

Expert Mode Worksheet - AAAR



Instructions: Use this worksheet to assist you in creating a 2397-AB accident report in ReportIt using Expert mode. Because Expert 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: *	

General Accident Information				
Date and time of accident: * _____ YYYYMMDD HHMM	Period of Day: *	Dawn	Accident Category: *	Aircraft Ground
		Day		Flight
		Dusk		
		Night		Flight Related
		Unknown		
Brief description of the accident ("one-liner" description for ReportIt use only):				
Primary event type: *		Secondary event type:		Tertiary event type:
Accountable unit UIC: *		Accountable unit name: *		Country unit is located:
State (if applicable):		Home Station:		Army Headquarters: *
Occurred on Post: * Yes <input type="checkbox"/> No <input type="checkbox"/>		Occurred on airfield: * Yes <input type="checkbox"/> No <input type="checkbox"/>		Country:
State (if applicable):			City nearest accident site:	
Nearest installation:		Grid coordinates/Lat-Long:		
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: ____-____-____	Gender: * Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/>	
Duty position at time of accident: *	Assigned UIC: (only if different from above) *	Made Mistake: Yes <input type="checkbox"/> No <input type="checkbox"/>	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"/>	Flight Activity Category (if applicable): Readiness Level (if applicable):	Lab tests accomplished: Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes": Pos <input type="checkbox"/> Neg <input type="checkbox"/>	
Date redeployed from combat zone: YYYYMMDD	Total flight hours in the accident aircraft MTDS (if applicable)? *	Total flight hours in all aircraft?	
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	<u>If fatality:</u> Date of Death: * YYYYMMDD Time of Death: HHMM Cause of Death: Autopsy performed: * Yes <input type="checkbox"/> No <input type="checkbox"/>		Escape difficulties or rescue required? Yes <input type="checkbox"/> No <input type="checkbox"/>
		Did protective/restraint/survival equipment function as designed? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Injured			
Home Street Address:		Date of Birth: YYYYMMDD	
Home Country		Date of Hire: YYYYMMDD	
Home State			
Home City and Zip Code:			

Duty Status: Was this individual on duty at the time of the accident? Yes <input type="checkbox"/> No <input type="checkbox"/> Time Employee began work: HHMM		Condition: Was this individual unconscious? * Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Hours/Minutes* _____ Did they experience amnesia? * Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Hours/Minutes* _____	
Body Parts and Injuries: Body Region: * Primary Aspect: * Secondary Aspect: *		Injury: Injury Type/Result: * Mechanism: Action: * Qualifier: Cause Factors: Subject: * Action: * Qualifier: *	
Additional Comments/Remarks:			
Treatment/Care OSHA Log number:		Was this individual treated in the emergency room? * Yes <input type="checkbox"/> No <input type="checkbox"/> What was the name of the physician/healthcare provider that provided the treatment? Was treatment provided away from the worksite? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes,:</i> Hospital Name: Hospital Address:	

If protective/restraint/survival equipment did not function as designed	
What was the PPE item?	Required: Yes <input type="checkbox"/> No <input type="checkbox"/>
Equipment:	Available: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Used: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Produced: Yes <input type="checkbox"/> No <input type="checkbox"/>
Type:	Allowed: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Prevented: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Reduced: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Functioned: Yes <input type="checkbox"/> No <input type="checkbox"/>
Information Code(s):	
Item (retention, type or component):	

Component (component, configuration or condition):	

Condition (condition or location) :	

If Escape difficulties or rescue required	
Personnel Evacuation/Escape	Method of Escape:
	Exit used:
	Aircraft Attitude during escape:
	Cockpit/Cabin conditions:
	Location in aircraft:
	Exit attempted:
	Escape difficulties:
	Lapsed time for rescue:
Personnel Survival/Rescue	Survival problems encountered:
	Means used to locate individual:
	Rescue equipment used:
	Factors that helped rescue:
	Factors complicating rescue:
	Select what best describes the individual's physical condition: 1-Fully able to assist 2-Partially able to assist 3-Immobile or unconscious 4-Fatal

What rescue vehicle was used?	Distance from aircraft to actual rescue vehicle at time of accident? Nautical miles <input type="text"/> Statute miles <input type="text"/>	Other vehicles assisting in Rescue?
Explain the failures, malfunctions, injuries, and other problems not adequately defined.		
Did individual make a mistake? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If "Yes", complete the mistake fields.</i>	What mistake?	
	When did the mistake occur in the accident sequence?	
	Where did the mistake occur in the accident sequence?	
	How was the activity / task performed incorrectly?	
	Explain the consequences of the error?	
	ATM Task number:	
	Caused Contributed State: <input type="checkbox"/> Present and Contributing <input type="checkbox"/> Present and Contributing to the Severity <input type="checkbox"/> Present but not Contributing <input type="checkbox"/> Special Observations <input type="checkbox"/> Pending <input type="checkbox"/> Unknown	
Contributing Role: <input type="checkbox"/> Definitely <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown <input type="checkbox"/> None		
Root cause (why):	Root Cause 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 Unit (if different than above)						
Assigned to UIC:		Accountable unit name: *		Country unit is located:		
State (if applicable):		Home Station:		Army Headquarters:		
Aircraft total loss? Yes <input type="checkbox"/> No <input type="checkbox"/>		Aircraft Damage cost: \$ _____	Man Hours: _____	Man Hours Cost / Hour: _____	Other Damage Military: \$ _____	Civilian Damage: \$ _____
Aircraft occupiable space compromised? Yes <input type="checkbox"/> No <input type="checkbox"/>		Mission Type:	Operation Type: * Single <input type="checkbox"/> Multiple <input type="checkbox"/>	Flight Plan: IFR <input type="checkbox"/> VFR <input type="checkbox"/> NA <input type="checkbox"/>	Night Vision Device/Systems: * Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If "Yes", name of Device: *</i>	
Field training exercise (FTX)? * Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If "Yes", name of FTX: *</i>	Fire present? * Yes <input type="checkbox"/> No <input type="checkbox"/>	Fluid spillage? * Yes <input type="checkbox"/> No <input type="checkbox"/>	Digital Source collector installed? * Yes <input type="checkbox"/> No <input type="checkbox"/>			
Fire Starts (if Yes to Fire?) <input type="checkbox"/> Inflight <input type="checkbox"/> Post Crash <input type="checkbox"/> Other Specify other	Digital Source Collector(s) (If yes to digital source collector installed): *	Flight Data	Emergency	Accident		
			Flight Duration*	Flight Duration*		
			Overgross Condition: * Yes <input type="checkbox"/> No <input type="checkbox"/>	Overgross Condition: * Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Phases of Operation _____	Phases of Operation _____		
			Altitude AGL*	Altitude AGL*		
			Airspeed KIAS*	Airspeed KIAS*		
			Aircraft Weight*	Aircraft Weight*		

Impact Data: Inflight Impact: Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, airspeed at impact (in knots)</i>	Airspeed at impact:	Obstacle Identity, Collision Height, Strike Sequence and Conspicuity	Obstacle: <i>(If wire(s)/cable(s) answer additional questions):</i> <i>If Tree, diameter:</i>
	Vertical direction and speed:		Conspicuity:
	Flight Path Direction and Angle:		Height above ground:
	Inflight Roll Direction and Angle:		Wires struck: Wire Type:
	Inflight Pitch Direction and Angle:		Diameter: Number of Wires:
Wire Strike? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If Yes:</i> WSPS installed: Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes:</i> WSPS Engaged Wire: Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If Yes:</i> WSPS cut wire: Yes <input type="checkbox"/> No <input type="checkbox"/> WSPS functioned as designed: Yes <input type="checkbox"/> No <input type="checkbox"/>	Ground speed at impact:	Vertical direction and speed at major impact:	
	Flight Path direction and angle:	Most accurate measurements (up to two): Ground speed <input type="checkbox"/> Vertical speed/direction <input type="checkbox"/> Flight path angle/direction <input type="checkbox"/>	
	Impact Angle	Roll direction and angle at major impact:	
	Pitch direction and angle at major impact:	Yaw direction and angle at major impact:	
	Rotation after impact: Yes <input type="checkbox"/> No <input type="checkbox"/>	Vertical impact direction and Force:	
	Longitudinal impact direction and force:	Lateral impact direction and force:	
	Enter any additional remarks regarding the impact of this aircraft.		

Damage/Spillage				
Fuselage deformation area: _____ Specific: _____ Amount of deformity: _____ Cause injury to personnel? Yes <input type="checkbox"/> No <input type="checkbox"/>	Large aircraft component: _____ If Landing gear indicate location: Check what applies to this component: Component displaced from normal position? <input type="checkbox"/> Component torn free? <input type="checkbox"/> Cockpit penetrated or entered? <input type="checkbox"/> Cabin penetrated or entered? <input type="checkbox"/>	Additional remarks: 		
Aircraft Fuel System 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"/>	Fluid Spillage	Fluid Type Amount in Gallons	
Spillage source	Part Part Name Part Number National Stock Number	Component/Part & Aircraft History Information	Type: Component or Part Nomenclature: Part Number: NSN: Manufacturer's Code: Serial Number	
Cause failure/malfunction	Materiel Definitely <input type="checkbox"/> Suspected <input type="checkbox"/> Undetermined <input type="checkbox"/> None <input type="checkbox"/>	Maintenance Definitely <input type="checkbox"/> Suspected <input type="checkbox"/> Undetermined <input type="checkbox"/> None <input type="checkbox"/>	Design Definitely <input type="checkbox"/> Suspected <input type="checkbox"/> Undetermined <input type="checkbox"/> None <input type="checkbox"/>	Manufacture Definitely <input type="checkbox"/> Suspected <input type="checkbox"/> Undetermined <input type="checkbox"/> None <input type="checkbox"/>

Component/part Failure:

Failure code:

Failure Role

- Present and Contributing
 Present and Contributing to the Severity
 Present but not Contributing
 Special Observations
 Pending
 Unknown

When did the failure happen in the accident sequence:

Where the failure happened in the accident sequence:

Consequences of the materiel failure:

Root cause of failure:

Description of how root cause caused failure:

Recommendation:

Corrective actions recommended:

Level of the unit responsible:

*If Army, Army agency:**If Other, define other:***Fire****Ignition Sources**

Ignition source:

Combustible Materiel

Combustible material:

Risk Management (if applicable)		
Level Mission Risk Conducted at:		
Who approved the risk: Rank: Duty Position:	Was risk management performed? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If "Yes":</i> Rank: Duty position of person:	Who accepted the risk? Rank: Duty position of person:
Risk Management Communicated: Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If Yes,</i> <input type="checkbox"/> Order <input type="checkbox"/> Verbal/Brief <input type="checkbox"/> Worksheet <input type="checkbox"/> Unknown <input type="checkbox"/> Other	Risk Considered during risk management process: Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, Risk Level:</i> <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> Extremely high <input type="checkbox"/> Unknown Was the accident event accepted as residual risk? Yes <input type="checkbox"/> No <input type="checkbox"/> Control measures applied: Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, responsible for implementing controls:</i> Rank: Duty Position:	Leader in charge: Rank: Duty Position: Senior Leader present: Rank: Duty Position:

Environmental		
General weather conditions at time of accident:	Aircraft Icing: Yes <input type="checkbox"/> No <input type="checkbox"/>	Aircraft Turbulence: Yes <input type="checkbox"/> No <input type="checkbox"/>
Moon above horizon? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If "Yes", answer the "moon" questions.</i>	Moon visible? Yes <input type="checkbox"/> No <input type="checkbox"/>	How far above the horizon? _____ degrees
	Percentage of illumination? _____%	Clock position from the flight patch or nose of the aircraft: _____ HH
	Weather conditions:	
	Condition:	
Contribution:		
<i>If Present and Contributing, or Present and Contributing to the severity of injury and/or damage:</i>		
Role:		
Describe:		
Where:		
When:		
Impact:		
Enter how the root cause actually led to the environmental condition to the accident:		

Recommendation:

What corrective actions are recommended?

Level of implementation?

If Army, select Army Level.

If Other, specify other:

Other Conditions:

Condition:

Contribution:

If Present and Contributing, or Present and Contributing to the severity of injury and/or damage:

Role:

Describe:

Where:

When:

Impact:

Enter how the root cause actually led to the environmental condition to the accident:

Recommendation:

What corrective actions are recommended?

Level of implementation?

If Army, Army Level:

If Other, specify other:

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 background: *		Location at time of accident: *	
Date of interview: * _____ YYYYMMDD	Board member conducting interview: *	Interview summary:	
Promise of confidentiality offered? Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>If offered, was it declined?</i> Yes <input type="checkbox"/> No <input type="checkbox"/>	Promise of confidentiality requested? Yes <input type="checkbox"/> No <input type="checkbox"/>	