Employer Incident Investigation Report (EIIR)

Please refer to the companion quick guide for assistance completing the investigation and this form.

1. Employer's information

Employer's name (legal name and trade name) Ministry of Children and Family Development-Burnaby Youth Custody Services		
WorkSafeBC account number 04000	Operating location number 295	
Employer's head office address BYCS 7900 Fraser Park Drive, Burnaby BC, V5J 5H1, Head Office- Youth Justice Suite#2-940 Blanchard Street		
City Victoria	Province BC	Postal code V8W 937
Employer's representative's name Pamela Drew		Phone number (include area code) 778-452-2055
Email address Pam.Drew@gov.bc.ca		

2. Injured persons

Last name	First name	Job title
a)		
b)		
c)		
d)		

3. Place, date, and time of incident

Location where incident occurred (street address or GPS coordinates) 7900 Fraser Park Drive		
City (nearest) Burnaby	Province BC	Postal code V5J 5H1
Date of incident (yyyy-mm-dd) 2016-07-19	Time of incident 20:26	☐ a.m. ☒ p.m.

4. Type of occurrence (select all that apply)

- ☐ Death of a worker
- ☐ Serious injury to a worker
- ☐ Major structural failure or collapse
- ☐ Major release of hazardous substance
- ☐ Blasting accident causing personal injury
- ☐ Dangerous incident involving explosives other than blasting incident
- ☐ Diving incident, as defined by regulation
- ☒ Incident of fire or explosion with potential for serious injury
- ☒ Minor injury or no injury but had potential for causing serious injury
- ☐ Injury requiring medical treatment beyond first aid

An incident investigation report is NOT required under the *Workers Compensation Act* if none of the above applies or if this incident is a vehicle accident occurring on a public street or highway.

5. Report type (select all that apply)

If this is a **revised version of a previous report**, please check here ☐

☒ Preliminary Investigation Report	☐ Interim Corrective Action Report	☐ **Full Investigation Report**	☐ Full Corrective Action Report
Report date (yyyy-mm-dd) 2016/07/21 Only provide to a WorkSafeBC officer **if requested** Officer's name Redonna Levis-	Report date (yyyy-mm-dd)	Report date (yyyy-mm-dd) 2016-08-20 **Must be provided to WorkSafeBC within 30 days* Fax 1.866.240.1434** Date sent (yyyy-mm-dd)	Report date (yyyy-mm-dd)

Employer Incident Investigation Report (EIIR)

6. Witnesses

Last name	First name	Job title
a) Graham	Caroline	Youth Supervisor
b) Steeple	Jason	Youth Supervisor
c) Bunker	Grant	Senior Youth Supervisor

7. Other persons whose presence might be necessary for proper investigation

Last name	First name	Job title
a) Harris	Jacquie	Senior Youth Supervisor
b) Cronkhite	Andrew	Director of Programs

8. Sequence of events that preceded the incident

Required in Preliminary Report. Update in Full Report if necessary. Describe events earlier that day or even in previous years that led up to the incident. Examples may include events such as training given or changes in equipment, procedures, or company management.

On July 18 2016 at approx. 20:20hrs a fight started with no prior signs of aggression between two s.22 unit youth in basketball program on the outside basketball court.

Code Yellow was called and staff responded and separated and restrained both youth. One minute following this code, a Code Red was called on the s.22 unit where 3 s.22 unit residents conducted a 3 on 1 assault on a 4th s.22 resident while he was on phone.

Upon investigation of both incidents, information came forward that both codes were pre-planned with the first incident in the outside basketball court was set up to be a distraction to slow response to the second incident of assault on s.22 unit. The three residents that were participants in the second incident of assault were all placed in rooms for the remainder of night. The 2 residents involved in first fighting incident were also incident were also placed in their rooms for the night.

The following day July 19 2016, decision was made to reclassify the victim from s.22 unit assault to another unit. The three boys involved in the assault were placed on separate confinement on s.22 Unit and restricted from programs. Another boy on this unit was the instigator of setting the first fight up in the adjacent unit so he was also placed on separate confinement. Another boy on unit was reclassified to Open Custody and the remaining boy who wasn't involved in anything was offered a move to another unit as this unit now housed all residents either serving separate confinement or who were on restricted programming. The remaining boy chose to stay on this unit with the understanding his programs will be restricted as staff can't take him but he does have option to attend programs with other units. Two other boys were reclassified to this unit who were on program restrictions from other units.

1215 -Boys were reviewed and removed from separate confinement at lunch time. Boys however remained on program restrictions.

s.22 Unit was housing a count of 7 boys on restricted programming.

1450- Information came forward that contraband was suspected on unit. Unit search was ordered by Assistant Director of Operations. Search Resulted in significant amount of extra clothing, food, juice, tattoo kit, s.15 and many non-allowable items being removed from resident rooms.

1500- Youth who had tattoo kit and s.15 for weapon was given IR and room time. This youth became agitated, hostile and escalated. He was banging and kicking on doors, demanding to speak with ADO.

1630- Dinner, Locked youth eats in room.

1645- dinner completed

1700 -All other youth taken to gym program.

1700- Locked youth remained in room 4.

1735 -6 youths returned from gym.

1800- All youths locked for staff meal break

1845 – All residents unlocked including resident who was serving room time.

1930 – All youth attended courtyard

2003- all youth return to unit

2025 – CODE RED s.22 Unit

Employer Incident Investigation Report (EIIR)

9. Unsafe conditions, acts, or procedures that significantly contributed to the incident

Required in all reports. Describe anything, or the absence of anything, that contributed to the hazard such as poor housekeeping or poor visibility, using equipment without guards, or the lack of safe work procedures.

- 2100 July 18 2016 -Program restrictions imposed on 4 youths due to they were threatening or likely to threaten the management operations or security of the Centre or endangering or is likely to endanger another person.
- 2100 July 18 2016-All 4 boys were destaged on the incentive program to level one and not earning money and received consequences.
- 1450 July 19 2016-Unit search conducted on unit due to suspicion that tattoo equipment may be on unit. Resulted in significant amount of extra clothing, food, juice, tattoo kit, s.15 and any non-allowable items being removed from resident rooms.
- 1500 July 19 2016- Incident report written which resulted in lock down and program restrictions imposed on one youth for possession of contraband (Tattoo kit and s.15 Locked youth escalated, banging and kicking door. Youth is suspected of being the youth who orchestrated the stand-off and disturbance.
- 2030 July 19 2016-It was bedtime and they all had been destaged to level one so they had early bedtime.
- New mix of youth on unit. Classification of 7 youth to s.22 Unit who were disgruntled and had recently been disciplined for negative behavior. 6 of these youth know each other in the s.22 Two youths are co-accused and are believed to be the youth who orchestrated and incited other to carry out the disturbance.
- s.15
-
-
- Youth had previously planned this event.

10. Nature of the serious injury (optional — complete only if there has been an injury)

☐ Life threatening or resulting in loss of consciousness	☐ Punctured lung or other serious respiratory condition
☐ Major broken bones in head, spine, pelvis, arms, or legs	☐ Injury to internal organ or internal bleeding
☐ Major crush injuries	☐ Injury likely to result in loss of sight, hearing, or touch
☐ Major cut with severe bleeding	☐ Injury requiring CPR or other critical intervention
☐ Amputation of arm, leg, or large part of hand or foot	☐ Diving illness such as decompression sickness or near drowning
☐ Major penetrating injuries to eye, head, or body	☐ Serious chemical or heat/cold stress exposure
☐ Severe (third-degree) burns	☐ Other (specify)

11. Brief description of the incident

Required in Preliminary Report. Briefly, summarize the sequence of events, the unsafe factors, and the resulting injury, if any.

Timeline of events:

- 2030: 7 boys involved in a standoff. There was one staff on the unit (Auxiliary female). One of Youth rushed into the office pushing past Youth Supervisor and appeared to try to grab the s.15 s.15 The staff member grabbed the youth and pushed him out of the office. The staff member closed the office door then called a "Code Red". At this point, all the youth on unit except one took various positions on various ledges around the unit. Responding staff attended and directed the youth to get down, 6 youth did not comply. The 7th youth complied after attempting to climb a ledge but he had nowhere to go as all ledges and cabinets already were occupied with the other residents. He sat on chair in dayroom and was directed to his room and locked. Approximately 13 staff responded to unit. Several attempts to verbally direct the six other youths to attend rooms were attempted. Youth were non-compliant to directions from staff and were verbally abusive, aggressive, and were at high risk of becoming assaultive. All responding Staff was directed by Senior Supervisor to disengage and leave the unit. Several staff remained in locked office to have visual of the youth.
- 2042: Acting Director Andrew Cronkhite was called at his home and notified of the disturbance.
- 2056: Mr. Cronkhite called again, advised that the youths were now starting to break items and barrack themselves. Mr. Cronkhite gave directions to call 911 and have RCMP attend.
- 2100: Fire and water suppression system turned off at control so residents couldn't attempt to flood unit.
- 2105: SYS Bunker calls 911 and explains situation and requests Police to attend site. Call is transferred to Dispatch Officer, then received message that # is no longer in service. The call is then transferred to another line that goes dead. RCMP calls back at approximately 2110 hrs. RCMP speaks with SYS Harris who briefs the

Employer Incident Investigation Report (EIIR)

Duty Officer. At approx. 2120 SYS Bunker calls back to RCMP and provides update. RCMP indicates they are on the way.

- 2126: Staff concerned for safety of themselves and other youth in the adjacent s.22 unit. Staff evacuates youth from s.22 unit to s.22 unit and leave the staff office with material such as log books and files.
- 2135: Youth break into staff office between s.22 and s.22 units.
- 2140: A/Director Cronkhite on site
- 2146: A separate incident on s.22 Unit: Youth floods room by pulling sprinkler.
- 2151: Youth breech the office door and enter into s.22 unit through staff office.
- 2212: s.15 A/Director Cronkhite on site.
- 0130: Youth s.15 light fire in s.22 unit
- 0133: Fire in corner of dayroom alights.
- 0134: Burnaby Fire Department called by staff
- 0140: Save Link contacts Centre (Fire Monitoring System). Staff pre-empted call by calling fire Department
- 0148: Appears youth extinguish fire with cups of water.
- s.15
- 0208: Fire Department arrives
- 0210: ERT instructs youth to comply with direction, and first youth surrenders to ERT.
- 0225: All Youths transferred to venture and Separate confinement area one at time with multiple escorts in restraints.
- 0230: Incident complete
- No injuries incurred by staff or youth due to disturbance.
- Short Debrief held with staff on shift.

12. Corrective actions identified and taken to prevent recurrence of similar incidents

Action (Required in Preliminary Report and Interim Corrective Action Report. Update in Full Report, if necessary.)	**Action assigned to** (name and job title)	**Expected completion date** (yyyy-mm-dd)	**Completed date** (yyyy-mm-dd)
a) Critical Incident/Operational Review to be conducted as well as Full investigation which may determine more corrective actions.	Youth Justice Services contracted with Colleen Goertz from Alberta to conduct Critical Incident review.	2016-08-21	TBA
b) All residents involved incident were isolated and placed on separate confinement.	Pam Drew -Director of Operations	2016-07-20	2016-07-20
c) Enhanced staffing put in place on Venture unit where youths are serving separate confinement.	Pam Drew -Director of Operations	2016-07-20	2016-07-20
d) Youths movements and programs restricted.	Pam Drew -Director of Operations	2016-07-20	2016-07-20
e) Mechanical restraints used for all movement of youth and visits are conducted in secure booths.	Pam Drew -Director of Operations	2016-07-20	2016-07-20
f) Professional debrief for all staff on shift during the incident Thursday July 21 2016	Denise Townsend- Director of Support Services	2016-07-20	2016-07-21
g) Professional Debrief for all employees at	Denise Townsend – Director of	2016-07-20	2016-07-25

Employer Incident Investigation Report (EIIR)

Action (Required in Preliminary Report and Interim Corrective Action Report. Update in Full Report, if necessary.)	Action assigned to (name and job title)	Expected completion date (yyyy-mm-dd)	Completed date (yyyy-mm-dd)
BYCS to discuss July 19 2016 incident on July 25 2016	Support Services		

13. Explanation of blank areas on this Preliminary Report, if any

If there are blank areas, describe the circumstances beyond your control that explain this lack of information.

Section 2 left blank due to no injuries incurred during this incident.

14. Persons who carried out or participated in the preliminary investigation

Representative	Name	Job title	Signature (optional)	Date signed (yyyy-mm-dd)
Employer representative (required)	Pam Drew	Director of Operations BYCS		July 21 2016
Worker representative (required)	Spencer Coen	Youth Supervisor, JOSH Committee Member		July 21 2016
Other	Kevin Lefevre	Ministry OSH Manager		July 21 2016
Other				

End of report

Completing all the sections above satisfies the requirements for a Preliminary Investigation Report and an Interim Corrective Action Report.

Note: If this was a simple investigation and **all needed corrective actions have been completed within 48 hours**, the Preliminary and Full Investigation portions of the report can be completed at the same time. If so, you can check both the Preliminary Investigation Report and the Full Investigation Report boxes in section 5 on page 1.

As of January 1, 2016, copies of **all** reports must also be provided to the joint occupational health and safety committee or worker representative, as applicable.

Employer Incident Investigation Report (EIIR)

15. Determination of causes of incident

Required in Full Report. Analyze the facts and circumstances of the incident to identify underlying factors that led to the incident. Underlying factors include factors that made the unsafe conditions, acts, or procedures in the Preliminary Report possible. Update items from section 9, if needed.

- All youths housed on this unit had been involved in various previous incidents days prior which they had been disciplined. -needed to proactively separate these individuals into different units after incidents. Classification of these youths is discussed at morning Managers meeting with Case Management Supervisor, Senior Youth Supervisors, and Managers who collectively developed classification strategies for all residents. The emotional and physical safety of youth and others, including age, maturity, size, and victimization, the need to separate specific youths or groups of youth and the overall safety and security of the building are all assessed. Building dynamics and operational needs are also considered. There are classification procedures in place but could be a benefit from review of this process.
- Two youths who are suspected of orchestrating and inciting the incident, are co-accused on their current charges. Allowing acquaintances to be housed together may lead to unwanted behaviors/mob mentality. Review of classification procedures recommended.
- Classification of these youths together could be a contributor that led to the incident.
- Suspicious behavior by youth involved in incident prior to the incident, such as whispering and grouping together was noticed by several staff and reported to Senior Supervisor. Are there procedures in place to deal with suspicious behavior to proactively prevent any potential issues? Review and develop protocol and procedures with Senior Supervisors.
- Are the current procedures for preventing contraband from entering the units sufficient? Review random search procedures and increase frequency of searches.
- Enhanced staffing was on s.22 unit, until 15 minutes prior to incident. At the time of incident only one staff was on unit. Clients may have been waiting for an opportunity when there would be minimal staff on unit. Lack of planning to ensure more than one staff is always available to deter this type of incident in future to be reviewed.

Environmental factors

- s.15
- s.15
-
- Office door was breeched by youth, s.15 s.15 Office door was not recognized to be unsafe or easily compromised.
- Domestic water, Fire suppression was turned off at 20:57 by order of Senior Supervisor to prevent flooding if sprinkler heads were activated by youth knocking off sprinkler heads. No sprinkler activation when fire started at 01:30 hrs. Heat from fire was never intense enough to activate sprinkler system? Smoke detectors did activate in s.22 unit. Save link fire monitoring calls BYCS Control to confirm smoke detectors activated at 01:40 hrs. Control had already called Burnaby Fire Dept at 01:34 hrs. Review of the fire suppression system recommended.
- s.15
- s.15
- s.15

Employer Incident Investigation Report (EIIR)

16. Full description of the incident

Required in Full Report. Use the brief description from the Preliminary Report and update it, if necessary.

On Tuesday July 19th 2016 at approximately 2022 hours, Youth Supervisor C. Graham was in the staff office calling Control to ask for another radio battery. As YS Graham hung up the phone, resident s.22 was asking her for the time. YS Graham noticed that resident s.22 was extremely nervous and fidgeting.

Previous staff had also observed and reported to Senior Youth Supervisor G. Bunker that the entire unit, consisting of residents s.22 and s.22 were acting suspicious, and doing a lot of whispering. YS Graham also discussed these concerns with Youth Supervisors N. Garcha and K. Underwood, who had also reported observing the similar type of behavior.

Resident s.22 continued to make conversation with YS Graham as she tried to walk out of the office, and close the door. At this time, 2026 hours, Resident s.22 pushed by YS Graham, and attempted to grab s.15 s.15 YS Graham then positioned herself in between s.22 and the desk with her hands up, and directed him out of the staff office while she called a code red. As YS Graham came out of the office, residents s.22 and s.22 climbed up on the cupboards above the sink, while residents s.22 and s.22 climbed up on the window ledge in the day room.

At this time, the first responders attended the unit. All residents began throwing food and hot water that they had made for tea, at staff while yelling "we don't give a fuck" as they were already on level 1, and "what, are you going to give me a two hour timeout?" SYS Bunker and responders attempted to direct all residents to go to their respective room, and began opening all of their room doors. Eventually, resident s.22 chose to go to his room. All the remaining residents continued to throw various items at staff, and began to yell "come and get me you fucking goofs." SYS Bunker and all staff shut the resident's doors and were directed to leave the unit for safety reasons.

After all staff had vacated the s.22 unit and had secured all the doors, SYS Bunker and a few other staff remained in the staff office to record all the events in the unit logbook. SYS Bunker and various staff made verbal attempts to direct all the residents to stand near their respective room doors so that they could be secured inside. None of the residents complied with any staff direction, and were overheard stating "fuck you goofs, we're not doing shit."

One of the residents took the s.15 and threw it on the floor near the staff office and s.15 all over the floor. These residents were witnessed throwing water bombs towards the staff office, and they were also putting their s.15 into the water bombs and throwing these s.15 bombs towards the staff office door causing the s.15 water to come into the staff office.

At this time, staff placed sandbags in front of the office door to prevent further s.15 water to enter the office. Staff also witnessed residents breaking the unit television which was attached to the wall, and the unit microwave. These residents then began to throw various items such as s.15 and the s.15 towards the staff in the office.

At this time the residents in the neighboring s.22 unit were directed out of their rooms, and escorted by staff to the s.22 unit to be housed for the night for their safety and security.

The residents on the s.22 unit continued to cause damage to the unit, with their emphasis directed towards the staff in the office. The residents also broke the dishwasher s.15 These residents continued to throw various items towards the staff in the office, and began to kick the office door in an attempt to breach the staff office.

At this time, all staff collected the unit logbooks and files, secured all doors, and exited the units. As we were in the rotunda, we had a visual of all residents through the unit door in the rotunda. We witnessed the residents covering their faces with clothing to conceal their identities.

The residents began to throw s.15 towards the unit door directed at staff members. We witnessed the residents kick in the staff door and breach the office. These residents were witnessed breaking the guitar, and using the s.15 to cover the unit door to s.15 of the residents. We then overheard the residents' state that they were using the phones in the staff office to call control, and to make phone calls to the public.

These residents were seen by staff members in the parking lot using the s.15 and other items to attempt to break the unit windows in an attempt to escape. We then began to smell smoke, and noticed that the residents had started a fire inside the s.22 unit. There was a tremendous amount of smoke coming from the s.22 unit which began to seep into the s.22 unit and the rotunda. Resident s.2 was also let out of his room for his safety, as we could not conduct 30 minute checks on him, and because of the large amounts of smoke entering his room.

The residents continued to cause damage to both the s.22 and s.22 units, the staff office, and continued to throw various items directed towards staff. We had also noticed that they had caused a flood on the unit, as there was water pouring into the classrooms in the rotunda.

Employer Incident Investigation Report (EIIR)

When the RCMP arrived, the Emergency Response Team split into two groups. One group of ERT Officers was set beside the s.22 unit in the access way, and the other group of ERT Officers was set in the s.22 room adjacent to the s.22 unit. All the youth were eventually directed into the MPR-1 one at a time, and were escorted by staff to the Venture and Sep con areas at approximately 0230 hours on July 20th 2016.

After the RCMP vacated the building, the Burnaby Fire Department was escorted by a few staff members to put out the fire on the s.22 unit. A short debrief was held with staff involved to assess mental well-being and check-in. Professional debrief was scheduled for all staff involved in incident, 2 days following the incident. A professional debrief for all other staff at BYCS was scheduled the following week.

A safety plan was developed for the youth being held in Venture Unit and Separate Confinement area. This plan consisted of enhanced staffing to three staff working with six residents. Residents were housed in three separate adjoining units. Two residents per unit. Require two staff on unit when face to face contact with youth. Youths are eating in their rooms. Programs were limited to Gym and Venture courtyard. Two youth scheduled with two staff for programs. School work was provided on unit for residents. Phone call monitoring placed on all youth involved in incident. All movement off unit was escorted in mechanical restraints. Visits are scheduled separate from all other youths involved in incident. Visits were scheduled behind glass. Ongoing reviews and updates of safety plan are discussed daily at 9:00am leadership meeting. Reintegration plans are developed and are continually reviewed and updated for each resident involved in incident.

17. Additional corrective actions necessary to prevent recurrence of similar incidents

Additional corrective action (Required in Full Report and Full Corrective Action Report.)	Action assigned to (name and job title)	Expected completion date (yyyy-mm-dd)	Completed date (yyyy-mm-dd)
a) Critical Incident Investigation/Review has been requested by the Provincial Executive Director, Lenora Angel, to be completed by September 15 2016. Recommendations from this review may create further corrective actions.	Youth Custody Services has contracted Colleen Goertz to conduct this review. She will be on site August 09 to August 11 2016.	2016-09-30	
b) Request an Operational Directive to Senior Supervisors regarding assessing the need for enhanced staffing or other supports. Responding immediately, to support staffs that have concerns regarding suspicious behavior/activity or safety concerns.	Pamela Drew, Director of Operations. Create new Operational Directive for making assessment and protocol for responding to behavior and safety concerns brought forward by staff.	2016-09-30	
c) Request a review of unit accessories, cutlery, furniture and appliances to determine if these items are required on unit. If required, develop safe storage and protocols for use.	JOSH Committee Members. Ross Hurst- worker rep, Spencer Coen-worker rep, Sheryl Hudspeth-employer rep, Pamela Drew-employer rep.	2016-09-30	
d) Request a review and quote on cost to reinforce existing office doors. s.15 s.15	Pamela Drew, Director of Operations. Will get quote from WSI on cost to reinforce existing office doors on all living units.	2016-10-30	
e) s.15		2016-10-30	
f) Request a review and testing of the Fire Suppression System to ensure it is working as sprinkler activation did not occur during the fire incident.	Pamela Drew, Director of Operations. Will request WSI to order fire system testing and review of smoke detectors and heat detectors on units.	2016-09-30	

Employer Incident Investigation Report (EIIR)

Additional corrective action (Required in Full Report and Full Corrective Action Report.)	Action assigned to (name and job title)	Expected completion date (yyyy-mm-dd)	Completed date (yyyy-mm-dd)
g) Request a meeting with RCMP to debrief the response to the July 19 2016 incident. Request to review the need to develop MOU with Burnaby RCMP.	Andrew Cronkhite, Acting Director.	2016-09-30	
h) s.15	Pamela Drew, Director of Operations. Will request quote and options s.15 s.15	2016-09-30	
I) Review classification process and establish an updated/enhanced process to assess suitability of residents to reside together. Example: no-contacts, community associates, gang affiliation, co-accused, level of risk, current events or incidents.	Andrew Cronkhite, Acting Director. Pamela Drew, Director of Operations. Kim McKinney, Case Management Supervisor.	2016-09-30	
j) Continue to review and update safety plan for the 6 youths directly involved in the disturbance. Develop and update integration plans for all youths involved.	Pamela Drew, Director of Operations	2016-07-20	Ongoing

18. Persons who carried out or participated in the full investigation

Representative	Name	Job title	Signature (optional)	Date signed (yyyy-mm-dd)
Employer representative (required)	Pamela Drew	Director of Operations		2016-08-12
Worker representative (required)	Spencer Coen	Youth Supervisor/JOSH Committee Member		2016-08-12
Worker representative	Ross Hurst	Youth Supervisor/JOSH Committee Member/Union Steward		2016-08-12
Other	Sonny Mangat	Ministry OSH Manager		2016-08-12

19. Other relevant workplace parties

Company name	Contact person	Contact number or email address
a)		

End of report

Completing all the sections above satisfies the requirements for a Full Investigation Report and a Full Corrective Action Report.

Employers are required to submit **full** investigation reports to WorkSafeBC **within 30 days* of the incident**. Reports may be submitted by fax to 604.276.3247 (Greater Vancouver), toll-free fax 1.866.240.1434, or by mail to PO Box 5350, Stn Terminal, Vancouver BC V6B 5L5. Do **NOT** submit a preliminary report unless you have been so directed by a WorkSafeBC officer.

* Employers can request an extension from a WorkSafeBC officer, **if the full investigation cannot be completed within 30 days.**

As of January 1, 2016, copies of **all** reports must also be provided to the joint occupational health and safety committee or worker representative, as applicable.

Drew, Pam M MCF:EX

From:	Drew, Pam M MCF:EX
Sent:	Friday, August 12, 2016 3:30 PM
To:	Levis, Redonna WCB:EX
Cc:	McDonnell, Anita MCF:EX; Cronkhite, Andrew MCF:EX; Angel, Lenora MCF:EX; Mangat, Sonny S MCF:EX; Coen, Spencer G MCF:EX; Hurst, Ross J MCF:EX; Drew, Pam M MCF:EX; Lefevre, Kevin MCF:EX
Subject:	Full Investigation BYCS July 19 2016 incident
Attachments:	Full Investigation BYCS July 19 2016 incident draft.doc

Please refer to the attached Employer Incident Investigation Report for your records. Regarding Inspection Report #201616709039A Burnaby Youth Custody Services I have faxed a copy of this report to WorkSafeBC at 604-276-3247.

Please contact me if you require further information.

Pamela Drew
Director Of Operations
Burnaby Youth Custody Services
7900 Fraser Park Drive
Burnaby B.C. V5J 5H1
778-452-2055 (office)
s.15; s.17 (cell)
Pam.Drew@gov.bc.ca

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