File No:

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| **Liquor Distribution Branch** | ***Employer Head Office Address***  ***3383 Gilmore Way, Burnaby BC V5G4S1*** | *Date of Preliminary Investigation dd/mm/yy* |
| *Workplace Incident Location/City/Postal Code* | *Store Number/DC or HO Acronym (E.g. DDC)* | *Operating Location Number* |
| *Last Name* | *First Name* | *Occupation/Job Title*  Click here to enter text |
| *Describe Accident Location* | *Date of Incident dd/mm/yy* | *Time of Incident hh:mm* |
| A*ccident Category*  Injury or Illness  Equipment  Motor  Property  Fire  Other  *(check)* Malfunction Vehicle Damage (specify) | | |
| *Severity of Injury* No Injury (near miss) First Aid Only Offsite Medical Treatment Time loss  [Serious Injury/Fatality\*\*](https://www2.gov.bc.ca/gov/content/careers-myhr/managers-supervisors/occupational-health-safety/worksafebc-reporting)  *or Illness (check)* | | |
| ***Describe Injury or Illness*** | | |
| **W*orker Account/Description of Incident. If an Occupational Disease (eg. MSI, chemical exposures) list exposure location, dates*** | | |
| ***Basic Timeline of Events Leading Up To and Immediately After the Incident*** | | |
| ***Names & Job Titles of Witness(s)*** | | |
| ***List Hazards, Unsafe Conditions, Acts, Procedures that Contributed to the Incident*** | | |
| ***Names of Any Other People or Resources that May Be Required to Conduct a Full Incident Investigation*** | | |

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| Name(s) & Occupations of Person (s) who Completed Above Preliminary Investigation | | | | | | | | | | |
| *Worker Representative (Are you Union Appointed? Yes* □ *No* □*)* | | | | | *Employer Representative* | | |  | | |
|  | | |  | |  | | |  | | |
| *Name* | | | *Occupation Phone* | | *Name* | | | *Occupation Phone* | | |
|  | | |  | |  | | |  | | |
| *Signature* | | | *Date* | | *Signature* | | | *Date* | | |
| *Email:* | | |  | | *Email:* | | |  | | |
| **List Interim Measures Taken to Prevent Reoccurrence of the Incident** | | | | | | | | | | |
|  | Item  # | Hazard, Unsafe Act, Procedure | | Corrective Measure Taken to  Prevent Reoccurrence | | Completed By  Name, job title | Date  Completed | | Comments |  |
| 1 |  | |  | |  |  | |  |
| 2 |  | | Click here to enter text. | |  |  | |  |
| 3 |  | |  | |  |  | |  |
| 4 |  | |  | |  |  | |  |
| 5 |  | |  | |  |  | |  |
| *Use add lines or use separate sheet if necessary*  **Any Outstanding Interim Measures Yet To Be Completed?** | | | | | | | | | | |
|  | Item  # | Hazard, Unsafe Act, Procedure | | Outstanding Corrective Measure Taken to Prevent Reoccurrence | | Name and Dept. responsible | Projected Completion Date | | Comments |  |
| 1 |  | |  | |  |  | |  |
| 2 |  | |  | |  |  | |  |
| 3 |  | |  | |  |  | |  |
| 4 |  | |  | |  |  | |  |
| 5 |  | |  | |  |  | |  |
| *If there are any empty fields in this report explain why:* | | | | | | | | | | |

File No:

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| **Liquor Distribution Branch** | | | | | ***Employer Head Office Address***  ***3383 Gilmore Way, Burnaby BC V5G4S1*** | | | | ***WSBC Employer#***  ***009406*** | | |
| *Workplace Incident Location/City/Postal Code* | | | | | *Store Number/DC or HO Acronym (E.g. DDC)* | | | | *Operating Location Number* | | |
| *Last Name of Injured (or ill) Person* | | | | | *First Name* | | | | *Date of Full Investigation dd/mm/yy* | | |
| *Describe Accident Location* | | | | | *Date of Incident dd/mm/yy* | | | | *Time of Incident hh:mm* | | |
| *Years of Service* | | *Time on Present Job* | | | *Occupation* | | | | *Hours worked in Previous*  *24 Hour Period* | |  |
| *Were Written Safe Work Procedures*  *Established and Available?*  Yes No N/A | | | *Were SWPs Adequate?*  Yes No N/A | | | | *Did the Worker Receive Training on the Safe Work Procedures?*  N/A No  Yes-Date of training: | | | | |
| ***Witnesses (names and job titles):***  Any further witnesses than those identified in the preliminary investigation? Yes No If yes list: | | | | | | | | | | | |
| ***Sequence of Events/Description of Incident*** | | | | | | | | | | | |
| ***Basic Causes and Contributory Factors. Fully Explain any Unsafe Conditions:*** | | | | | | | | | | | |
| Review of Interim Corrective Measures From Preliminary Investigation (completed and outstanding) use addition pages if required | | | | | | | | | | | |
| Item  # | Completed Corrective Measure  Taken to Prevent Reoccurrence | | | Is the Corrective  Measure Effective?  Y/N/ Somewhat | | Corrective Measure  Becoming Permanent? | | If not Permanent, Why Not? (i.e. replacing with another corrective measure) | | Comments | |
| 1 |  | | |  | |  | |  | |  | |
| 2 |  | | |  | |  | |  | |  | |
| 3 |  | | |  | |  | |  | |  | |
| 4 |  | | |  | |  | |  | |  | |
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| ***Have ALL outstanding interim corrective measures been implemented?***  *(if no, list measures and why not)* | | | | |
| After reviewing the interim corrective measures from the preliminary investigation, are the any further corrective measures taken and/or recommended by the full Investigation team? | | | | |
| Item # | Recommended Corrective Measure Taken to Prevent Reoccurrence, Reduce Severity or Improve Response | Referred To | Date to be Completed By | Comments |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |
| *Use add lines or use separate sheet if necessary* | | | | |
| Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary) | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | *Names & Occupations of Persons who Completed Full Investigation* | | | | | *Worker Representative (Are you Union Appointed? Yes* □ *No* □*)* | | *Employer Representative* |  | |  |  |  |  | | *Name & Occupation* | *Phone* | *Name & Occupation* | *Phone* | |  |  |  |  | | *Signature* | *Date* | *Signature* | *Date* | | *Email:* |  | *Email:* |  | | *Preliminary Investigation*  *completed by* | | *Preliminary Investigation completed by* | | | | | | |