because the youth</i> 3) <i>Supervisor's preferred the leaning</i> 4) <i>back function</i> 5) <i>Recommend removing all the old</i> 6) <i>chains from the units</i>	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: <i>MEL SAUVE</i>	Phone #: <i>250-708-2202</i>	Occupation: <i>SUPERVISOR OF STAFFING</i>
	Investigated By: <i>Tony Guarascio</i>	Phone #: <i>250 708 2204</i>	Occupation: <i>Youth Supervisor</i>
	Signature of Workers' Representative <i>[Signature]</i>	Signature of Employer Representative <i>Melanie Sauve</i>	Date: <i>Feb 17 2011</i>
	Reviewed By:	Date: <i>FEB. 10 2011</i>	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			

JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence FEB. 04	Date Reported FEB. 04
Exact Location of Incident GYM		Time (select)	Reported to: (name) JEFF ROBINSON
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) YOUTH SUPERVISOR	1) s.22
2)	4)	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost: \$); <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 5 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) BRUISE OR CRACK		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIBS	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) () 3) ()	
Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)			
During the restraint refresher course, Youth Supervisor fell forward during a take down practice. Youth Supervisor injured his ribs.			
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) <i>fall</i> 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) <i>no contributing factors</i> 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) <i>there was adequate warm-up</i> 2) <i>technique was performed slowly</i> 3) <i>Youth Supervisor fell while being</i> 4) <i>off-balance.</i> 5) <i>Soft mats were used at the time</i> 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: <i>MEL SAUVE</i> Investigated By: <i>Tony Guarascio</i> Signature of Workers' Representative: <i>[Signature]</i>	Phone #: <i>250-708-2202</i> Phone #: <i>250 708 2224</i> Signature of Employer Representative: <i>Melanie Sauve</i>	Occupation: <i>SUPERVISOR OF STAFFING</i> Occupation: <i>Youth Supervisor</i> Date: <i>Feb 17 2011</i>
	Reviewed By:	Date: <i>FEB. 09</i>	Comments:

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

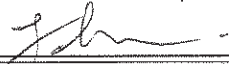
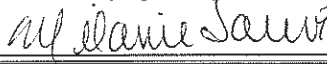
This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence JAN. 05 2011	Date Reported JAN. 06 2011
Exact Location of Incident HALLWAY		Time 1640 (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) YOUTH SUPERVISOR	1) s.22
2)		2)	2)
3)		3)	3)
4)		4)	4)
5)		5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) STRAIN LOWER BACK & NECK		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.)	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable)	Phone #
		1) s.15, s.22	
		2)	()
		3)	()
Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)			
Employee slipped and fell after walking on freshly mopped floor.			
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) WET FLOOR 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
	1) INADEQUATE SIGNAGE (sign was posted outside of man trap. 2) another sign should be posted on the other entry into 3) mantrap) 4) 5)		
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:
	1) COMMUNICATE TO JANITOR ABOUT THE 2) IMPORTANCE OF SIGNAGE AND WHERE 3) TO PLACE SIGNAGE 4) Investigate options to make floors less slippery 5) 6)		OFA Phone # (for First Aids)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		Date to be Completed By:
	Investigated By: MELANIE SAUVE		Phone #: 250-708-2202
	Investigated By: Tony Guarascio		Phone #: 250 708 2224
	Signature of Workers' Representative 	Signature of Employer Representative 	Occupation: SUPERVISOR OF STAFFING Occupation: Youth Supervisor Date: Feb 17, 2011
	Reviewed By:	Date: JAN. 06 - 2011	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</p>			



This form must be initiated immediately after notification.

This information is required by WorkSafeBC when serious workplace injuries and/or incidents occur that result in loss time (past the day of injury) or medical intervention. This report is also to be used for recording and investigating less serious incidents which include incidents with the **potential** to cause serious injury, violent incidents (threats, physical assault etc.) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

MCFD TRACKING NUMBER

--

INCIDENT LOCATION INFORMATION

REPORTING OFFICE PHONE

250-708-2202

DATE OF OCCURRENCE

2012-12-10

DATE REPORTED

2012-12-10

TIME OF INCIDENT

17:13 PM

TO

ADDRESS OF INCIDENT (street address, city/town)

94 Talcott Road, Victoria BC

EXACT LOCATION OF INCIDENT (parking lot, meeting room etc)

Unit 3

PEOPLE INVOLVED

NAME OF PERSON INCIDENT REPORTED TO

PHONE NUMBER
(if different than reporting
office)

1) Michael MacPhee

250-708-2226

NAME OF PERSON DIRECTLY AFFECTED

POSITION
(e.g. Social Worker, Team Leader, Office Manager)

PHONE NUMBER
(if different than reporting
office)

1) s.22

Youth Supervisor

250-708-2224

NAME OF WITNESS

POSITION
(e.g. Social Worker, Team Leader,
Office Manager)

PHONE NUMBER
(if different than reporting
office)

INVOLVEMENT
(e.g. what they saw, heard, their location at time
of the incident, etc.)

1) s.15, s.22

Youth Supervisor

250-708-2224

Partner on unit 3, witnessed
the altercation and the
ensuing break up of the
altercation between to
residents s.79 YCJA

INCIDENT DETAIL INFORMATION

INCIDENT CATEGORY (CHECK ALL THAT APPLY)

<input checked="" type="checkbox"/> Violence Related Incidents	<input type="checkbox"/> Verbal Threat (i.e. abusive swearing, physical harm, veiled or perceived) <input type="checkbox"/> Written Threat (i.e. abusive swearing, physical harm, veiled or perceived) <input type="checkbox"/> Bomb Threat (i.e. written, verbal) <input type="checkbox"/> Weapon Threat <input type="checkbox"/> Intimidating Behaviour (i.e. stalking, infringement on physical space) <input type="checkbox"/> Aggressive Behaviour (slamming fist, kicking door, damaged property) <input checked="" type="checkbox"/> Physical Assault (i.e. physical injury) <input type="checkbox"/> Animal Related (i.e. attacked, menacing behaviour) <input type="checkbox"/> Vehicular Assault <input type="checkbox"/> Worker to Worker (i.e. actual or perceived threats, intimidation) <input type="checkbox"/> Other	<input type="checkbox"/> Environmental Incidents	<input type="checkbox"/> General Incidents
--	--	--	--

SEVERITY OF INJURY OR ILLNESS (CHECK ALL THAT APPLY)

<input type="checkbox"/> No Physical Injury	<input type="checkbox"/> First Aid Only	<input checked="" type="checkbox"/> Medical Intervention (Dr. Clinic, Ambulance)	<input type="checkbox"/> Time Loss (Not including day of injury)	<input type="checkbox"/> Fatal
---	---	---	---	--------------------------------

TYPE OF INJURY OR ILLNESS (CHECK ALL THAT APPLY)

<input type="checkbox"/> Knocks, Scrapes, Abrasions, Bruises	<input type="checkbox"/> Muscle/Tendon Strains	<input checked="" type="checkbox"/> Sprains	<input type="checkbox"/> Medical Sensitivity (scents, chemicals)	<input type="checkbox"/> Post Traumatic Stress
<input type="checkbox"/> Muscle/Tendon Tears	<input type="checkbox"/> Fractures	<input type="checkbox"/> Lacerations/Cuts	<input type="checkbox"/> Disease	<input type="checkbox"/> Burns
<input type="checkbox"/> Other				

BODY PART(S) INJURED OR AFFECTED (CHECK ALL THAT APPLY)

<input type="checkbox"/> Upper					
<input checked="" type="checkbox"/> Mid Body (including arms)	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Right Elbow	<input type="checkbox"/> Right Wrist	<input type="checkbox"/> Right Hand/Fingers
	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Left Elbow	<input checked="" type="checkbox"/> Left Wrist	<input type="checkbox"/> Left Hand/Fingers
	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Mid Back	<input type="checkbox"/> Lower Back		
<input type="checkbox"/> Lower Body					

PHYSICAL SURROUNDINGS DETAILS (IF APPLICABLE)

Object/Equipment/Substance inflicting injury or damage	Environmental Conditions at time of incident (i.e. lighting, sound, chemical exposure)	Office Structures implicated in incident (i.e. doors)
Hit wall during restraint	NA	Door Jam

DESCRIPTION OF INCIDENT

Who, What, Where, When, Why - Employee's Account (be specific as possible with worker's names, times, locations and use initials for client names)

Injured wrist while physically restraining a young person who was fighting another young person.

ANALYSIS

Return to Basic Causes

1) Immediate Basic Cause:

Physical intervention to stop a fight between two residents.

Recommended Control, Corrective Measures or Treatment Provided
(goal is to prevent/minimize re-occurrence of accident/incident)

Actioned by

Completion Date

Recommended Control, Corrective Measures or Treatment Provided
(goal is to prevent/minimize re-occurrence of accident/incident)

Actioned by

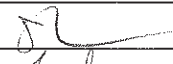
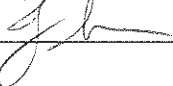
Completion
Date

A)

No recommendations

ADDITIONAL COMMENTS OR OBSERVATIONS Where applicable, give details of other hazards, which may or may not be related to the incident.

OSH COMMITTEE JOINT INVESTIGATORS

NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:			
Name	Signature	Occupation	Phone
J. Rob...		Supervisor of Staffing	708-7202
T. Guarascio		Senior Youth Supervisor	708-2226

Keep Original and Forward a copy of the interim report to:

- (1) Local JOSH Committee co-chairs for committee discussion and further recommendations.

Keep Original and Forward a copy of the completed report to:

- (1) Employer for their review and action;
- (2) BCGEU Area Office
- (3) Regional MCFD OSH Advisor
- (4) Local WorkSafeBC Office if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy.

SIGNATURE OF WORKER'S REPRESENTATIVE

DATE (YYYY-MM-DD)

2013/01/02

SIGNATURE OF EMPLOYER'S REPRESENTATIVE

DATE (YYYY-MM-DD)

2013/01/02



This form must be initiated immediately after notification.

This information is required by WorkSafeBC when serious workplace injuries and/or incidents occur that result in loss time (past the day of injury) or medical intervention. This report is also to be used for recording and investigating less serious incidents which include incidents with the **potential** to cause serious injury, violent incidents (threats, physical assault etc.) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

MCFD TRACKING NUMBER

INCIDENT LOCATION INFORMATION

REPORTING OFFICE PHONE

250-708-2202

DATE OF OCCURRENCE

2012-12-10

DATE REPORTED

2012-12-10

TIME OF INCIDENT

17:13 PM

TO

ADDRESS OF INCIDENT (street address, city/town)

94 Talcott Road, Victoria BC

EXACT LOCATION OF INCIDENT (parking lot, meeting room etc)

Unit 3

PEOPLE INVOLVED

NAME OF PERSON INCIDENT REPORTED TO

1) Michael MacPhee

PHONE NUMBER
(if different than reporting
office)

250-708-2226

NAME OF PERSON DIRECTLY AFFECTED

1) s.22

POSITION
(e.g. Social Worker, Team Leader, Office Manager)

Youth Supervisor

PHONE NUMBER
(if different than reporting
office)

250-708-2224

NAME OF WITNESS

1) s.15, s.22

POSITION
(e.g. Social Worker, Team Leader,
Office Manager)

Youth Supervisor

PHONE NUMBER
(if different than reporting
office)

250-708-2224

INVOLVEMENT
(e.g. what they saw, heard, their location at time
of the incident, etc.)

Partner on unit 3, witnessed
the altercation and the
ensuing break up of the
altercation between to
residents s.79 YCJA

INCIDENT DETAIL INFORMATION

INCIDENT CATEGORY (CHECK ALL THAT APPLY)

<input checked="" type="checkbox"/> Violence Related Incidents	<input type="checkbox"/> Verbal Threat (i.e. abusive swearing, physical harm, veiled or perceived) <input type="checkbox"/> Written Threat (i.e. abusive swearing, physical harm, veiled or perceived) <input type="checkbox"/> Bomb Threat (i.e. written, verbal) <input type="checkbox"/> Weapon Threat <input type="checkbox"/> Intimidating Behaviour (i.e. stalking, infringement on physical space) <input type="checkbox"/> Aggressive Behaviour (slamming fist, kicking door, damaged property) <input checked="" type="checkbox"/> Physical Assault (i.e. physical injury) <input type="checkbox"/> Animal Related (i.e. attacked, menacing behaviour) <input type="checkbox"/> Vehicular Assault <input type="checkbox"/> Worker to Worker (i.e. actual or perceived threats, intimidation) <input type="checkbox"/> Other	<input type="checkbox"/> Environmental Incidents	<input type="checkbox"/> General Incidents
--	--	--	--

SEVERITY OF INJURY OR ILLNESS (CHECK ALL THAT APPLY)

<input type="checkbox"/> No Physical Injury	<input type="checkbox"/> First Aid Only	<input checked="" type="checkbox"/> Medical Intervention (Dr. Clinic, Ambulance)	<input checked="" type="checkbox"/> Time Loss (Not including day of injury) # of Days Loss: <input type="text" value="3"/>
<input type="checkbox"/> Fatal			

TYPE OF INJURY OR ILLNESS (CHECK ALL THAT APPLY)

<input type="checkbox"/> Knocks, Scrapes, Abrasions, Bruises	<input type="checkbox"/> Muscle/Tendon Strains	<input checked="" type="checkbox"/> Sprains	<input type="checkbox"/> Medical Sensitivity (scents, chemicals)	<input type="checkbox"/> Post Traumatic Stress
<input type="checkbox"/> Muscle/Tendon Tears	<input type="checkbox"/> Fractures	<input type="checkbox"/> Lacerations/Cuts	<input type="checkbox"/> Disease	<input type="checkbox"/> Burns
<input type="checkbox"/> Other				

BODY PART(S) INJURED OR AFFECTED (CHECK ALL THAT APPLY)

<input checked="" type="checkbox"/> Upper	<input type="checkbox"/> Head	<input type="checkbox"/> Ear	<input type="checkbox"/> Eyes	<input checked="" type="checkbox"/> Neck
<input checked="" type="checkbox"/> Mid Body (including arms)	<input checked="" type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Right Elbow	<input type="checkbox"/> Right Wrist
	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Left Elbow	<input type="checkbox"/> Left Wrist
	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Mid Back	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Right Hand/Fingers
				<input type="checkbox"/> Left Hand/Fingers
<input type="checkbox"/> Lower Body				

PHYSICAL SURROUNDINGS DETAILS (IF APPLICABLE)

Object/Equipment/Substance inflicting injury or damage	Environmental Conditions at time of incident (i.e. lighting, sound, chemical exposure)	Office Structures implicated in incident (i.e. doors)
Hit wall during restraint	NA	Door Jam

DESCRIPTION OF INCIDENT

Who, What, Where, When, Why - Employee's Account (be specific as possible with worker's names, times, locations and use initials for client names)

Altercation between two residents ^{s.79 YCJA} requiring physical intervention. While performing these duties did fall back against wall / door jam causing injury to shoulder / neck area

ANALYSIS

Return to Basic Causes

1) Immediate Basic Cause:

Physical intervention to stop a fight between two residents.

Recommended Control, Corrective Measures or Treatment Provided
(goal is to prevent/minimize re-occurrence of accident/incident)

Actioned by

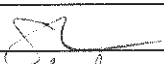
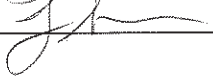
Completion
Date

A)

No recommendations

ADDITIONAL COMMENTS OR OBSERVATIONS Where applicable, give details of other hazards, which may or may not be related to the incident.

OSH COMMITTEE JOINT INVESTIGATORS

NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:			
Name	Signature	Occupation	Phone
S. Rob.		Supervisor of Staff	708-2262
T. Amurascio		Senior Youth Supervisor	708-2226

Keep Original and Forward a copy of the interim report to:

- (1) Local JOSH Committee co-chairs for committee discussion and further recommendations.

Keep Original and Forward a copy of the completed report to:

- (1) Employer for their review and action;
- (2) BCGEU Area Office
- (3) Regional MCFD OSH Advisor
- (4) Local WorkSafeBC Office if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy.

SIGNATURE OF WORKER'S REPRESENTATIVE

DATE (YYYY-MM-DD)

SIGNATURE OF EMPLOYER'S REPRESENTATIVE

DATE (YYYY-MM-DD)



2013/01/02



2013/01/02



This form must be initiated immediately after notification.

This information is required by WorkSafeBC when serious workplace injuries and/or incidents occur that result in loss time (past the day of injury) or medical intervention. This report is also to be used for recording and investigating less serious incidents which include incidents with the **potential** to cause serious injury, violent incidents (threats, physical assault etc.) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

MCFD TRACKING NUMBER

INCIDENT LOCATION INFORMATION

REPORTING OFFICE PHONE

250-708-2202

DATE OF OCCURRENCE

2012-09-12

DATE REPORTED

2012-09-12

TIME OF INCIDENT

1:00

PM

TO

PM

ADDRESS OF INCIDENT (street address, city/town)

94 Talcott Road, Victoria, BC

EXACT LOCATION OF INCIDENT (parking lot, meeting room etc)

Unit 4

PEOPLE INVOLVED

NAME OF PERSON INCIDENT REPORTED TO

1) Jeff Robinson

PHONE NUMBER
(if different than reporting
office)

250-708-2202

NAME OF PERSON DIRECTLY AFFECTED

1) s.22

POSITION
(e.g. Social Worker, Team Leader, Office Manager)

Youth Supervisor

PHONE NUMBER
(if different than reporting
office)

250-708-2224

NAME OF WITNESS

1) s.15, s.22

POSITION
(e.g. Social Worker, Team Leader,
Office Manager)

Youth Supervisor

PHONE NUMBER
(if different than reporting
office)

250-708-2224

INVOLVEMENT
(e.g. what they saw, heard, their location at time
of the incident, etc.)

Involved with restraint of young person, young person was physically aggressive and non compliant. Young person kicked s.22 during the course of restraint.

INCIDENT DETAIL INFORMATION

INCIDENT CATEGORY (CHECK ALL THAT APPLY)

<input checked="" type="checkbox"/> Violence Related Incidents	<input type="checkbox"/> Verbal Threat (i.e. abusive swearing, physical harm, veiled or perceived) <input type="checkbox"/> Written Threat (i.e. abusive swearing, physical harm, veiled or perceived) <input type="checkbox"/> Bomb Threat (i.e. written, verbal) <input type="checkbox"/> Weapon Threat <input type="checkbox"/> Intimidating Behaviour (i.e. stalking, infringement on physical space) <input type="checkbox"/> Aggressive Behaviour (slamming fist, kicking door, damaged property) <input checked="" type="checkbox"/> Physical Assault (i.e. physical injury) <input type="checkbox"/> Animal Related (i.e. attacked, menacing behaviour) <input type="checkbox"/> Vehicular Assault <input type="checkbox"/> Worker to Worker (i.e. actual or perceived threats, intimidation) <input type="checkbox"/> Other	<input type="checkbox"/> Environmental Incidents	<input type="checkbox"/> General Incidents
--	--	--	--

SEVERITY OF INJURY OR ILLNESS (CHECK ALL THAT APPLY)

☐ No Physical Injury
 ☐ First Aid Only
 ☒ Medical Intervention (Dr. Clinic, Ambulance)
 ☒ Time Loss (Not including day of injury)
 # of Days Loss:

☐ Fatal

TYPE OF INJURY OR ILLNESS (CHECK ALL THAT APPLY)

<input type="checkbox"/> Knocks, Scrapes, Abrasions, Bruises	<input type="checkbox"/> Muscle/Tendon Strains	<input type="checkbox"/> Sprains	<input type="checkbox"/> Medical Sensitivity (scents, chemicals)	<input type="checkbox"/> Post Traumatic Stress
<input type="checkbox"/> Muscle/Tendon Tears	<input type="checkbox"/> Fractures	<input type="checkbox"/> Lacerations/Cuts	<input type="checkbox"/> Disease	<input type="checkbox"/> Burns

☒ Other

PLEASE SPECIFY

minor concussion

BODY PART(S) INJURED OR AFFECTED (CHECK ALL THAT APPLY)

<input checked="" type="checkbox"/> Upper	<input checked="" type="checkbox"/> Head	<input type="checkbox"/> Ear	<input type="checkbox"/> Eyes	<input type="checkbox"/> Neck
<input type="checkbox"/> Mid Body (including arms)	<input type="checkbox"/> Lower Body			

PHYSICAL SURROUNDINGS DETAILS (IF APPLICABLE)

Object/Equipment/Substance inflicting injury or damage	Environmental Conditions at time of incident (i.e. lighting, sound, chemical exposure)	Office Structures implicated in incident (i.e. doors)
Foot of young person	NA	NA

DESCRIPTION OF INCIDENT

Who, What, Where, When, Why - Employee's Account (be specific as possible with worker's names, times, locations and use initials for client names)

s.22, s.79 YCJA

s.79 YCJA

the back of the head. CO s.22 s.22

to be assaultive and in while kicking did manage to strike COs.22 in did see the Nurse (KC) on site, this was then followed up by seeing a Doctor

ANALYSIS

Return to Basic Causes

1) Immediate Basic Cause:

Physical control of an assaultive young person.

Recommended Control, Corrective Measures or Treatment Provided
(goal is to prevent/minimize re-occurrence of accident/incident)

Actioned by


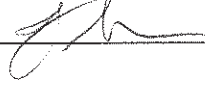
Completion Date

A)

No recommendations

ADDITIONAL COMMENTS OR OBSERVATIONS Where applicable, give details of other hazards, which may or may not be related to the incident.

OSH COMMITTEE JOINT INVESTIGATORS

NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:			
Name	Signature	Occupation	Phone
J. Robinson		Supervisor of Staffing	708-2202
T. Anarascio		Senior Youth Supervisor	707-2206

Keep Original and Forward a copy of the interim report to:

- (1) Local JOSH Committee co-chairs for committee discussion and further recommendations.

Keep Original and Forward a copy of the completed report to:

- (1) Employer for their review and action;
- (2) BCGEU Area Office
- (3) Regional MCFD OSH Advisor
- (4) Local WorkSafeBC Office if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

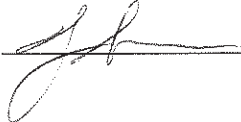
This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy.

SIGNATURE OF WORKER'S REPRESENTATIVE

DATE (YYYY-MM-DD)

SIGNATURE OF EMPLOYER'S REPRESENTATIVE

DATE (YYYY-MM-DD)



2013/01/02



2013/01/02



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence <i>Aug - 13, 2012</i>	Date Reported <i>Aug - 13, 2012</i>
Exact Location of Incident <i>Courtroom, inside MP room</i>		Time (select)	Reported to: (name) <i>M-MacPhee</i>
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) <i>s.22</i>	1)	1) <i>s.22</i>	1)
2)	2)	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost: \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) <i>Bruised ribs.</i>		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) <i>Ribs, right side.</i>	
Object/equipment/substance inflicting injury or damage <i>Restraining resident, threat of violence.</i>		Witnesses (Attach statements if applicable) Phone # 1) <i>s.15, s.22</i> 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	<i>– Resident ^{s.79 YCJA} attempted to assault ^{s.22} the ground landing hand and bruising ribs. ^{s.22} restrained resident to</i>		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1)		
	2)		
	3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1)		
	2)		
	3)		
	4)		
	5)		
	6)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):	Action By:	Date to be Completed By:
	1) No Recommendation	OFA Phone # (for First Aids)	1)
	2)		2)
	3)		3)
	4)		4)
	5)		5)
	6)		6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: M MacPhee	Phone #: 250-708-2202	Occupation: Sup of Staffing
	Investigated By: T Anarascio	Phone #:	Occupation: SC02
	Signature of Workers' Representative	Signature of Employer Representative	Date: Aug 14, 2012
	Reviewed By:	Date: Aug - 14/12	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</p>			



All reported accidents/incidents or unsafe conditions/acts **must** be investigated initially by the supervisor without delay as per WCB Health and Safety Regulation 3.10 and Ministry Policy. Please complete this form in its entirety and follow the distribution guidelines at the bottom of the form.

DATE (YYYY-MM-DD)

2012-08-13

REGION

Provincial Services

MCFD TRACKING NUMBER

SUPERVISOR CONTACT INFORMATION

NAME OF SUPERVISOR SUBMITTING FORM

Blade Tickner

PHONE NUMBER

250 708-2219

WORKSITE ADDRESS

94 Tallcott Road

CITY / TOWN

Victoria

POSTAL CODE

V8W 9J1

REGIONAL OSH CONTACT

Dan Stevens

DATE OF INCIDENT (YYYY-MM-DD)

2012-08-13

DATE INCIDENT REPORTED (YYYY-MM-DD)

2012-08-13

LOCATION OF INCIDENT

Victoria Youth Custody Services, Courtyard

Critical Incident Stress Debriefing has been offered and/or made available in accordance with policy? ☒ Yes ☐ No

Accepted? ☐ Yes ☒ No

MCFD STAFF DIRECTLY OR INDIRECTLY INVOLVED

EMPLOYEE NAME

s.22

WITNESS

☒ Yes ☐ No

WORK PHONE NUMBER

250 708-2224

☐ Check here if the employee's work address is different than above.

INCIDENT TABLE check all that apply

☒ Violence Related Incidents

☐ Verbal Threat

(i.e. abusive swearing, physical harm, veiled or perceived)

☐ Written Threat

(i.e. abusive swearing, physical harm, veiled or perceived)

☐ Bomb Threat

(i.e. written, verbal)

☐ Weapon Threat

☐ Intimidating Behaviour

(i.e. stalking, infringement on physical space)

☒ Aggressive Behaviour

(slamming fist, kicking door, damaged property)

☐ Physical Assault

(i.e. physical injury)

☐ Animal Related

(i.e. attacked, menacing behaviour)

☐ Vehicular Assault

☐ Worker to Worker

(i.e. actual or perceived threats, intimidation)

☐ Other

☐ Environmental Incidents

☐ General Incidents

☐ Death of an Employee

Did the incident result in Medical Aid (Physician, Clinics, Ambulance)? ☒ Yes ☐ No ☐ Unknown
Time Loss (other than the day of injury)? ☒ Yes ☐ No ☐ Unknown
Did the incident have potential for serious injury if no injury occurred? ☒ Yes ☐ No

You must complete the Pre-Filled Regional Form 7.

You can find the form for your region here: <http://icw.mcf.gov.bc.ca/shrs/osh/forms.shtm>

POLICE NOTIFIED <input type="radio"/> Yes <input checked="" type="radio"/> No	CHARGES LAID <input type="radio"/> Yes <input checked="" type="radio"/> No	OTHER AGENCY <input type="radio"/> Yes <input checked="" type="radio"/> No	FIRE DEPT. CALLED <input type="radio"/> Yes <input checked="" type="radio"/> No	PROPERTY LOST / DAMAGED <input type="radio"/> Yes <input checked="" type="radio"/> No
NEGOTIABLE DOCS LOST / DAMAGED <input type="radio"/> Yes <input checked="" type="radio"/> No				

DESCRIPTION OF INCIDENT / ACCIDENT – Please provide a detailed description of the incident **INCLUDING client and employee names** who were directly involved.

With his fist clenched, a youth made a punching motion toward s.22 fell on the youth which resulted in s.22 receiving an injury to his chest muscles as they landed on the youth's shoulder. s.22 was escorted to a medical clinic where he was advised that he had a chest injury and should take some time off work.

Possible Causes and Contributing Factors to Incident/Accident and Immediate action taken to eliminate or minimize the risk to workers

Causes/Contributing Factors: Angry aggressive youth who attempted to assault staff. Immediate action taken to eliminate/minimize risk: Youth was restrained and issued consequences for his behaviour.

DISTRIBUTION

Forward the completed form to:

- 1) JOSH Committee Employer Co-chair
- 2) CSM

EMAIL

JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence <i>Aug - 11, 2012</i>	Date Reported <i>Aug - 11, 2012</i>
Exact Location of Incident		Time (select) <i>16:00</i>	Reported to: (name) <i>Dean Reid (s.c.2)</i>
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) <i>s.22</i>	1)	1) <i>Youth Supervisor</i>	1)
2)	2)	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input checked="" type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); <i>3 (11.5 + 3)</i> # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) <i>Strain to Achilles tendon and thigh</i>		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) <i>Heel : Thigh (Left side)</i>	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable)	Phone #
		1) <i>See attached IR -</i>	()
		2)	()
		3)	()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	<i>- Pushing through blocked door during hostage incident. Staff were attempting to gain access to rescue resident hostage.</i> <i>s.22</i>		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1)		
	2)		
	3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1)		
	2)		
	3)		
	4)		
	5)		
	6)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	Action By:		Date to be Completed By:
	1) <i>No recommendations</i> 2) 3) 4) 5) 6)		1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
Investigated By: <i>M MacPhur</i>		Phone #: <i>250-708-2202</i>	
Investigated By: <i>T. Anwaris</i>		Phone #:	
Signature of Workers' Representative <i>[Signature]</i>		Signature of Employer Representative <i>[Signature]</i>	
Occupation: <i>Sop - Staffing</i>		Occupation: <i>SC02</i>	
Date: <i>Aug 14/12</i>			
Reviewed By:		Date:	
Comments:			

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



Ministry of Children and Family Development
Youth Justice Branch
Youth Custody Incident Form (Primary)

Page 1 of 6

Master Incident Number: YIF-0050971-01

Current State: Awaiting Approver

Creator's Section - by ^{s.15}

Incident Date & Time: 2012.08.11 15:58

Code: ☒ Red ☐ Blue ☐ Yellow

Primary Incident Type: Critical Incident

Incident Location

Reporting Centre: Victoria Youth Secure Custody

Location: Unit 3

Residents Involved

CS Number	Last Name	First Name	Role	Injured	Treatment		
					Onsite	Offsite	Hospital
s.79 YCJA							

Staff Involved

User Id	Last Name	First Name	Role	Injured	Treatment		
					Onsite	Offsite	Hospital
s.15	s.22		Responder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Responder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Responder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Responder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Responder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Responder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Involved Participants

Type	Last Name	First Name	Role	Injured	Treatment		
					Onsite	Offsite	Hospital
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Access, collection, use, disclosure and disposal of this document must be in accordance with the British Columbia Freedom of Information Protection of Privacy Act and the Youth Criminal Justice Act.

Requested by: s.15 Michael Macphee

Printed on: 2012.08.14 08:07

Page 88

CFD 2013 00081

v1.2



Ministry of Children and Family Development
Youth Justice Branch
Youth Custody Incident Form (Primary)

Page 2 of 6

Master Incident Number: YIF-0050971-01

Current State: Awaiting Approver

Incident Details

s.22, s.79 YCJA

Use of Restraint Details

Reviewer's (Senior Youth Supervisor) Section - by s.15

Incident Classifications

Incident Type	Incident Detail Classifications			
Violence	<input type="checkbox"/> Assault	<input type="checkbox"/> Attempted Assault	<input type="checkbox"/> Threat	<input type="checkbox"/> Fight
Critical Incident	<input type="checkbox"/> Riot	<input checked="" type="checkbox"/> Hostage Taking	<input type="checkbox"/> Disturbance	<input type="checkbox"/> Fire
	<input type="checkbox"/> Escape	<input type="checkbox"/> Attempted Escape	<input type="checkbox"/> Escape Escorted RL	<input type="checkbox"/> Escape Unescorted RL
Contraband	<input type="checkbox"/> Drugs	<input type="checkbox"/> Pharmaceuticals	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Weapons
	<input type="checkbox"/> Electronics	<input type="checkbox"/> Tattoo Equipment	<input type="checkbox"/> Drug Paraphernalia	<input type="checkbox"/> Correspondence
	<input type="checkbox"/> Other			
Injury/Illness	<input type="checkbox"/> Self-Harm	<input type="checkbox"/> Serious Illness	<input type="checkbox"/> Death	
	<input type="checkbox"/> Accident			
Behaviour	<input type="checkbox"/> Sexual	<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Non-compliant	<input type="checkbox"/> Mental Health
	<input type="checkbox"/> Theft	<input type="checkbox"/> Horseplay	<input type="checkbox"/> Verbally Abusive	<input type="checkbox"/> Inciting
	<input type="checkbox"/> Peer Problem	<input type="checkbox"/> Bullying	<input type="checkbox"/> Other	
Security	<input type="checkbox"/> Missing Items	<input type="checkbox"/> Unauthorized Access	<input type="checkbox"/> Damage To Property	
	<input type="checkbox"/> Unauthorized Communication			

Consequences for s.79 YCJA



Ministry of Children and Family Development
Youth Justice Branch
Youth Custody Incident Form (Primary)

Page 3 of 6

Master Incident Number: YIF-0050971-01

Current State: Awaiting Approver

s.79 YCJA

Consequences for s.79 YCJA

s.79 YCJA

Use of Restraint for s.79 YCJA

s.79 YCJA

Access, collection, use, disclosure and disposal of this document must be in accordance with the *British Columbia Freedom of Information Protection of Privacy Act* and the *Youth Criminal Justice Act*.

Requested by: s.15 Michael Macphee

Printed on: 2012.08.14 08:07

Page 90

CFD 2013 00081

v1.2



Ministry of Children and Family Development
Youth Justice Branch
Youth Custody Incident Form (Primary)

Page 4 of 6

Master Incident Number: YIF-0050971-01

Current State: Awaiting Approver

s.79 YCJA

Use of Restraint for s.79 YCJA

s.79 YCJA



Ministry of Children and Family Development
Youth Justice Branch
Youth Custody Incident Form (Primary)

Page 5 of 6

Master Incident Number: YIF-0050971-01

Current State: Awaiting Approver

Resident's Comment

s.79 YCJA

Reviewer's Comment

A serious situation handled very well by all staff involved.



Ministry of Children and Family Development
Youth Justice Branch
Youth Custody Incident Form (Primary)

Page 6 of 6

Master Incident Number: YIF-0050971-01

Current State: Awaiting Approver

Approver's (Director) Section - by

Use of Restraint - Administrative Review

s.79 YCJA

Approver's Comment



Amended Aug 10/12
Two days lost time - mtr

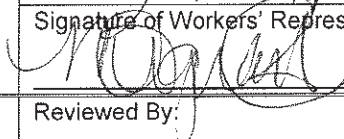


PSC 38 Equivalent

JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence Aug 7, 2012	Date Reported Aug 7, 2012
Exact Location of Incident Courtroom near Unit 2.		Time (select) 1635	Reported to: (name) M. MacPhee
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 1) 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) Youth Supervisor 2) 3) 4) 5)	Phone # 1) 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input checked="" type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost: \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <i>mtr</i> <input type="checkbox"/> No Physical Injury; <input checked="" type="checkbox"/> First Aid only (OFA phone # Nurse; Kelly Barbin 250-708-2212) <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 2 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) Sprain to Left Thumb.		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) Left Thumb.	
Object/equipment/substance inflicting injury or damage Flailing resident during restraint.		Witnesses (Attach statements if applicable) Phone # 1) See attached IR () 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	→ See attached IR for staff involved. → Staff ^{s.22} was struck by residents leg when he resisted staff restraint. Restraint was initiated when the resident refused to attend his unit.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) Struck by resident leg during restraint - 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
	1) Nature of the work. Adequate back-up was present - 2) 3) 4) 5)		

PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:	Date to be Completed By:
	1) No Recommendations - 2) 3) 4) 5) 6)		OFA Phone # (for First Aids)	1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.			
	Investigated By: M. Agudo	Phone #: 250-708-2202	Occupation: Sup. of Staffing	
	Investigated By: M. Agudo	Phone #: 250-708-2220	Occupation: H/S member	
Signature of Workers' Representative: 		Signature of Employer Representative: 		Date: 20/2/08/08
Reviewed By: 		Date:		Comments:

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



Ministry of Children and Family Development
Youth Justice Branch
Youth Custody Incident Form (Primary)

Page 1 of 5

Master Incident Number: YIF-0050791-01

Current State: Initial Review

Creator's Section - by s.15

Incident Date & Time: 2012.08.07 16:35

Code: ☐ Red ☐ Blue ☐ Yellow

Primary Incident Type:

Incident Location

Reporting Centre: Victoria Youth Secure Custody

Location: Courtyard

Residents Involved

CS Number	Last Name	First Name	Role	Injured	Onsite	Treatment	
						Offsite	Hospital
s.79 YCJA							

Staff Involved

User Id	Last Name	First Name	Role	Injured	Onsite	Treatment	
						Offsite	Hospital
s.15	s.22						

Other Involved Participants

Type	Last Name	First Name	Role	Injured	Onsite	Treatment	
						Offsite	Hospital
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Incident Details

Access, collection, use, disclosure and disposal of this document must be in accordance with the British Columbia Freedom of Information Protection of Privacy Act and the Youth Criminal Justice Act.

Requested by: s.15 Michael Macphee

Printed on: 2012.08.08 11:51

Page 96

CFD 2013 00081

v1.2



Ministry of Children and Family Development
Youth Justice Branch
Youth Custody Incident Form (Primary)

Page 2 of 5

Master Incident Number: YIF-0050791-01

Current State: Initial Review

s.22, s.79 YCJA

Written by s.22

Use of Restraint Details

s.79 YCJA



Ministry of Children and Family Development
Youth Justice Branch
Youth Custody Incident Form (Primary)

Page 3 of 5

Master Incident Number: YIF-0050791-01

Current State: Initial Review

Reviewer's (Senior Youth Supervisor) Section - by s.15

Incident Classifications

Incident Type	Incident Detail Classifications			
Violence	<input type="checkbox"/> Assault	<input type="checkbox"/> Attempted Assault	<input type="checkbox"/> Threat	<input type="checkbox"/> Fight
Critical Incident	<input type="checkbox"/> Riot	<input type="checkbox"/> Hostage Taking	<input type="checkbox"/> Disturbance	<input type="checkbox"/> Fire
	<input type="checkbox"/> Escape	<input type="checkbox"/> Attempted Escape	<input type="checkbox"/> Escape Escorted RL	<input type="checkbox"/> Escape Unescorted RL
Contraband	<input type="checkbox"/> Drugs	<input type="checkbox"/> Pharmaceuticals	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Weapons
	<input type="checkbox"/> Electronics	<input type="checkbox"/> Tattoo Equipment	<input type="checkbox"/> Drug Paraphernalia	<input type="checkbox"/> Correspondence
	<input type="checkbox"/> Other			
Injury/Illness	<input type="checkbox"/> Self-Harm	<input type="checkbox"/> Serious Illness	<input type="checkbox"/> Death	
	<input type="checkbox"/> Accident			
Behaviour	<input type="checkbox"/> Sexual	<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Non-compliant	<input type="checkbox"/> Mental Health
	<input type="checkbox"/> Theft	<input type="checkbox"/> Horseplay	<input type="checkbox"/> Verbally Abusive	<input type="checkbox"/> Inciting
	<input type="checkbox"/> Peer Problem	<input type="checkbox"/> Bullying	<input type="checkbox"/> Other	
Security	<input type="checkbox"/> Missing Items	<input type="checkbox"/> Unauthorized Access	<input type="checkbox"/> Damage To Property	
	<input type="checkbox"/> Unauthorized Communication			

Consequences for s.79 YCJA

s.79 YCJA



Ministry of Children and Family Development
Youth Justice Branch
Youth Custody Incident Form (Primary)

Page 4 of 5

Master Incident Number: YIF-0050791-01

Current State: Initial Review

s.79 YCJA

Use of Restraint for s.79 YCJA

s.79 YCJA

Resident's Comment

s.79 YCJA

Reviewer's Comment



Ministry of Children and Family Development
Youth Justice Branch
Youth Custody Incident Form (Primary)

Page 5 of 5

Master Incident Number: YIF-0050791-01

Current State: Initial Review

Approver's (Director) Section - by

Use of Restraint - Administrative Review

s.79 YCJA

Approver's Comment



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence MAY 21 / 2012	Date Reported MAY 21 / 2012
Exact Location of Incident 94 Talbot Rd. Unit 3.		Time 1502 (select)	Reported to: (name) Jeff Robinson
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # s) 4) 5)	Position (e.g. Social Worker, etc.) 1) Youth Supervisor 2) Youth Supervisor 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost: \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 5/1 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) s.22 Strain - s.22 Strain - sprain / - sprain		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) s.22 - Wrist / s.22 - Knee	
Object/equipment/substance inflicting injury or damage		witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc) While attempting to physically control an assaultive young person, the two above mentioned employees and the young person fell to the ground in a semi-uncontrolled manner. s.22		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

ANALYSIS	1) Sudden impact due to uncontrolled fall to ground. 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) No underlying causes, 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		
	1) No recommendations 2) 3) 4) 5) 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: <i>Jeff Robinson</i>	Phone #: 250-708-2202	Occupation: Supervisor of Staffing
	Investigated By:	Phone #:	Occupation:
	Signature of Workers' Representative <i>[Signature]</i>	Signature of Employer Representative <i>[Signature]</i>	Date:
	Reviewed By:	Date: May 22 / 2012	Comments:
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>			



Supervisor's OSH Incident Report

All reported accidents/incidents or unsafe conditions/acts **must** be investigated initially by the supervisor without delay as per WCB Health and Safety Regulation 3.10 and Ministry Policy. Please complete this form in its entirety and follow the distribution guidelines at the bottom of the form.

DATE (YYYY-MM-DD)

2012-05-22

REGION

Vancouver Island

MCFD TRACKING NUMBER

SUPERVISOR CONTACT INFORMATION

NAME OF SUPERVISOR SUBMITTING FORM

Blade Tickner

PHONE NUMBER

250 708-2219

WORKSITE ADDRESS

94 Talcott Road, Victoria Youth Custody Services Centre

CITY / TOWN

Victoria

POSTAL CODE

V8W 9J1

REGIONAL OSH CONTACT

Dan Stevens

DATE OF INCIDENT (YYYY-MM-DD)

2012-05-21

DATE INCIDENT REPORTED (YYYY-MM-DD)

2012-05-21

LOCATION OF INCIDENT

Unit 3

Critical Incident Stress Debriefing has been offered and/or made available in accordance with policy? ☐ Yes ☐ No

MCFD STAFF DIRECTLY OR INDIRECTLY INVOLVED

EMPLOYEE NAME

s.22

WITNESS

☒ Yes ☐ No

WORK PHONE NUMBER

250 708-2224

☐ Check here if the employee's work address is different than above.

INCIDENT TABLE check all that apply

☒ Violence Related Incidents

☐ Verbal Threat

(i.e. abusive swearing, physical harm, veiled or perceived)

☐ Written Threat

(i.e. abusive swearing, physical harm, veiled or perceived)

☐ Bomb Threat

(i.e. written, verbal)

☐ Weapon Threat

☐ Intimidating Behaviour

(i.e. stalking, infringement on physical space)

☒ Aggressive Behaviour

(slamming fist, kicking door, damaged property)

☒ Physical Assault

(i.e. physical injury)

☐ Animal Related

(i.e. attacked, menacing behaviour)

☐ Vehicular Assault

☐ Worker to Worker

(i.e. actual or perceived threats, intimidation)

☐ Other

☐ Environmental Incidents

☐ General Incidents

- ☒ Injuries ☐ No Physical Injury
- ☒ Knocks, Scrapes, Abrasions, Bruises
- ☐ Muscle/Tendon Strains
- ☐ Sprains
- ☐ Muscle/Tendon Tears
- ☐ Fractures
- ☐ Lacerations/Cuts
- ☐ Disease
- ☐ Burns
- ☐ Other

☐ Death of an Employee

Did the incident result in Medical Aid (Physician, Clinics, Ambulance)? ☐ Yes ☐ No ☒ Unknown

Time Loss (other than the day of injury)? ☐ Yes ☐ No ☒ Unknown

Did the incident have potential for serious injury if no injury occurred? ☐ Yes ☐ No

POLICE NOTIFIED

☐ Yes ☐ No

CHARGES LAID

☐ Yes ☐ No

OTHER AGENCY

☐ Yes ☐ No

FIRE DEPT. CALLED

☐ Yes ☐ No

PROPERTY LOST / DAMAGED

☐ Yes ☐ No

NEGOTIABLE DOCS LOST / DAMAGED

☐ Yes ☐ No

DESCRIPTION OF INCIDENT / ACCIDENT – Please provide a detailed description of the incident **INCLUDING client and employee names** who were directly involved.

A resident was directed to go to his room for being disrespectful to staff. He refused and threw a blue chair against the wall. At that point staff member **s.22** called a code red, the resident then threw a grey chair which bounced off the dining table and struck **s.22** lower body, **s.22** again directed the resident to his room and he refused. whereby the resident appeared to advance toward **s.22** and at that point **s.22** attempted to restrain the resident. He resisted, at which point **s.22** and **s.22** assisted in restraining the resident. The resident continued to resist during the entire incident. During the incident **s.22** suffered an injury to his lower body from when the chair hit him **s.22** received an injury to his wrist during the restraint of the resident.

Possible Causes and Contributing Factors to Incident/Accident and Immediate action taken to eliminate or minimize the risk to workers

Youth was upset about being sent to his room. Youth threw plastic chairs that were designed to minimize risk to staff. Staff were required to restrain the youth.

DISTRIBUTION

Forward the completed form to:

- 1) JOSH Committee Employer Co-chair
- 2) CSM



EMAIL



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence 2012/03/18	Date Reported 2012/03/18
Exact Location of Incident GYM		Time (select) 1736	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # -/ 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # s.22 1) 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input checked="" type="checkbox"/> First Aid only (OFA phone # -); <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) STRAIN, SENSITIVITY		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) BACK, NECK, ELBOWS	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) Phone # 1) s.15, s.22 2) 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) -- Employees Account (be as specific as possible with names etc)		
	While playing floor hockey, above mentioned employee slipped on a hockey stick. Employee fell striking his back and elbow. Employee reported a whiplash effect.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1)			
	2)			
	3)			
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)			
	1)	No underlying causes, situation was accidental while s.22		
	2)	was actively involved in youth programming -		
PREVENTION	3)			
	4)			
	5)			
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:	Date to be Completed By:
	1)	No recommendation other than attempt to		1)
	2)	not step on a hockey stick blade again.		2)
3)			3)	
4)			4)	
5)			5)	
6)			6)	
Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.				
Equipment involved was a hockey stick. s.22 stepped on the blade of a young person's hockey stick.				
Investigated By:		Phone #:	Occupation:	
JEFF ROBINSON		250-708-2202	Senior Youth Supervisor	
Investigated By:		Phone #:	Occupation:	
OWEN RUSSELL		250-708-2224	Youth Supervisor	
Signature of Workers' Representative		Signature of Employer Representative		Date:
				April 16th / 12.
Reviewed By:		Date:	Comments:	

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence FEB. 19. 2012	Date Reported FEB. 19. 2012
Exact Location of Incident 94 TALCOTT RD. UNIT 4		Time 1300 (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # -/ 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); 3 # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) STRAIN OR SPRAIN		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) LOWER BACK	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) 1) s.15, s.22 2) 3)	Phone # () ()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	While conducting searches, above employee moved several objects and was bent over, crawling on hands and knees. Due to this repetitive movement, employee's lower back started aching and employee experienced back spasms.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) <i>repetitive movement using lower back</i> 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
PREVENTION	1) <i>there were no underlying causes.</i> 2) 3) 4) 5)		
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):	Action By:	Date to be Completed By:
	1) <i>no recommendations</i> 2) 3) 4) 5) 6)	OFA Phone # (for First Aids)	1) 2) 3) 4) 5) 6)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: <i>HELANIE SAUVE</i>	Phone #: <i>250-708-2202</i>	Occupation: <i>SUPERVISOR OF STAFFING</i>
	Investigated By:	Phone #:	Occupation:
Signature of Workers' Representative	Signature of Employer Representative <i>Helanie Sauve</i>	Date:	
Reviewed By:	Date: <i>FEB. 22. 2012</i>	Comments:	

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence JAN. 09 TH . 12	Date Reported JAN. 09 TH . 12
Exact Location of Incident UNIT 1		Time 1630 (select)	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) YOUTH SUPERVISOR	1) s.22
2)	-	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost: \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input checked="" type="checkbox"/> Other (describe): SEE BELOW			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) EXPOSURE TO BODY FLUIDS (SALIVA)		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) FACE/ HEAD	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable) s.15, s.22	Phone #
		1)	()
		2)	()
		3)	()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	While closing a room door, a young person spit (saliva) striking the Youth Supervisor in the facial area.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) agitated youth 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist -- e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
	1) N/A 2) 3) 4) 5)		
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:
	1) no recommendations 2) 3) 4) 5) 6)		OFA Phone # (for First Aids)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		Date to be Completed By:
	Investigated By: MELANIE SAUVE		Phone #: 250-708-2202
	Investigated By: Tony Guarascio		Phone #:
	Signature of Workers' Representative		Signature of Employer Representative
	Date: Feb 3/12		Date:
	Reviewed By:		Date: JAN. 16
	Comments:		

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence JAN. 09 TH . 12	Date Reported JAN. 09 TH . 12
Exact Location of Incident UNIT 1		Time (select) 1630	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name	Employee ID #	Position (e.g. Social Worker, etc.)	Phone #
1) s.22		1) YOUTH SUPERVISOR	1) s.22
2)	4)	2)	2)
3)	3)	3)	3)
4)	4)	4)	4)
5)	5)	5)	5)
Incident: <input type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input checked="" type="checkbox"/> Other (describe): SEE BELOW			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); <input checked="" type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) Exposure to body fluids (saliva) to face & head.		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) → face/head.	
Object/equipment/substance inflicting injury or damage		Witnesses (Attach statements if applicable)	Phone #
		1) s.15, s.22	
		2)	()
		3)	()
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc) While closing a room door, a young person spit (saliva) striking the Youth Supervisor in the facial area.		
	Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)		

ANALYSIS	1) <i>agitated youth</i> 2) 3)			
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)			
PREVENTION	1) <i>N/A</i> 2) 3) 4) 5)			
	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):			
PREVENTION	1) <i>no recommendations</i> 2) 3) 4) 5) 6)	Action By: OFA Phone # (for First Aids)	Date to be Completed By: 1) 2) 3) 4) 5) 6)	
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.			
	Investigated By: <i>MELANIE SAUVE</i>	Phone #: <i>250-708-7202</i>	Occupation: <i>SUPERVISOR OF STAFFING</i>	
	Investigated By: <i>Tony Anicaccio</i>	Phone #: <i>250-708-2224</i>	Occupation: Date:	
	Signature of Workers' Representative <i>[Signature]</i> <i>Feb 3/12</i>	Signature of Employer Representative <i>Melanie Sauve</i>	Date:	
	Reviewed By: <i>[Signature]</i>	Date: <i>JAN.16</i>	Comments:	
<p>* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.</p> <p>Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.</p> <p>Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.</p> <p><i>This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!</i></p>				



JOINT INJURY / INCIDENT INVESTIGATION REPORT

This information is required by WorkSafe BC when serious workplace injuries and incidents occur that result in loss time (pass the day of injury) or medical intervention. This report form should also be used to record and investigate less serious incidents including incidents with the potential to cause serious injury, Violent Incidents (threats, physical assault etc) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

Ministry of Children and Family Development Regional Tracking Number:		Date of Occurrence JAN. 04 TH .12	Date Reported JAN. 04 TH .12
Exact Location of Incident UNIT 1		Time (select) 1420	Reported to: (name) MELANIE SAUVE
Directly Affected Person's Name 1) s.22 2) 3) 4) 5)	Employee ID # 2) 3) 4) 5)	Position (e.g. Social Worker, etc.) 1) YOUTH SUPERVISOR 2) 3) 4) 5)	Phone # 1) s.22 2) 3) 4) 5)
Incident: <input checked="" type="checkbox"/> Injury or Illness; <input type="checkbox"/> Near Miss; <input type="checkbox"/> Spill/Release; <input type="checkbox"/> Chem. Exposure; <input type="checkbox"/> Property/Equip Malfunction <input type="checkbox"/> Motor Vehicle; <input type="checkbox"/> Ergonomic; <input type="checkbox"/> Violence (threat, assault); <input type="checkbox"/> Theft (Estimated Cost : \$) <input type="checkbox"/> Fire; <input type="checkbox"/> Flood; <input type="checkbox"/> Indoor Air Quality (IAQ); <input type="checkbox"/> Occupational Disease; <input type="checkbox"/> Other (describe):			
Severity of Injury, Illness or Incident: <input type="checkbox"/> No Physical Injury; <input type="checkbox"/> First Aid only (OFA phone # -); 39.5 HOURS <input type="checkbox"/> Medical Treatment (Dr., clinic, ambulance); <input checked="" type="checkbox"/> Time Loss (not including day of injury); # of days loss			
Injury or Illness Type (cut, bruise, strain or sprain, fracture, sensitivity, disease, post traumatic stress, etc.) STRAIN		Body Part(s) Injured or affected (e.g. arm, foot, hand, back, internal injury etc.) RIGHT BICEP	
Object/equipment/substance inflicting injury or damage		W s.15, s.22 (Attach statements if available) Phone # 1) () 2) () 3) ()	
DESCRIPTION	Description of incident (Who, What, Where, When, Why) – Employees Account (be as specific as possible with names etc)		
	While physically restraining two combatant youth, above mentioned employee injured his right bicep.		
Immediate Basic Cause(s): (What triggered event- e.g. fall from height, caught in machinery, child removal etc.)			

ANALYSIS	1) youth involved in a physical altercation 2) 3)		
	Underlying Cause and Contributing Factors: (What allowed the trigger to exist – e.g. inadequate training, supervision or work procedures; poor lighting; defective equipment or tools; working alone; lack of orientation; noise etc.)		
	1) there were no underlying causes or contributing factors 2) 3) 4) 5)		
PREVENTION	Recommended Control, Corrective Measures or Treatment Provided (goal is to prevent/minimize re-occurrence of accident/incident):		Action By:
	1) no recommendations 2) 3) 4) 5) 6)		OFA Phone # (for First Aids)
	Additional Comment or Observations. Where applicable, give details of makes and models of machines, equipment, tools, structures etc. involved in this incident.		
	Investigated By: Tony Guarascio	Phone #: 250-708-2224	Occupation:
	Investigated By: MELANIE SAUVE	Phone #: 250-708-2202	Occupation: SUPERVISOR OF STAFFING
Signature of Workers' Representative		Signature of Employer Representative	
Date: Jan. 11.12		Reviewed By:	
Date:		Comments:	

* if FATAL, ensure employer has contact the local WorkSafeBC Office as per WCB Act #172 (1)(a), local BCGEU office, BCPSA Minister's office and your Human Resources Department.

Keep Original and Forward a copy of the completed report to: (1) Regional OSH Advisor; (2) Local JOSH Committee Co-Chairs; (3) Local BCGEU area office; (4) Local WorkSafeBC Office if a lost time injury, had potential for serious injury, required medical aid, or if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy. Thanks!



BRITISH
COLUMBIA

Ministry of Children
and Family Development

**OSH Joint Incident
Investigation Form**
PSC 38 Equivalent

This form must be initiated immediately after notification.

This information is required by WorkSafeBC when serious workplace injuries and/or incidents occur that result in loss time (past the day of injury) or medical intervention. This report is also to be used for recording and investigating less serious incidents which include incidents with the **potential** to cause serious injury, violent incidents (threats, physical assault etc.) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

MCFD TRACKING NUMBER

--

INCIDENT LOCATION INFORMATION

REPORTING OFFICE PHONE

250-708-2202

DATE OF OCCURRENCE

2012-12-24

DATE REPORTED

2012-12-24

TIME OF INCIDENT

1649 PM

TO

ADDRESS OF INCIDENT (street address, city/town)

94 Talcott Road, Victoria BC

EXACT LOCATION OF INCIDENT (parking lot, meeting room etc)

Unit 3

PEOPLE INVOLVED

NAME OF PERSON INCIDENT REPORTED TO

1) Mike Lewis

PHONE NUMBER
(if different than reporting
office)

250-708-2226

NAME OF PERSON DIRECTLY AFFECTED

1) s.22

POSITION

(e.g. Social Worker, Team Leader, Office Manager)

Youth Supervisor

PHONE NUMBER
(if different than reporting
office)

250-708-2224

NAME OF WITNESS

1)

POSITION
(e.g. Social Worker, Team Leader,
Office Manager)

PHONE NUMBER
(if different than reporting
office)

INVOLVEMENT
(e.g. what they saw, heard, their location at time
of the incident, etc.)

INCIDENT DETAIL INFORMATION

INCIDENT CATEGORY (CHECK ALL THAT APPLY)

<input checked="" type="checkbox"/> Violence Related Incidents	<input type="checkbox"/> Verbal Threat (i.e. abusive swearing, physical harm, veiled or perceived) <input type="checkbox"/> Written Threat (i.e. abusive swearing, physical harm, veiled or perceived) <input type="checkbox"/> Bomb Threat (i.e. written, verbal) <input type="checkbox"/> Weapon Threat <input type="checkbox"/> Intimidating Behaviour (i.e. stalking, infringement on physical space) <input type="checkbox"/> Aggressive Behaviour (slamming fist, kicking door, damaged property) <input checked="" type="checkbox"/> Physical Assault (i.e. physical injury) <input type="checkbox"/> Animal Related (i.e. attacked, menacing behaviour) <input type="checkbox"/> Vehicular Assault <input type="checkbox"/> Worker to Worker (i.e. actual or perceived threats, intimidation) <input type="checkbox"/> Other	<input type="checkbox"/> Environmental Incidents	<input type="checkbox"/> General Incidents
--	--	--	--

SEVERITY OF INJURY OR ILLNESS (CHECK ALL THAT APPLY)

<input type="checkbox"/> No Physical Injury	<input type="checkbox"/> First Aid Only	<input type="checkbox"/> Medical Intervention (Dr. Clinic, Ambulance)	<input type="checkbox"/> Time Loss (Not including day of injury)	<input type="checkbox"/> Fatal
---	---	--	---	--------------------------------

TYPE OF INJURY OR ILLNESS (CHECK ALL THAT APPLY)

<input checked="" type="checkbox"/> Knocks, Scrapes, Abrasions, Bruises	<input checked="" type="checkbox"/> Muscle/Tendon Strains	<input type="checkbox"/> Sprains	<input type="checkbox"/> Medical Sensitivity (scents, chemicals)	<input type="checkbox"/> Post Traumatic Stress
<input type="checkbox"/> Muscle/Tendon Tears	<input type="checkbox"/> Fractures	<input type="checkbox"/> Lacerations/Cuts	<input type="checkbox"/> Disease	<input type="checkbox"/> Burns
<input type="checkbox"/> Other				

BODY PART(S) INJURED OR AFFECTED (CHECK ALL THAT APPLY)

<input checked="" type="checkbox"/> Upper	<input type="checkbox"/> Head	<input type="checkbox"/> Ear	<input checked="" type="checkbox"/> Eyes	<input checked="" type="checkbox"/> Neck
<input checked="" type="checkbox"/> Mid Body (including arms)	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Right Elbow	<input type="checkbox"/> Right Wrist
	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Left Elbow	<input checked="" type="checkbox"/> Left Wrist
	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Mid Back	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Left Hand/Fingers
<input type="checkbox"/> Lower Body				

PHYSICAL SURROUNDINGS DETAILS (IF APPLICABLE)

Object/Equipment/Substance inflicting injury or damage	Environmental Conditions at time of incident (i.e. lighting, sound, chemical exposure)	Office Structures implicated in incident (i.e. doors)
Client	NA	NA

DESCRIPTION OF INCIDENT

Who, What, Where, When, Why - Employee's Account (be specific as possible with worker's names, times, locations and use initials for client names)

s.22 involved in a physical altercation with client s.79 YCJA while working on unit 3. Verbal abuse that quickly escalated into a physical confrontation at approximately 1649hrs on 2012-12-24.

ANALYSIS

Return to Basic Causes

- 1) Immediate Basic Cause:
Verbal confrontation / abuse

Recommended Control, Corrective Measures or Treatment Provided
(goal is to prevent/minimize re-occurrence of accident/incident)

Actioned by

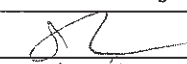
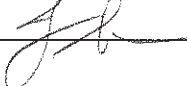
Completion
Date

A)

No recommendation

ADDITIONAL COMMENTS OR OBSERVATIONS Where applicable, give details of other hazards, which may or may not be related to the incident.

OSH COMMITTEE JOINT INVESTIGATORS

NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:			
Name	Signature	Occupation	Phone
J.D. Robinson		Supervisory Staffing	708-2202
T. Guariseo		Senior Youth Supervisor	708-2202

Keep Original and Forward a copy of the interim report to:

- (1) Local JOSH Committee co-chairs for committee discussion and further recommendations.

Keep Original and Forward a copy of the completed report to:

- (1) Employer for their review and action;
- (2) BCGEU Area Office
- (3) Regional MCFD OSH Advisor
- (4) Local WorkSafeBC Office if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy.

SIGNATURE OF WORKER'S REPRESENTATIVE

DATE (YYYY-MM-DD)

SIGNATURE OF EMPLOYER'S REPRESENTATIVE

DATE (YYYY-MM-DD)



2013-02-05



This form must be initiated immediately after notification.

This information is required by WorkSafeBC when serious workplace injuries and/or incidents occur that result in loss time (past the day of injury) or medical intervention. This report is also to be used for recording and investigating less serious incidents which include incidents with the **potential** to cause serious injury, violent incidents (threats, physical assault etc.) and IAQ complaints. Completed investigation reports must be kept at the worksite for a minimum of 7 years.

MCFD TRACKING NUMBER

INCIDENT LOCATION INFORMATION

REPORTING OFFICE PHONE

251-708-2202

DATE OF OCCURRENCE

2012-12-19

DATE REPORTED

2012-12-19

TIME OF INCIDENT

2110 PM

TO

ADDRESS OF INCIDENT (street address, city/town)

94 Talcott Road, Victoria BC

EXACT LOCATION OF INCIDENT (parking lot, meeting room etc)

Unit 3/4 time out room

PEOPLE INVOLVED

NAME OF PERSON INCIDENT REPORTED TO

1) Mike MacPhee

PHONE NUMBER
(if different than reporting
office)

250-708-2226

NAME OF PERSON DIRECTLY AFFECTED

1) s.22

POSITION

(e.g. Social Worker, Team Leader, Office Manager)

Youth Supervisor

PHONE NUMBER
(if different than reporting
office)

250-708-2224

NAME OF WITNESS

1) s.15, s.22

POSITION
(e.g. Social Worker, Team Leader,
Office Manager)

Senior YS

PHONE NUMBER
(if different than reporting
office)

250-708-2226

INVOLVEMENT
(e.g. what they saw, heard, their location at time
of the incident, etc.)

While searching a client
after an escort to the time
out room client kicked staff
member s.22 in the
nose causing it to bleed.

2)

Youth Supervisor

250-708-2224

As above

3)

Youth Supervisor

250-708-2224

As above

INCIDENT DETAIL INFORMATION

INCIDENT CATEGORY (CHECK ALL THAT APPLY)

<input checked="" type="checkbox"/> Violence Related Incidents	<input type="checkbox"/> Verbal Threat (i.e. abusive swearing, physical harm, veiled or perceived) <input type="checkbox"/> Written Threat (i.e. abusive swearing, physical harm, veiled or perceived) <input type="checkbox"/> Bomb Threat (i.e. written, verbal) <input type="checkbox"/> Weapon Threat <input type="checkbox"/> Intimidating Behaviour (i.e. stalking, infringement on physical space) <input type="checkbox"/> Aggressive Behaviour (slamming fist, kicking door, damaged property) <input type="checkbox"/> Physical Assault (i.e. physical injury) <input type="checkbox"/> Animal Related (i.e. attacked, menacing behaviour) <input type="checkbox"/> Vehicular Assault <input type="checkbox"/> Worker to Worker (i.e. actual or perceived threats, intimidation) <input type="checkbox"/> Other	<input type="checkbox"/> Environmental Incidents	<input type="checkbox"/> General Incidents
--	---	--	--

SEVERITY OF INJURY OR ILLNESS (CHECK ALL THAT APPLY)

<input type="checkbox"/> No Physical Injury	<input checked="" type="checkbox"/> First Aid Only	<input type="checkbox"/> Medical Intervention (Dr. Clinic, Ambulance)	<input type="checkbox"/> Time Loss (Not including day of injury)	<input type="checkbox"/> Fatal
---	--	--	---	--------------------------------

TYPE OF INJURY OR ILLNESS (CHECK ALL THAT APPLY)

<input checked="" type="checkbox"/> Knocks, Scrapes, Abrasions, Bruises	<input type="checkbox"/> Muscle/Tendon Strains	<input type="checkbox"/> Sprains	<input type="checkbox"/> Medical Sensitivity (scents, chemicals)	<input type="checkbox"/> Post Traumatic Stress
<input type="checkbox"/> Muscle/Tendon Tears	<input type="checkbox"/> Fractures	<input type="checkbox"/> Lacerations/Cuts	<input type="checkbox"/> Disease	<input type="checkbox"/> Burns
<input type="checkbox"/> Other				

BODY PART(S) INJURED OR AFFECTED (CHECK ALL THAT APPLY)

<input checked="" type="checkbox"/> Upper	<input checked="" type="checkbox"/> Head	<input type="checkbox"/> Ear	<input type="checkbox"/> Eyes	<input type="checkbox"/> Neck
<input type="checkbox"/> Mid Body (including arms)	<input type="checkbox"/> Lower Body			

PHYSICAL SURROUNDINGS DETAILS (IF APPLICABLE)

Object/Equipment/Substance inflicting injury or damage	Environmental Conditions at time of incident (i.e. lighting, sound, chemical exposure)	Office Structures implicated in incident (i.e. doors)
Client s.79 YCJA	NA	NA

DESCRIPTION OF INCIDENT

Who, What, Where, When, Why - Employee's Account (be specific as possible with worker's names, times, locations and use initials for client names)

While s.22 was conducting a pat frisk search on a client after being escorted to time out, Client s.79 YCJA kicked in the nose causing it to bleed.

ANALYSIS

Return to Basic Causes

1) Immediate Basic Cause:

Agitated Client

Recommended Control, Corrective Measures or Treatment Provided
(goal is to prevent/minimize re-occurrence of accident/incident)

Actioned by


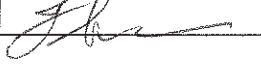
Completion Date

A) No recommendations, staff are trained in use of force options and precautionary measures.

ADDITIONAL COMMENTS OR OBSERVATIONS Where applicable, give details of other hazards, which may or may not be related to the incident.

--

OSH COMMITTEE JOINT INVESTIGATORS

NAME(S) AND OCCUPATION(S) OF PERSON(S) WHO INVESTIGATED INCIDENT:			
Name	Signature	Occupation	Phone
J.D. Robinson		Supervisor of Staffing	708-2262
Tony Guarascio		Senior Youth Supervisor	708-2246

Keep Original and Forward a copy of the interim report to:

- (1) Local JOSH Committee co-chairs for committee discussion and further recommendations.

Keep Original and Forward a copy of the completed report to:

- (1) Employer for their review and action;
- (2) BCGEU Area Office
- (3) Regional MCFD OSH Advisor
- (4) Local WorkSafeBC Office if requested.

Further assistance can be obtained by contacting your Regional OSH Advisor or the BCGEU.

This form is considered confidential once it has been completed. If you have received a completed form in error please forward it to your Regional OSH Advisor and destroy/permanently delete your copy.

SIGNATURE OF WORKER'S REPRESENTATIVE

DATE (YYYY-MM-DD)

SIGNATURE OF EMPLOYER'S REPRESENTATIVE

DATE (YYYY-MM-DD)



2013-07-05