

City of Decatur

Supervisors Investigation of Work Incident

INSTRUCTIONS FOR USE OF ACCIDENT INVESTIGATION REPORT

This page need not be submitted to Personnel or Safety. These steps will help you investigate an accident or near miss and complete the form. This form has been designed to be completed electronically.

1. All injuries regardless of how minor or whether a doctor is seen or not are to be reported.
2. Complete your report within twenty-four (24) hours of incident and forward to the Personnel Department.
3. Complete all blanks on the report. If a question can not be answered, then write "unknown" or N/A (Not Applicable). **Incomplete reports will be returned.**
4. Discuss the accident/near miss with the employee involved along with any witnesses. Be sure to question **WHY, WHAT, WHERE, WHO, HOW** aspects of the accident/near miss.
5. Inspect the equipment or materials involved for conditions that could be made safer.
6. Study the job set-up and process of doing the work. Could it be improved?
7. Use the accident/near miss causes below as an aid during your investigation.
8. Is the employee involved suited for the job he/she is doing? Did he/she receive adequate training? Is there any other contributing problems, i.e. use of drugs, use of alcohol, or emotional problems
9. Recommendations to correct the problem must be practical. Be sure your recommendations will not create other situations which could result in injury to employees.

EXAMPLES OF ACCIDENT/NEAR MISS CAUSES

Unsafe Acts - Personal Factors	Unsafe Conditions	Fundamental Cause
Making safety devices inoperable	Inadequate guards or protection	Inadequate hiring standrds
Using defective equipment or tools	Defective tools or equipment	Inadequate job placement standard
Servicing equipment in motion	Unsafe condition of machine or equipment	Lack of proper procedures
Failure to use proper tools or equipment	Poor housekeeping	Inadequate job instruction
Operating equipment or machine at unsafe speed	Improper material storage	Inadequate enforcement of work standards
Failure to use personal protective equipment	Unsafe floors, ramps stairways, platforms	Inadequate supervision
Lack of skills or knowledge	Fire or explosion hazards	Inadequate job planning methods
Unsafe loading or placing	Hazardous atmosphere (gases, dust, fumes, vapors)	Inadequate preventative maintenance program
Improper lifting, lowering or carrying	Hazardous substances	Improper layout or design
Taking an unsafe position	Excessive noise	Unsafe design or construction
Unnecessary haste		
Influence of drugs or alcohol		
Unaware of hazards		
Unsafe act of other		
Inattention		

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DATE OF THIS REPORT: / /

ACCIDENT NEAR MISS INCIDENT

EMPLOYEE: SS# / / DOB: / /

ADDRESS: PHONE: - - DEPENDENTS UNDER 18:

MARITAL STATUS: M S D W Sep. AGE:

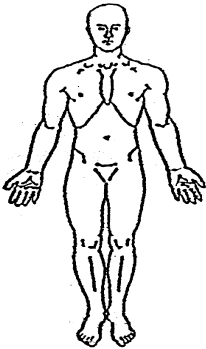
DEPARTMENT: OCCUPATION: TIME IN CURRENT POSITION:

DATE OF INCIDENT: / / TIME: AM PM DATE SUPERVISOR NOTIFIED: / /

NATURE OF INJURY:

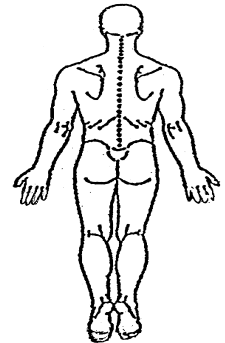
PLEASE INDICATE THE SPECIFIC PART OF BODY INJURED.

FRONT



- | | | | | | |
|--------------------------------|--------------------------------|--------------------------------|-----------------------------------|--|--------------------------------------|
| EAR | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both | <input type="checkbox"/> NECK | <input type="checkbox"/> DIGESTIVE |
| EYE | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both | <input type="checkbox"/> SCALP | <input type="checkbox"/> CIRCULATORY |
| HAND | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both | <input type="checkbox"/> TORSO | <input type="checkbox"/> RESPIRATORY |
| FINGER | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Multiple | <input type="text"/> | |
| BACK | <input type="checkbox"/> Lower | <input type="checkbox"/> Upper | <input type="checkbox"/> Middle | <input type="checkbox"/> FACE (including mouth & nose) | |
| HIP | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both | <input type="checkbox"/> MUSCLE/SKELETAL | |
| KNEE | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both | <input type="checkbox"/> MULTIPLE BODY PARTS | |
| FOOT | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both | <input type="text"/> | |
| TOE | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Multiple | <input type="text"/> | |
| <input type="checkbox"/> OTHER | <input type="text"/> | | | | |

BACK



Was employee sent for medical treatment? YES NO If YES, where: Physician
Hospital
Medical Clinic

Did employee return to finish shift? YES NO Is employee losing time? YES NO Date lost time began / /

Type of Injury ALLERGIC REACTION BREAK/FRACTURE BURN CAUGHT BETWEEN CUT FALL FOREIGN BODY
 SLIP SPRAIN STING STRAIN STRUCK BY OTHER

Exact location where incident occurred:

Were there any witnesses?

Was employee working at assigned duties at time of incident? YES NO

From your investigation, describe in detail what incident occurred and what the individual/crew was trying to accomplish:

How did the incident occur? (What specific events resulted in the incident occurring?)

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Describe any unsafe acts:

Describe any unsafe conditions:

Fundamental accident cause:

Was equipment being used at the time of the incident that directly contributed to the incident?

YES NO

If YES, list equipment being used

Was the proper equipment available for the job? YES NO

If NO, why

Was the appropriate PPE being worn at the time of the incident? YES NO

If YES, list equipment being used or worn

Was the proper PPE available for the job? YES NO

If NO, why

Was there any safety rules/procedures being violated by the employee/crew that contributed to the incident?

YES NO

If YES, which rule/procedure was violated

What safety measures should have been taken to prevent this incident?

Recommend short term solution to prevent recurrence:

Person Responsible:

Completion Date:

 / /

What long term solution is required to prevent recurrence?

Person Responsible:

Completion Date:

 / /

Supervisor Signature

Date:

 / /

Department Directors Signature

Date:

 / /