# SUPERVISOR'S FIRST REPORT OF INCIDENT / MISHAP

*PLEASE PRINT – COMPLETE ALL ITEMS IF DWC –1 FORM SUBMITTED TO WORKERS' COMP– SUBMIT IMMEDIATELY*
*COMPLETE HIGHLIGHTED ITEMS TO DOCUMENT FIRST AID INCIDENT ONLY*

SUPERVISOR SECTION

Employee: Joe Williams  Dept/Div: PW/Parking Services  Classification: Parking Control Rep

Address  City/Zip:  Home Phone:

Birthdate: / /  Age:  M ☐ F ☐  Date of Hire: / /  Shift: Day ☐ Evening ☐ Night ☐

Date of Incident: 5 /31 /12  Time of Incident: 8:10 (AM) PM  Time reported to work: Date: 5 /31/12  Time: 8:30 (AM) PM

Date Incident Reported: 5 /31/12  Reported to Whom? Security Guard and Arlene Armendariz

Location of Incident: City Hall parking structure stairwell at main entrance.

Type of Incident: Injury X  Property Damage ☐  Equipment Damage ☐  Vehicle Collision ☐  Near-Miss ☐

(1) Was employee given 1st Aid  Yes X No ☐  (2) Was treatment refused by employee  Yes ☐ No X

**Notify Workers' Compensation for "YES" answers to Items #3, #4 & #5**

(3) Was employee sent to:
- Emergency Room  Yes X No ☐  Name of Hospital Riverside Community Hospital
- Preferred Clinic  Yes ☐ No ☐  Name of Clinic
- Pre-designated Physician  Yes ☐ No ☐  Name of Physician
- Other

(4) Was employee admitted to hospital  Yes ☐ No X  (5) Fatality  Yes ☐ No X

Did employee wear protective equipment  Yes X No ☐  List equipment used:

**Part of Body**
- ☐ No Injury
- X Fill in Blank (be specific) Right radial head fracture on elbow. Abrasion on back of head.

**Type of Injury** (check)
- ☐ Reaction to foreign substance/object
- ☐ Puncture
- ☐ Loss of Consciousness
- ☐ Chemical Exposure
- ☐ Other
- ☐ Contusion
- ☐ Burn
- ☐ Sprain / Strain
- ☐ OPIM Exposure
- X Fracture
- ☐ Amputation
- ☐ Laceration

**Incident Cause** (check)
- X Fall from stairs / obstacle / elevation
- ☐ Defective equipment
- ☐ Horseplay
- ☐ Other
- ☐ Act or procedure
- ☐ Fall on floor / surface
- ☐ Repetitive Motion
- ☐ Injury from falling objects
- ☐ Improper use of equipment / instrument
- ☐ Back injury from lifting

**Witnesses**
(1)Name: JOHN PEINE  Dept/Address: COMM. DEV. BLDG DIV  Phone: X 5720
(2)Name:  Dept/Address:  Phone:

***City Vehicle Information:*** Year/Make/Model  Type Vehicle  Asset#
Headlights on: Yes ☐ No ☐  Warning Lights on: Yes ☐ No ☐  Turn signals used: Yes ☐ No ☐  Horn used: Yes ☐ No ☐
Seatbelts Worn: Driver Yes ☐ No ☐  Passenger Yes ☐ No ☐  Police Report #  Reporting Agency

***Other Vehicle Information***: (if applicable)
Driver Name:  Address  City  Phone
Driver's License #  Vehicle Year/Make/Model  Vehicle License #
Insurance Company & Policy #

***Damages:*** List all damage to property, equipment and/or vehicles

***Select conditions present at time of incident:***

Environment (Internal / External)
- X Sunny
- ☐ Bright sun / glare
- ☐ Cloudy / fog
- ☐ Windy
- ☐ Hot or Cold
- ☐ Rain
- ☐ Night
- ☐ Dusk / dawn
- ☐ Other

Equipment / Materials
- ☐ Tire condition
- ☐ Belt condition
- ☐ Improper adjustment
- ☐ Incorrect tool
- ☐ Improper design / type
- ☐ Lights inoperative
- ☐ Insulation failure
- ☐ Loose / missing hardware
- ☐ Defective materials
- ☐ Other
- ☐ Lubrication
- ☐ Belt adjustment
- ☐ Corroded
- ☐ Leaking hose / fitting
- ☐ Guards defective / missing
- ☐ Incorrect materials

Facility
- ☐ Layout of equipment
- ☐ Housekeeping
- ☐ Lighting
- ☐ Floors wet / uneven
- ☐ Ventilation
- ☐ Other

Personnel
- ☐ Fatigue
- ☐ Action of other(s)
- ☐ Insufficient training
- ☐ Other
- ☐ Improper work practice
- ☐ PPE not used

Form No. 1210.041 (8/03)

# SUPERVISOR'S FIRST REPORT OF INCIDENT / MISHAP

## ATTACH ADDITIONAL SHEETS OF PAPER AS NEEDED FOR NARRATIVES

**EMPLOYEE SECTION**

***Employee statement on how incident occurred:*** ☑ check box if statement is attached

SEE ATTACHED

***Employee statement on how recurrence could be prevented:*** ☑ check box if statement is attached

**SUPERVISOR SECTION**

***Describe in detail what employee was doing at time of incident*** (what, how, why): ☐ check box if statement is attached

Employee returned to his vehicle parked in the City Hall garage to retrieve his mister. When he was going down the stairs he slipped and fell forward. He tried to grab the rail but missed it and fell on his right hand.

***Describe what act / condition(s) contributed to the incident*** (i.e. improper use of equipment, wet floor, etc.): ☐ check box if statement is attached

Employee slipped and fell while taking the steps down and lost his balance.

***Supervisors conclusions:*** ☐ check box if statement is attached

Employee did not hold on to the railing which could have prevented his fall. Employees shoes are worn and may have contributed to the fall. Employee may have felt dizzy from seizure medication. Employee takes medication at night to prevent seizures and causes dizziness. Medication is required to be taken with food. Employee has shown signs of being incoherent before.

***Supervisors recommendation(s) to prevent recurrence:*** (Type of training, repair/replace equipment, etc.) ☐ check box if statement is attached

Employee should purchase new walking shoes immediately. Employee should also hold on to the railing whenever taking the stairs.

Employee has been reminded to take his medication which caused dizziness with food before bedtime.

**Employee's Signature:** Joe Williams **Date:** 6/6/12

**Supervisor's Signature:** [signature] **Date:** 6/6/12

**Superintendent/ Manager Signature:** [signature] **Date:** 6/7/12

**Distribution:** **City Safety Officer (Original)**
Department / Division (File copy)

**Safety Officer will route copies as needed**

# PCR INCIDENT REPORT

PCR Name: Joe Williams # 100

Date of Incident: 5/31/12

Time of incident: 8:10 AM

Citation #: _____

Location: _____

Vehicle Information:

_____

_____

Summary of Events: AT APPROX. 810 HRS ON MAY 31, 2012, I WENT TO THE PARKING GARAGE AT CITY HALL TO GET MY MISTER OUT OF MY CAR. I WAS WALKING DOWN THE STAIRS IN THE GARAGE, WHEN I SLIPPED ON THE STEPS. I TRIED TO GRAB THE RAIL, BUT MISSED. I FELL DOWN THE STAIRS. PARAMEDICS WERE CALLED BECAUSE I INJURED MY RIGHT ARM AND WRIST. I WAS TAKEN TO THE HOSPITAL TO GET CHECKED. NO FURTHER ACTION TAKEN.

* Attach any additional notes taken during incident that would support your summary of events

PCR Signature: Joe Williams Date: 6/6/12

Administrators Signature: _____ Date: _____

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**SUPERVISOR SECTION**

Employee: Joe Williams  Dept/Div: Public Works / Parking Services  Classification: Parking Control Representative

Address  City/Zip:  Home Phone:

Birthdate: / /  Age:  M xx F☐  Date of Hire: / /  Shift: Day ☐ Evening ☐ Night ☐

Date of Incident: 11/15 /2012  Time of Incident: 10:00 (AM) PM  Time reported to work: Date: / /  Time: AM PM

Date Incident Reported: / /  Reported to Whom?

Location of Incident: 4000 block of Orange Street, between 10th and 11th Street

Type of Incident: Injury ☐ Property Damage ☐ Equipment Damage ☐ Vehicle Collision ☐ Near-Miss ☐

(1) Was employee given 1st Aid  Yes xx No ☐  (2) Was treatment refused by employee  Yes ☐ No xx

**Notify Workers' Compensation for "YES" answers to Items #3, #4 & #5**

(3) Was employee sent to: Emergency Room Yes xx No ☐  Name of Hospital Riverside Community Hospital

Preferred Clinic Yes ☐ No ☐  Name of Clinic _____

Pre-designated Physician Yes ☐ No ☐  Name of Physician _____

Other _____

(4) Was employee admitted to hospital  Yes ☐ No xx  (5) Fatality  Yes ☐ No xx

Did employee wear protective equipment  Yes ☐ No ☐  List equipment used: _____

**Part of Body**
xx No Injury
☐ Fill in Blank (be specific)
_____

**Type of Injury (check)**
☐ Reaction to foreign substance/object ☐ Contusion ☐ Fracture
☐ Puncture ☐ Burn ☐ Amputation
☐ Loss of Consciousness ☐ Sprain / Strain ☐ Laceration
☐ Chemical Exposure ☐ OPIM Exposure
xx Other - Possible brain seizure

**Incident Cause** (check)
☐ Fall from stairs / obstacle / elevation ☐ Act or procedure ☐ Injury from falling objects ☐ Back injury from lifting
☐ Defective equipment ☐ Fall on floor / surface ☐ Improper use of equipment / instrument
☐ Horseplay ☐ Repetitive Motion
xx Other - no apparent cause

**Witnesses**
(1)Name: unknown female (called 911)_____ Dept/Address: _____ Phone: _____
(2)Name: Mario Herrera (notified parking services dispatch)_ Dept/Address: _____ Phone: (909) 533-9774

***City Vehicle Information:*** Year/Make/Model n/a_____ Type Vehicle _____ Asset# _____
Headlights on: Yes ☐ No ☐  Warning Lights on: Yes ☐ No ☐  Turn signals used: Yes ☐ No ☐  Horn used: Yes ■ No ☐
Seatbelts Worn: Driver Yes ☐ No ☐  Passenger Yes ☐ No ☐  Police Report # _____ Reporting Agency _____

***Other Vehicle Information:*** (if applicable)
Driver Name: _____ Address _____ City _____ Phone _____
Driver's License # _____ Vehicle Year/Make/Model _____ Vehicle License # _____
Insurance Company & Policy # _____

***Damages:*** List all damage to property, equipment and/or vehicles ____n/a _____

***Select conditions present at time of incident:***

Environment (Internal / External)
☐ Sunny ☐ Rain
☐ Bright sun / glare ☐ Night
xx Cloudy / fog ☐ Dusk / dawn
☐ Windy ☐ Other _____
☐ Hot or Cold

Facility
☐ Layout of equipment ☐ Floors wet / uneven
☐ Housekeeping ☐ Ventilation
☐ Lighting ☐ Other _____

Equipment / Materials
☐ Tire condition ☐ Lights inoperative ☐ Lubrication ☐ Corroded
☐ Belt condition ☐ Insulation failure ☐ Belt adjustment ☐ Leaking hose / fitting
☐ Improper adjustment ☐ Loose / missing hardware ☐ Guards defective / missing
☐ Incorrect tool ☐ Defective materials ☐ Incorrect materials
☐ Improper design / type ☐ Other _____

Personnel
☐ Fatigue ☐ Insufficient training ☐ Improper work practice ☐ PPE not used
☐ Action of other(s) ☐ Other _____

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**ATTACH ADDITIONAL SHEETS OF PAPER AS NEEDED FOR NARRATIVES**

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**EMPLOYEE SECTION**

***Employee statement on how incident occurred:*** ☐ check box if statement is attached

Mr. Williams (Parking Control Representative) was on his normal foot patrol of the downtown area for parking enforcement duties. Mr. Williams had stopped to talk to an unidentified female on th 4000 block of Ornage Street between 10th and 11th Street. It is unclear what transpired next, either the unidentified female or a second person (Mr. Mario Herrera) noticed that Mr. Williams was "blanking out" and called 911 for assistance.

Approximately 10:03am, Sr. Office Specialist (Ms. Anna Riddle) received at telephone call from Mario Herrera (909-533-9774) advising that Mr. Williams had a possible seizure and emergency responders were on scene. Two other Parking Control Representatives (Juan Moreno and Andrew Medrano) in the downtown area arrived at the scene and observed that Mr. Williams was responsive to emergency responders.

Mr. Williams was taken by ambulance to Riverside Community Hospital Emergency for further diagnoses and treatment an. Mr. Williams wife was notified and met Mr. Williams at hospital.

AS FOR 2:20pm MR. WILLIAMS WAS RELEASED FROM HUSPITAL AND HAS GONE HOME.

***Employee statement on how recurrence could be prevented:*** ☐ check box if statement is attached

**SUPERVISOR SECTION**

***Describe in detail what employee was doing at time of incident*** (what, how, why): ☐ check box if statement is attached

***Describe what act / condition(s) contributed to the incident*** (i.e. improper use of equipment, wet floor, etc.): ☐ check box if statement is attached

***Supervisors conclusions:*** ☐ check box if statement is attached

Mr. Williams has not fully disclosed to his supervisor the extent of his medical history or medication (if any). However, Mr. Williams wife stated today that he has gone through cancer treatment some years ago.

Additionally, Mr. Williams has been observed by his co-workers and supervisor to be "spaced or zoned out", but usually become responsive within 15 to 20 minutes.

***Supervisors recommendation(s) to prevent recurrence:*** (Type of training, repair/replace equipment, etc.) ☐ check box if statement is attached

**Employee's Signature:** _____ **Date:** _____

**Supervisor's Signature:** FOR ARLENE ARMENDARIZ **Date:** 11/15/12

**Superintendent/ Manager Signature:** _____ **Date:** _____

**Distribution:** City Safety Officer (Original)
Department / Division (File copy)

**Safety Officer will route copies as needed**