

County of Knox

Accident Investigation Written Program



**County Administrative Offices
62 Union Street
Rockland, ME 04841**

COUNTY OF KNOX

Accident Investigation – Written Program

It is important to provide written documentation of each accident that occurs involving county employees.

Each employee shall be responsible for completing an *Employee's Report of Injury* within 24 hours of when he/she sustains an injury or illness while at work. It will then be the responsibility of the employee's supervisor to complete the *Supervisor's Report of Employee Injury* as well as the *Accident Analysis Form*. These three forms must be submitted to the county administrator as soon as possible after an accident.

The county administrator or designee shall then be responsible for completing a *Workers' Compensation First Report of Injury* form and submitting it to the county's workers' compensation carrier and the state Workers' Compensation Commission, as appropriate.

Adopted this 8th day of November, 2005.

William Post

William Post, County Administrator

Revised March, 2006

EMPLOYEE'S REPORT OF INJURY

County of Knox

FILL OUT THIS REPORT COMPLETELY AND SUBMIT IT TO YOUR SUPERVISOR WITHIN 24 HOURS.

1. Name _____ Department _____

2. Social Security Number _____ Job Title _____

3. Home Address _____

4. Home Phone _____ Work Phone _____

5. Date of Birth _____ Work week: _____
Indicate schedule of days worked and shift

6. Supervisor _____ Work Location: _____

7. Do you work for another employer? _____ Name of employer: _____

8. Date and time of injury: _____

9. Location where injury occurred: _____

10. Describe fully how injury occurred: _____

11. Name the object, substance, or exposure which directly brought about your injury: _____

12. Describe your (check one) injury disease in detail brought about your injury: _____

12. Witnesses: _____ Name
and title: _____ Work phone _____ Name
and title: _____ Work phone _____

13. Date, time and to whom you reported your injury: _____

14. Did you lose time from work: _____ If yes, date and time: _____

15. Date and time you returned to work (if applicable:) _____

16. Doctor(s): _____ Hospital(s):
Name _____ Name _____
Address _____ Address _____

Date

Signature

Report to be completed by employee

Supervisor's Report of Employee Injury

Employee Name		Employee Address			Home Phone	
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title		Department Name		
Length of Employment	Time on Job	Facility City/State		Specific Place of Accident		
Date Reported	Date of Occurrence	Day of Occurrence <input type="checkbox"/> Mon. <input type="checkbox"/> Wed. <input type="checkbox"/> Fri. <input type="checkbox"/> Tues. <input type="checkbox"/> Thurs. <input type="checkbox"/> Sat. <input type="checkbox"/> Sun.		Time am pm	Shift 1 _____ to _____ 2 _____ to _____ 3 _____ to _____	Doctor/Hospital
Did injury cause loss of time (other than On day of injury)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date last worked _____	Time lost from work on day of injury ____ hrs.	Will this injury restrict employee's normal job duties?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If restricted, for approximately how many days? _____

Check one item in each of the following four categories:

INJURY ILLNESS

- Abrasion
- Amputation
- Bruise, contusion
- Burn
- Crushing injury
- Cumulative trauma
- Cut, puncture
- Dermatitis
- Emotional
- Fracture
- Hearing
- Hernia
- Occupational Illness
- Radiation
- Shock, electrical
- Sprain, strain
- Visual
- Multiple (Describe in section A)
- Other (Describe in section A)

PART OF BODY

- Abdomen
- Arm
- Back
- Chest/Shoulder
- Ear
- Eye
- Finger
- Foot
- Hand
- Head
- Internal
- Leg
- Neck
- Nose
- Mouth
- Toe
- Wrist
- Multiple (Describe in section A)
- Other (Describe in section A)

SOURCE OF INJURY

- Bodily motion
- Building
- Chemical (attach MSDS)
- Electrical
- Machine
- Material handled
- Motor vehicle
- Stairs, ladder
- Tool
- Walking surface
- Work surface
- Unknown
- Other (Describe specific source in section B: name of chemical, tool machine, material, etc)

ACCIDENT TYPE

- Absorption, inhalation, ingestion of toxins (Circle one)
- Bodily reaction
- Caught in, under, between
- Contact w/electrical
- Contact w/radiation noise (Circle one)
- Contact w/temperature extreme
- Fall from elevation
- Fall from same level
- Motor vehicle
- Overexertion
- Rubbed, abraded
- Struck against
- Struck by
- Unknown
- Other (Describe in Section B)

Check as many items as necessary in this category:

IMMEDIATE ACCIDENT CAUSES

ACTIONS

- Bypassing safety devices
- Distraction, inattention
- Failure to secure or warn
- Failure to use protective equipment
- Failure to wear proper attire
- Horseplay
- Improper use of body
- Improper use of equipment, tools
- Inadequate maintenance
- Incorrect lifting, carrying
- Operating at unsafe speeds
- Operating without authority
- Poor housekeeping
- Taking unsafe position
- Unstable loading, stacking
- Using defective equipment, tools
- Working on live equipment
- Other (Describe in section C)

CONDITIONS

- Arrangement
- Congestion
- Design, construction
- Dress
- Guarding
- Illumination
- Tools
- Traffic
- Ventilation
- Other (Describe in section C)

A. DESCRIPTION OF INJURY/ILLNESS/BODY PART/TREATMENT

B. DESCRIPTION OF ACCIDENT (Include names of any witnesses)

C. BASIC UNDERLYING CAUSES THAT ALLOWED THE ABOVE ACT(S) OR CONDITION(S) TO OCCUR (Avoid terms such as *careless.*)

MANAGEMENT ACTION (Check as many items as necessary. If action pending, document on follow-up worksheet on reverse side of "Immediate Supervisor" copy.)

- | | | |
|--|---|---|
| <input type="checkbox"/> Develop, revise written Process/SOP | <input type="checkbox"/> Install, replace, adjust guards | <input type="checkbox"/> Provide/monitor protective equipment |
| <input type="checkbox"/> Initiate, revise, enforce rules | <input type="checkbox"/> Institute job hazard/ergonomics analysis | <input type="checkbox"/> Provide special communications |
| <input type="checkbox"/> Improve emergency/medical system | <input type="checkbox"/> Modify, replace tools, equipment | <input type="checkbox"/> Review via task force, consultant |
| <input type="checkbox"/> Improve housekeeping | <input type="checkbox"/> Provide inspections, observations | <input type="checkbox"/> Revise equipment, layout |
| <input type="checkbox"/> Improve job orientation, training | <input type="checkbox"/> Provide proper employee placement | <input type="checkbox"/> Other (Specify) |

Immediate Supervisor _____ Date _____

Operations Manager _____ Date _____

ACCIDENT INVESTIGATION PROCEDURE

The following steps should be taken following report of a work-related accident resulting in property loss or injury/illness requiring medical attention. The investigation procedure outlined must be completed by the immediate supervisor within 24 hours of notification of the incident.

1. Immediately secure proper medical treatment for injured.
2. Investigate/report accident:
 - A. Do not disturb accident site until adequate review has been completed.
 - B. Talk to eyewitnesses; take notes.
 - C. Carefully recreate accident, and take photographs as appropriate.
 - D. Consider all aspects of accident cause: who, what, when, where, how, why.
 - E. Complete the Employee Injury Report. Take note that the purpose of accident investigation is prevention of future accidents, not fixing blame. If more space is needed, write "See attached" in the space, complete the information on an additional sheet of paper, and attach it to the completed form. With chemical-related incidents, provide the following additional information:
 - A list of all chemical substances at employee work station.
 - Complete the Material Safety Data Sheet for suspected chemical the employee was exposed to.
 - Length of time on job during which exposure occurred and estimated exposure time per shift.
 - F. When the accident involves a manufacturing process/procedure, make joint investigation with support engineer.
3. For accidents involving serious injury/illness or property loss, immediately notify the following:
 - A. Departmental management
 - B. Safety program administrator

CORRECTIVE ACTION FOLLOW-UP WORKSHEET

The items listed below may assist you in the development of a specific corrective action plan.

1. Purchase requisition number/delivery date _____
2. Work order number/completion date _____
3. Training plan/completion date _____
4. Operating procedure change/completion date _____
5. Review with manufacturing engineering/completion date _____
6. Other action _____

- Serious
- Non-Serious
- Near Miss

FACTORS TO CONSIDER

Management

- Do we have:**
 Policy Enforcement
 Hazard Recognition
 Accountability
 Supervisor Training
 Corrective Action
 Production Priority
 Proper Resources
 Job Safety Training
 Hiring Practices
 Maintenance
 Adequate Staffing

Employee

Was the employee:

- Following Procedure
 Training
 Previous Injury
 Mental Ability
 Physical Capacity
 Equipment Use
 Short Cuts
 PPE Worn
 Safety Attitude

Equipment

- Do we have:**
 Proper Tool Selection
 Tool Availability
 Maintenance
 Visual Warnings
 Appropriate Guards

Environment

- What about:**
 Worksite Layout
 Chemical
 Temperature
 Noise
 Radiation
 Weather
 Terrain
 Vibration
 Ergonomics
 Lighting
 Ventilation
 Housekeeping
 Biological

Additional

Causal Factors:

- Faulty Equipment
- Non-Employee
- Prior Injury
- Late Reporting
- Off-the-Job Injury

(Explain any checked boxes on separate sheet)

Accident/Incident Analysis

Immediate supervisor should complete this form promptly with employee.

Department: _____

Job Position/Title: _____

Where Incident Occurred: _____

Date/Time: _____

If injury, describe (Nature/Body part)

Treatment: None First Aid Only Doctor Hospital

Witnesses: _____

Describe Accident/Incident: _____

Identify factors which contributed to or caused accident (refer to list on left side of page):

Management	Employee
Equipment	Environment

List at least one idea or best practice which might prevent a reoccurrence:	Who should be responsible for doing this?
--	--

If accident/incident was caused by a person not employed by us, who?

Name: _____ Phone: _____

(Attach additional sheet if needed)

Date: _____

Supervisor's Signature

(When completed, submit this form to the County Administrator through your Department Head)

Completing the Accident/Incident Analysis

All close calls, near-misses, incidents, and accidents should be analyzed for corrective action regardless of severity. Time and distance work against a thorough analysis as most people quickly forget important facts and key details. Distance from the incident means loss of visual information, so complete the analysis at the scene as soon as possible. This form should be completed by the immediate supervisor of the person(s) directly involved in the incident. A manager, safety committee, safety coordinator or analysis team can assist in the absence of the immediate supervisor. The form asks no questions other than a brief description of an injury, if one occurred. Questions often provide closed answers, so the key items on the analysis document are designed to encourage open dialogue and communication about facts and details. This is the primary opportunity for those involved to gather key information for preventing similar incidents in the future.

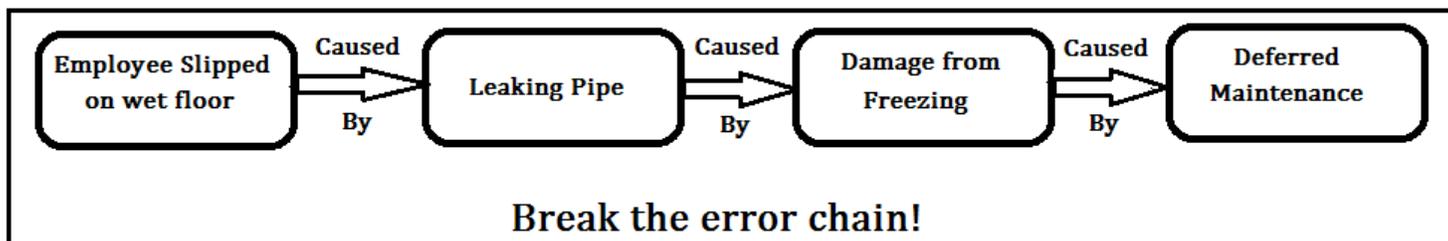
A Successful Analysis Process: The person(s) conducting the analysis need to look at the systems/procedures/policies within the department which may have contributed in some way to the incident. Even minor contributions should be listed. The systems to review are: Management, Employee, Equipment, and Environment (MEEE). Review system items shown in the left margin of the Accident/Incident Analysis form **in relation to the incident**. These are areas to explore within these systems, they are not questions. Once the contributing system elements are identified, write them in the Counter measures/best practices box along with any other system changes that will prevent recurrence.

First Step - Care for the injured: Insure appropriate medical care or first aid is provided for anyone injured.

Second Step - Secure the scene of the accident: Make certain that key evidence is preserved so that all pertinent facts of the accident can be determined. In the case of serious accidents, photographs of the scene are a valuable tool in determining causes, particularly if the area needs to be put back in order quickly. Note the position of equipment and materials, presence or lack of equipment safeguarding, specific materials and chemicals involved, warning signs and any other physical evidence.

Third Step - Interview witnesses: Witnesses to the accident or persons having knowledge valuable to the analysis should be met with individually. Emphasis should be placed on determining the facts, not on placing blame. If the injured employee(s) is/are not seriously injured, they should be interviewed while awaiting transport for medical treatment. All questions should be open-ended (who, what, when, where, how and why), to encourage a detailed account of the facts. Yes and No questions should be avoided.

Fourth Step - Analyze data to determine causes and best practices to prevent recurrence: Refer to your notes from the scene of the accident and witness interviews. Work backwards from the accident to trace all causes to their source. It is helpful to have multiple people involved in determining possible solutions. Each cause identified presents an opportunity for intervention to reduce the potential for future accidents



Fifth Step - Follow up on corrective actions: This is usually the function of the safety coordinator or safety committee. At the next safety committee meeting, any accident analysis reports should be reviewed to ensure appropriate corrective actions (Countermeasures/Best Practices) were identified. Furthermore, steps should be taken to ensure that these actions have been implemented at the site of the accident as well as in any other areas appropriate in the organization. Any accidents or incidents occurring, for which a report was not completed, should be referred to the appropriate person responsible for completion of the report.

Maine County Commissioners Association

Self-Funded Risk Management Pool

ACCIDENT REPORT - AUTO AND TRUCK

(FOR BODILY INJURY OR DAMAGE TO ANOTHER'S PROPERTY OR FOR DAMAGE TO YOUR VEHICLE)

CLIENT					
NAME	PHONE	DRIVER NAME	PHONE	DATE OF BIRTH	
County of Knox	594-0420				
ADDRESS		ADDRESS		NUMBER OF YEARS WITH COMPANY	
62 Union Street					
CITY	STATE	ZIP	CITY	STATE	ZIP
Rockland	ME	04841			
DRIVER'S LICENSE NO.					

VEHICLE					
MAKE OF YOUR VEHICLE	YEAR	MODEL	SERIAL NUMBER	LICENSE NUMBER	WHERE VEHICLE CAN BE SEEN
TRAILER (IF APPLICABLE)	YEAR	MODEL	AREA OF DAMAGE	USED FOR BUSINESS) YES () NO	ESTIAMTED COST TO REPAIR

ACCIDENT						
DATE OF LOSS	TIME OF LOSS	LOCATION (STREET OR HIGHWAY)			CITY	STATE
WERE POLICE CALLED TO SCENE? [] YES [] NO		POLICE DEPT. CALLED	DRIVER	ARRESTED	TICKETED	VIOLATION
NAME OF OFFICER		BADGE NUMBER				
STATION ADDRESS						

CLAIMANT 1								
OWNER OF OTHER VEHICLE			AGE	ADDRESS	CITY	STATE	ZIP	PHONE
DRIVER, IF OTHER THAN ABOVE			AGE	ADDRESS	CITY	STATE	ZIP	PHONE
MAKE OF VEHICLE	YEAR	MODEL	LICENSE NO.	AREA OF DAMAGE	ESTIMATE OF DAMAGE	WHERE CAN VEHICLE BE SEEN		

CLAIMANT 2								
OWNER OF OTHER VEHICLE			AGE	ADDRESS	CITY	STATE	ZIP	PHONE
DRIVER, IF OTHER THAN ABOVE			AGE	ADDRESS	CITY	STATE	ZIP	PHONE
MAKE OF VEHICLE	YEAR	MODEL	LICENSE NO.	AREA OF DAMAGE	ESTIMATE OF DAMAGE	WHERE CAN VEHICLE BE SEEN		

PROPERTY DAMAGE -- OTHER THAN AUTO (i.e. FENCE, CANOPY)							
OWNER OF PROPERTY			ADDRESS	CITY	STATE	ZIP	PHONE
DESCRIBE DAMAGED PROPERTY			LOCATION OF PROPERTY	CITY	STATE	EXTENT OF DAMAGE	

WITNESS INFORMATION					
NAME	ADDRESS	CITY	STATE	ZIP	PHONE
NAME	ADDRESS	CITY	STATE	ZIP	PHONE

NOTE: PLEASE COMPLETE REVERSE SIDE

Signature of Trainer: _____