	Terryville Fire Department **Best Practices**	
	Subject **Accident, Injury, & Exposure Reporting and Investigation**	BP# 1-10 Initiated 1/1/2016
	Authority **Chief of Department**	Revised 3/20/2017

A. PURPOSE

1. To provide a process for reporting & investigation of accidents, injuries and exposure to communicable diseases. These procedures serve as an administrative best practice and do not provide the best practices for emergency response.

B. POLICY

1. All accidents, injuries and exposures to communicable diseases shall be reported.

C. PROCEDURES

1. For all accidents, injuries, or exposures to communicable diseases.

    - Report the incident immediately to your company officer or Officer in Charge (OIC). The company officer or OIC should then report the incident immediately to a Chief Officer. Depending on the severity of the incident, a chief officer will determine the next line of notification.

    - In the event of a serious injury or incident, the Chief of Department should be notified without delay.

    - Depending on the type of incident, the affected member and OIC will complete the appropriate forms (on file in the Radio Room) and submit to the chief's office as soon as possible.

    - The Chief's Office may request the Department Safety Officer or designee to conduct an accident investigation to determine the root cause and recommend solutions.

2. Communicable Disease Exposure Procedure

    - A communicable disease exposure includes exposure to someone else's blood, bodily fluids, vomit, urine feces, etc., and aerosol droplets from coughing, sneezing, etc.

    - All Exposure Incidents require immediate notification to the District Manager or other district representative for guidance from the Terryville Fire District Exposure Control Plan.

- The affected member shall immediately complete a Terryville Fire Department Exposure Report (on file in the Radio Room) and submit said report to the Chiefs Office which will review and forward to the Board of Fire Commissioners.

D. VEHICLE CRASHES

1. The driver of the involved vehicle must provide a verbal report to a company or chief officer as soon as possible following the crash. Failure to make this notification will result in severe disciplinary action.

2. If the crash occurs during a response, the response will cease and the dispatcher and Incident Commander (IC) will be notified immediately. In all cases, should an apparatus crash involve injury or cause property damage to anything other than the fire district property, the Suffolk County Police Department shall be notified.

3. Photos may be taken at the scene if requested by the Terryville Fire District, the Department Safety Officer (DSO) or a Chief Officer.

4. Immediately following the incident (as soon as feasible), the member driving the vehicle will be suspended from driving Terryville Fire District apparatus until such time as the incident receives a preliminary investigation. The Chief of Department will determine if the member may resume driving or if they remain suspended until the investigation is concluded.

5. The involved driver must complete a Terryville Fire Department Report of Occupational Accident/Injury and/or Crash Report (filed in the Radio Room) within 1 hour of the incident. This timeframe may be extended only if the member was receiving medical treatment as a result of the incident or if delayed to alarm response when authorized by the OIC. Reports shall be submitted to the Chiefs Office and be forwarded to the Board of Fire Commissioners.

E. INJURY REPORTS

1. The Terryville Fire Department Report of Occupational Accident/Injury is an immediate priority following the appropriate medical treatment. Reports shall be submitted to the Chiefs Office and be forwarded to the Board of Fire Commissioners.

2. All fire ground injuries must be reported to the Incident Commander (IC) as soon as possible. Other injuries occurring during a drill, work detail, etc., should be reported to the OIC as soon as possible.

F. INVESTIGATION

1. If a crash or incident results in serious personal injury or death, the initial investigation shall normally be conducted by the Suffolk County Police Department and any fire department investigations shall not hamper the law investigation.

2. Based on the crash/incident information provided, the Chief of Department may request an investigation to determine the cause and prevent such accidents/incidents from reoccurring.

    - Any investigation will be conducted by at least 3 members of the Terryville Fire Department Safety Committee, led by the DSO.

- The DSO will determine whether a full or condensed investigation is necessary based on the circumstances of the incident/accident.

- A full investigation should be completed under the following circumstances:

    a. Estimated damage greater than the district's insurance deductible
    b. Damaged vehicle requiring tow
    c. Member received traffic summons
    d. Injuries requiring medical treatment
    e. Accidents/Incidents resulting in significant property damage
    f. Any other accident/incident with extenuating circumstances
    g. Near misses when requested by the DSO, an ISO, or chief

- Investigations should begin within 48 hours of the incident and should ordinarily be concluded within seven (7) days.

- The investigation report will detail the root causes of the accident/incident, a corrective action plan that will help prevent similar occurrences in the future, and recommendations for additional training or disciplinary action if necessary.

- A final report shall be provided to the Chief of Department and Board of Fire Commissioners for review and appropriate action.

REPORT OF OCCUPATIONAL ACCIDENT/INJURY

A. ASSIGNED WORK LOCATION OF PERSON INJURED

Employee ❑Y ❑N	Volunteer ❑Y ❑N	Work Title	Company	Years In Title	Service Start Date

B. IDENTIFICATION

Last Name	First Name	Sex ☐ Male ☐ Female	Home Phone # Area Code ( )	Mobile Phone # Area Code ( )

Home Address (No., Street, Apt.)	City/Town	Language spoken if not English

State	Zip Code	Date of Birth MM DD YYYY	Age	Height ___ft.___I	Weight _____lb	Social Security Number

C. DATE, TIME AND LOCATION OF ACCIDENT/INJURY

Date of Injury Month Day Year	Time of Injury ☐ AM ☐ PM	Date Injury Reported Month Day Year	Occurred on Shift ☐ Day 6am-6pm ☐ Night 6pm-6am	# of Hours Worked Prior	Location Of Occurrence See Below:

☐ Station maintenance	☐ Fundraising	☐ Standing by station for call
☐ Apparatus maintenance	☐ Convention	☐ Training
☐ Emergency scene	☐ Emergency vehicle to emergency	☐ Auxiliary services
☐ Private auto to emergency	☐ Emergency vehicle to Non-emergency	☐ Other:
☐ Private auto Non-emergency	☐ Parades, picnics, contests	☐ Responding/returning to emergency (non-vehicle)

D. DUTY STATUS

Was person ☐ On Duty ☐ Off Duty when injured? If employed, when is employee scheduled to work next?
Date / / Time

E. NATURE OF INJURY

☐ Fractures	☐ Multiple Injury	☐ Loss of consciousness
☐ Inflammation	☐ Recurrence	☐ Heat exhaustion, fatigue
☐ Infectious Disease (exposure report)	☐ Strain, Sprain, torn ligament	☐ Heart malfunction
☐ Frostbite, Cold exposure	☐ Cuts, lacerations, punctures	☐ Eye injury
☐ Pinched nerve, ruptured disc	☐ Abrasions, contusions, bruises	☐ Burns
☐ Electric Shock	☐ Inhalation, fumes	☐ Other not listed:
☐ Chemical Injury	☐ Inhalation, smoke	

F. OCCURRENCE/CAUSATION CATEGORIES

☐ Struck by or contact with.	☐ Lifting, carrying pushing, or pulling	☐ Civil Disturbance
☐ Caught in, on or between.	☐ Repetitive motion	☐ Inadequate Ventilation
☐ Slip, trip, or fall.	☐ Hazardous materials (Fill Section H)	☐ Inadequate Illumination
☐ Patient/visitor action	☐ Weather	☐ Irrational Civilian
☐ Exposure (Airborne)	☐ Structural Collapse	☐ Communication
☐ Exposure (BBP / Biological)	☐ Back Draft	☐ Other :

G. TASKS BEING PERFORMED AT TIME OF INJURY

☐ Forcible entry	☐ Overhauling	☐ Rescue Operation
☐ Using ladders	☐ Salvage	☐ Administering first aid
☐ Advancing / directing hose line	☐ Servicing / repairing equipment	☐ Physical fitness
☐ Ventilating	☐ Extrication	
☐ Other:		

H. HAZARDOUS MATERIALS, PROCESSES OR CONDITIONS

1.☐ Mechanical Equipment, tools, VDTs:_____

2.☐ Physical Hazards:_____

3.☐ Materials Handling:_____

4.☐ Patient/Visitor Handling:_____

5.☐ Patient Care Related Equipment:_____

6.☐ Chemical(s):_____☐Solid ☐ Liquid ☐ Gas ☐ Vapor/Mist ☐ Particulates

7.☐ Metal(s):_____☐Solid ☐ Liquid ☐ Gas

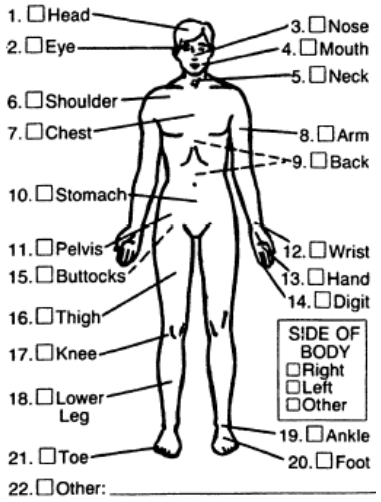
8.☐ Radiation: _____☐ Ionizing (X-ray) ☐ Non-ionizing (UV)

9.☐ Noise: (db level if known) _____☐ High Freq. ☐ Low Freq.

10.☐ Other:_____

I. BODY PART(S) INJURED OR

If more than one, circle primary



J. DESCRIPTION OF OCCURRENCE

In the person's own words describe exactly the events leading up to the occurrence, where it occurred, what the person was doing, size, weight, and type of equipment or materials involved, etc.

K. *District Safety Use Only*: RECOMMENDATIONS TO PREVENT REOCCURRENCES (Employees /Volunteers Do not fill out)

Evaluation whether the accident was avoidable or not and the reasons why

Contributing Factors:

☐ Safety devices made inoperative	☐ Improper lifting	☐ improper placement
☐ Using defective equipment	☐ Horseplay	☐ Lack of knowledge or skill
☐ Using equipment improperly	☐ Inadequate guards or protection	☐ Abuse or misuse

L. INFORMATION ABOUT PERSONNEL COMPLETING REPORT*

Title:_____ Name: _____Signature: _____

Work Phone #: _(_____)_____ Date of Report: _____/_____/_____

*If not the injured party, why?

M. WITNESSES (if witness is a employee, list department, unit and work phone number)

Names, Addresses, and phone numbers of witnesses to this occurrence.

N. MEDICAL DISPOSITION (to be completed by the Emergency Department if applicable)

Injured party examined in: 1.☐ District Medical Office 2.☐ ED (Name of Hospital)_____

3.☐ Private Physician (Documents to be forwarded to District Medical) Name of practice: _____

If employee was not seen by DMO or ED, please indicate why_____

Statement of Medical Findings/Diagnosis:

☐ Unable to Work ☐ Returned to Duty Date of Examination: _____/_____/_____

Name of Examining Physician: _____ _____

Print *Signature*

License No.: _____

Completion Check list

	Completed By:
☐ C2F Filled	
☐ Accident and Sickness Claim	
☐ Incident Statement form(s)	
☐ Attending Physician's statement	
☐ Biological Exposure Report	
☐ MVC incident / Accident form	
☐ Copy for injured	
☐ Copy to Safety	
☐ Discharge Paperwork	
☐ Health Services Referral	District Received Stamp:
☐ District Mail	
☐ Notifications:	Who:
□ Chiefs	
□ District	
□ BOFC	
District Use:	
☐ Pertinent Documents Sent to Carrier	

TERRYVILLE FIRE DEPARTMENT

VEHICLE CRASH REPORT

DATE _____ ALARM / NON-INCIDENT # _____

DRIVER NAME _____ VEHICLE ID _____

DATE OF CRASH _____ TIME OF CRASH _____

LOCATION OF CRASH _____

WEATHER / ROAD CONDITIONS _____

REASON FOR VEHICLE USE _____

OTHER PERSONNEL ON VEHICLE - YES NO

IF YES, PROVIDE THEIR NAMES _____

INJURIES - YES NO

IF YES, PLEASE DESCRIBE _____

WHAT WAS INVOLVED IN CRASH _____

WAS THIS CRASH AVOIDABLE - YES NO

WAS THIS CRASH REPORTED TO THE POLICE - YES NO

IF YES, PROVIDE NAME OF OFFICER AND/OR UNIT NUMBER _____

STATE IN YOUR WORDS WHAT HAPPENED _____

_____

_____

_____

SIGNATURE OF DRIVER _____

This report is to be completed in triplicate.

SAFETY OFFICER SIGNATURE _____ DATE _____

CHIEF'S SIGNATURE _____ DATE _____

DATE RECEIVED BY DISTRICT _____

BP# 1-10 (3/20/2017)

TERRYVILLE FIRE DISTRICT STATEMENT FORM

STATEMENT OF INCIDENT

Name:_____

Title:_____

Date of Incident:_____ Date Incident Reported:_____

Description of Incident (What happened?)_____

TERRYVILLE FIRE DISTRICT STATEMENT FORM

Incident Witnesses: ☐ Yes ☐ No If checked yes, list name(s) & telephone number(s) on back.

Cause of Incident (What caused it to happen?):_____

_____

_____

_____

How could this incident have been prevented?_____

_____

_____

_____

I certify that I have read the above information and that it is a true, accurate, and factual statement. I further certify that if I am injured that my injury/illness arose out of and in the course of my employment with Terryville Fire District. (I have read the above or it has been reviewed and explained to me.)

_____ _____

Signature Print Witness Name (For statement and signature only)

_____ _____

Date Witness Signature

_____ _____

_____ Date

Home Address (only if above is an injured party)

_____

Home Phone (Area code-Local number)