



Accident/Incident Investigation:

How to Turn a Bad Event into a Learning Experience

LEARNING OBJECTIVES

An in-depth investigation of an accident or a near miss is not only the best tool for eliminating the chance that it could happen again, but it also provides a learning opportunity for the company to identify and eliminate operational deficiencies associated with accidents. With top management commitment and a well-defined investigation process, supervisors can take the lead and improve the overall operation.

At the end of this training session on accident investigations, you will be able to:

1. Use the three primary production factors to effectively investigate any workplace accident.
2. Develop an effective corrective action plan following an accident investigation.
3. Develop a formal process in your organization for accident investigation procedures.

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ACCIDENT VS. INCIDENT

ACCIDENT

An Undesired or Unplanned Event that results in a loss.

INCIDENT

An Undesired or Unplanned Event that, under slightly different circumstances, would have resulted in a loss.



NOTES:

ASPECTS TO CONSIDER FROM LOSSES

HUMAN ASPECTS

1. Emotional hardship experienced by family members of the injured person.
2. Physical pain and distress suffered by the injured person.
3. Psychological issues related to the injury (disfigurement, unproductive feeling, lack of self-worth).
4. Financial hardships associated with being out of work.

ECONOMIC LOSS

Direct

Indirect

Redirected

MEMIC COST ANALYSIS WORKSHEET

Indirect Cost Worksheet for Lost Time Injuries

Complete shaded areas with actual costs or estimated costs

	Hours	Avg. Hourly Wage	Final Cost
1. How much production time did employees lose who were not injured in the accident?			
2. What is the overtime cost or replacement workers cost to recover lost production?			
3. Is there a cost to replace or repair damaged machinery or property?			
4. How many hours were spent investigating the accident/incident?			
5. Were there any regulatory fines levied as a result of the accident/incident?			
6. What are the costs due to lost production or lost sales?			
7. What is the value of damaged or spoiled product?			
8. Are there retraining costs or training costs to new workers?			
9. If so, what are the trainer's costs?			

What are the medical costs as a result of the accident/incident?

INDIRECT COSTS	\$
TOTAL COSTS	\$

EXAMPLE OF INCIDENT COSTS

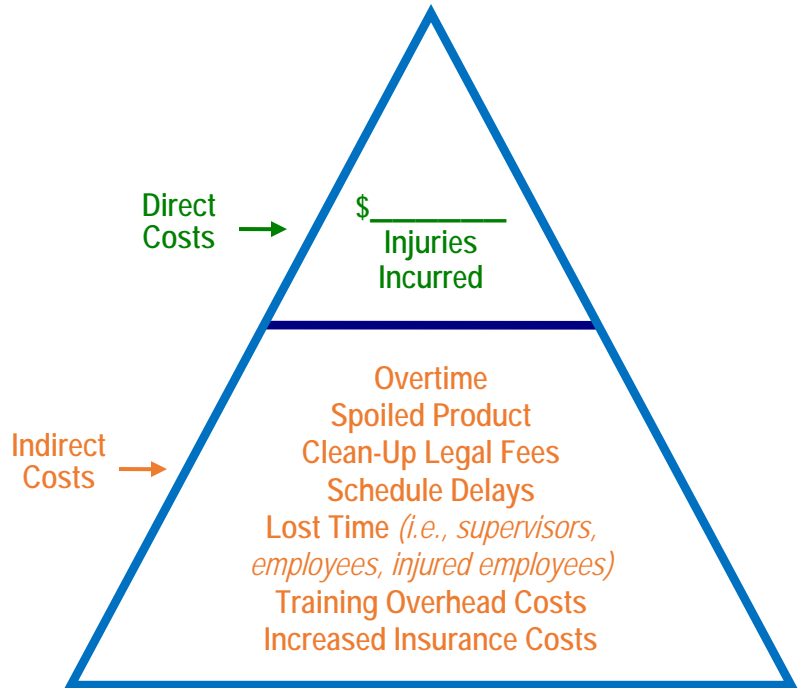
COST ANALYSIS

National statistics have proven for years that the **direct costs** associated with personal injury are dramatically outweighed by the **indirect costs**. MEMIC's numbers hold true to this fact. As Maine's largest workers' compensation carrier, our volume of accident data is statistically in line with the national norms relating to accident causation and the resulting costs.

The following financial analysis summarizes *XYZ Company* according to these trends.

Direct Costs + **Indirect Costs** = **Total Costs**

_____ + _____ = _____



Sales required to pay for accident costs: $\frac{\text{Total Costs}}{\text{Profit Margin}} = \text{Required Sales}$

REQUIRED SALES	=====	=====	=====	=====	=====
COMPANY PROFIT MARGIN	2%	4%	6%	8%	10%

EXAMPLE OF INCIDENT COSTS

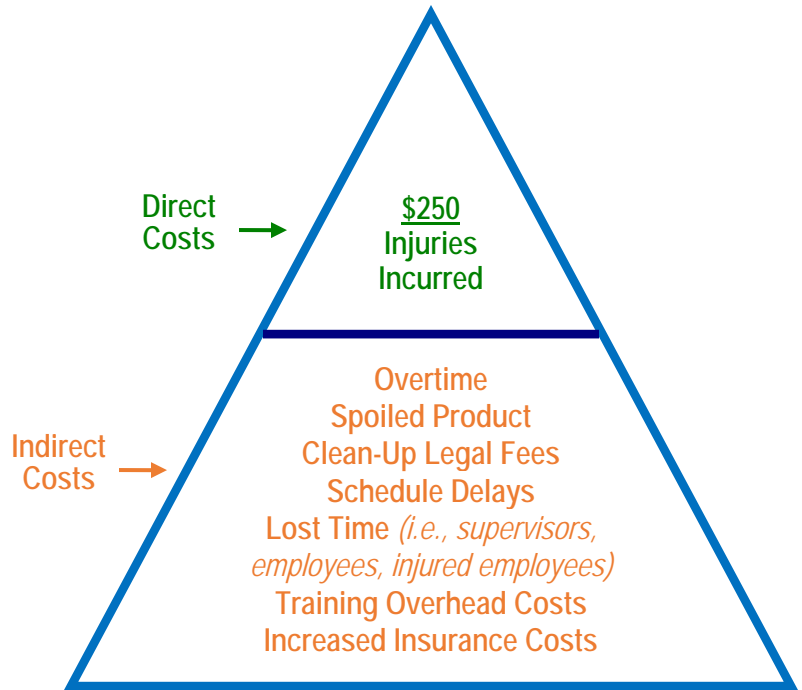
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The following financial analysis summarizes *XYZ Company* according to these trends.

Direct Costs + **Indirect Costs** = Total Costs

\$250 + **\$1250** = **\$1500**



$$\text{Sales required to pay for accident costs: } \frac{\text{Total Costs}}{\text{Profit Margin}} = \text{Required Sales}$$

REQUIRED SALES	<u>\$75,000</u>	<u>\$37,500</u>	<u>\$25,000</u>	<u>\$18,750</u>	<u>\$15,000</u>
COMPANY PROFIT MARGIN	2%	4%	6%	8%	10%

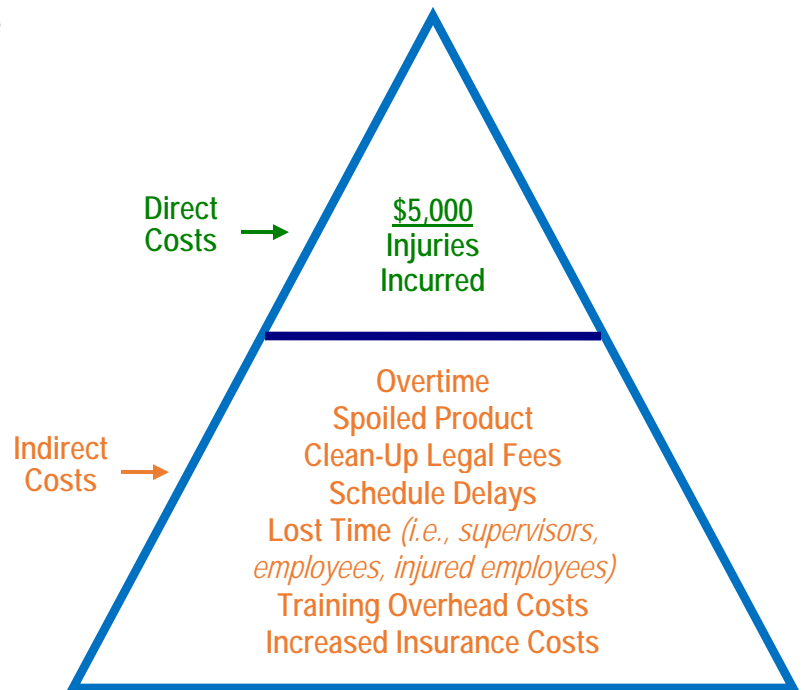
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The following financial analysis summarizes *XYZ Company* according to these trends.

Direct Costs + **Indirect Costs** = Total Costs

\$5,000 + **\$25,000** = **\$30,000**



$$\text{Sales required to pay for accident costs: } \frac{\text{Total Costs}}{\text{Profit Margin}} = \text{Required Sales}$$

REQUIRED SALES	<u>\$1,500,000</u>	<u>\$750,000</u>	<u>\$500,000</u>	<u>\$375,000</u>	<u>\$300,000</u>
COMPANY PROFIT MARGIN	2%	4%	6%	8%	10%

VALUE-ADDED PROCESSES

Value-added is any task performed that a customer is willing to pay for. Otherwise it is a loss, as well as a possible source of accidents.

HIERARCHY OF CONTROLS

Value added:

1. Eliminate
2. Engineer

Non-value added:

3. Administrative
4. Personal protective equipment
5. Training



Notes:

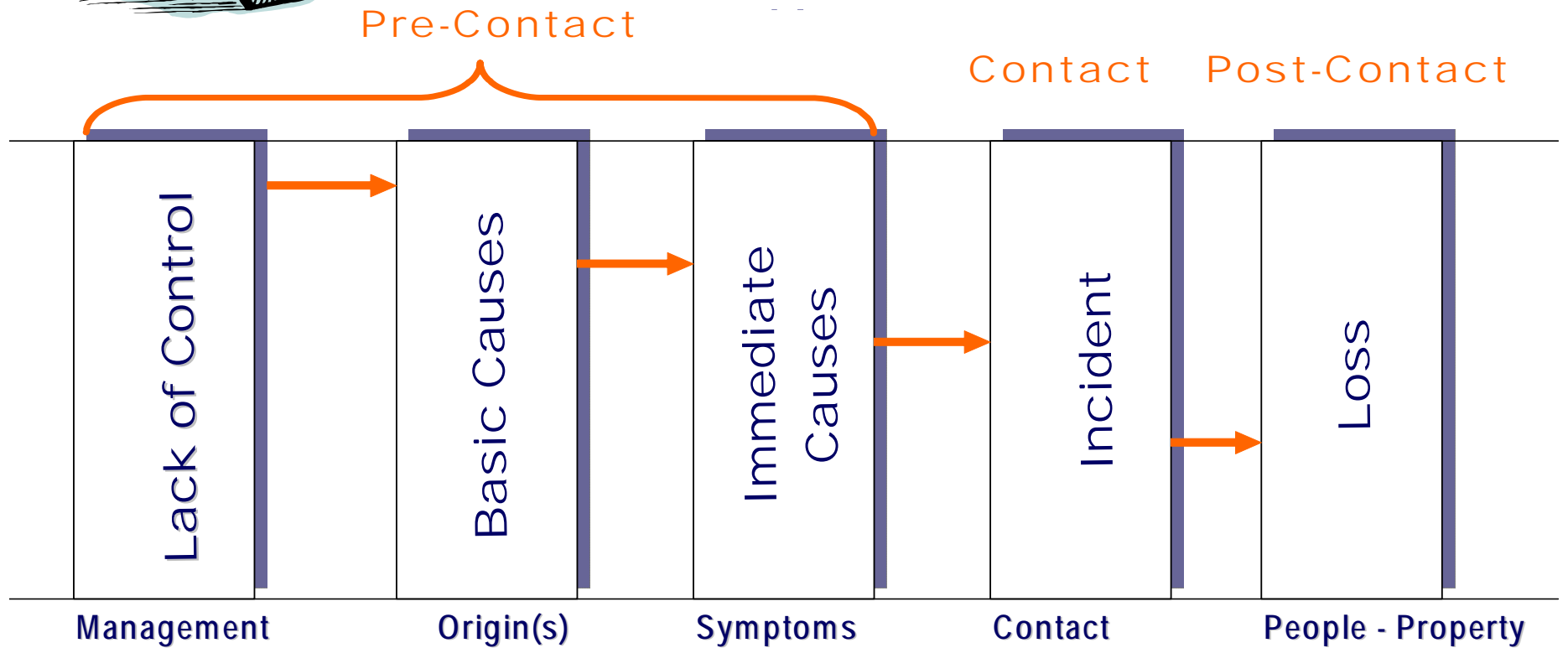
SINGLE CAUSATION MODEL

Unsafe Acts	Unsafe Conditions
Operating without authority	Lack of guards
Not wearing PPE	Defective tools
Bypassing guards	Congested work space
Using equipment improperly	Noise
Horseplay	No PPE provided
Improper lifting	Poor housekeeping
Using defective equipment	Uncontrolled ergonomic hazards



Notes:

MULTIPLE CAUSATION MODEL



MANAGEMENT FUNCTION

Management and supervisors have four primary functions:

1. Plan

2. Lead

3. Organize

4. Control

MANAGEMENT FUNCTION

OPERATIONS

Operations are every part of the process that ensures the product or service is efficiently produced or provided.

OPERATIONS CONTROL

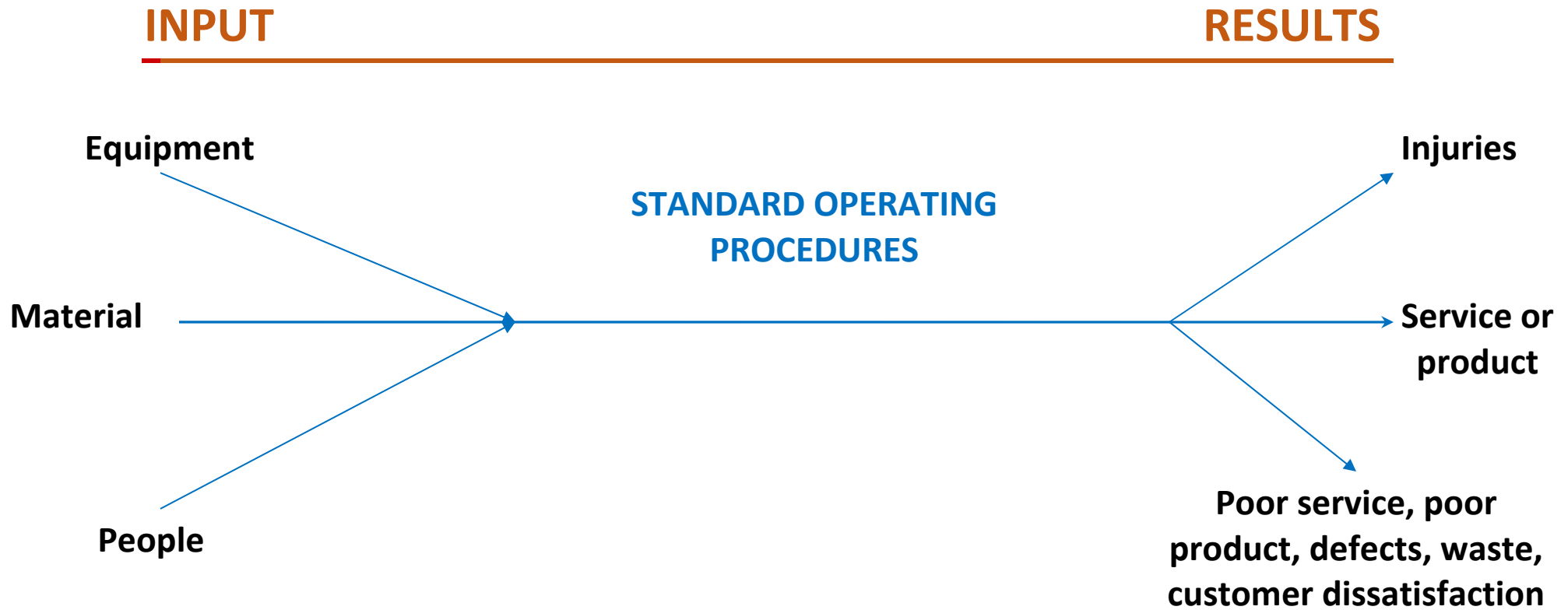
Operations control is ensuring that the product or service is produced or provided without waste, defects, or injuries.

PROCESS CONTROL = ACCIDENT CONTROL

An accident is an indication that something within the process is not being controlled.

GENERIC OPERATION

What We Produce



CONTROL THE INPUT

Equipment:

Material:

People:

Standard Operating Procedures:

Work Environment:

INVESTIGATION PROCESS

- Control the accident scene. Secure the site and ensure that medical services have been provided and that all hazards are being abated.
- Check the site and circumstances of the incident thoroughly before anything has been changed or removed.
- Discuss the incident with the involved employee after he or she has been treated. Talk with those who saw the accident and others familiar with the conditions immediately before and after the incident occurred.
- Determine the cause of the incident. The smallest detail may point to the real cause. Ask “why” repeatedly.
- Reconstruct the events which resulted in the accident. Consider all possible causes. Look for the unsafe act as well as the unsafe conditions which separately or in combination were contributing factors.



NOTES:

METHOD OF INVESTIGATION

- Gather the facts
- Identify the problems (root causes)
- Develop solutions (action plan)
- Evaluate the benefits (follow up)



Notes:

METHOD OF INVESTIGATION

Employee: _____ Date: _____
Location: _____ Department: _____
Supervisor: _____ Manager: _____

SUMMARY:

Executive summary of parties involved. When and where it happened, and if personal injuries or property damage occurred.

FACTS:

Chronological facts in bullet form are best in this section. Give the reader factual contributing factors without drawing conclusions.

Medical Treatment

-
-

People

-
-

Training

-
-

Material

-
-

Equipment & Machinery

-
-

Process

-
-

Environment

-
-

CONCLUSIONS:

Draw your conclusions here. Be specific, cite the incident's root cause(s), and use your facts.

RECOMMENDATIONS:

What are the recommendations made by you and the responsible party? Create an Action and Service Plan to address the recommendations and ensure that the persons responsible for each corrective action understand that corrective action on their part is required to conclude the investigation. (This section may be filled in at a later date after a draft report is prepared and discussed).

IDENTIFY THE ROOT CAUSE(S)

- List the facts in chronological order:
 - ▶ Equipment
 - ▶ Material
 - ▶ People
 - ▶ Standard operating procedures
 - ▶ Environmental conditions

- Brainstorm the facts with others to draw conclusions.

- Typically there are two or more root causes.



Notes:

DEVELOP AN ACTION PLAN

- Develop a plan to correct the hazardous or unsafe conditions identified.
- Assign persons responsible for each action.
- Establish due dates.
- Get management commitment for the corrective action plan.
- Document each action above.



NOTES:

SAMPLE ACCIDENT INVESTIGATION ACTION PLAN

Company: _____

Policy Number: _____

Date: _____

Goal:

ACTION STEPS	PERSON RESPONSIBLE	TARGET DATE	FOLLOW-UP

Supervisor's Signature

Manager's Signature

EVALUATE THE BENEFITS

- Once corrective action has been taken, it is essential to follow up and ensure that the corrective action is:
 - ▶ Improving the operations.
 - ▶ Not creating other non-value-added processes.
 - ▶ Effectively eliminating the root causes of the accident.
- Failure to follow up will result in recurrence of events that led to the accident.



NOTES:

THE REPORT

- **Heading Data:** Who, what, when, where of the accident.
- **Executive Summary:** Begin with a brief summary of the facts. Basically, what happened, when, and where:
- **List Facts** in chronological order in the report. Use the headings as prompts.
- **Conclusions** (root causes) must be drawn from the facts. Do not speculate.
- **Recommendations:** List recommended action included in the action plan.



NOTES:

SAMPLE REPORT FORMAT

Employee: _____ Date: _____
Location: _____ Department: _____
Supervisor: _____ Manager: _____

SUMMARY:

Executive summary of parties involved. When and where it happened, and if personal injuries or property damage occurred.

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Medical Treatment

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Material

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Equipment & Machinery

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Process

-
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Environment

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-

CONCLUSIONS:

Draw your conclusions here. Be specific, cite the incident's root cause(s), and use your facts.

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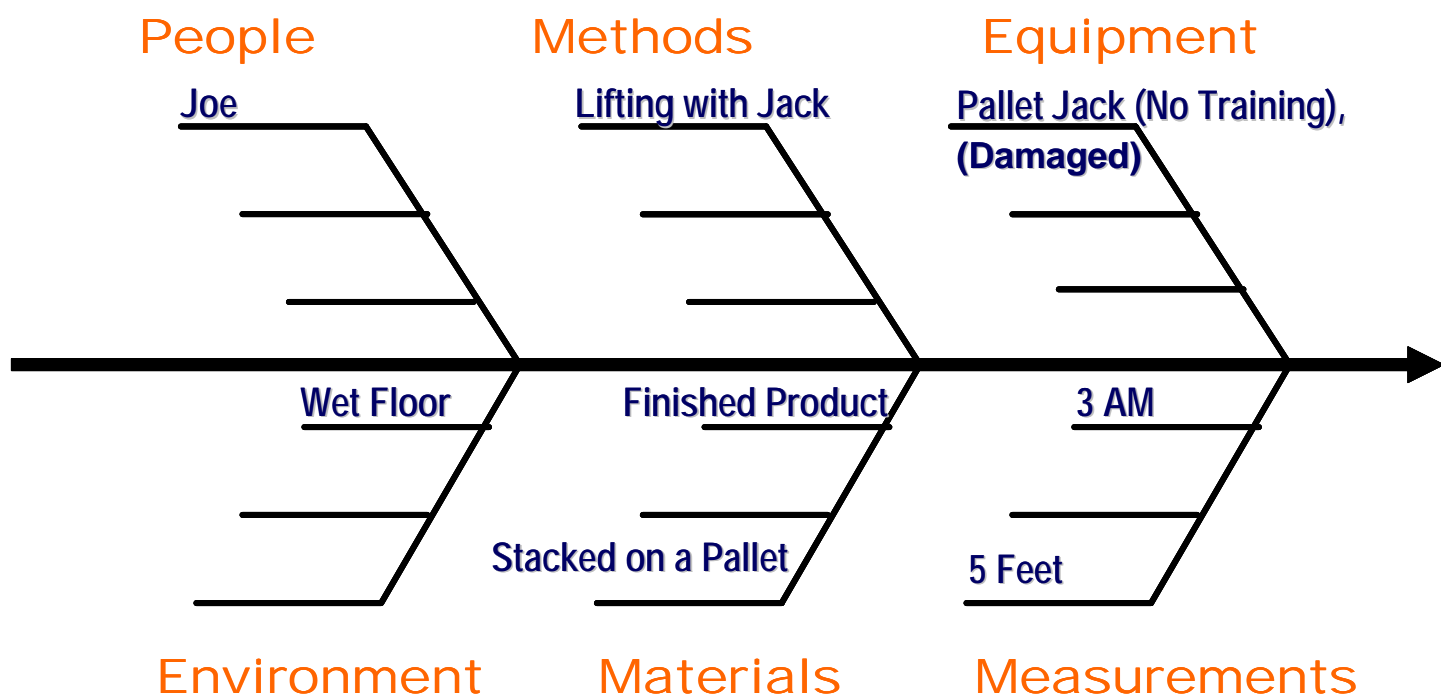
THE FISHBONE (CAUSE AND EFFECT) DIAGRAM

- Joe was lifting the finished product.
- Joe was operating a pallet jack.
- Joe had not received training.
- The floor was wet.
- The pallet jack “wasn’t working right.”
- The time of the accident was 3 A.M.
- The stack of product fell 5 feet.



NOTES:

THE FISHBONE (CAUSE AND EFFECT) DIAGRAM



NOTES:

SUPERVISOR'S REPORT OF INJURY

Insert Company Name

Date: _____

By: _____

Name of Employee: _____ Job Title: _____

Time and date of injury: _____

Date reported: _____ To whom: _____

Where did injury occur? _____

How was employee injured? _____

Nature of injury (*be specific*): _____

Recommended safeguards to prevent similar occurrences: _____

Corrective actions taken to prevent recurrence of this type of accident: _____

TREATMENT ACTION TAKEN (*check all that apply*):

- Recorded Only
- Doctor's Care
- First Aid
- Lost Time
- Hospital Care

Name of Doctor: _____ Name of Hospital: _____

Signature of Supervisor

NOTE: Supervisors must advise employees that a doctor's note is needed if the employee is going to be out of work. Also, a note is needed upon the employee's return to work. These notes should state the reason for being out of work and the time frame. Doctor's notes and Supervisor's Report of Injury should be turned in to the Human Resources Department.

SUPERVISORY ACCIDENT INVESTIGATION REPORT

1. Employee		2. Date of Birth		3. Date of Report	
4. Street Address					
5. Job Title			6. Location of Accident		
7. Time of Accident		8. Date of Accident		9. Day of Week	
10. Sex <input type="radio"/> Male <input type="radio"/> Female					

11. Injury Requiring: First Aid Outpatient Hospitalization

An accident is a mishap or unintended event generally caused by an unsafe act or unsafe condition or a combination of the two.

Each accident, regardless of whether it results in an injury, physical damage, or near miss, should be investigated to seek the cause and to take proper corrective action to prevent recurrence.

The accident should be investigated by the injured employee's general foreman. It should be conducted on the day that the accident occurred. Your purpose is to gain facts and accurate accounting from the injured party and witnesses. Your purpose is not to place blame.

This report cannot be considered completed until the supervisor has indicated what corrective action has been taken or will be taken to prevent a recurrence.

Complete this report in its entirety. If not, the report will be sent back to the originator for completion.

12. Investigative Supervisor	13. General Superintendent
-------------------------------------	-----------------------------------

CHECK THE FOLLOWING QUESTIONS THAT APPLY, TO COMPLETE YOUR INVESTIGATION:

14. The Person	15. Tools & Equipment	16. The Environment
WAS THE EMPLOYEE:	WAS THE MACHINE:	WAS THE AREA:
<input type="checkbox"/> Placed on the right job? <input type="checkbox"/> Properly trained for the job? <input type="checkbox"/> Experienced in the job? <input type="checkbox"/> Tired, using medication, drinking, or taking drugs? <input type="checkbox"/> Under emotional stress, worried, or having distracting personal problems? <input type="checkbox"/> Operating equipment/tools at unsafe speeds? <input type="checkbox"/> Taking an unsafe position? <input type="checkbox"/> Distracted through horseplay, practical joking, quarreling, fighting, startling act of another employee? DID THE EMPLOYEE HAVE: <input type="checkbox"/> The skills to do the job? <input type="checkbox"/> The physical and mental ability to do the job?	<input type="checkbox"/> Working properly? <input type="checkbox"/> Adjusted correctly? <input type="checkbox"/> Was it the right tool or machine for the job? <input type="checkbox"/> Was it properly guarded, with guards adjusted and working correctly? <input type="checkbox"/> Was the stock or material correct and positioned correctly? <input type="checkbox"/> Was the tool in proper condition?	<input type="checkbox"/> Well lighted? <input type="checkbox"/> Too hot or too cold? <input type="checkbox"/> Crowded or congested? <input type="checkbox"/> Noisy, or were vapors, smoke, etc. present to be distracting? <input type="checkbox"/> Did the noise, smoke, vapors, etc. present a health hazard? <input type="checkbox"/> Was the floor surface in good condition and clean?

SUPERVISORY ACCIDENT INVESTIGATION REPORT

17. Accident Type:		
<input type="checkbox"/> Absorption (skin contact) <input type="checkbox"/> Assault <input type="checkbox"/> Caught in/on/between <input type="checkbox"/> Contact with electricity <input type="checkbox"/> Explosion <input type="checkbox"/> Exposure to radiation <input type="checkbox"/> Exposure to temperature extremes (burns, scalding, freezing, heat exhaustion, sunstroke) <input type="checkbox"/> Ingestion (swallowing) <input type="checkbox"/> Inhalation (breathing)	<input type="checkbox"/> Overexertion (lifting) <input type="checkbox"/> Overexertion (reaching, pushing, pulling, bending) <input type="checkbox"/> Repeated trauma (noise, vibration) <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Slip, trip, fall – different level <input type="checkbox"/> Slip, trip, and/or fall – same level <input type="checkbox"/> Struck against <input type="checkbox"/> Struck by falling, sliding, or moving object(s) <input type="checkbox"/> Struck by flying objects <input type="checkbox"/> Welding flash	
18. Nature of Injury:		
<input type="checkbox"/> Amputation (<i>all injuries other than spinal cord</i>) <input type="checkbox"/> Angina pectoris (<i>chest pain</i>) <input type="checkbox"/> Burn <input type="checkbox"/> Concussion (<i>head injury</i>) <input type="checkbox"/> Contusion (<i>bruise</i>) <input type="checkbox"/> Crushing <input type="checkbox"/> Dislocation <input type="checkbox"/> Electric shock <input type="checkbox"/> Enucleation (<i>removal of the eyeball</i>) <input type="checkbox"/> Foreign body <input type="checkbox"/> Fracture <input type="checkbox"/> Freezing <input type="checkbox"/> Hearing loss – traumatic only <input type="checkbox"/> Heat prostration <input type="checkbox"/> Hernia	<input type="checkbox"/> Infection <input type="checkbox"/> Laceration <input type="checkbox"/> Myocardial infarction (<i>heart attack</i>) <input type="checkbox"/> Puncture <input type="checkbox"/> Rupture <input type="checkbox"/> Severance (<i>for spinal cord only</i>) <input type="checkbox"/> Sprain <input type="checkbox"/> Strain <input type="checkbox"/> Vascular <input type="checkbox"/> Vision loss <input type="checkbox"/> Suffocation <input type="checkbox"/> Asphyxia <input type="checkbox"/> Headache <input type="checkbox"/> Nausea <input type="checkbox"/> Dust disease (<i>other than those listed</i>)	<input type="checkbox"/> Asbestosis <input type="checkbox"/> Black lung <input type="checkbox"/> Byssinosis <input type="checkbox"/> Silicosis <input type="checkbox"/> Respiratory disorders (<i>gases, fumes, chemicals, etc.</i>) <input type="checkbox"/> Poisoning (<i>chemical</i>) <input type="checkbox"/> Poisoning (<i>metal</i>) <input type="checkbox"/> Dermatitis <input type="checkbox"/> Mental disorder <input type="checkbox"/> Radiation <input type="checkbox"/> All other occupational diseases <input type="checkbox"/> Loss of hearing (<i>other than traumatic</i>) <input type="checkbox"/> Contagious disease <input type="checkbox"/> Cancer <input type="checkbox"/> All other cumulative injuries
19. Part of the Body		
<input type="checkbox"/> Multiple Head Injury <input type="checkbox"/> Skull <input type="checkbox"/> Brain <input type="checkbox"/> Ear(s) <input type="checkbox"/> Eye(s) <input type="checkbox"/> Nose <input type="checkbox"/> Teeth <input type="checkbox"/> Mouth <input type="checkbox"/> Other Facial Soft Tissue <input type="checkbox"/> Facial Bones <input type="checkbox"/> Multiple Neck Injury <input type="checkbox"/> Vertebrae <input type="checkbox"/> Disc <input type="checkbox"/> Spinal Cord <input type="checkbox"/> Larynx	<input type="checkbox"/> Soft Tissue – Neck Area <input type="checkbox"/> Trachea <input type="checkbox"/> Multiple Upper Extremities <input type="checkbox"/> Upper Arm (<i>including clavicle & scapula</i>) <input type="checkbox"/> Elbow <input type="checkbox"/> Lower Arm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger(s) <input type="checkbox"/> Thumb <input type="checkbox"/> Multiple Trunk <input type="checkbox"/> Upper Back Area (<i>thoracic area</i>) <input type="checkbox"/> Low Back Areas (<i>including lumbar and lumbrosacral</i>) <input type="checkbox"/> Disc	<input type="checkbox"/> Chest (<i>including ribs, sternum, soft tissue</i>) <input type="checkbox"/> Sacrum & Coccyx <input type="checkbox"/> Pelvis <input type="checkbox"/> Spinal Cord <input type="checkbox"/> Internal Organs <input type="checkbox"/> Heart <input type="checkbox"/> Multiple Lower Extremities <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Lower Leg <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Toe(s) <input type="checkbox"/> Multiple Body Parts
20. Employee's Job or Activity at Time of Accident:		
21. Accident Type:		
22. Nature of Injury:		
23. Part of Body:		
Provide a description of the accident. Also the name(s) of the object, substance, or exposure which directly brought about the injury. Please include the names of all witnesses:		
Names of Witnesses:		

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Insert Company Name

(This form does not replace the regular report sent to the Insurance Company or any form required by law.)

Name of Employee: _____ Date of accident: _____

Type of work employee was doing: _____

How long employed? _____ Date accident reported: _____

Department name: _____ Immediate supervisor: _____

CAUSE of the injury (what happened; machinery, materials, etc. involved; all pertinent details):

Nature of the injury: _____

First aid given? _____ By whom? _____

Other treatment (describe): _____

What can be done to prevent similar accidents? _____

What action, and by whom, has been taken? _____

Other comments: _____

Signature of Supervisor: _____ Date: _____

Review by Safety Committee and/or Appropriate Manager

Recommendations: _____

Final disposition: _____

Signature: _____ Date: _____

(Use the other side if more space is needed to answer any of the above questions.)

SUPERVISOR'S REPORT

Name of Employee: _____

Date of the Injury: _____ Time: _____ am/pm Date Reported: _____

Please describe clearly how the accident/injury occurred:

Were there witnesses? Yes No (Note: If yes, attach witness statements)

Please list the name of any witnesses:

Was medical attention needed? Yes No

If yes, where did the employee receive treatment and what type of treatment did he/she receive?

What time did the employee's shift start? a.m. p.m.

Did the employee leave work early after the injury? Yes No

At what time did the employee leave? a.m. p.m.

Will the employee lose time from work as a result of the injury? Yes No

What acts, failures to act, and/or unsafe conditions contributed most directly to this accident/injury (immediate cause)?

What actions do you recommend should be taken to prevent recurrence of a similar accident/injury?

SUPERVISOR'S REPORT

Additional comments:

Supervisor's Signature

Date: _____

Time: _____



ACCIDENT INVESTIGATION QUESTIONNAIRE

Company Name: _____ Date: _____

Please provide completed and detailed information:

1. What was the employee doing?

2. How was the employee injured?

3. Was there an unsafe act? If so, describe:

4. What reason did employee give for acting unsafely?

5. What unsafe condition existed or what wrong method was in operation?

6. Was the employee using the safeguards and protective equipment provided for the job?

7. Was there a witness? If so, please list name(s).

8. Statement from witness:

9. Are further safeguards needed to prevent repetition of injury? If so, please list:

ACCIDENT INVESTIGATION FORM

Sample to Develop Your Own

EMPLOYEE INFORMATION

Employee Name:	SS#:	
Address:		
City:		
State & Zip:		
Phone #:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female

GENERAL ACCIDENT INVESTIGATION

Name of individual completing the report:		
Date of accident:	Time of accident:	Date of report:
Type of accident: <input type="checkbox"/> Lost time <input type="checkbox"/> Medical only <input type="checkbox"/> First aid <input type="checkbox"/> Near miss		
Date of notification:		
Describe location where accident occurred:		
Supervisor's Name:	Manager's Name:	
When was supervisor notified? <input type="checkbox"/> Immediately <input type="checkbox"/> Later Explain:		
Describe work being performed during accident:		
How long has employee been performing these duties?		
Was work within normal job duties?		

ACCIDENT INVESTIGATION

(DESCRIBE THE ACCIDENT IN AS MUCH DETAIL AS POSSIBLE)

Contributing factors: <input type="checkbox"/> Human error <input type="checkbox"/> Unsafe conditions <input type="checkbox"/> Weather <input type="checkbox"/> Equipment <input type="checkbox"/> Other Explain:
Type of equipment, tool, vehicle, etc. involved:
Was the right tool or equipment being used for the job?
List any outside agencies that may be involved in this investigation (police, insurance, customer, subcontractor, etc.):

ACCIDENT INVESTIGATION FORM

Sample to Develop Your Own

PREVENTION

Safety device available? Yes No / In use? Yes No / In use correctly? Yes No

Describe the safety appliance:

Was a job safety analysis or work activity plan performed for the job? Yes No

Explain and attach a copy (if Yes):

What has supervision initiated to prevent this accident from recurring?

Has this accident been discussed with employees and corrective action communicated? Yes No

How?

Special comment area for corrective action taken to prevent recurrence of accident:

ACCIDENT INVESTIGATION FORM

Sample to Develop Your Own

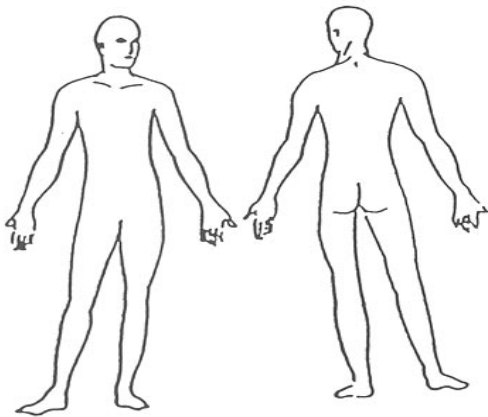
EMPLOYEE STATEMENT OF ACCIDENT

Employee Name:

Signature:

Please describe the accident to the best of your ability:

Please identify the area in which you received an injury and any areas where you are feeling pain:



Do you have any suggestions to prevent this accident from recurring?

Do you feel any discomfort? Yes No

Please describe the type of discomfort you are feeling:

ACCIDENT INVESTIGATION FORM

Sample to Develop Your Own

WITNESS(ES) STATEMENT OF ACCIDENT
--

WITNESS #1

Please describe your observation of the accident:

Do you have any suggestions to help prevent future accidents such as this?

Witness Signature:	Date:
---------------------------	--------------

WITNESS #2

Please describe your observation of the accident:

Do you have any suggestions to help prevent future accidents such as this?

Witness Signature:	Date:
---------------------------	--------------

STATEMENT OF INJURED EMPLOYEE

Full Name of Injured Employee: _____

Address: _____ Home Phone #: _____

Sex: _____ Age: _____ Single Married Spouse's First Name: _____

Employer's Name: _____

Occupation when injured: _____ Name of Supervisor: _____

Were you doing your regular work? _____ If not, what work? _____

Work location where injury occurred: _____

Date of injury: _____ Hour of Day: _____ AM PM

Witness(es)' Name(s): _____

Describe fully how injury happened: _____

Have you ever had an injury of this type before? _____ If yes, describe injury in detail: _____

First doctor seen (name and address): _____

Name and address of current treating doctor: _____

Are you still receiving treatment? _____ Date of next appointment: _____

Are you enrolled in a physical therapy program? Yes No

If yes, list contact information for physical therapist: _____

Did you lose time from work? Yes No If so, when did disability begin? _____

If you have returned to work, what was the date? _____

If you have not returned to work, when do you expect to return? _____

EMPLOYEE INCIDENT REPORT

Name of Employee: _____

Date of the Injury: _____ Time: _____ am/pm Date Reported: _____

Where did the injury occur (be specific):

Please describe clearly how the accident/injury occurred:

Please indicate the bodily part injured and the symptoms you are experiencing:

Who is your immediate supervisor? _____

To whom did you give notice of this injury/accident? _____

Were there witnesses? Yes No

Please list the name of any witnesses:

Did you seek medical attention? Yes No (If yes, please completed the section below)

- Where did you receive treatment? _____
- What type of treatment did you receive? _____
- Who was the treating physician? _____

Additional Comments: _____

Employee Signature

Date

Please return this form to the Human Resources Department within 24 hours.

ACCIDENT INVESTIGATION WITNESS STATEMENT

_____ has indicated that you have witnessed an injury on
(employee name)

_____ at _____
(date) (time and location)

Please explain in detail what you witnessed:

Did the employee say anything to you about this accident/injury? If so, please explain:

_____ Date

_____ Time

_____ Signature

Please return this form to the Human Resources Department with 24 hours.

CONFIDENTIAL

DEVELOPING AN INVESTIGATION PROGRAM

- **Formal policy and procedure**
 - ▶ Accident reporting
 - ▶ Accident investigation

- **Assigned roles and responsibilities for investigating an accident**
 - ▶ Management
 - ▶ Supervisory
 - ▶ Employee



NOTES:

FORMAL POLICY

- The written policy signed by the company president.
- Include provisions for accident reporting.
- Assign specific responsibilities for investigating accidents (manager, supervisor, team leader, etc.).
- Identify when to investigate.
- Provide a method for management to review investigations and a method for follow-up on action plans.
- Provide for accident investigation training.
- A formal policy signed by the company president will serve to validate the need for all accident investigations.
- To increase the importance of conducting meaningful and effective investigations, the company president should make a commitment to review and sign off on all investigation reports.



NOTES:

ROLES IN ACCIDENT INVESTIGATIONS

- **Managers:** Should be actively involved in the investigation. At a minimum, the manager must ensure that an effective investigation is conducted and hold the supervisor who is performing it accountable.
- **Supervisors:** This is the primary level where accident investigations should occur. Supervisors know the people, know the equipment, and know the process.
- **Employees:** Must be aware they are to report all accidents and incidents to their supervisor.



NOTES:

SAMPLE ACCIDENT INVESTIGATION ACTION PLAN

Company: XYZ Company

Policy Number: _____

Date: January 1, XXXX

Goal: XYZ Company will develop a written accident investigation program by January 1.

ACTION STEPS	PERSON RESPONSIBLE	TARGET DATE	FOLLOW-UP
<p>A written policy specifying the requirements for investigating accidents will be drafted and signed by the company president. The policy will include the following elements:</p> <ol style="list-style-type: none"> 1. Clearly define the roles and responsibilities of executives, managers, and supervisors for investigating accidents. 2. Provide guidance on when to investigate accidents. 3. Provide provisions requiring a review of all accident investigations by department managers and executives. 4. Provide direction on how managers and executives will follow up on accident investigation corrective action plans. 5. Provide for the training of all persons who may be asked to conduct a workplace accident investigation. 	Company President	January 1, XXXX	