

**City of Oak Harbor**

**OAK HARBOR MARINA**

**ACCIDENT INVESTIGATION  
AND  
REPORTING POLICY**

**December 2000**

## OAK HARBOR MARINA

# ACCIDENT INVESTIGATION AND REPORTING POLICY

## DEFINITION AND PURPOSE

ALL ACCIDENTS, no matter how minor, shall be reported PROMPTLY to the immediate supervisor for evaluation/investigation. Since every accident includes a sequence of contributing causes, it is possible to avoid a repeat performance of the first event by recognizing and eliminating these causes. The removal of just a single cause can prevent a recurrence.

During the supervisor's evaluation, he/she must determine the possible consequences that could take place if the situation is not corrected. They must take appropriate action based upon those findings (i.e., investigate, report, correct, etc.).

## MEDICAL EMERGENCY PROCEDURE

Call 911 if emergency medical attention is necessary, or an aid car will be called in the case where the employee needs immediate medical attention. The Marina telephone number is 360-679-2628, or extension 240 or 242 on the City's internal telephone system. A supervisor will accompany the employee to the doctor's office or hospital.

## DOCUMENTATION PROCEDURE

1. Minor Injuries and Illnesses (requiring doctor and/or outpatient care)

After the emergency actions following an accident, an investigation of the accident will be conducted by the immediate supervisor in conjunction with any witnesses to the accident to determine the causes. The findings of the investigation shall be documented on an accident investigation form. Distribution of the completed form will be as follows:

- a. Copy to City Administrator
- b. Copy to office files
- c. Copy to safety committee
- d. Copy to Marina personnel file

Note: Please submit the original report to the Harbormaster, for distribution as indicated above.

2. Major Injuries and Illnesses (fatality or multiple hospitalization)
  - a. City's top management official, supervisor and safety/health committee chairperson are to be notified immediately by the person in charge. An investigation under the direction of the top management official will be conducted. In addition to the management official, the inspection party will include the supervisor of the injured person(s), and a representative from the safety/health committee.
  - b. In the case of a fatality, or if two or more employees are hospitalized for the same injury or illness, the supervisor will report the accident to the nearest office of the Department of Labor and Industries, or call the Department's toll-free telephone number 1-800-423-7233 within 24 hours after the occurrence of the accident.
  - c. The report shall relate the circumstances, the number of fatalities, and the extent of any injuries or illnesses.

#### **COMPLETE FORMS A, B & D**

*Note: Any equipment involved in an accident resulting in an immediate fatality is not to be moved until a representative of the Department of Labor and Industries investigates the accident and authorizes its removal. If, however, it is necessary to move the equipment to prevent further accidents or to remove the victim, the equipment may be moved as required.*

2. Near-Misses (likelihood of personal injury or property damage)

To the greatest extent possible, all "near-miss" accidents shall be investigated by a top management official (if the situation warrants), safety officer, supervisor, and safety/health committee representative. Documentation will be made on the City of Oak Harbor's accident investigation form.

A near-miss accident is defined as an unplanned event where damage resulted to equipment but there was no personal injury to employees, OR where damage did not result but the likelihood of personal injury to the employee was great. If the conditions which permitted the near-miss or "close-call" to exist are not eliminated, they will continue to be available to cause additional accidents which could eventually result in personal injury to the employee.

#### **COMPLETE FORM E**

## OAK HARBOR MARINA

### ACCIDENT AND INCIDENT REPORTING PROCEDURES

In the event department personnel, vehicles, or equipment are involved in an accident that results in injury to personnel or damage to equipment, the following procedures shall be completed. All accidents must be reviewed by the Safety Committee. This policy pertains to all Marina employees.

### VEHICLE, VESSEL AND PROPERTY DAMAGE ACCIDENTS

If a Marina vehicle or vessel is involved in an accident, first determine the severity of injuries, if any.

Notify Harbormaster or Assistant Harbormaster, and the Oak Harbor Police Department of the following:

- a. Location of accident
- b. Type of accident (pedestrian, pole, motor vehicle, boat, etc.)
- c. Injuries, if any (type and number)
- d. Equipment needed for assistance at the accident

The vehicle is to remain on scene until accident is investigated and released.

### MARINA SUPERVISOR'S RESPONSIBILITIES

1. Protect civilians and crew from traffic. If a boating accident, protect those involved from further injury to the maximum extent possible.
2. Request an Oak Harbor Police Officer to the scene of the accident for investigation. If a motor vehicle accident, fill out the Accident Reporting Kit (located in vehicle glove box).
3. If boats are involved, and potential for oil or fuel spill exists, notify ICOM and request assistance from Oak Harbor Fire Department. If danger of sinking exists, notify other Marina staff immediately via FM or 911, and call Marina crash cart to the scene.

4. Check for witnesses. Get names, addresses, telephone numbers and a brief description of what was seen. (Remember other employees are witnesses too.)
5. Make no statements at the scene of the accident except for information needed by police.
6. Attempt to get all pertinent information on an accident form.
7. Submit a report outlining details of the incident along with a copy of the accident report to the Harbormaster, who will make distribution within 24 hours. (Harbormaster forwards the report to the City Administrator.) If the Marina vehicle is involved, a copy of the accident report must be routed to the Public Works Equipment Coordinator for the vehicle file.
8. In the event of a vehicle accident, take pictures of the scene and the vehicle, and submit them with the report. Copies of the pictures will be routed to the Equipment Coordinator for the vehicle file.

#### COMPLETE FORM C & D

## DRIVER'S RESPONSIBILITY

CONTACT SUPERVISOR IMMEDIATELY. The driver of the vehicle and all employees involved shall complete an Accident or Incident Report Form, with the details of the accident, to the Harbormaster, who will forward it to the City Administrator within 24 hours of the accident.

## VEHICLE DAMAGE

Notify the Mechanics about the damaged equipment and let them evaluate whether or not it can remain in service. Complete a repair request form and submit it to the Mechanics as soon as a problem has been determined.

## PROPERTY DAMAGE

If property damage occurs, notify the Division Head for an evaluation of the damage. A narrative of the incident, and pictures of the damage, shall be completed by those employees involved and forwarded to the Harbormaster, who will make distribution within 48 hours.

## INJURED PERSONNEL

When an employee is injured on the job, involving a City vehicle or equipment, the Harbormaster or his assistant must be notified immediately. Log injury on Department of Labor and Industries Accident Log forms.

As part of the medical evaluation, complete your portion of the DEPARTMENT OF LABOR AND INDUSTRIES ACCIDENT REPORT. This document should be provided by your medical evaluator.

After completion of a medical evaluation, a report of your fitness for duty should be returned to the Harbormaster. If engaged in an activity that results in an injury requiring medical attention and time off from work, notify Harbormaster also. A medical release is required prior to returning to work.

**FORM A**  
**SAFETY & HEALTH**  
**INCIDENT/SECURITY REPORT**  
*(to be used for all occupational injuries or illnesses)*

**Part 1 - Please check appropriate category**

Medical Emergency     Personal Injury     Indoor Air Quality     Security (see part 2)     Motor Vehicle Accident     Ergonomic Issue     Other

Employee's Name (Last, First, MI)		Social Security Number (for ID only)		Work phone	
Date of incident		Department		Division	

*Please check the appropriate box(es) to the left of the text. Use "L" or "R" to designate left or right side of body, when applicable.*

Y	What is the part of the body affected?	Left or Right	Y	What is the nature of the injury?	Y	What were the contributing causes?	Y	What were the conditions during the incident?
	Abdomen			Abrasion		Absorption		Abused or misused equipment
	Ankle(s)			Bruise		Bypassing safety device		Chemical fire
	Arm(s)			Burn - chemical/illness		Caught in, under, between		Confined space
	Back (lower, middle)			Burn - radiation/illness		Collision		Defective equipment
	Chest (includes ribs)			Burn - thermal		Communication		Distracted by outside
	Ear(s) external			Carpal Tunnel Syndrome		Driving errors		Electrical fire
	Ear(s) internal			Dermatitis/illness		Exposure/contact with		Environmental (atmosphere)
	Elbows			Dislocation		Facilities/equipment		Excessive exposure
	Eye(s)			Electric shock		Failure to accommodate		Failure of tool or equipment
	Finger(s)			Foreign body		Failure to follow safety		Faulty floor or surface
	Groin			Fracture		Failure to get assistance		Hazardous material
	Hand(s)			Hearing loss/illness		Hazard		Inadequate or no guarantee
	Head (including neck)			Hearing loss/injury		Horseplay		Liquid spill
	Hip			Heat stroke		Improper lifting/pushing		New or modified equipment
	Knee(s)			Irritation/inflammation		Improper use of equipment		Obstructions present
	Leg(s)			Multiple injuries		Improper use of hands		Poor design/arrangement
	Multiple body parts			Near miss		In a hurry		Poor housekeeping
	Multiple toes			Puncture		Inadequate instruction		Poor lighting
	Neck			Repetitive trauma/injury		Inattention to surroundings		Proper tool/equipment
	Respiratory system			Scratches, abrasions		Inhaling/swallowing		Slippery floor
	Shoulder(s)			Sliver		Motor vehicle		Unsafe clothing
	Spine			Strains/sprains		Operating at unsafe speed		Weather - fog
	Toe			Unsafe act		Other factors		Weather - icy
	Wrist(s)			Other		Overexertion		Weather - rain
						Procedures		Weather - snow
						Repetitive motion		Working - other
						Slip/trip/fall		
						Struck against/struck by		<b>Did you:</b> Yes    No
						Training		Receive First Aid? <input type="checkbox"/> <input type="checkbox"/>
						Unsafe position		See a Doctor? <input type="checkbox"/> <input type="checkbox"/>
						Using unsafe equipment		Go to the Hospital? <input type="checkbox"/> <input type="checkbox"/>
						Wearing unsafe clothing		
						Working on moving equipment		
						Other		

**Part 2 - For security incidents only**

Name of suspect (last, first, MI)			
Address			
City known)	Claim # (if		
Date reported		Struck against/struck by	
To whom		Training	
Witness 1		Unsafe position	
Witness 2		Using unsafe equipment	
		Wearing unsafe clothing	
		Working on moving equipment	
		Other	

**FORM B**

**EMPLOYEE'S REPORT OF ACCIDENT**  
*(to be used for all occupational injuries or illnesses)*

EMPLOYEE'S NAME \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

JOB TITLE \_\_\_\_\_

EXACT TIME OF INJURY \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_

PLANT LOCATION WHERE INJURY OCCURRED \_\_\_\_\_

NAME OF PERSON TO WHOM THIS INCIDENT WAS REPORTED \_\_\_\_\_

NAME(S) OF WITNESS(ES) \_\_\_\_\_

SUMMARIZE WHAT YOU THINK HAPPENED \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WHAT COULD HAVE BEEN DONE TO AVOID THIS ACCIDENT? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**EXPLAIN IN DETAIL WHAT PART OF YOUR BODY WAS INJURED (BE SPECIFIC)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IS THIS AN ORIGINAL INJURY OR A RE-INJURY? \_\_\_\_\_

IF A RE-INJURY, WHEN AND WHERE WAS PREVIOUS INJURY? \_\_\_\_\_

WHO WAS THE EMPLOYER? \_\_\_\_\_ CLAIM NUMBER \_\_\_\_\_

WOULD YOU BE WILLING TO PERFORM LIGHT-DUTY WORK DURING YOUR RECOVERY? \_\_\_\_\_

DATE AND TIME YOU SOUGHT MEDICAL ATTENTION \_\_\_\_\_

WHOM DID YOU SEE? \_\_\_\_\_ OFFICE/HOSPITAL \_\_\_\_\_

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**THIS FORM IS TO BE RETURNED TO YOUR EMPLOYER AS SOON AS POSSIBLE**

DATE EMPLOYER RECEIVED REPORT \_\_\_\_\_

**USE SUPPLEMENTAL FORM IF MORE SPACE IS REQUIRED**

**FORM C**  
**OAK HARBOR MARINA**  
**SUPERVISOR'S REPORT OF AN ACCIDENT**  
*(to be used for all occupational injuries or illnesses)*

NAME OF INJURED EMPLOYEE: \_\_\_\_\_ DATE OF REPORT: \_\_\_\_\_

AGE	LENGTH OF EMPLOYMENT WITH CITY	LENGTH OF EMPLOYMENT CURRENT POSITION	DIVISION
<input type="checkbox"/> HEAD <input type="checkbox"/> HANDS <input type="checkbox"/> EYES <input type="checkbox"/> LEGS <input type="checkbox"/> TRUNK <input type="checkbox"/> TOES <input type="checkbox"/> ARMS <input type="checkbox"/> INTERNAL		<input type="checkbox"/> WOUNDS <input type="checkbox"/> AMPUTATION <input type="checkbox"/> BURNS <input type="checkbox"/> STRAIN/SPRAIN <input type="checkbox"/> HERNIA <input type="checkbox"/> FOREIGN BODY <input type="checkbox"/> FRACTURE <input type="checkbox"/> SKIN (occupational)	
REMARKS: _____		REMARKS: _____	
DATE OF INJURY		HOUR	EXACT LOCATION

EYEWITNESSES \_\_\_\_\_

DESCRIBE ACCIDENT, INCLUDE THE MACHINE, EQUIPMENT, OBJECT OR SUBSTANCE INVOLVED ... ALL DETAILS ... USE BACK SPACE IF NECESSARY \_\_\_\_\_

CAUSE: Mark basic cause

**UNSAFE CONDITIONS**

- 1  inadequately unguarded
- 2  unguarded
- 3  defective tools, equipment, or substance
- 4  unsafe design or construction
- 5  hazardous arrangement
- 6  unsafe illumination
- 7  unsafe ventilation
- 8  unsafe clothing
- 9  insufficient instruction

Mark contributing cause, if any

**UNSAFE ACTS**

- 1  operating without authority
- 2  operating at unsafe speed
- 3  making safety devices inoperative
- 4  using unsafe equipment or equipment unsafely
- 5  unsafe loading, placing, mixing
- 6  taking unsafe position
- 7  working on moving or dangerous equipment
- 8  distraction, teasing, horse play
- 9  failure to use personal protective devices

WHY DID THE UNSAFE CONDITION EXIST? **OR** WHY WAS THE UNSAFE ACT COMMITTED?

\_\_\_\_\_

\_\_\_\_\_

ANY PHYSICAL DISABILITIES? \_\_\_\_\_

NUMBER OF PREVIOUS DISABLING INJURIES? \_\_\_\_\_

**GUIDES TO CORRECTIVE ACTION**

BASED ON THE CAUSE CHECKED ABOVE, I AM TAKING THE FOLLOWING CORRECTIVE ACTION:

**UNSAFE ACT**

- 1  stop the worker
- 2  study the job
- 3  instruct (tell/show/try check)
- 4  follow up
- 5  enforce

**UNSAFE CONDITION**

- 1  remove
- 2  guard
- 3  warn
- 4  supervisory training

**IF SUPERVISOR CAN'T HANDLE, THEN**

- 5 recommend to: a)  own boss, or  
 b)  safety committee, or  
 c)  maintenance dept., or  
 d)  \_\_\_\_\_

FOLLOW UP \_\_\_\_\_

WHAT I AM ACTUALLY DOING TO PREVENT SIMILAR INJURIES? \_\_\_\_\_

WHAT FURTHER RECOMMENDATIONS? \_\_\_\_\_

\_\_\_\_\_

SIGNATURES

\_\_\_\_\_  
IMMEDIATE SUPERVISOR

\_\_\_\_\_  
HARBORMASTER



**FORM E**

**INCIDENT REPORT FORM**

*(to be used in the event of a non-injury accident)*

DATE \_\_\_\_\_

LOCATION \_\_\_\_\_ AREA \_\_\_\_\_

EMPLOYEE \_\_\_\_\_ TITLE \_\_\_\_\_

SUPERVISOR \_\_\_\_\_

**INCIDENT DESCRIPTION**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RECOMMENDED ACTION**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PREVENTIVE or CORRECTIVE ACTION THAT WILL BE TAKEN**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WORK ORDER ISSUED      Yes    No  
WORK ORDER #

SUPERVISOR \_\_\_\_\_  
ASST. HARBORMASTER \_\_\_\_\_  
HARBORMASTER \_\_\_\_\_

DATE \_\_\_\_\_  
DATE \_\_\_\_\_  
DATE \_\_\_\_\_

DATE RESOLVED/COMPLETED \_\_\_\_\_

**FORM F**  
**JOB/EQUIPMENT HAZARD FORM**

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

LOCATION \_\_\_\_\_

EMPLOYEE \_\_\_\_\_ TITLE \_\_\_\_\_

SUPERVISOR \_\_\_\_\_ TITLE \_\_\_\_\_

NOTIFICATION TO BE FORWARDED TO \_\_\_\_\_

LOCATION \_\_\_\_\_

**UNSAFE CONDITION or HAZARD**

(regarding public safety and/or possible damage to City owned piers, docks, buildings, parking lots, drainage, parks, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PREVENTIVE or CORRECTIVE ACTION THAT WILL BE TAKEN**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REPORTING PERSON \_\_\_\_\_

DATE \_\_\_\_\_

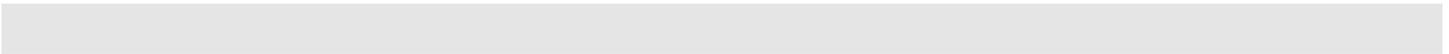
DIVISION HEAD \_\_\_\_\_

DATE \_\_\_\_\_

DATE RESOLVED/COMPLETED \_\_\_\_\_

**PLEASE FORWARD A COPY OF THE LETTER SENT TO RESPONSIBLE PARTY TO:**

\_\_\_\_\_



# ACCIDENT INVESTIGATION AND REPORTING TRAINING CERTIFICATION

I have received training as described in the Accident Investigation and Reporting Policy and Procedure.

The training was conducted on \_\_\_\_\_ (date).

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Social Security Number

I hereby certify that the above named employee has been provided with Accident Investigation and  
Reporting Training on: \_\_\_\_\_ (date).

\_\_\_\_\_  
Instructor's Signature

Description of Training/Location of Manual or Training Materials:

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