

**WHAT YOU DO IN THE EVENT OF:  
Injury, Spill, Regulatory Inspection, Vehicle Accident, Contractor Incident, or any  
other Environmental Health or Safety issue**

***All injuries, no matter how slight must be reported to your EH&S manager and Supervisor immediately!***

**First Aid / Minor Injuries:**

1. Notify Supervisor & Plant Manager.
2. Assess the situation, remove immediate dangers, and secure equipment if appropriate.
3. Provide care for injured employee utilize the plant's First Responders
4. First Responders to clean area/tools, etc. utilizing BBP kit and precautions
5. Keep area secured for investigation – take photos and complete Accident Report
6. Notify **your EH&S manager via phone** and provide a copy of the Accident Report **prior to shift end** via email.
7. Medical Treatment / Significant Injuries requiring the Transporting of Injured Employee to Care Facility / Hospital:
  - **Follow same basic steps above but consider the severity of the injury and the need for emergency services (911).**
  - **Ensure your EH&S manager is contacted prior to sending anyone to a medical facility so the company medical review doctor may be contacted – You may contact your EH&S manager in route for severe injuries and medical emergency situations.**

**Spills:**

- Follow established spill response measures and prevent any spilled product from entering a drain and/or the soil. Once the spill is contained **contact your EH&S manager** with the details of the spill (location, product spilled, amount, etc.)

**Regulatory Inspections:**

- If an OSHA, EPA, or local EHS authority shows up to conduct and inspection of the location **contact your EH&S manager via phone** immediately. Let the official know that the company EHS Manager is not onsite, and they will give you the time to make the call.

**Vehicle Accident:**

1. **Call 911** - This is so that the accident is reported to the proper officials and medical assistance can be dispatched if necessary.
2. **Call Your Supervisor** - Immediately notify your supervisor that you were involved in a motor vehicle accident. If your supervisor is in the general vicinity, he/she should come to the scene to assist you in investigating the accident (this is not always possible). Your supervisor will **contact your EH&S manager** to inform him that an accident has occurred.
3. **Gather Information**
  - Investigate damage that may have occurred to all vehicles involved in the accident. Document vehicle(s), especially vehicles that aren't ours, appearance by taking photographs regardless of severity of damages.
  - Obtain information of the owner and driver involved.

**Contractor Incident or other EHS issues:** **Contact your EH&S manager** for any incident that occurs on the property by a Contractor, Vendor or Visitor that results in them being injured or some type of property damage.

# Incident Investigation Report

NOTIFY YOUR EHS MANAGER IMMEDIATELY OF ANY INCIDENTS.

## PART I - Identifying the Incident (Fill in the blanks, check boxes)

Region:	Plant Location:	
Riskonnect Number:		Incident Type: <input type="checkbox"/> Near Miss <input type="checkbox"/> First Aid <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Property Damage <input type="checkbox"/> Auto Injury
Date of incident:	Day of week: _____	Date Claim Closed:
Time: _____ am/pm	Hours into shift: _____	Months into Task: _____
Department: <input type="checkbox"/> Plant <input type="checkbox"/> Yard <input type="checkbox"/> Other _____  <input type="checkbox"/> Office <input type="checkbox"/> Transportation <input type="checkbox"/> Sales		EE was Performing: <input type="checkbox"/> Regular Task  <input type="checkbox"/> New Task <input type="checkbox"/> Infrequent Task
Location in Plant/Office/Yard:		Job Description:
Name of Employee:		Who was: <input type="checkbox"/> Injured <input type="checkbox"/> Involved
Employee date of birth:		
Injury Type:  <input type="checkbox"/> Bite <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Cut <input type="checkbox"/> Crush <input type="checkbox"/> Fall <input type="checkbox"/> Irritation <input type="checkbox"/> Puncture <input type="checkbox"/> Soreness <input type="checkbox"/> Sprain <input type="checkbox"/> Strain <input type="checkbox"/> Vehicle <input type="checkbox"/> Other: _____		Body Part: <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> ankle(s) <input type="checkbox"/> arm(s) <input type="checkbox"/> back <input type="checkbox"/> calf <input type="checkbox"/> chest <input type="checkbox"/> ear <input type="checkbox"/> elbow <input type="checkbox"/> eye <input type="checkbox"/> finger <input type="checkbox"/> foot <input type="checkbox"/> forearm <input type="checkbox"/> groin <input type="checkbox"/> head <input type="checkbox"/> hip <input type="checkbox"/> knee <input type="checkbox"/> neck <input type="checkbox"/> palm <input type="checkbox"/> shoulder <input type="checkbox"/> stomach <input type="checkbox"/> thigh <input type="checkbox"/> toe <input type="checkbox"/> wrist
Cause of Injury: <input type="checkbox"/> Body Motion <input type="checkbox"/> Caught In or by  <input type="checkbox"/> contact with object <input type="checkbox"/> equipment <input type="checkbox"/> fall to same level <input type="checkbox"/> fall to lower level <input type="checkbox"/> harmful substance <input type="checkbox"/> debris <input type="checkbox"/> struck from above <input type="checkbox"/> struck from behind <input type="checkbox"/> struck from side <input type="checkbox"/> vehicle accident <input type="checkbox"/> other: _____		Equipment Involved: <input type="checkbox"/> Block/Paver Machine <input type="checkbox"/> Bagger/Packer <input type="checkbox"/> Conveyor <input type="checkbox"/> Forklift <input type="checkbox"/> Mobile Equipment <input type="checkbox"/> Ladder <input type="checkbox"/> Mixer <input type="checkbox"/> Pattern Maker <input type="checkbox"/> Splitter <input type="checkbox"/> Vehicle <input type="checkbox"/> Other: _____

Describe the Injury:

Describe the Conditions:

Describe the Immediate Incident Event: (use additional pages if necessary)

Names of Others Involved:	Location:
Names of Witnesses:	Location:
Required Additional Information: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Describe Initial Medical Treatment:

Name/Phone number of Medical Treatment Facility:

Injured Employee's estimated R-T-W dates: for Light Duty: for Full Duty:

Injured Employee's actual R-T-W dates: for Light Duty: for Full Duty:

Date Received:	Reported in a Timely Fashion: <input type="checkbox"/> Yes <input type="checkbox"/> No
Reported To:	Dr. Lee Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No

## PART II - Possible Cause

### 1. Contributing Factors resulting from:

- Methods / Procedures:
- Equipment & Tools:
- Environment:
- Personal Preparation:

### 2. Weak Link:

## PART III – Risk Analysis

### 1. Risk Likelihood – how likely is it of this incident occurring again if nothing changes?

- Very Likely- could happen once a day or week
- Likely- could happen once a month
- Occasional- could happen once a year
- Unlikely- could happen once every 10 years
- Very Unlikely- typically happens once every 100 years

### 2. Risk Severity- How severe could this incident have been?

- Extreme- Death or permanent disability
- Major- Serious bodily injury
- Moderate- Requires medical treatment (lost time injury or restricted duty)
- Minor – Medical Treatment (no lost time)

### 3. Significant Injury or Fatality Potential Category

<input type="checkbox"/> NO SIF <input type="checkbox"/> Arc Flash/Electrical <input type="checkbox"/> Confined Space Entry <input type="checkbox"/> Falling off trailer <input type="checkbox"/> Line of fire/significant energy <input type="checkbox"/> LOTO <input type="checkbox"/> Machine Guarding/Barriers <input type="checkbox"/> Other Life Altering Event	<input type="checkbox"/> Powered Industrial Truck Contact <input type="checkbox"/> PPE not used <input type="checkbox"/> Pressure Vessel <input type="checkbox"/> Vehicle Collision/Trailer Incident <input type="checkbox"/> Working at elevations <input type="checkbox"/> Working under suspended load <input type="checkbox"/> Workplace Violence
--	---

### 4. Injured/Involved Employee Suggestion:

### 5. Recommended Change(s)

The employee's signature, as required below indicates *only* that he or she has been given a copy of this completed report.

The employee may check here, \_\_\_\_\_,  and attach an additional statement if he or she chooses.

Employee Signature:

Date signed:

Supervisor Signature:

Date signed:

Safety Committee's Signature:

Date signed:

Plant/Site Manager's Signature:

Date signed:

#### PART IV – (Requires Completion)

- 1. Prepare one or more sketches** detailing the incident. Use engineering, or "graph" paper, and choose a scale based on the grid lines in the paper. Include labels to identify people, equipment and actions relevant to this accident.
- 2. Attach as many digital photos to this report as needed** to show the incident scene, movable equipment, and conditions present, etc., as it was involved.
- 3. Complete (BELOW) Anatomical Sketch of Injured Persons.**

Any additional info:

---

---

#### PART V - Identifying Questionable Injury Claims

- 1. Does the incident description seem plausible? (Workers Comp claim status)** Most states allow an employer no more than 7 days from learning of an injury to validate the employee's account of the event. **If you have any doubt about the work-related basis** of this injury, you should discuss your concerns and the details of your investigation immediately with your **EHS Manager, Liberty Mutual** or other insurance *claim administrator*, and the physicians treating the injured party, *in that order*.

This Incident  **DOES**, or  **DOES NOT** need further review. (Check one) Indicate questions below.

---

---

#### PART VI – Site Certification

- Prior to review by the Safety Committee, the Plant/Site Manager will review, and certify the completeness and accuracy of this Report.

What further actions **WILL BE** taken to reduce the likelihood of this incident being repeated?

Approved by: \_\_\_\_\_ (Signature of highest-ranking manager on site) Date: \_\_\_\_\_

- When accepted by the Plant Safety Committee as a complete and thorough analysis of the incident described, scan this Incident Analysis Report, including sketches, photos, and any additional statements by the employees involved, to your EHS Manager.

Accepted at Plant Safety Committee meeting, on \_\_\_\_\_ (date).

