

Incident Detail	
<b>Incident Name:</b> Benjermin Jones/Elwood	<b>Date of Incident:</b> 01/10/2023 09:30 AM
<b>Incident Type:</b> INJURY	
<b>Workday Period:</b> N/A	<b>Activity Details:</b> Employee was headed to work.
<b>Person's Name:</b> Benjermin Jones	<input type="checkbox"/> Self <input checked="" type="checkbox"/> Employee <input type="checkbox"/> 3rd Party/Visitor
<b>Location:</b> Indianapolis - SR 13 And 1400 N	
<b>Was employee sent for a drug/alcohol screen?:</b> no he was life flighted to ST Vincents hospital	<b>Was JSA posted and properly filled out?:</b> NA

**Incident Activities**

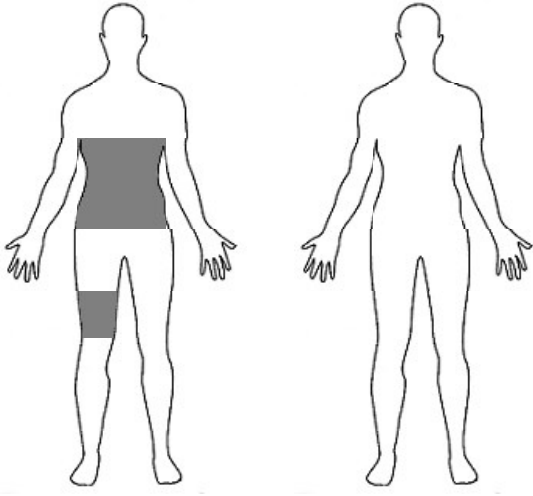
**What lead up to the incident?**

Luke Called and stated he was running behind but was on his way to work. At about 9:30 Am we were called by a deputy at the accident scene letting us Know Luke had been in an accident.

**Describe what happened?**

After speaking with the Police and investigating the scene it appears Luke ran a stop sign and was hit by a Semi

**Reported Injuries**

 <p style="text-align: center;"><b>FRONT</b>                      <b>BACK</b></p>	<p><b>Nature of Injury:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> Abrasion/scrape</td> <td><input type="checkbox"/> Amputation</td> </tr> <tr> <td><input checked="" type="checkbox"/> Broken bone</td> <td><input checked="" type="checkbox"/> Bruise/Contusion</td> </tr> <tr> <td><input type="checkbox"/> Burn (heat)</td> <td><input type="checkbox"/> Burn (chemical)</td> </tr> <tr> <td><input type="checkbox"/> Concussion (to the head)</td> <td><input checked="" type="checkbox"/> Crushing Injury</td> </tr> <tr> <td><input type="checkbox"/> Cut, laceration, puncture</td> <td><input type="checkbox"/> Hernia</td> </tr> <tr> <td><input type="checkbox"/> Irritation (eye, skin, etc.)</td> <td><input type="checkbox"/> Sprain, strain</td> </tr> <tr> <td><input checked="" type="checkbox"/> Damage to body system</td> <td><input type="checkbox"/> Other</td> </tr> </table> <p><b>Body Parts Affected:</b></p> <p><b>Front:</b> Ribs, Right Upper Leg</p> <p><b>Back:</b> None</p>	<input type="checkbox"/> Abrasion/scrape	<input type="checkbox"/> Amputation	<input checked="" type="checkbox"/> Broken bone	<input checked="" type="checkbox"/> Bruise/Contusion	<input type="checkbox"/> Burn (heat)	<input type="checkbox"/> Burn (chemical)	<input type="checkbox"/> Concussion (to the head)	<input checked="" type="checkbox"/> Crushing Injury	<input type="checkbox"/> Cut, laceration, puncture	<input type="checkbox"/> Hernia	<input type="checkbox"/> Irritation (eye, skin, etc.)	<input type="checkbox"/> Sprain, strain	<input checked="" type="checkbox"/> Damage to body system	<input type="checkbox"/> Other
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<p><b>Describe injuries and body parts affected</b> kidney, legs, ribs</p>	<p><b>Describe object that directly harmed</b> kidney, legs, ribs</p> <p>Truck totaled</p>														

**Treatments**

**Type of treatment given:**

- First Aid/On site
- Treatment by Doctor
- Treated in emergency room
- Hospitalized overnight
- None/refused
- Other treatment

**Treatment given by:**

**Facility:** St. Vincents  
**Address:** 2001 w 86th St  
**City:** Indianapolis  
**State:** IN  
**Zip:** 46260  
**Physician:** N/A

**Treatment Detail:**

air lifted to St. Vincents and had surgery on his leg and possibly had kidney removed

**Incident Conditions****Conditions contributing to incident:**

- |  |  |
|--|--|
| <input type="checkbox"/> Poor housekeeping                     | <input type="checkbox"/> Congested work area                     |
| <input type="checkbox"/> Poorly designed workstation           | <input type="checkbox"/> Walking/working surfaces in poor repair |
| <input type="checkbox"/> Guards/barriers missing or inadequate | <input type="checkbox"/> Machinery/equipment not maintained      |
| <input type="checkbox"/> Vehicle not properly maintained       | <input type="checkbox"/> Tools not properly maintained           |
| <input type="checkbox"/> Poor lighting/illumination            | <input type="checkbox"/> Safety device was defective             |
| <input type="checkbox"/> Hazardous atmosphere/poor ventilation | <input type="checkbox"/> Working from height                     |
| <input type="checkbox"/> Inclement weather                     | <input checked="" type="checkbox"/> Other                        |

**Why did unsafe conditions exist?**

employee was rushing to work

**Incident Behaviors****Behaviors contributing to incident:**

- |  |  |
|--|--|
| <input type="checkbox"/> Did not adhere to company policy            | <input type="checkbox"/> Acted unprofessionally/horseplay              |
| <input checked="" type="checkbox"/> Took unnecessary risk            | <input checked="" type="checkbox"/> Distracted/mind not on task        |
| <input type="checkbox"/> Worked at unsafe speed/rushed               | <input type="checkbox"/> Performed task when not authorized or trained |
| <input type="checkbox"/> Used equipment in improper or unsafe manner | <input type="checkbox"/> Failed to use available equipment             |
| <input type="checkbox"/> Used poor posture/poor ergonomics           | <input type="checkbox"/> Used improper lifting technique               |
| <input type="checkbox"/> PPE not used or not worn properly           | <input type="checkbox"/> Bypassed safety devices                       |
| <input type="checkbox"/> Working under the influence                 | <input checked="" type="checkbox"/> Other                              |

**Why did unsafe acts/behaviors occur?**

ran a stop sign

**Witness Information**

Name	Phone	Email	Address	City	State	Zip
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**Submission Detail**

Submitted by: Sylvester Hardrick

Date/Time: 01/10/2023 12:04 PM

Doc ID: #10666

Incident Photo(s)

