Accident Investigation Report

Employee's Name: **Incident Date:**

INSTRUCTIONS TO THE SUPERVISOR - INVESTIGATION PROCEDURE

- => **Complete this report with full detail** **Fax a completed copy to MPA at (925) 946-4183.**
- => Return the original completed report to your Human Resources department within 72 Hours of the day you first became aware of the injury or illness.
- => Conduct a walk through of the accident location as needed to gain an understanding of how the incident occurred.
- => Interview and get signed statements form the injured employee and witnesses at the scene, if appropriate. Use the attached EMPLOYEE/WITNESS ACCOUNT OF ACCIDENT form.
- => Take photographs or make a sketch of the accident scene as needed, and attach to report.
- => Ensure hazardous conditions are corrected immediately. Isolate and restrict access to accident-related equipment, areas, etc, as needed.
- => **Develop appropriate corrective measures to prevent this incident from recurring, and list on this report.**

SUPERVISOR TO COMPLETE:

1. Employee's usual shift: to (use 24 hour format, ie.e., 6:00pm = 18:00)

2. Time employee started work on day of injury:

3. Time of accident/injury:

4. Extended shift/overtime on day of injury? ☐ **Yes** ☐ **No**

5. ROOT CAUSE ANALYSYS: Which of the following may have caused or were underlying factors that resulted in the incident? (Check all that apply)

PEOPLE Factors		
☐ Employee Training / Instruction	☐ Operating without authority	☐ Correct tool not used
☐ Distraction, inattention	☐ Operating at unsafe speeds	☐ Improper Motiviation
☐ Fatigue / condition of individuals	☐ Incorrect lifting, carrying	☐ Bypassing safety devices
☐ PPE not utilized	☐ Taking unsafe position / posture	☐ Combative Person / Actions of Others
☐ Staffing shortage	☐ Tool used improperly	☐ Other (list)

EQUIPMENT, MATERIALS or ENVIRONMENT		
☐ Lighting too much / too little	☐ Proper tool not available	☐ HVAC / ventilation maintenance
☐ Guard / safety device missing	☐ Tools / equipment malfunction	☐ Motor Vehicle maintenance
☐ Unstable load / Storage / Congestion	☐ Inadequate work space	☐ Walking surface unsafe
☐ PPE unavailable	☐ Chemical Used (attach MSDS)	☐ Other (list)

PROCESSES & PROCEDURES		
☐ No warning system	☐ S.O.P. not followed	☐ Inadequate Traffic Control
☐ No warning provided / posted	☐ S.O.P. contributed	☐ Operational tactics
☐ Spills, debris, housekeeping inadequate	☐ No procedure in place	☐ Other (list)

6. Do you agree with the Triage Description and Employee/Witness statements? ☐ **Yes** ☐ **No**

If not, please describe your understanding of the events that resulted in injury or occupational illness, including tasks assigned.

7. Were other employees also injured? ☐ **Yes** ☐ **No**

If YES, list names:

Corrective Action

What action will be taken to prevent recurrences of this incident? (Check as many as necessary):

☐ Request ergonomic evaluation	☐ Install, replace, adjust guards	☐ Provide / monitor protective equip
☐ Train Staff	☐ Modify, replace tools, equipment	☐ Repair (explain below)
☐ Improve emergency system	☐ Provide inspections, observations	☐ Revise equipment, layout
☐ Improve housekeeping	☐ Personal Safety Coaching	☐ Review at roll call / staff mtg.
☐ Improve job orientation	☐ Develop, revise operating procedure	☐ No action taken / Other (explain below)

Follow Up on Corrective Action

1. Specific Action taken:

a. Work or Purchase Order to correct condition? ☐ **Yes - Order #:** ☐ **No**

b. Operating procedure change? ☐ **Yes** ☐ **No**

=> If YES, description:

2. Other Comments - explain:

3. PHOTOGRAPHS OR SKETCH ATTACHED? ☐ **Yes** ☐ **No**

4. Employee / Witness statement(s) attached? ☐ **Yes** ☐ **No**

5. No Action Taken - explain:

Supervisor's Name:

Supervisor's Signature: **Date:**

Management Review - I have reviewed this report and its findings.

Division / Department Head: **Date:**

Fax a copy of the completed report to Municipal Pooling Authority 925-946-4183

EMPLOYEE/WITNESS ACCOUNT OF ACCIDENT

Note: PRINT this form, have completed and forward along with the Accident Investigation Report.

Use one form per person - CHECK below as noted:

☐ **Injured Employee** ☐ **Witness (City/Town Employee?** ☐ **Yes** ☐ **No)**

Name: _____ Department: _____

Today's Date: _____ Date/Time of _____

Location of Accident: _____

Accident Description (explain in detail what you were doing immediately prior to the accident and then how you believe the accident happened):

_____

Signature

Name(s) of Other Witness(es) to Accident:

1. _____
2. _____
3. _____

ATTACH TO THE ACCIDENT INVESTIGATION REPORT

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