

Procedure for Reporting and Investigating Accidents/Incidents

All injuries, accidents, and incidents should be reported. An incident cannot be investigated if it is not reported. Employees must immediately notify their supervisor of any work site injury. The immediate supervisor must submit an Injury and Investigation Report.

Procedure for filing an KCS Injury Form

Go to Kanawha County Website

Click on Employees

Click on Intranet

Log-on Intranet

Click on Departments on the left of the page

Click on Safety and Security

Scroll down and click Student Injury Report

Click “to open a new tab”

Fill out the form, be sure that prior to submitting you have notified administration and they approve you to fill out the form.

Submit

Investigations

The purpose of on-site investigation is to document conditions and collect information, as well as to do a root-cause analysis to determine the cause(s).

It is important to take notes and document any and all information that might be important to the investigation. It is better to have too much information and not use it, than not have the correct information and not be able to get it after the fact.

WHO SHOULD CONDUCT AND PARTICIPATE IN THE INCIDENT INVESTIGATION?

- Administration
- Members of the safety committee
- Crisis Response Team

WHEN SHOULD THE INCIDENT INVESTIGATION BE CONDUCTED?

- As soon as possible, after the incident occurs or is reported.
- Before the scene of the incident is disturbed or changed.
- Before victim(s) and witnesses forget what happened.

I. Collecting evidence at the scene.

a. Document conditions using:

- photographs
- video tapes
- written notes
- ⌚ Taking measurements

b. What to look at and what information to collect.

- In the area where the incident occurred, look for conditions such as steam, fog, or haze from chemicals which may have contributed to problems with visibility.
- Safety conditions (e.g. slippery floors, uneven floors, cracked floors, ice on floors, clogged drains)
- Physical obstacles (e.g. tripping hazards, blocked exits)

II. Interviews

a. Who to interview?

- Victim
- Co-workers
- Person who reported incident, near-miss or injury (This person may be different from the victim.)
- Supervisor of area where incident occurred
- Witnesses

REPORT

INJURIES

in

24

HRS.

Human Resources

304-348-7749 or 304-348-6656

Complete the KCS Employee Injury Form

Benefits of early reporting:

- * Establishes the claim
- * Allows claims adjuster to begin management of the claim sooner
- * Speeds delivery of necessary benefits
- * Increases early return-to-work opportunities
- * Helps avoid costly litigation
- * Results in lower costs to the policyholder

BrickStreet
INSURANCE

EMPLOYEE INJURY REPORT

INJURED EMPLOYEE'S NAME *

FIRST

LAST

EMAIL

EMPLOYEE ID#

PHONE

WORK LOCATION *

EMPLOYEE POSITION

SUPERVISOR

EMAIL

PHONE

DATE OF INJURY *

TIME OF INJURY *

HH

:

MM

AM ▼

DATE REPORTED TO EMPLOYER *

DATE SUBMITTED TO HR

SCHOOL/SITE WHERE INJURY OCCURRED *

SPECIFIC LOCATION *

DETAILED DESCRIPTION OF WHAT EMPLOYEE WAS DOING AT TIME OF INJURY AND ALL FACTORS INVOLVED: *

NATURE OF INJURY: *

ABRASION

BITE

BROKEN BONE

BURN

CUT

EXPOSURE TO COVID-19

HEAD INJURY

HORSEPLAY

PUNCTURE

SEIZURE

SPILL

SPRAIN/STRAIN

OTHER

PART OF BODY INJURED: *

ABDOMEN

ANKLE

ARM

BACK

CHEST

EAR

FACE

FINGER

FOOT

HAND

HEAD

KNEE

LEG

NOSE

TEETH

WRIST

OTHER

SIDE OF BODY *

RIGHT

LEFT

MIDDLE

DID INJURY INVOLVE LOST SCHOOL BEYOND DATE OF INJURY?

No 

WHAT TYPE OF INITIAL MEDICAL TREATMENT WAS RECEIVED *

NO MEDICAL TREATMENT

FIRST AID BY SCHOOL EMPLOYEE

MINOR ON-SITE REMEDIES BY SCHOOL NURSE

MINOR CLINICAL/HOSPITAL MEDICAL REMEDIES AND DIAGNOSTIC TESTING

EMERGENCY EVALUATION, DIAGNOSTIC TESTING, AND MEDICAL PROCEDURES

ADMITTED TO HOSPITAL

OTHER

WHERE SPECIFICALLY WAS TREATMENT ADMINISTERED? (MEDEXPRESS, WHICH HOSPITAL OR CLINIC, ETC)

ARE YOU AWARE OF ANY ISSUES THAT WOULD MAKE YOU QUESTION THIS INJURY?

WAS THERE PRIOR INJURY OF PRE-EXISTING CONDITION?

WAS THERE ANY VIDEO OF THE INCIDENT? IF YES, PLEASE PROVIDE.

WITNESS STATEMENTS (IF ANY)

WITNESS #1

NAME

FIRST

LAST

EMAIL

PHONE

DESCRIPTION OF INCIDENT

WITNESS STATEMENTS (IF ANY)

WITNESS #2

NAME

FIRST

LAST

EMAIL

PHONE

DESCRIPTION OF INCIDENT

CAUSE OF INJURY *

- BEE STING
- BITE
- EQUIPMENT FAILURE
- EXPOSURE
- EXPOSURE TO COVID-19
- FALLING/FLYING OBJECT
- HORSEPLAY
- IMPROPER TASK FOCUS
- IMPROPER USE OF TOOLS/EQUIPMENT
- LIFTING
- SLIP
- TRIP
- FALL
- SPORTS INJURY
- VEHICLE ACCIDENT
- VIOLENCE
- OTHER

SLIPS/TRIPS/FALLS SPECIFIC (PLEASE FILL OUT THIS SECTION IF A SLIP/TRIP/FALL OCCURRED)

TYPE OF SHOES

FLOOR TYPE

CONDITION OF SOLES

FLOOR CONDITION

OBJECT, EQUIPMENT, SUBSTANCE OR TASK CONTRIBUTING TO SLIP/TRIP/FALL?

NAME OF PRINCIPAL OR SUPERVISOR WHO REVIEWED AND APPROVED THIS INJURY REPORT *

FIRST

LAST

EMAIL *

NAME OF PERSON SUBMITTING FORM *

FIRST

LAST

EMAIL *

NAME OF SCHOOL NURSE *

FIRST

LAST

EMAIL *

SUBMIT

VISITOR INJURY REPORT

INJURED VISITOR'S NAME *

FIRST

LAST

EMAIL

PHONE

ADDRESS

STREET ADDRESS

CITY

STATE

ZIP CODE

SUPERVISOR

EMAIL

PHONE

[Empty text input field]

DATE OF INJURY *

[Empty text input field]

TIME OF INJURY *

[Hour input field]

HH

: [Minute input field]

MM

AM ▼

DATE REPORTED *

[Empty text input field]

DATE SUBMITTED TO HR *

07/22/2021

SCHOOL/SITE WHERE INJURY OCCURRED *

[Empty dropdown menu]

SPECIFIC LOCATION *

Ball Field ▼

DETAILED DESCRIPTION OF WHAT VISITOR WAS DOING AT TIME OF INJURY AND ALL FACTORS INVOLVED: *

[Empty text input field]

NATURE OF INJURY: *

ABRASION

BITE

BROKEN BONE

BURN

CUT

EXPOSURE TO COVID-19

HEAD INJURY

HORSEPLAY

PUNCTURE

SEIZURE

- SPILL
- SPRAIN/STRAIN
- OTHER

PART OF BODY INJURED: *

- ABDOMEN
- ANKLE
- ARM
- BACK
- CHEST
- EAR
- FACE
- FINGER
- FOOT
- HAND
- HEAD
- KNEE
- LEG
- NOSE
- TEETH
- WRIST
- OTHER

SIDE OF BODY *

- RIGHT
- LEFT
- MIDDLE

DID INJURY INVOLVE LOST SCHOOL BEYOND DATE OF INJURY?

No ▼

WHAT TYPE OF INITIAL MEDICAL TREATMENT WAS RECEIVED *

- NO MEDICAL TREATMENT
- FIRST AID BY SCHOOL EMPLOYEE
- MINOR ON-SITE REMEDIES BY SCHOOL NURSE
- MINOR CLINICAL/HOSPITAL MEDICAL REMEDIES AND DIAGNOSTIC TESTING
- EMERGENCY EVALUATION, DIAGNOSTIC TESTING, AND MEDICAL PROCEDURES

ADMITTED TO HOSPITAL

OTHER

WHERE SPECIFICALLY WAS TREATMENT ADMINISTERED? (MEDEXPRESS, WHICH HOSPITAL OR CLINIC, ETC)

ARE YOU AWARE OF ANY ISSUES THAT WOULD MAKE YOU QUESTION THIS INJURY?

No ▼

WAS THERE PRIOR INJURY OF PRE-EXISTING CONDITION?

No ▼

WAS THERE ANY VIDEO OF THE INCIDENT? IF YES, PLEASE PROVIDE.

No ▼

WITNESS STATEMENTS (IF ANY)

WITNESS #1

NAME

FIRST

LAST

EMAIL

PHONE

DESCRIPTION OF INCIDENT

WITNESS STATEMENTS (IF ANY)

WITNESS #2

NAME

FIRST

LAST

EMAIL

PHONE

DESCRIPTION OF INCIDENT

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FLOOR TYPE

CONDITION OF SOLES

FLOOR CONDITION

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NAME OF PRINCIPAL OR SUPERVISOR WHO REVIEWED AND APPROVED THIS INJURY REPORT *

FIRST

LAST

EMAIL *

NAME OF PERSON SUBMITTING FORM *

FIRST

LAST

EMAIL *

NAME OF SCHOOL NURSE *

FIRST

LAST

EMAIL *

STUDENT INJURY REPORT

INJURED STUDENT'S NAME *

FIRST

LAST

PHONE

ADDRESS

STREET ADDRESS

CITY

STATE

ZIP CODE

HOME SCHOOL *

MALE

FEMALE

HOME ROOM TEACHER

GRADE

SUPERVISING ADULT

PHONE

DATE OF INJURY *

TIME OF INJURY *

HH

:

MM

AM

DATE REPORTED TO PARENT/GUARDIAN *

DATE SUBMITTED TO SAFETY DEPARTMENT *

SCHOOL/SITE WHERE INJURY OCCURRED *

SPECIFIC LOCATION *

DETAILED DESCRIPTION OF WHAT STUDENT WAS DOING AT TIME OF INJURY AND ALL FACTORS INVOLVED: *

NATURE OF INJURY: *

ABRASION

BITE

BROKEN BONE

BURN

CUT

EXPOSURE TO COVID-19

HEAD INJURY

HORSEPLAY

PUNCTURE

SEIZURE

SPILL

SPRAIN/STRAIN

OTHER

PART OF BODY INJURED: *

ABDOMEN

ANKLE

ARM

BACK

CHEST

EAR

FACE

FINGER

FOOT

HAND

HEAD

KNEE

LEG

NOSE

TEETH

WRIST

OTHER

PART OF BODY INJURED *

RIGHT

LEFT

MIDDLE

DID INJURY INVOLVE LOST SCHOOL BEYOND DATE OF INJURY?

No 

WHAT TYPE OF INITIAL MEDICAL TREATMENT WAS RECEIVED *

NO MEDICAL TREATMENT

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MINOR ON-SITE REMEDIES BY SCHOOL NURSE

MINOR CLINICAL/HOSPITAL MEDICAL REMEDIES AND DIAGNOSTIC TESTING

EMERGENCY EVALUATION, DIAGNOSTIC TESTING, AND MEDICAL PROCEDURES

ADMITTED TO HOSPITAL

OTHER

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ARE YOU AWARE OF ANY ISSUES THAT WOULD MAKE YOU QUESTION THIS INJURY?

No ▼

WAS THERE PRIOR INJURY OF PRE-EXISTING CONDITION?

No ▼

WAS THERE ANY VIDEO OF THE INCIDENT? IF YES, PLEASE PROVIDE.

No ▼

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NAME

FIRST

LAST

EMAIL

PHONE

DESCRIPTION OF INCIDENT

WITNESS STATEMENTS (IF ANY)

WITNESS #2

NAME

FIRST

LAST

EMAIL

PHONE

DESCRIPTION OF INCIDENT

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FIRST

LAST

EMAIL *

NAME OF PERSON SUBMITTING FORM *

FIRST

LAST

EMAIL *

DKISE@mail.kana.k12.wv.us

NAME OF SCHOOL NURSE *

FIRST

LAST

EMAIL *

SUBMIT