CHANGE NOTICE

Title: **Reporting Serious Incidents**	**Directive Number:** OPS.020.0003 - Revised
Related MD Statute/Regulations: Correctional Services Article, §2-103, Annotated Code of Maryland	**Supersedes:** OPS.020.0003 01/01/2017
Related ACA and MCCS Standards: 1-CORE-2A-08;1-CORE-2B-05; 1-CORE-4D-15; 5-1A-4018; .01A and .01B	**Authorized By:** Director of Security Operations
Related Directives: OPS.110.0005 – Use of Force—Policy DPSCS.010.0022 Newsworthy Event Reporting	**Effective Date:** June 4, 2021
Variance: No agency or facility directive is required to implement this directive	**Number of Pages: 6**

Wayne Hill
Deputy Secretary of Operations

Robert L. Green
Secretary

OPS.020.0003 CHANGE NOTICE 01-21 EFFECTIVE DATE 06-04-2021

CHANGE NOTICE #1 TO THIS DIRECTIVE

Insert as:

§ .05E. Employee Health and Risk Management.

(1) An employee who physically participated in a Use of Force (UOF) against an inmate, or in subduing through physical force an inmate assault against staff shall, before the end of a shift during which a UOF or assault occurred, be given, complete, and submit an *Employee First Report of Incident Form—DPSCS IR-1* 11/2019 (Appendix H) whether or not an injury was received.

(2) If an employee's injury is urgent or emergent, treatment should not be delayed in order to complete the required paperwork.

(3) An employee involved in a UOF or assault shall:

(a) If an injury was received, complete the form in its entirety and include the UOF/Serious Incident Report Control Number (SIR) number (e.g. UOF/SIR# MCIJ-20-006); or

(b) If no injury was received, complete the top half of the form as required and in the "Describe the Event" box enter:

(i) UOF/SIR# ____-__-___; and

(ii) Check the box that indicates that the form is "Report Only".

(4) If the employee chooses to waive the offered medical evaluation following the assault or UOF, the employee shall indicate that choice in the appropriate location on the form.

(5) If an injury was sustained the employee shall also complete the second page of the *IR-1* form-*Employee's Authorization for Release of Medical Information* whether or not medical attention was received.

(6) The supervisor of an employee involved in a UOF or assault shall:

(a) Receive the employee's completed *IR-1* form; and

(b) Complete *Supervisor's First Report of Incident Form—DPSCS IR-3* 11/2019 (Appendix I) whether or not the employee received an injury.

(7) When completing the *IR-3* form, the supervisor shall:

(a) Complete all of the required fields;

(b) Indicate in the "Incident Report Type" field whether the incident resulted in a death, injury, or a "Potential Work Related Injury"; and

(c) Indicate whether the form is being completed for "Report Only" purposes.

(8) A supervisor shall:

(a) If the employee received an injury, complete the form in its entirety and include the UOF/SIR # ____-__-___ in the "Description of the Incident" field; or

(b) If the employee was not injured or appeared uninjured at the time, enter the UOF/SIR# ____-__-___ into the "Description of the Incident" field, and indicate whether the employee was given the opportunity to be evaluated by a health care professional and the outcome of that offer.

(9) The supervisor shall within 24 hours of the UOF or serious incident, and in accordance with the *First Report of Incident – Report Check List* (appendix J), provide the report packets to the:

(a) Employee Health Services Unit – HR.EmployeeHealth@Maryland.gov;

(b) Risk Management Unit – HR.RiskManagement@Maryland.gov; and

(c) Injured Workers' Insurance Fund (IWIF) – FROI@IWIF.com.

(10) The supervisor shall include the *IR-1* and *I-R3* forms in the final UOF report package submitted to the Security Operations Unit.

The Department of
Public Safety and Correctional Services

First Report of Incident
Report Checklist

Employee Name:		
Date of Incident:	**Time of Incident:**	**Employee Date of Birth:**
Policy Number:	**Claim Number:**	

☐ **IR 1 – Employee's Report:**
- ☐ **Report of Injury / Illness (Page 1)**
- ☐ **Authorization for Release of Medical Information (Page 2)**

☐ **IR 2 – Authorization for Treatment or Examination**

☐ **IR 3 – Supervisor's Investigation Report**

☐ **IR 4 – Witness Statement**

☐ **IR 5 – IWIF Workers Compensation Report (if unable to report online or by phone)**

☐ **Workers' Compensation Temporary Prescription ID Card**

☐ **Photos or Videos of the Injured Worker (if available)**

Completed Incident Report Packets Must Be Forwarded, Within 24 Hours, to the Following Email Addresses:

HR.EmployeeHealth@Maryland.gov

HR.RiskManagement@Maryland.gov

FROI@IWIF.com

The Department of
Public Safety and Correctional Services

First Report of Incident
IR 1- Employee's Report

Policy Number:			Claim Number:	
Last Name:	First Name:	M. I.	Social Security Number:	Date of Birth:
Home Address:		Home phone number:		Cell phone number:
Home email address:		Marital Status: ☐Single ☐Divorced ☐Married ☐Widowed	Number of dependents:	Gender: ☐Male ☐Female
Race: ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Hispanic or Latino ☐Native Hawaiian or Other Pacific Islander ☐White ☐Other				
Date of Hire:	Job title:	Employment Status: ☐Permanent employee ☐Contractual/temp employee ☐Full-time ☐Part-time		Rate of pay per week: $
Date of event:	Time of event:	Hours you were scheduled to work:	Name & contact information of the person you notified regarding this event & the date of notification:	
Name of the facility where the event occurred:	Phone number of the facility where the event occurred:	Address where the event occurred:		

If applicable, indicate the area(s) where the event occurred:
☐Housing Unit: ☐Tier: ☐Cell #: ☐Wing: ☐Dorm: ☐Room/Office #: ☐Gatehouse: ☐Parking Lot:

Department (example: library, infirmary, recreation room, etc.):

Did this event involve a motor vehicle accident? ☐Yes ☐No If yes, please notify your chain of command as soon as possible and refer to the DPSCS Vehicle Accident Guide.
Where were you sitting? ☐Driver's seat ☐Passenger seat ☐Rear seat
Was a State vehicle involved? ☐Yes ☐No

In full detail, describe the event, as it occurred, to include: the name(s) of the individual(s) involved in the event (if applicable), the object, substance, or exposure involved in the event, and the injury, illness or potential work related injury or illness that resulted because of the event.
➔ ➔➔ If this event did not result in an injury or illness, please check the box to indicate that you are filing as a ☐ "REPORT ONLY" and continue to describe the event. Use additional sheets of paper if necessary and attach the information to this document:

Did an inmate assault you during this event? ☐Yes ☐No	As it relates to this event, did you inhale or touch a substance that is affecting your health? ☐Yes ☐No If yes, describe and/or name the substance:		
As it relates to this event, do you have someone else's blood on your person? ☐Yes ☐No	If you have blood on your person, is it on your (select one): ☐Skin ☐Clothes ☐Both	Does the body part affected have an open cut, wound, or is the skin compromised? ☐Yes ☐No	Is the affected body part your eyes, mouth or nostril? ☐Yes ☐No
Did you use safety equipment and/or personal protective equipment during the event? ☐Yes ☐No If not, why:		List the safety equipment and/or personal protective equipment that you used during this event:	

Was there a witness to this event? ☐Yes ☐No If yes, name and contact information:

My employer has offered me the opportunity to be medically evaluated by a **Health Care Professional** for treatment of my injury or illness. I choose/chose to:
☐(1) Waive medical evaluation for my injury or illness ☐(2) Be medically evaluated for my injury or illness ☐(3) Instead, as determined by me and at my request, I choose to receive "*first aid*" treatment by my employer.

If you chose to be medically evaluated for your injury or illness did you or are you leaving the worksite during your scheduled work hours? ☐Yes ☐No
If yes, departure time:

If you are seeking or sought medical treatment away from the worksite, list the name of the medical provider, their address, and telephone number:

Date:	Employee Signature:	Title:

The Department of
Public Safety and Correctional Services

Employee's Authorization for Release of Medical Information

Employee Name:		SSN:
Job Title:	Date of Injury:	Claim Number:

Pursuant to COMAR 14.09.01.10, Disclosure of Medical Information; the Annotated Code of Maryland, Labor and Employment Article S 9-709, and 9-711; this authorization must be signed and filed with the Workers' Compensation Commission of Maryland in conjunction with any claim for workers' compensation benefits.

A. This document authorizes the disclosure of protected health information for the purpose of processing, adjudicating, and resolving workers' compensation claims.

B. Entities Authorized to Make Disclosure:
   a. This document authorizes any health plan, health care professional, dentist, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment, or services to you or on your behalf to disclose your protected health information consistent with this directive.

C. Entities Authorized to Receive Protected Health Information:
   a. This document authorizes the disclosure of your protected health information to the following entities and their agents: your attorney, your employer, and your employer's workers' compensation insurer.

D. Information to be Disclosed:
   a. This document authorizes the entities listed in (B) to disclose protected health information that is relevant to:
      i. The member of the body that was injured as indicated on the Employee's Report of Injury;
      ii. The description of how the accidental injury occurred as indicated on the Employee's Report of Injury;
      iii. The description of how the occupational disease occurred as indicated on the Employee's Report of Injury.

E. The protected health information that may be disclosed includes, but is not limited to: history, findings, office and patient charts, files, examination and progress notes, and physical evidence.

I understand that I may revoke this authorization by giving notice to all parties to my claim for workers' compensation, except to the extent that this authorization has already been acted on prior to receipt of my revocation.

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient to a medical manager, health care professional, or registered rehabilitation practitioner, and others consistent with State and Federal law.

By signing this form, I am authorizing the disclosure of my protected health information. This authorization is valid for one year from the date the claim is filed.

_____ _____

Signature of Claimant Date

A photocopy, facsimile, or electronic transmission of this signed authorization form is valid.

The Department of
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First Report of Incident

IR 3 - Supervisor's Investigation Report

IWIF Policy Number:	**Claim Number:**	

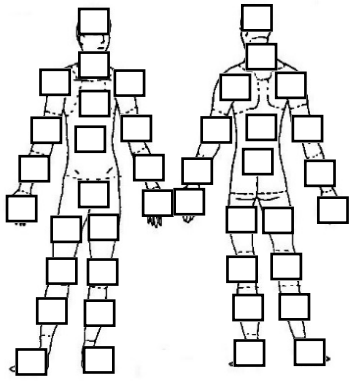
Supervisor Information

Supervisor Name:	
Phone Number:	**Email Address:**
Job Title:	**Date:**

Injured Employee Information

Injured Employee Last Name:	**Injured Employee First Name:**	**Injured Employee Middle Initial:**
Date of Birth:	**Sex:** ☐ Male ☐ Female	**Job Title:**

Parts of the Body Affected (Check all that apply):



Description of the Injury or Illness (Check all that apply):

- ☐ Abrasion, Scrapes
- ☐ Amputation
- ☐ Bite/Sting from Insect
- ☐ Bite from Human
- ☐ Bite from an Animal
- ☐ Bleeding
- ☐ Breathing Difficulty
- ☐ Broken Bone
- ☐ Burn
- ☐ Cut
- ☐ Blood From Another Person
- ☐ Bodily Fluid From Another Person
- ☐ Unknown Substance
- ☐ Dizzy
- ☐ Disoriented
- ☐ Itching
- ☐ Puncture
- ☐ Skin Discolored (Bruised)
- ☐ Strain
- ☐ Swollen / Inflamed
- ☐ Unconscious
- ☐ Vomiting
- ☐ Other:

List Body Parts Affected:

Incident Report Type

This is to report a:

☐ Death* ☐ Injury* ☐ Illness ☐ Potential Work Related Injury or Illness

*** All employers are required to notify MOSH when an employee is killed on the job or suffers a work-realted in-patient hospitalization, amputation, or loss of an eye. A fatality must be reported within eight (8) hours of the event. An in-patient hospitaliztion, amputation, or loss of an eye must be reported within 24 hours of the event. To report to MOSH call 1-888-257-6674.**

At the Time of This Report, the Event Resulted in:

☐ A Report Only ☐ Emergency Visit to the Hospital ☐ Visit to an Out-Patient Medical Center ☐ First Aid Treatment

Incident Details

Date of Incident:	**Time of Incident:** ☐ AM ☐ PM	**Date Notified of Incident:**
Name of Facility Where Incident Occurred:	**Address of Facility Where Event Occurred:**	
Exact Location on Facility Grounds Where Incident Occurred (ex: park lot, lobby, housing unit, tier, cell, wing, dorm, room number, etc.):	**Description of Environment Where Incident Occurred (ex: lighting, debris, ground/floor surface, weather conditions, etc.):**	

Cause of Incident:

☐ Slip, Trip, or Fall ☐ Motor Vehicle Accident ☐ Bite/Sting ☐ Allergic Reaction ☐ Object/Substance (assault) ☐ Object/Substance (non-assault)

The Employee Was Wearing the Appropriate Personal Protective Equipment / Following Proper Safety Procedures at Time of Incident:

☐ Yes ☐ No

If yes, name the protective equipment:

If no, why not:

Description of the Employee's Clothing After the Incidient (ex: intact, wet, dirty, bloody, torn, etc.):

Description of the Incident (as it was reported or witnessed) – to include the following information:

1. **Names of the individual(s) involved in the event;**
2. **Object, substance, or exposure involved;**
3. **The result of the incident:**

This incident involved: ☐ **Use of Narcan** ☐ **unknown powdery substance** ☐ **blood from another person**
☐ **bodily fluid from another person** ☐ **unknown liquid substance** ☐ **none of the options are applicable to this incident**

The incident happened because of (ex: another person's negligence or behavior, improper dress, unsafe positions, lack of training, improper safety device or equipment):

Employee sought medical attention during their scheduled work hours:
☐ **Yes** ☐ **No**

If yes, What is the Name of the Medical Facility Treating the Employee?

Time employee left to seek medical attention: ☐ **AM** ☐ **PM**
Note: if the employee did leave the worksite to seek medical attention during their scheduled work hours, then the timesheet designation for this occurance must reflect accident leave for a permanent employee or TTD for a temporary/contractual employee (unless denied by IWIF).

The employee was scheduled to work the following shift:

The Incident Occurred While the Employee was: ☐ **Entering Work** ☐ **Leaving Work** ☐ **at Lunch**
☐ **on Break** ☐ **Working Overtime** ☐ **Working their Assigned Scheduled Hours**

Supervisor's Information

As the on duty supervisor,
☐ **I witnessed the incident**
☐ **I did not witness the incident**

Name and Contact Information of Person who Notified You of this Incident:

Concerns I have about this incident:

Recording devices are stationed in the area of the incident: ☐ **Yes** ☐**No**
If yes, was the recording reviewed? ☐ **Yes** ☐ **No**

# of Witness Statements Attached:	**# of Photographs Attached:**	**# of Maps and/or Diagrams Attached:**

Supervisor Signature

Date

How to Submit an Incident Report Packet:

All complete and legible incident report packets must be submitted via email to the following addresses:

1. Hr.RiskManagement@Maryland.gov
2. Hr.EmployeeHealth@Maryland.gov
3. FROI@IWIF.com (this eliminates the need to report the event to IWIF by phone)

If you must report the event to IWIF by phone, please call 1-888-410-1400 and you will only need to e-mail the reports to the Claims Adjuster handling the claim.