

Guided Worksheet - AAAR



Instructions: Use this worksheet to assist you in creating a 2397-AB accident report in ReportIt using Guided mode. Because Guided mode does not always follow the form flow, this worksheet can assist you in gathering only the information you need and then enter the accident details in ReportIt.

Required*

Investigation board (if applicable)		
Member Name: *	Member AKO Email Address: *	
Member Rank:	Member Branch:	Member Classification:
Member Board Position: *	Member Rating	

General Accident Information		
Date and time of accident: * _____ YYYYMMDD	Period of Day* _____	Accident Type:
Primary event type: *	Secondary event type:	Tertiary event type:
Occur on Post: * Yes <input type="checkbox"/> No <input type="checkbox"/>	Country:	State (if applicable):
City nearest accident site:	Nearest installation:	
Take place on airfield: * Yes <input type="checkbox"/> No <input type="checkbox"/>	Grid coordinates/Lat-Long:	
Accountable unit UIC: *	Accountable unit name: *	Country unit is located:
State (if applicable):	Home Station:	Army Command: *
Summary of events from the initial onset of the accident until the aircraft was at rest:		

Personnel					
Personnel service code: *		Rank/Pay Grade (if applicable): *		Last: *	First: *
Middle Initial:	Social security number: _____ - _____ - _____		Date of birth: YYYYMMDD	Gender: * Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/>	
Assigned UIC: (only if different from above) *		On duty at time of accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Duty position at time of accident: *	FAC:	RL:
On flight controls? * Yes <input type="checkbox"/> No <input type="checkbox"/>	Activity (last 24 hrs) Hrs slept <input type="checkbox"/> Hrs worked <input type="checkbox"/> Hrs flown <input type="checkbox"/>			Date redeployed from combat zone: YYYYMMDD	
Lab tests accomplished: Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes": Pos <input type="checkbox"/> Neg <input type="checkbox"/>		Total flight hours in the accident aircraft MTDS? *	Total flight hours in all aircraft?	Did protective/restraint/survival equipment function as designed? Yes <input type="checkbox"/> No <input type="checkbox"/> If "No", answer questions about PPE equipment; otherwise skip these questions.	
What was the PPE item?		For the PPE item, what were the problems/conditions? Item (retention, type or component): _____ Component (component, configuration or condition): _____ Condition (condition or location) : _____			
Escape difficulties or rescue required? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", answer the questions about the escape/rescue; otherwise skip these questions.		What was the individual's location in the aircraft at the time of the accident:		How did the individual escape? Exit used to escape: Aircraft position at time of escape	
Cockpit/Cabin conditions occupied by person at time of accident?	The individual's physical condition: Fatal <input type="checkbox"/> Fully able to assist <input type="checkbox"/> Immobile/unconscious <input type="checkbox"/> Partially able to assist <input type="checkbox"/>				
Explain failures, malfunctions, injuries or other problems not already adequately defined.					

Personnel		
How did this individual attempt to exit?	Why was it difficult to escape the aircraft?	
Indicate escape and/or rescue problems for:	Survival problems encountered:	
	Means used to locate individual:	
	Rescue equipment used:	
	Factors that helped rescue:	
	Factors complicating rescue:	
Rescue event details:	Phase (event) of the rescue	
	When was it initiated (date/time) _____	
	How much time lapsed from beginning to end of this phase: Hrs <input style="width: 40px;" type="text"/> Minutes <input style="width: 40px;" type="text"/>	
What rescue vehicle was used?	Distance from aircraft to actual rescue vehicle at time of accident? Nautical miles <input style="width: 40px;" type="text"/> Statute miles <input style="width: 40px;" type="text"/>	What was the rescue assist vehicle?
Was this person injured? * Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", to what extent: * <input type="checkbox"/> Fatal <input type="checkbox"/> Permanent Total Disability <input type="checkbox"/> Permanent Partial Disability <input type="checkbox"/> Days away from work (Lost workday case) <input type="checkbox"/> Restricted Work Activity <input type="checkbox"/> Medical treatment beyond first aid <input type="checkbox"/> First aid <input type="checkbox"/> Missing and presumed dead	If fatality: Date of Death: * YYYYMMDD Time of Death: HHMM Cause of Date: Autopsy performed: * Yes <input type="checkbox"/> No <input type="checkbox"/> If "yes", date: YYYYMMDD	
	Unconscious? * Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" * How long: ____:____	Amnesia? * Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" * How long: ____:____
		Treated in emergency room: * Yes <input type="checkbox"/> No <input type="checkbox"/> Who provided the treatment? _____

Personnel					
Treatment away from worksite? Yes <input type="checkbox"/> No <input type="checkbox"/>		If "Yes", Name of facility:			
		Country:			
		Street/City/State/Zipcode			
Days hospitalized:	Days lost not due to hospitalization:	Day restricted:	OSHA Log #	Date Hired YYYYMMDD	Time began work: HHMM
Home address	Country:				
	Street/City/State/Zip:				
Illness/Injury	Body part injured: *				
	Primary aspect of the injury: *				
	Secondary aspect of the injury: *				
	What was the injury? *				
	Cause of the injury?				
	Injury mechanism qualifier? *				
	Object/substance directly causing injury?				
	Injury cause factor subject: *				
	Injury cause factor action: *				
	Injury cause factor qualifier: *				
	Additional comments?				
Did individual make a mistake? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", complete the mistake fields..	What mistake?				
	How was the task/activity performed improperly?				
	When did the mistake occur in the accident sequence?				
	Where did the mistake occur in the accident sequence?				
	What standard governs the performance?				
	Overall impact of the mistake.				
	What effect and how confident are you of the mistake effect?				
	ATM Task number:				
Phase of operation:					

Personnel		
Root cause (why):	Description:	
Recommendation:	Corrective actions taken or planned?	Level to be implemented: (If army, what agency)

Aircraft				
Serial number: *	Mission, Type, Design and series (MTDS):		Assigned to (UIC): *	
Digital source collector installed? *	Night visual aid used? *		Mission type: *	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Single <input type="checkbox"/> Multiple <input type="checkbox"/>	
If "Yes", name the DSC: *	If "Yes", type: *		IFR <input type="checkbox"/> VFR <input type="checkbox"/> NA <input type="checkbox"/>	
Field training exercise (FTX)? *	Aircraft total loss?	Damage cost:	If not total loss, man-hours to repair:	Military property damage by aircraft?
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$ _____		\$ _____
If "Yes", name of FTX: *				
Damage to civilian property:	Icing?	Turbulence?	Fire? *	If "Yes" to fire,
\$ _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Phase fire started:
Ignition source:	Combustible material:	Fluid spillage? *	Type of fluid:	
How certain are you?	How certain are you?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Specific type:	
		If "Yes", complete the fluid spillage questions.	Spillage amount:	
			Type of part that leaked?	
			Name of part:	
			Mfg Part #:	
			National Stock Number:	

Aircraft				
Was there a crash resistant fuel system? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", did systems valves breakaway as designed? Yes <input type="checkbox"/> No <input type="checkbox"/>	Were there auxillary fuel tanks? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", External or internal? Were they crashworthy? Yes <input type="checkbox"/> No <input type="checkbox"/>	Emergency Flight Data details	Phase of operation(s):	
			Planned duration of flight: *	
			AGL Altitude: *	
			KIAS speed at emergency: *	
			Weight at emergency: *	
		Overgross conditions: * Yes <input type="checkbox"/> No <input type="checkbox"/>		
Accident Flight details		Phase of operation:		
		Second and third if needed:		
		Planned duration of flight: *		
		AGL Altitude: *		
		KIAS speed at emergency: *		
		Weight at emergency: *		
		Overgross conditions: * Yes <input type="checkbox"/> No <input type="checkbox"/>		
Collide with object in-flight and/or terrain? Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes", was occupiable space compromised? Yes <input type="checkbox"/> No <input type="checkbox"/>	Damage to aircraft as a result of an inflight collision? Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes", answer these questions	KIAS or true speed just before impact:
				Vertical speed/direction just before impact:
				Flight path angle/direction at major impact:
				Pitch angle/vertical direction at moment of impact:
				Roll angle/horizontal direction at moment of impact:
What obstacle struck the aircraft? If Tree, diameter:	How high above ground did aircraft strike obstacle?	How noticeable was the obstacle (from crew's position)?	Where did the obstacle strike the aircraft?	Was damage a result of collision with terrain? Yes <input type="checkbox"/> No <input type="checkbox"/>

Aircraft		
If "Yes" to damage due to terrain, answer these questions.	Ground speed at point of impact:	Did the aircraft rotate about any axis after major impact? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", answer questions below:
	Vertical speed/direction just before impact:	
	Flight path angle/direction just before impact:	Pitch/vertical pitch direction after impact:
	Which two measures are more accurate: Ground speed <input type="checkbox"/> Vertical speed/direction <input type="checkbox"/> Flight path angle/direction <input type="checkbox"/>	
	Impact angle:	Roll/horizontal roll direction after impact:
	Pitch attitude/vertical pitch direction at instant of impact:	
	Roll attitude/horizontal roll direction at impact:	Yaw/horizontal yaw direction after impact:
	Yaw attitude/horizontal yaw direction at impact:	
Estimated/analytically determined vertical force (G's) and force direction at aircraft center of gravity:	Estimated/analytically determined longitudinal force (G's) and force area at aircraft center of gravity:	Estimated or analytically determined lateral force (G's) and force direction at the aircraft center of gravity:
Fuselage deformation area: _____ Specific: _____ Amount of deformity: _____ Cause injury to personnel? Yes <input type="checkbox"/> No <input type="checkbox"/>	Large aircraft component: _____ Check what applies to this component: Component displaced from normal position? Component torn free? Cockpit penetrated or entered? Cabin penetrated or entered?	Additional remarks about the impact:

Aircraft		
Materiel Failure? Yes <input type="checkbox"/> No <input type="checkbox"/>	<u>Component/part details:</u> Name: Model (if component): Part #: National Stock No.: Serial No.: Manufacturer code:	Did component have causative role in accident? Did maintenance act of omission or commission have a causative role? Did design have a causative role? Did the manufacture have a causative role?
<u>(Component/part) Failure:</u> Indicate failure: When did the failure happen in the accident sequence: Where the failure happened in the accident sequence: Effects of the failure on the overall performance of the component/part: Overall impact of the failure on the event itself: The caused contributed state:		
Phase of operation:	Root cause of failure:	Description of how root cause caused failure:
Recommendation:	Corrective actions recommended:	Level of the unit responsible:

Risk Management (if applicable)			
What level was the mission or training conducted?	Rank of person who approved mission/training?	Duty position of person who approved the mission/training?	
Rank of person in charge of mission/training:	Duty position of person in charge of mission/training:	Rank of senior leader during the mission/training:	Duty position of senior leader present during mission/training:

<p>Was risk management performed?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>If "Yes":</p> <p>Rank of person performing risk management:</p> <p>Duty position of person:</p>
<p>Was the risk management process communicated?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>If "Yes": Which methods of communication were used? (You can select more than one)</p> <p><input type="checkbox"/> Order <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Verbal/Brief <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Worksheet</p>
<p>Was the accident event identified or considered during risk management?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>If "Yes": What was the level of identified risk? (Select one)</p> <p><input type="checkbox"/> Low <input type="checkbox"/> Extremely High</p> <p><input type="checkbox"/> Moderate <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> High</p>
<p>Were control measures applied?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>If "Yes":</p> <p>What was the rank of the person who was responsible for implementing controls?</p> <p>What was the duty position of the person who was responsible for implementing controls?</p> <p>What was the level of risk after the controls were applied?</p> <p><input type="checkbox"/> Low <input type="checkbox"/> Extremely High</p> <p><input type="checkbox"/> Moderate <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> High</p>

Environmental		
<p>General weather conditions at time of accident:</p> <p>IMC <input type="checkbox"/></p> <p>VMC <input type="checkbox"/></p> <p>Unknown <input type="checkbox"/></p>	<p>Move above horizon?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes", answer the "moon" questions.</p>	<p>Moon visible? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>How far above the horizon? ____ degrees</p> <p>Percentage of illumination? ____%</p> <p>Clock position from the flight patch or nose of the aircraft:</p> <p>HH ____</p>

Weather conditions:

Condition present at time of accident:

Effect on accident:

If “Present and contributed” or “Present and contributed to the severity of the injury or damage” complete the following fields:

How confident are you?

Detailed description of the weather condition:

When did the weather condition happen in the sequence of events:

Where the weather condition occurred in the sequence of events:

Overall impact of the weather condition:

How did the weather condition actually cause and/or contribute the accident:

What do you recommend to minimize this happening again?

What corrective actions are recommended?

Level of implementation?

Narrative (if applicable)			
History of Flight	Human Factors	Materiel Factors	Analysis

Witness (if applicable)			
Witness Name: Last: * _____ First: * _____ MI: _____	Residing Address: * Country: _____ State: _____ Address: _____ City: _____ Zip: _____-____	Duty/Work Phone #: _____ Date of birth: _____ _____ YYYYMMDD	Occupation or job title: * Organization or Company: Rank or pay grade: *

Witness (if applicable)		
Witness background: *	Location at time of accident: *	
Date of interview: * _____ YYYYMMDD Board member conducting interview: *	Interview summary:	
Promise of confidentiality offered?	Promise of confidentiality offered?	If offered, was it declined?