Mission Safe: Workplace Incident Report Instructions

The Workplace Incident Report is the form suggested for initial workplace incident reporting. From it a state-required First Report of Injury (FROI) can be prepared. OSHA only accepts about ½ of the state FROIs as equivalent documents to the OSHA 301 because the FROIs often do not include all the information OSHA requires. Sections I and II, when completed, contain all the necessary data fields, making the Workplace Incident Report an equivalent form that meets statutory requirements.

SECTION I is to be completed by the injured/ill employee unless the individual is incapacitated because that individual is usually the person who knows the most about the incident or illness. Completion should be as soon after the incident as is medically feasible. If medical care beyond any first aid administered at your location is needed, s/he should so indicate on the form. If your state allows designated medical care providers the supervisor should direct the employee to the appropriate medical facility. If designating a provider is not allowed, the supervisor should provide the employee with one or more suggested (but not mandatory) medical facilities.

SECTION II is to be completed by the injured/ill employee's immediate supervisor with the assistance of the Human Resources Department, who will have the specifics of home address, phone number, date of birth, and date of hire. They are generally who maintains the OSHA 300 log, so they can provide the applicable case number from that document as well. If so desired, all those fields can be left blank for HR to complete.

SECTION III is the supervisor's incident investigation. Using the report and conversations with the injured/ill employee and any witnesses, the supervisor is to determine all of the causes of the incident. There may be several causes - an immediate cause, one or more intermediary causes, and an ultimate root cause. For example, the immediate cause of the employee's fall might be *the ladder moved*. An intermediary cause might be that *the ladder moved because it was not secured*. The root cause is the answer to the last "Why?" question relating to the ladder's moving. Intermediary causes might be *it was being held by someone who failed to prevent its moving*, or *the means of securing failed*, or *the employee did not secure it*. However, following each of those is another why question. For example, why was it being held why instead of being physically secured? Was the individual inattentive or just not physically strong enough to prevent the movement? If the securing method failed, was it because it wasn't tied properly, or because the rope broke, or some other reason? If it was unsecured, was that because no policy exists requiring securing of ladders, or because although there is a policy the employee was not informed of it, or because the employee was trained but did not follow the existing policy? Whichever answer lies at the end of the chain of why-questions is the ultimate root cause.

Once all of the causes have been identified, some appropriate action generally needs to be taken to prevent a reoccurrence of the incident. If the cause is a missing, insufficient, or errant protocol, then a recommendation for correction should be made. If the cause is broken equipment, then there probably should be a recommendation to use stronger or more durable equipment, to inspect and/or replace equipment before its mean failure time has elapsed, or not to use defective equipment should be made. If the cause is lack of training, then a recommendation for that training to be completed should be made – possibly a recommendation for a means of ensuring that training is not overlooked or done sooner needs to be made as well. If the cause was the choice of the employee (who, though trained, elected to not secure the ladder), or a supervisor (who, when told by the employee that he didn't have a

means of securing the ladder, told her/him to proceed without securing it), then corrective action should be taken of the responsible party for disobeying a safety rule.

The completed report has all the information needed to complete a FROI. The form should be reviewed by both the supervisor's director and the top executive at that location. Such review ensures that the supervisor properly investigated and responded and keeps management informed on what is happening at the location. Best practices would have the document reviewed by the safety committee both to ensure that correct conclusions were made and for general learning by the rest of the work group and association.