County of Knox

Accident Investigation Program

County Administrative Offices
62 Union Street
Rockland, Maine 04841

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COUNTY OF KNOX

Accident Investigation Program

Purpose

The purpose of this program is to outline the employee accident or injury reporting and analysis process. It details the internal forms and procedures for reporting, analyzing and processing employee injuries or accidents. The program both allows for timely processing of Workers Compensation claims while also looking to determine the cause of and prevent future accidents. Employee, Supervisor, Department Manager and County Administrator responsibilities and timelines are described in this program.

After consulting with the County Administrator, a Department Manager may use the Accident Investigation process to investigate and document injuries to non-employees on county property or in county-owned vehicles.

The accident investigation and analysis process is not designed to set blame for an injury or incident. Striking a balance between employee and management responsibility and trust is essential to maintain program effectiveness. Information obtained during the analysis should not normally become the basis for disciplinary or other administrative action. Incidents which can be described as a *near-miss event* should also be considered for analysis with a goal of promoting county-wide workplace safety.

The specific steps by the County Administrator for processing and payment of workers compensation injury claims with the County insurer or Risk Pool are not included in this program.

Definitions

- **Report of Employee Injury:** The formal written report provided by the injured or affected employee which provides personally identifiable information and describes the accident or injury. This document serves as the initial notification of an injury by the affected employee. The employee's Supervisor will complete the ***Supervisor Portion*** of the form providing additional relevant information regarding the employee, their work status and the injuries sustained. The completed form provides information necessary to complete the Workers Compensation process. Some information on this form may be subject to HIPAA protections.

- **Accident/Incident Analysis:** This is a management tool for uncovering hazards that were missed earlier or have managed to slip out of the controls designed for them. It is the formalized process used by the affected employee's Supervisor and Department Manager to determine the causal factors of an accident, injury or *near-miss*. The form is completed by the affected employee and his/her supervisor; however, the name of the employee will not be on the form to keep the incident anonymous when the form is reviewed by the Safety Committee. The information on the form is used specifically to identify and control hazards before they cause a repeated or more serious incident.

- **Best Practice:** A set of guidelines, ethics, ideas or processes which represent the most efficient or prudent course of action to protect employee occupational health and safety.

- **Near Miss:** (OSHA) Describe incidents where no property was damaged and no personal injury sustained, but when given a slight shift in time or position, damage and/or injury easily could have occurred.

- **HIPAA:** (*Health Insurance Portability and Accountability Act*) The federal law which protects certain individually identifiable health information from public disclosure.

- **County Health Care Provider:** *Health Connections*, located at the Pen Bay Medical Center in Rockport, provides non-emergency employee occupational health services, evaluations and routine medical services related to on-the-job injuries or illnesses. *Employees who suffer injuries requiring emergency treatment should be seen at the Emergency Department of the nearest hospital*.

Responsibilities

Affected Employee:

- The employee must submit the *Employee Portion* of the ***Report of Employee Injury*** to his/her Supervisor within 24 hours of incidents which occur.
- The employee will work with his/her supervisor when he/she conducts the Accident/Incident Analysis.
- The employee must also follow recommendations or medical orders provided by the County Health Care Provider.
- Any suggestions for avoiding similar injury in the future provided by medical professionals should be passed on to the County Administrator.

Supervisor:

- The Supervisor must complete the *Supervisor's Portion* of the ***Report of Employee Injury*** and forward it to the County Administrator via the Department Manager.
- The Supervisor will normally conduct the Accident/Incident Analysis.
- If the injury is a result of an accident involving a county vehicle or a private vehicle being operated by a county employee for county business, Supervisors should check with their Department Manager or the County Administrator to determine if a MCCA Accident Report-Car and Truck form should be completed.

Department Manager (Department Head):

- Responsible for reviewing and submitting the completed ***Report of Employee Injury*** to the County Administrator within the established timeline.
- Initiates the Accident/Incident Analysis process, reviews findings with supervisory staff and where possible, incorporates recommended changes or best practices necessary to promote workplace safety.
- Department Managers should also consider initiating an Accident/Incident Analysis for employee near-miss events and non-employee incidents.

County Administrator:

- The County Administrator or designee has oversight of the Workers Compensation process and serves as the County liaison with insurers and the Workers Compensation Commission.
- Responsible for completing a *Workers' Compensation First Report of Injury* form and submitting it to the county's workers' compensation carrier.
- Assists Department Managers with injury reporting and accident/incident analysis as needed.
- Provides accident/incident analysis and other HIPAA-compliant injury information to the County Safety Committee for review.

County Safety Committee:

- Reviews incidents, injuries and recommendations resulting from the analysis process.
- Seeks clarification when necessary.
- Provides process feedback to Supervisors through Department Managers and the Administrator. Identifies funding when necessary to implement workplace safety improvements.

Attachments

A. Report of Employee Injury (Includes Supervisor Portion).
B. Accident/Incident Analysis form
C. MCCA Accident Report - Auto and Truck

REPORT OF EMPLOYEE INJURY

County of Knox

EMPLOYEE PORTION:

FILL OUT THIS REPORT COMPLETELY AND SUBMIT IT TO YOUR SUPERVISOR WITHIN 24 HOURS OF RECEIVING THE INJURY.

Employee Name:	Employee Mailing Address:	Employee contact number(s): Home Phone: Cell Phone if Different:

Date of Injury:	Time of Injury:	Day of Injury: ☐ Mon. ☐ Wed. ☐ Fri. ☐ Tues. ☐ Thurs. ☐ Sat. ☐ Sun.	Date Reported:	Supervisor reported to (Name and Title):

Shifts You Work:		From:	To:		From:	To:
	☐ Monday			☐ Friday		
	☐ Tuesday			☐ Saturday		
	☐ Wednesday			☐ Sunday		
	☐ Thursday					

Witness 1 (Name and Title):	Work Phone:
Witness 2 (Name and Title):	Work Phone:

Do you work for another Employer? ☐ Yes ☐ No If Yes, name of employer:	Date & Time you returned to work (if applicable):	Location/Address of Accident:

Object, substance, or exposure which directly brought about your injury:

Describe your (check one) ☐ Injury ☐ Disease in detail which brought about your injury:

Doctor(s): Name: Address:	Hospital(s): Name: Address:

SUPERVISOR PORTION:

CHECK THIS REPORT FOR COMPLETENESS AND SUBMIT IT TO YOUR DEPARTMENT MANAGER ASAP

Did injury cause loss Of time (other than On day of injury)? ☐ Yes ☐ No	If yes, date last worked:	Time lost from work on day of injury: hrs.	Will this injury restrict employee's normal job duties? ☐ Yes ☐ No	If restricted, for approximately how many days?

(Continued on the next page)

A. DESCRIPTION (if different, or if you have more information, than what's in the narrative by the employee above) OF INJURY/ILLNESS ~ BODY PART AFFECTED ~ TREATMENT:

Employee _____ Date _____

Immediate Supervisor _____ Date _____

Department Manager _____ Date _____

Supervisor Accident/Incident Analysis has been completed, reviewed and is attached? ☐ Yes ☐ No

DEPARTMENT MANAGERS – TURN THIS FORM INTO THE COUNTY ADMINISTRATOR WITHIN 24 HOURS FROM WHEN THE INJURY IS REPORTED TO YOU

☐ 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*)

This form may be used to investigate non-employee incidents or accidents

Accident/Incident Analysis*

Immediate supervisor should complete this form promptly with employee. **DO NOT INCLUDE EMPLOYEE'S NAME ON THIS FORM.**

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:

Date corrective action taken: _____ Corrective action taken by: _____

Describe corrective action taken (attach additional pages if needed):

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?**

Date: _____ _____
Supervisor's Signature

_____
Supervisor's Printed Name

(*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.

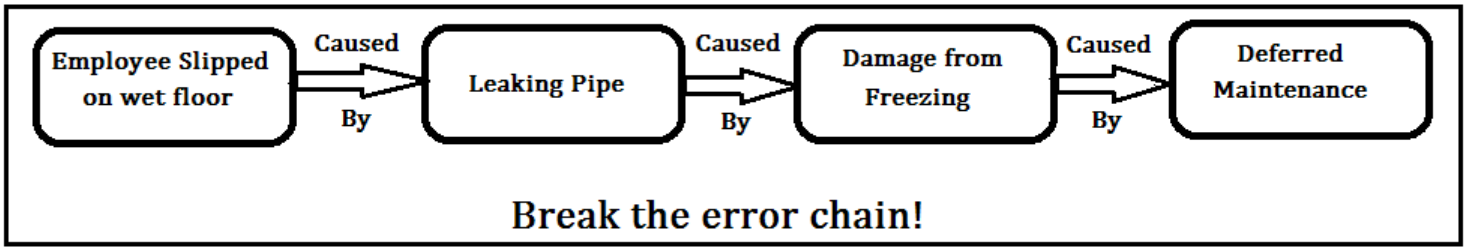
A Successful Analysis Process: The person(s) conducting the analysis need to look at the systems/procedures/policies within the department which may have contributed in some way to the incident. Even minor contributions should be listed. The systems to review are: Management, Employee, Equipment, and 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.

Immediately after an accident, fill out this form and send it to:

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:	DOB:
ADDRESS:		ADDRESS:		NO. YEARS WITH COMPANY:
CITY: / STATE: / ZIP:		CITY: / STATE: / ZIP:		DRIVER'S LICENSE#:

VEHICLE

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

ACCIDENT

DATE OF LOSS:	TIME OF LOSS:	LOCATION (STREET OR HIGHWAY):	CITY:	STATE:

WERE POLICE CALLED TO THE SCENE? ☐ Y ES ☐ NO	POLICE DEPT. CALLED:	DRIVER:	ARRESTED:	TICKETED:	VIOLATION:

NAME OF OFFICER:	BADGE NUMBER:	STATION ADDRESS:	STATE:	ZIP:

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 VEHICLE CAN 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 VEHICLE CAN 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

PERSONS INJURED

NAME:	AGE:	NAME:	AGE:
ADDRESS:	PHONE:	ADDRESS:	PHONE:

CITY:	STATE:	ZIP:	CITY:	STATE:	ZIP:

OCCUPATION:	WHERE TAKEN:	OCCUPATION:	WHERE TAKEN:

☐ FATALITY	☐ PEDESTRIAN	☐ FATALITY	☐ PEDESTRIAN
☐ BLEEDING OR DISTORTED WOUND	☐ IN YOUR VEHICLE	☐ BLEEDING OR DISTORTED WOUND	☐ IN YOUR VEHICLE
☐ UNCONSCIOUSNESS	☐ IN CLAIMANT VEHICLE	☐ UNCONSCIOUSNESS	☐ IN CLAIMANT VEHICLE
☐ NO VISIBLE INJURY – COMPLAINED OF PAIN		☐ NO VISIBLE INJURY – COMPLAINED OF PAIN	
☐ OTHER		☐ OTHER	

ADDITIONAL REMARKS

DESCRIBE ACCIDENT

VEHICLES → 1 2 ← PEDESTRIAN O←

ACCIDENT DIAGRAM:

INDICATE NORTH

BY ARROW

WHAT STREET WERE YOU ON?	CLAIMANT 1:	CLAIMANT 2:
WHAT DIRECTION WERE YOU TRAVELING?	CLAIMANT 1:	CLAIMANT 2:

WEATHER CONDITIONS:

☐ DRY ☐ WET ☐ ICY ☐ FOGGY ☐ SNOWY ☐

TRAFFIC CONDITIONS:

☐ LIGHT ☐ MODERATE ☐ HEAVY

SPEED LIMIT:	WERE YOU FAMILIAR WITH THE AREA?: ☐ YES ☐ NO	TRAFFIC CONTROLS:

THIS SECTION MUST BE COMPLETED BY SUPERVISOR

1. DO YOU THINK A CLAIM WILL BE MADE AGAINST YOU? ☐ YES ☐ NO
2. IN MY OPINION, ARE WE AT FAULT FOR THIS ACCIDENT? ☐ YES ☐ NO

DATE OF THIS REPORT:	SIGNATURE AND TITLE: