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THE UNIVERSITY OF BRITISH COLUMBIA

University of British Columbia
Risk Management Services
#336 – 2389 Health Sciences Mall, Vancouver BC V6T 1Z3
Phone: 604-822-2029
WorkSafeBC Account # 11284

Investigation and Corrective Action

Standard Investigation Report

Incident ID: 122190 (Supervisor Report)

Incident Information

Incident Details		
Incident Title: Minor skin burn		
Date: Jul 27, 2018	**Time:** 9:00 AM	**Building:** OK - EME - Engineering /Management/Education
Description of Incident Location: EME 0204		
Main Body Part Injured: Arm	**Side of body injured:** Right	**Accident Type:** Exposure to Heat/Cold
Injury Type: Heat Burns	**Is this a serious injury?:** No	
Describe fully what happened before, during, and after the incident (please do not include names or personal information): Minor burn on autoclave		

Accident Investigation

Task Related Causes	
☑**Hot load**	

Environment Related Causes	
☑**Cold / Hot**	

Equipment Related Causes
☑**No "Equipment" causes**

Organizational Related Root Causes	
☑**Poor job design / work layout**	

Human Related Root Causes	
☑**Physical limitations**	

(reach, height, etc.)	

Root cause
Incorporating the above factors, determine and describe the root cause of the incident or accident: Equipment is in difficult location. Worker was accessing equipment under cover and came in to contact with hot surface.

Corrective Actions

Corrective Action to prevent recurrence of similar incidents (1)		
Corrective Action Identified: In future, letting the autoclave cool down prior to servicing.		
Assigned to (name): Michelle Tofteland	**Job title:** Research Technician	
Final Actions Taken:		
Date to be Completed: 2018-07-27	**Date Completed:**	

Corrective Action to prevent recurrence of similar incidents (2)		
Corrective Action Identified: Technician was attempting to reach main power switch for autoclave which is located behind large, removable metal panels. Because of congestion adjacent to this side of the autoclave (water treatment equipment), the panels are difficult to remove and thus the worker was reaching behind the still-attached panel in an attempt to reach the switch when she burned her arm on a hot pipe within the unit. This corrective action is to investigate the possibility of moving the water treatment equipment from the left side of the autoclave to the right side (which is less frequently accessed) to allow more room and reduce awkwardness for removing the large metal panels when servicing or troubleshooting the autoclave.		
Assigned to (name): Alec Smith	**Job title:** Acting Lab Manager	
Final Actions Taken: left equipment in its location and provided another corrective action.		
Date to be Completed: 2018-08-31	**Date Completed:**	

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Corrective Action to prevent recurrence of similar incidents (3)		
Corrective Action Identified: Technician was attempting to reach main power switch for autoclave which is located behind large, removable metal panels. Because the panels are awkward and heavy to remove as well as re-attach, the corrective action is to investigate the possibility of cutting an opening into the rear metal panel on the left side of the autoclave to allow access to the power switch without having to remove the panels.		
Assigned to (name): Alec Smith	**Job title:** Acting Lab Manager	
Final Actions Taken: Hole cut in panel (with hinged door access) to allow easy access to power switch without having to reach behind or remove the awkward panel.		
Date to be Completed: 2018-08-31	**Date Completed:** 2018-08-03	