File No:

|  |  |  |
| --- | --- | --- |
| **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 toPrevent Reoccurrence | Completed ByName, job title | DateCompleted | 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 MeasureTaken to Prevent Reoccurrence | Is the CorrectiveMeasure Effective?Y/N/ Somewhat | Corrective MeasureBecoming Permanent? | If not Permanent, Why Not? (i.e. replacing with another corrective measure) | Comments |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |

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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) |
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| *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 Investigationcompleted by* |

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