



# COUNTY OF SAN JOAQUIN ACCIDENT / INCIDENT INVESTIGATION REPORT

**Please Print Clear and Legibly**

**This Report is for:**

Work Related Injury/Illness    
  Auto Accident    
  Other ( \_\_\_\_\_ )    
 DATE: \_\_\_\_\_

Work Related Injury Illness=Injury to employee / Auto Accident = Involves damage to vehicle / Other = Involves damage to property or equipment

**Name of Employee(s) involved:** \_\_\_\_\_

**Review of Supporting Documents**

Identify the documents reviewed as part of this investigation; attach a copy of each to this report.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Injury Illness Prevention Program<br>(related sections only) | <input type="checkbox"/> Inspection Records      | <input type="checkbox"/> Job Hazard Analysis (JHA)   |
| <input type="checkbox"/> Other Written Safety Documentation                           | <input type="checkbox"/> Safety Data Sheet (SDS) | <input type="checkbox"/> Employee Statement          |
| <input type="checkbox"/> Standard Operating Procedure (SOP)                           | <input type="checkbox"/> Training Records        | <input type="checkbox"/> Written/Email Communication |
| <input type="checkbox"/> Hazardous Energy Control                                     | <input type="checkbox"/> Lock Out/Tag Out        | <input type="checkbox"/> Confined Space              |
| <input type="checkbox"/> Other (list): _____  |  |  |

**\*Use Additional Paper if needed. Attach to this report\***

Provide a step-by-step account leading up to, during, & after the incident:	
Detail the condition of the worksite, controls that were implemented, & other misc. information:	
Identify contributing factors to the Accident / Incident:	

Has Human Resources been informed of the Injury/Illness (Worker's Compensation)?

Yes     No    If Yes, when? \_\_\_\_\_

Did injury result in hospitalization for 24 hrs or more?

Yes     No    If Yes, what hospital, time and date was employee admitted? \_\_\_\_\_

**This form does not negate or replace other required County forms that must be submitted. This form is a supporting document.**

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Investigators should be sure their investigation answers the following questions: **\*Use additional paper if needed\***

WHO?		WHERE?	
<input type="checkbox"/>	Who had instructed/assigned the employee duties?	<input type="checkbox"/>	Where did the incident occur?
<input type="checkbox"/>	Who else was involved, include job titles?	<input type="checkbox"/>	Where was the employee at the time?
<input type="checkbox"/>	Is there an open personnel issue?	<input type="checkbox"/>	Where was the supervisor at the time?
WHAT?		WHY?	
<input type="checkbox"/>	What had the employee been told to do?	<input type="checkbox"/>	Why was the employee injured?
<input type="checkbox"/>	What tools was the employee using?	<input type="checkbox"/>	Why and what did the employee do?
<input type="checkbox"/>	What operation was the employee performing?	<input type="checkbox"/>	Why and what did the other person/witness do?
<input type="checkbox"/>	What instructions had the employee been given?	<input type="checkbox"/>	Was protective equipment used?
<input type="checkbox"/>	What specific precautions were necessary?	<input type="checkbox"/>	Were specific instructions given to the employee?
<input type="checkbox"/>	What specific precautions was the employee given?	<input type="checkbox"/>	Why was the employee in the position?
<input type="checkbox"/>	What protective equipment should have been used?	<input type="checkbox"/>	Why was the employee using the tools or machine? Why didn't the employee check with the supervisor when the employee noted things were not as they should be?
<input type="checkbox"/>	What protective equipment was the employee using?	<input type="checkbox"/>	Why did the employee continue working under the circumstances?
<input type="checkbox"/>	What had other persons done that contributed to the incident?	<input type="checkbox"/>	Could supervisor have prevented the accident?
<input type="checkbox"/>	What problem or questions did the employee encounter?		
<input type="checkbox"/>	What safety rules were violated?		
<input type="checkbox"/>	What written training records are relevant?		
<input type="checkbox"/>	What previous incidents/accidents has employee had? Include dates		
<input type="checkbox"/>	What similar tasks has the employee performed in the past?		
WHEN?		Corrective Action: <i>Not All Inclusive</i>	
<input type="checkbox"/>	When was the employee assigned the job?	<input type="checkbox"/>	Who else can help prevent recurrence?
<input type="checkbox"/>	When were the hazards pointed out to the employee?	<input type="checkbox"/>	What will be done to prevent recurrence?
<input type="checkbox"/>	When did the employee's supervisor last check on job progress?	<input type="checkbox"/>	What new rules are needed?
<input type="checkbox"/>	When did the employee first sense something was wrong?	<input type="checkbox"/>	Could the employee have avoided it?
		<input type="checkbox"/>	Could fellow workers have avoided it?
		<input type="checkbox"/>	Could supervisors have prevented it - could it be prevented?
		<input type="checkbox"/>	Will a Standard Operating Procedure or Job Hazard Analysis be constructed?

Was a Department program/procedure violated?  Yes  No If Yes, define which one(s) \_\_\_\_\_

Were pictures taken?  Yes  No If Yes, attach them to this report

**Root Cause & Corrective/Preventive Actions**

What was identified as the root cause  Unsafe Act  Unsafe Condition

Specify: \_\_\_\_\_

Corrective/Preventive Actions	Responsible Person	Date Closed Out
1.		
2.		
3.		

Who completed this report?

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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