News & Training
Safety Alert
Powered by SuccessFuel
April 2023



# OSHA comes out swinging with aggressive start in 2023

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# In This Month's Issue



## Insider Content



## Articles

# News Briefs

## Safety Stories You Might Have Missed

### Inside the East Palestine train disaster: Were outdated brakes to blame?

**February 15, 2023**

Statistically speaking, commercial rail transport of oil, liquefied gas, chemicals and other hazardous materials is very safe.

Just don't try telling that to the residents of East Palestine, Ohio whose lives were upended by the Norfolk Southern train derailment.

The results of a controlled burn of toxic chemicals in damaged rail cars and untold spillage of chemicals that killed fish in the Ohio River won't be fully known a while.

Fourteen of the train's cars carried vinyl chloride, a flammable and toxic gas used in making PVC pipes, wiring and other materials. Norfolk Southern deliberately released vinyl chloride from breached railcars and burned them to avoid cataclysmic explosions that threatened to level the town.

Two gas byproducts from burning vinyl chloride are phosgene (used to make mustard gas in World War I) and hydrogen chloride. For days, dark clouds hovered over the town.

In addition to vinyl chloride, EPA kept track of ethylhexyl acrylate, ethylene glycol monobutyl, butyl acrylate and isobutylene running down storm drains.

Five days after the train fire went out, EPA air monitoring didn't detect any chemicals of concern.

Safety investigations will focus on the train's brakes. Norfolk Southern fought rules to update air brakes to hydraulic brakes.

One of the rail car's axles failed due to faulty bearings. The train crew applied emergency brakes but they couldn't stop the train smoothly and safely. We'll learn more about the age and condition of the train's braking system soon.

Like other U.S. railways, Norfolk Southern is owned by hedge funds.

Read the story online

### New task force created to address teen worker safety following increase in child labor violations

**February 28, 2023**

Following a 69% increase in child labor violations since 2018 and the resolution of one of the largest child labor cases in history at Packers Sanitation Services Inc., the U.S. Department of Labor (DOL) announced new enforcement efforts to protect teen workers.

The DOL is teaming up with the Department of Health and Human Services (HHS) in a new task force that will, among other things, pay close attention to the safety of teen workers and ensure they're not employed in hazardous jobs.

Because of the increase in violations like those found at Packers, the DOL and HHS have formed a task force that is meant to:

- further collaboration and improve information sharing among agencies, and
- allow for jointly conducted education and training initiatives in relevant communities.

The task force will also oversee a national strategic enforcement initiative on child labor, which will involve the DOL Wage and Hour Division using "data-driven, worker-focused strategies to initiate investigations where child labor violations are most likely to occur."

If an investigation finds violations, then the DOL "will use all available enforcement tools, including penalties, injunctions, stopping the movement of goods made with child labor, and criminal referrals."

According to the DOL, unaccompanied migrant children are particularly vulnerable to workplace exploitation, so the task force is mandating follow-up calls for those children who report safety concerns.

The task force will also oversee the training of staff and the creation of new training materials to provide more information to unaccompanied children about child labor laws in the U.S. to ensure they know their rights and understand the legal restrictions on working while under the age of 18.

Read the story online

## Board decision clarifies how close water must be kept to work areas to prevent heat illness

**February 28, 2023**

California employers now have clarification on how close they must keep water provisions to work areas to prevent heat illness thanks to a ruling by the state's Occupational Safety and Health Appeals Board (OSHAB).

OSHAB's Feb. 6 precedential decision affirmed that water provisions must be "as close as practicable to the areas where employees are working to encourage frequent consumption."

The case clarified the definition of what "as close as practicable" means with water placement at the workplace. In terms of providing water to prevent heat illness, the phrase means "that the water must be as close as reasonably can be accomplished in order to encourage frequent water consumption."

A complaint led to Cal/OSHA safety inspection at the Rios Farming Co. vineyard on Aug. 6, 2018. Inspectors found some workers had to climb through multiple grape trellises to access drinking water. On January 7, 2019, Cal/OSHA cited the farm for a repeat-serious violation for not having water as close as practicable for their employees.

Rios Farming Co. appealed the citation and an administrative law judge affirmed the citation on October 12, 2022, with a modified penalty of $27,000.

The judge found, and OSHAB affirmed, that the trellises were an obstacle that discouraged the employees from frequently drinking water. Other reasonable options were available to the employer, according to the judge and OSHAB. Those options included providing a jug of water in each row where the employees were working or providing individual water bottles to employees that they could refill from the jugs.

"This decision provides clarity and should serve as a reminder that employers must take adequate steps to ensure that potable drinking water is as close as practicable to workers," said Cal/OSHA Chief Jeff Killip. "Staying adequately hydrated is essential to preventing heat illness, particularly during the hot summer months."

Read the story online

## Can injured worker get workers' compensation despite pre-existing back problems?

**March 1, 2023**

A worker who injured his back on the job can collect workers' compensation benefits despite having a history of back problems, according to an appeals court.

The Arkansas Court of Appeals found that the evidence supported the fact that the worker suffered a compensable back injury from a specific work-related incident that differentiated it from his pre-existing back problems.

Dillon Chaulsett was a grocery delivery driver for Springfield Grocer. After making a delivery on July 19, 2021, Chaulsett suffered a back injury while getting back into his vehicle. The injury caused pain from his lower back down into his right leg and got worse the longer he sat.

A few days later, Chaulsett saw his chiropractor, Dr. Alan Alexander, who had been treating him for mild pain he'd been experiencing in the middle of his back. Dr. Alexander had also treated him for a minor back injury he suffered while working for Coca-Cola five years prior to the new injury.

Chaulsett claimed that he'd recovered from the Coca-Cola incident after only a few weeks and that his pain from the new injury was different and more severe than what he'd experienced in the past.

On July 29, 2021, Chaulsett filed a workers' compensation claim. However, the company's human resources department initially discouraged him from doing so.

While Chaulsett was undergoing treatment, Springfield Grocer contested the workers' compensation claim he filed in July.

On Jan. 26, 2022, an administrative law judge found that Chaulsett met his burden of proof proving that he'd suffered a compensable back injury on July 19, 2021. The judge said that the preponderance of medical evidence differentiated the work injury from the previous back issues Chaulsett had suffered in the past.

On appeal, the Arkansas Workers' Compensation Commission upheld the judge's decision. Springfield Grocer appealed the commission's decision.

Read the story online

## Julie Su nominated to replace Marty Walsh as head of U.S. Department of Labor

**March 1, 2023**

Julie Su, deputy to U.S. Labor Secretary Marty Walsh, was nominated Feb. 28 by President Biden to be Walsh's successor.

Su is a former California Labor Secretary who served under Governor Gavin Newsom. She also headed the state's Labor and Workforce Development Agency.

She helped oversee the U.S. Department of Labor (DOL) along with Walsh, who is planning to leave his position sometime in March.

Walsh and Su together have "made strong overtures to organized labor and to workers, both by communicating support for workers who are striking or seeking to unionize and through a series of regulatory, enforcement and legislative actions," according to The New York Times.

Like Walsh, Su is popular with labor unions and workers.

Su, whose parents were immigrants, speaks Mandarin and before entering government work was known for her work in the 1990s on behalf of a group of Thai seamstresses who'd been forced to work in a California sweatshop until they were freed by law enforcement.

She helped the seamstresses win compensation from the companies that used the sweatshop as a supplier.

Under Su's leadership, the California's Labor and Workforce Development Agency won praise from worker groups for quickly establishing rules to protect workers from COVID-19 hazards. The agency was also accused of paying out billions of dollars in fraudulent unemployment claims, which Su acknowledged did occur.

As California's labor commissioner under Governor Newsom, Su "was known as an innovative regulator, reorienting the agency so that it relied on worker complaints as the basis for investigations rather than random inspections of workplaces," The New York Times states.

Read the story online

## No workers' compensation if carpal tunnel wasn't caused by 'distinctive feature of employment'

**March 2, 2023**

A station agent with the New York Transit Authority can't collect workers' compensation for carpal tunnel syndrome despite having expert testimony from her doctor.

The station agent couldn't prove to a New York appeals court that her occupational disease was caused by a "distinctive feature of her employment."

Brenda Sanchez was a railroad clerk for the New York Transit Authority until 1995, when she became a station agent. Prior to 1995, her job duties included:

- manual tasks and maintenance at transit turnstiles
- heavy lifting, and
- protracted coin and token handling and counting.

After 1995, the New York Transit Authority adopted the MetroCard system, causing a change in duties for Sanchez. Her primary task became adding money to MetroCards for passengers while manning a booth.

Although the position still required some currency and coin counting, her regular tasks mostly required her use of a keyboard and typing. This led to the development of pain in her wrists.

Sanchez sought medical treatment for her worsening wrist symptoms in February 2020. Her doctor diagnosed work-related carpal tunnel syndrome, leading Sanchez to file a workers' compensation claim in October 2020.

In court before a workers' compensation law judge, Sanchez and her doctor testified regarding her job duties and how they had impacted her wrists.

Despite the doctor's assertions, the judge found there was no causal relationship between the work Sanchez was doing and her carpal tunnel syndrome.

The New York Workers' Compensation Board affirmed the judge's decision, finding that Sanchez had failed to prove a causal link between her disease and a distinctive feature of her employment.

On appeal, the court agreed with the judge's decision, finding that based on the definition of an occupational disease, Sanchez failed to successfully link her carpal tunnel syndrome to her job.

Read the story online

## 2 new issues at East Palestine train derailment: Melted protective coverings, ill clean-up workers

**March 3, 2023**

Two new issues have come up in the ongoing clean-up of the toxic chemicals spilled in the East Palestine, OH train derailment: melted protective coverings on pressure relief valves and clean-up workers getting sick.

The Pipeline and Hazardous Materials Safety Administration (PHMSA) is urging all freight rail companies to examine the protective coverings placed over a tank car's pressure relief valves, according to CNN. In the East Palestine incident, the aluminum coverings on the relief valves melted in the fire caused by the derailment.

There have also been instances of Norfolk Southern workers who have been tasked with cleaning up the derailment getting sick from the toxic chemicals in the area. CNN states that these same workers claimed the company hasn't provided them with proper PPE.

The PHMSA issued an advisory March 2 urging major freight rail companies "to take immediate safety measures to look at the performance of the protective coverings over the pressure relief valves."

Investigators found that several of the tank cars involved in the incident had aluminum coverings that were meant to protect the valves. Those coverings melted in the fire caused by the derailment, the PHMSA found.

The PHMSA advisory "requests all rail companies review their fleets to determine if they have aluminum protective coverings and consider actions including replacing these covers with steel that can withstand greater exposure to heat and fire."

Transportation Secretary Pete Buttigieg and Federal Railroad Administration head Amit Bose met with railroad union leaders regarding safety on March 1.

The meeting follows a letter the unions issued to Buttigieg and Ohio Governor Mike DeWine criticizing Norfolk Southern for putting workers at risk and not providing clean-up workers in East Palestine, who are exposed to toxic chemicals, with proper PPE.

Clean-up employees "reported that they continue to experience migraines and nausea, days after the derailment, and they all suspect that they were willingly exposed to these chemicals at the direction of Norfolk Southern," according to the letter.

Read the story online

## Owner sentenced to 6 years in jail, ordered to repay $8M for workers' compensation fraud

**March 6, 2023**

The owner of a large San Francisco-based janitorial company was sentenced to jail and ordered to pay more than $8 million in restitution for a workers' compensation fraud scheme.

Gina Gregori, owner of GMG Firenze and Billings DBA Apex, was sentenced to six years in jail and ordered to repay $8,382,788 in premiums owed to the California State Compensation Insurance Fund and a private insurance company.

The sentencing is a "split sentence" meaning Gregori will be able to serve half of the jail time outside of prison.

Gregori was taken into custody March 2 to begin serving her sentence.

An investigation by the California Department of Insurance Fraud Investigators and the San Francisco District Attorney's Office found that Gregori and her companies "grossly underreported payroll."

In executing her fraud scheme, Gregori:

- submitted falsified California Employment Development Department documents
- claimed far lower numbers of employees and wages paid than were stated in the records she filed
- maintained two separate ledgers for payroll, each with a different set of numerical data
- changed the company name and registration with the Secretary of State
- substituted a family member for herself as the listed owner, and
- opened new company bank accounts, making hers appear to be a newly established company to obtain lower premiums.

The investigation involved the execution of three search warrants, the search of nine locations and the seizure of more than two terabytes of evidence.

Read the story online

## OSHA officials onsite at East Palestine train derailment over concerns of worker safety

**March 7, 2023**

Officials with federal OSHA arrived at the clean-up site of the train derailment and toxic chemical spill in East Palestine, OH to investigate the safety concerns of Norfolk Southern workers.

Workers with the railroad have complained of a lack of proper PPE and illnesses caused by the toxic chemicals. They've collected more than 2,000,000 gallons of toxic liquid and more than 700 tons of contaminated soil so far, according to WFMJ 21 News.

The news station reports that OSHA officials have arrived onsite to inspect safety precautions as the remediation of the toxic chemicals continues.

This follows complaints from a railroad workers' union to Secretary of Transportation Pete Buttigieg that workers were falling ill with nausea, migraines and other symptoms because Norfolk Southern wasn't providing proper PPE to its workers who are cleaning up the site of the derailment.

The union claims Norfolk Southern didn't provide 40 maintenance workers performing clean-up duties at the site with appropriate PPE, including respirators, eye protection, protective chemical suits, and rubber boots and gloves.

First responders at the incident are also being monitored for illness after working close to the fire and smoke they initially encountered following the train derailment.

Local fire fighters and hazardous materials clean-up crews requested a list of all chemicals on the train immediately following the derailment, but the list they received didn't include all of the chemicals leaking or on fire at the time.

That list was fully updated two days after the incident.

Read the story online

## Alert offers 3 key lessons for chemical facilities based on past pressure release valve incidents

**March 7, 2023**

A new safety alert has been issued by a federal agency focusing on the potential hazards of emergency discharges from pressure release valves at chemical manufacturing facilities.

The U.S. Chemical Safety and Hazard Investigation Board (CSB) issued a new safety alert on emergency discharges from pressure release valves based on information gathered from four investigations.

This alert advises facilities that "while a discharge from emergency pressure-relief systems can help protect equipment from unexpected and undesired high-pressure events, it can also seriously harm or fatally injure workers and cause extensive damage to a facility if the discharge is not made to a safe location."

All four investigations highlighted in the alert "underscore the importance of thoroughly evaluating emergency pressure-relief systems to ensure they discharge to a safe location where they will not harm people," according to CSB Chairperson Steve Owens.

The investigations are from four incidents that resulted in 19 deaths and 207 injuries. They include:

**May 2018 ethylene release at Kuraray America**

The May 19, 2018, ethylene release that ignited at the Kuraray America ethylene and vinyl alcohol copolymer plant in Pasadena, Texas injured 23 workers.

This incident occurred during the startup of a chemical reactor system following a turnaround, which caused high-pressure conditions inside the reactor and activated its emergency pressure relief system. That caused a discharge of flammable ethylene vapor horizontally into the ambient air in an area where a number of contractors were working.

**November 2014 methyl mercaptan release in La Porte, Texas**

About 24,000 pounds of highly toxic methyl mercaptan were released on Nov. 15, 2014, from an insecticide production unit at the DuPont chemical manufacturing facility in La Porte, Texas.

The release killed three operators and a shift supervisor inside one of the facility's manufacturing buildings.

CSB investigators found that, separate from the release incident, there were a number of safety issues at the plant, including that several emergency pressure-relief

systems at the facility were designed to discharge hazardous materials in a way that posed a risk to workers and the public.

**May 2009 flammable vapor release in West Carrollton, Ohio**

Highly flammable vapor was released May 4, 2009, from a waste recycling process at Veolia ES Technical Solutions in West Carrollton, Ohio.

The vapor ignited and violently exploded, injuring four employees. After the initial explosion, multiple explosions occurred, significantly damaging every structure onsite. Residences and businesses in the surrounding community were also damaged.

Uncontrolled venting from emergency pressure-relief valves allowed tetrahydrofuran (THF) vapors to accumulate to explosive concentrations outside process equipment and they eventually found an ignition source, according to CSB investigators.

**March 2005 explosions at BP refinery in Texas City**

On March 23, 2005, during the startup of an isomerization unit following a maintenance turnaround, a series of explosions occurred at the BP refinery in Texas City, Texas, killing 15 workers and injuring 180 more.

A distillation tower flooded with flammable hydrocarbons and was over-pressurized during the startup, causing the tower's emergency pressure-relief system to activate. This created a geyser-like release from the vent stack and formed a flammable vapor cloud that ignited and exploded.

**3 key lessons based on these incidents**

The CSB's alert uses these incidents to illustrate three key lessons for chemical facilities:

- follow existing good practice guidance
- evaluate whether the atmosphere is the appropriate discharge location or if there are safer alternatives, and
- ensure hazardous chemicals vented into the atmosphere discharge to a safe location.

Companies should also evaluate and update their emergency pressure relief systems, when appropriate. This will help prevent future incidents and protects workers and surrounding communities from harm.

Read the story online

## Feds investigating Norfolk Southern safety culture over derailments, worker fatalities

**March 8, 2023**

A federal agency announced a special investigation of Norfolk Southern Railway's organization and safety culture following the Feb. 3 East Palestine incident and a second derailment in Springfield, Ohio on March 4.

The National Transportation Safety Board will be investigating the East Palestine incident, which resulted in a massive toxic chemical release, along with four other incidents that occurred between December 2021 and March 2023.

NTSB states that it's "concerned that several organizational factors may be involved in the accidents, including safety culture."

The agency said it will conduct an in-depth investigation into the safety practices and culture of the company while encouraging Norfolk Southern to improve safety immediately.

The incidents under investigation include:

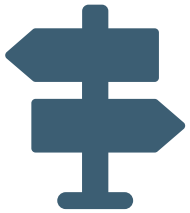
- the Dec. 8, 2021 death of a National Salvage and Service Corporation employee who was killed in Reed, Pennsylvania when the operator of a Norfolk Southern spike machine reversed direction and struck the employee
- an incident in Bessemer, Alabama on Dec. 13, 2022 involving a train conductor killed, and another injured, when a locomotive struck a steel angle iron protruding from a gondola car on a different train stopped on an adjacent track
- the Feb. 3, 2023 East Palestine, Ohio derailment that resulted in a significant fire and hazardous materials release
- a March 4, 2023 derailment near Springfield, Ohio, and
- the March 7, 2023 death of an employee during a rail car movement in Cleveland, Ohio.

As part of the special investigation, the NTSB said it will also review an Oct. 8, 2022, Norfolk Southern derailment in Sandusky, Ohio.

Read the story online

## What Would You Do?

# Was gap in guard too small to warrant putting machine out of service?



Manager Mike Kelly was walking through manufacturing on his way back to his office when he saw Alicia Carter, a machine operator, working at her station.

*That's right, I need to pay Alicia for the cookies her daughter is selling,* Mike thought.

As Mike approached, he noticed that a guard on Alicia's machine had a gap between it and the machine's pinch point. It wasn't quite big enough to cause the kill switch to keep the machine from running, but it was certainly big enough that Alicia's hand could slide under it.

"I was just coming to pay you for the cookies," Mike said, offering Alicia the money. "But I also see that there's something wrong with your machine guard."

"Thanks, Mike," Alicia said, taking the money. "Yeah, I reported the guard to maintenance, but I was told to just use it as it is."

## 'Too busy to shut down the machine'

"Who told you that?' Mike asked.

"The maintenance guy who came and looked at it. I think his name is Louis," said Alicia. " My supervisor said that if maintenance said it was OK then I could continue to use the machine."

Mike shook his head. *Unbelievable,* he thought.

"That gap in the guard is too large for this machine to stay in operation," Mike said. "It needs to get put out of service until maintenance can fix it properly."

"We're too busy to shut down any of our machines," Alicia's supervisor, Ken Dawson said, walking up to join the conversation. "Maintenance said it was OK, so I think we're good, Mike."

If you were Mike, what would you do in this situation?

## If not fully functional, it's no longer a guard

Guards are on machines for a reason: to keep an operator's hands and fingers out. Why? To prevent serious, life-changing injuries.

If the gap is big enough that fingers or hands can bypass it, then the guard is no longer doing its job. That means it isn't a guard anymore and the machine should be put out of service until it can be fixed properly.

Mike is right to have the machine shut down until the guard is repaired.

## Safety v. production

Production needs shouldn't be placed above safety. If the guard doesn't close completely, then there's a chance Alicia, or another operator, could get injured.

The machine should be placed out of service. Maintenance should be told to prioritize fixing the guard if that particular machine is such a dire need for production during a busy period.

## Farm worker's hand mangled thanks to gap in guard

A gap in a machine guard can lead to a life-altering injury, as a farm worker in Washington found out on Sept. 8, 2022.

The 32-year-old farm worker had been working for the family-owned farm for eight days during the annual hop harvest. He worked the night shift as a machine mechanic's assistant.

At 4 a.m., the worker's shift was ending, but as he was clocking out he noticed a long bine sticking out from a hop harvester's arm picker. The picker stripped leaves and stems from hop bines using a chain and sprocket drive.

When the worker reached over into an open 11-inch gap above the picker to remove the bine, the energized rotating chain pulled his left hand in, shredded his work glove and badly mangled his fingers and the palm of his hand.

Co-workers gave him first aid and drove him to the hospital where doctors amputated his index and middle fingers and part of his thumb. He was hospitalized for 10 days. The worker didn't return to the job

## What Would You Do?

### Was gap in guard too small to warrant putting machine out of service? (continued)

and needed more treatment for his physical and mental trauma.

### Guard was too low to prevent incident

Investigators with the Washington State Fatality Assessment and Control Evaluation (FACE) program reported that the:

- hop harvester's arm picker had a horizontal steel mesh guard that was too low to prevent someone from reaching into the 11-inch unguarded gap above the chain and sprocket drive, and
- worker didn't follow his training to notify a lead mechanic to perform lockout/tagout procedures before cleaning out debris.

FACE investigators found that, to prevent similar incidents, employers should:

- make sure guards are made of strong, durable materials, securely fastened to the machine, regularly inspected and replaced if not in serviceable condition
- make sure guards protect workers by preventing hands or other body parts from reaching through, over, under or around the guard into the hazard area
- install warning signs on and near machines to remind workers of operating hazards and lockout/tagout requirements, and
- conduct job hazard analysis (JHA) to identify machine operation hazards and solutions before use.

Read more What Would You Do? in your Membership Dashboard

# 5 reasons you need to improve your safety program in 2023

by Merriell Moyer


Why should you improve your safety program in 2023? There are multiple reasons, including enhanced injury prevention and compliance with an increasingly aggressive federal OSHA.

Let's start with compliance and how OSHA came out swinging at the beginning of the year.

## 1 OSHA compliance

At the end of January 2023, OSHA made a formal announcement that it was changing its enforcement guidance to "target employers who put profit over safety."

How is it doing this? By allowing its regional administrators and area office directors to have the authority to cite:

- certain kinds of violations as "instance-by-instance citations" for high-gravity serious violations, and
- violations separately instead of grouping them.

This means, in short, that the agency will be able to impose more impactful penalties than it did before because there will be a wider range of violations that count as egregious, according to law firm Morgan Lewis & Bockius.

Law firm Keller and Heckman feel OSHA is taking a page out of the U.S. Environmental Protection Agency's book, which says, "If a penalty is to achieve deterrence, both the violator and the general public must be convinced that the penalty places the violator in a worse position than those who have complied in a timely fashion."

By the way, federal OSHA's maximum fines for willful and repeat violations increased from $145,027 per violation to $156,259 per violation in January 2023.

If compliance and saving the company money by avoiding fines is important, then now would be a great time to improve your safety program.

## 2 More importantly, enhanced injury, illness prevention

However, everyone knows that safety professionals care about more than just compliance and saving the company money – they want to make sure the workers on their watch go home safe and sound every day.

And there's no better reason than that to begin improving your safety program.

Workers do care about safety. No one wants to get injured and workers who feel that their place

of employment isn't safe won't stick around for long.

Ideally, making improvements to an existing safety program will help further reduce the rate of injuries and illnesses in the workplace by more efficiently addressing hazards and preparing employees to do the same.

## 3 Reduced workers' compensation costs

Thanks to that reduction in work-related injuries and illnesses, there will also be a reduction in workers' compensation costs.

Improvements made to a safety program will drive down the number of injuries and illnesses workers suffer, which means the company will save money by not having to:

- pay associated workers' compensation costs, and
- face expenses for training new workers to replace those who have been injured long-term..

Considering that the average workers' compensation claim cost $41,353 in 2020 and there were 2.6 million nonfatal workplace injuries and illnesses reported in 2021, the money saved isn't "chump change" by any stretch of the imagination.

## 4 Worker engagement

An improved safety program will enhance your company's safety culture, which leads to better worker engagement.

As stated above, workers do care about safety and the company should want to cater to that. Why?

Because "it's all about creating a good experience, because negative experiences tend to persist in the mind longer than the good ones," according to safety expert Shawn Galloway at a National Safety Council conference.

Engagement is made of three things, according to Galloway:

- buy-in
- participation, and
- ownership.

To get employee buy-in, get them to participate in the process of developing safety. That gives them a sense of ownership not just over the safety program, but over their job as a whole.

## 5 Increased productivity

Workers who make the effort to pay attention to their own safety and the safety of their co-workers are likely to pay closer attention to other aspects of their job – that means a safer workplace is also a more productive workplace.

Making improvements to your safety program means you're also contributing to the overall productivity of the workforce as a side benefit.

OSHA, the National Safety Council and other experts agree that a good safety program will have a positive impact on a company's productivity.

## What improvements to make

Now that there are multiple reasons to make improvements to your safety program, the question becomes, "What improvements should I make?"

A good starting point would be to go over your existing procedures and training programs with a critical eye to make sure they cover all of the hazards that need addressing in your workplace. If you find that anything is lacking, take the time to address it.

After that, take a look at the program as a whole and determine if your company's leadership has taken an active role in promoting safety. Management buy-in is extremely important and a safety program that's got leadership support will be more effective. The reason for this is because workers will see managers leading by example and managers will be more likely to factor safety into operational planning and decision making. If your program doesn't have much management support, you may want make an effort to get company leaders onboard.

You also want to make sure workers have an active part in the program. They typically know the most about the hazards they face everyday on the job and when they're involved in finding solutions to these hazards they'll feel more invested in the program, which leads to better engagement. If you don't already have this kind of buy-in from employees, you'll have to make sure they feel respected and have no fear of retaliation.

Finally, make sure you conduct regular inspections to see if there are any new or emerging hazards in the workplace. Involve employees and management as both will have unique perspectives and this will help lead to buy-in from both sides. Address any new hazards as they come up, ensuring that you add procedures and training for mitigating them going forward.

Ideally, making improvements to an existing safety program will help further reduce the rate of injuries and illnesses in the workplace by more efficiently addressing hazards and preparing employees to do the same. Learn more on how you can save time, improve efficiency, and transform your workplace safety program from reactive to proactive.

Read this story online

## Sharpen Your Judgment

# Who's responsible for fatality on multi-employer site: Lift operator or other company's foreman?

"I don't understand why you'd be this upset," said John Jenkins, the company attorney. "It wasn't one of our people."

"You didn't finish the sentence, John," said Safety Manager Pete Travers. " 'It wasn't one of our people' that died. Someone died while working with our employees on a worksite. Of course I'm upset!"

"OK, I get it," John replied. "But you said our employees weren't at fault for the incident and I need to have all the details. OSHA's citing us for this."

### 3 workers in 2-person lift basket results in fatal fall

"Our company was hired to provide a crane, personnel basket and rigging system to lift another company's workers and equipment onto a communications tower that was being upgraded," Pete explained.

"The personnel basket was rated to carry no more than two people," said Pete. "The other company's foreman at the worksite was responsible for determining who or what was going to be lifted.

"Our crane operator, Carter Hammond, was responsible for determining where to set up the crane, assembling the crane, and rigging the personnel basket," Pete continued. "Larry Washington was our onsite supervisor for the job.

"On the first day, Carter hoisted two of the other company's employees with no problem," Pete said. "Second day was more of the same, with Carter hoisting one or two people with the personnel basket.

"On the third day, the other company's foreman loaded the personnel basket with equipment and three of his employees," Pete explained. "Carter couldn't see how many people were in the basket because of some trees that obstructed his view. When he saw the basket was overloaded, he decided it would be safer to take them the rest of the way up, rather than to set them back down.

"One of the workers in the basket fell more than 100 feet to his death while attempting to tie off to the tower when he reached the top," said Pete.

### Pre-lift meetings conducted separately?

"OSHA is citing us for overloading the personnel basket," John said. "But if our employee couldn't see what was going on and the other company's foreman didn't communicate to him that more than two people were in the lift, then how is this our fault?"

"I don't know," Pete replied. "From what I understand, the OSHA inspector seemed to focus on the fact that Carter was the one who chose where to place the crane. He also asked a lot of questions about how we and the other company handled pre-lift meetings, from what Carter told me."

"Were there pre-lift meetings?" John asked.

"Yes," said Pete. "The other company's foreman held one with Carter, but no one seems to know if he held one with the workers who were being hoisted. Technically, they should have all been briefed together."

"We're going to fight this," John said. "OSHA is putting the blame on us when they should be citing the other company."

Pete's company fought the citation. Did it win?

### The decision

Initially, yes. Pete's company won when an administrative law judge with the Occupational Safety and Health Review Commission (OSHRC) vacated the citation because OSHA failed to prove that:

- the employees from Pete's company were exposed to the hazard, and
- they had control over the safety of the other company's employees.

However, the full commission has since remanded the case back to the judge to see if he thinks the company was the "creating employer" who caused the hazard

## Sharpen Your Judgment

### Who's responsible for fatality on multi-employer site: Lift operator or other company's foreman? (continued)

in the first place. If the judge finds that to be the case, then the full commission wants him to reconsider his decision and allow OSHA to go forward with the citation.

### OSHA: We never claimed it was the controlling employer

OSHA appealed the judge's decision, asserting that it never alleged the crane company was the controlling employer, rather it made its case around the fact that it considered the crane company to be the creating employer.

The full commission agreed with OSHA, finding that the inspector testified that he considered the crane company both the creating and the exposing employer because:

- its operator actually lifted the personnel basket
- it allowed more than two employees inside of the basket while it was being elevated, and
- it created the hazard of the pre-lift meeting by not ensuring that they conducted a mandatory, pre-lift meeting in accordance with the regulation.

This led to the commission to remand the case back to the judge for further consideration.

### Analysis: Creating v. controlling on multi-employer worksites

Responsibility for worker safety on multi-employer worksites is tricky business, with court cases like this one tripping up employers, judges and even OSHA itself sometimes.

According to law firm Haynes and Boone, an employer on a multi-employer worksite "could be categorized as a controlling, creating, exposing or correcting employer, and the safety obligations of the employer vary by category."

In this case, the full commission believed one of its judges got confused by the differences between a creating and a controlling employer.

To clear things up, Haynes and Boone define:

- A **creating employer** as the employer that caused a hazardous condition that violates an OSHA standard. It can be cited even if the only employees exposed are those of other employers at the multi-employer worksite.
- A **controlling employer** as the employer who has general supervisory authority over the worksite, including the power to correct safety and health violations itself or require others to correct them.

In the case of a controlling employer, the extent of the measures it must take to satisfy the duty of reasonable care is less than what is required of an individual employer who is protecting its own employees.

That means a controlling employer isn't "normally required to inspect for hazards as frequently or to have the same level of knowledge of the applicable standards or of trade expertise as the employer it has hired."

However, safety professionals want everyone to go home safe at the end of the day, even if they're not all their own employees, so if you can go the extra mile for everyone's safety on the worksite, do so.

**Cite:** *Secretary of Labor v. A Crane Rental LLC,* Occupational Safety and Health Review Commission, No. 19-1667, 1/10/2023. Dramatized for effect.

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Read more You Be The Judge in your Membership Dashboard

# LACK OF HOT WORK POLICY CONTRIBUTED TO INCIDENT

HAZARDS

# Smoldering fire results in $1.5M in damages: 4 tips to remember for hot work

by Merriell Moyer

A federal investigation revealed that a fire that caused $1.5 million in damages to a New Orleans passenger vessel was caused by combustible materials left unprotected near hot work.

National Transportation Safety Board (NTSB) investigators found that the vessel's operator and the contractor hired to perform the work didn't have hot work policies, which led to the fire.

## Fire extinguishing system offline during overhaul

The passenger vessel *Natchez* – which operated daytime and dinner jazz cruises on the Mississippi River – had been moored and out of service since January 2021 while undergoing renovations and an extensive overhaul.

On May 3, 2022, contractors from Dixie Marine were on the vessel to remove its main electrical panel and install a replacement.

The fixed carbon dioxide fire extinguishing system for the engine room and its generator space were taken out of operation during the overhaul to prevent accidental discharge. There were no fire detection systems on board the *Natchez*, nor were they required.

At about 8:30 a.m., the project superintendent from Dixie Marine evaluated the generator space to determine if it was safe for hot work, including:

- checking the environment for flammable vapors
- looking for oil on the deck, and
- ensuring there were no combustible materials immediately next to the hot work area.

## Fire watch maintained during cutting process

Once the space was determined safe for hot work, Dixie Marine employees used an acetylene torch to cut the panel's metal framing so it could be removed. As one worker was cutting with the acetylene torch, the other served as the fire watch and had a bucket of water, charged garden hose and fire extinguisher at the ready in case a fire started.

While the hot work was underway, the chief engineer had two *Natchez* crewmembers place a piece of sheet metal along the side of the port generator, about 3 feet from the hot work at the electrical panel, so that the sparks from the acetylene torch cutting wouldn't damage it.

The hot work was completed by 3:45 p.m. Workers cleaned up the area and collected and stored their tools while monitoring for fires as the cuts cooled down.

## No signs of smoke until it was too late

Dixie Marine employees began to depart the vessel at 4:30 p.m., with the project supervisor departing at 3:46 p.m. None of them reported any unusual concentrations of smoke within the generator space before they left for the day.

While the hot work was being performed on the port side of the engine room, another contractor was installing fuel, lube oil and water lines for a new diesel generator on the starboard side of the vessel. The deckhand serving as security for the *Natchez* checked in with that contractor employee at around 6 p.m. with neither of them noting any smoke in the room. However, the contractor employee said he could smell an odor he associated with hot work that seemed to linger.

At 7:45 p.m., the deckhand was in the captain's salon when he saw smoke passing by the window. When he left the room to investigate, he saw a big puff of smoke coming from the main deck at the vessel's aft.

## No injuries, most damage occurred in engine room

The deckhand moved down the gangway and along the dock toward the vessel's stern to investigate the source of the smoke. He saw small flames that were growing and expanding inside the open starboard-side engine room doors.

From his cell phone, he immediately called 911 before calling the captain and additional company personnel to inform them of the fire.

The New Orleans Fire Department extinguished the fire. Most fire damage was contained within the generator space that housed the panel, with minor heat damage to the engine room and minor smoke damage to the external passenger decks located directly above the fire.

No injuries were reported and there was about $1.5 million in damages.

## No one thought to move combustible materials in storage room

An investigation by the Bureau of Alcohol, Tobacco, Firearms and Explosives determined the fire originated near the deck along the forward bulkhead, adjacent to where the hot work was performed.

NTSB investigators saw photos taken prior to the fire that showed cardboard boxes, wooden shelves and other combustibles that were in the storage area about 3 feet from where the hot work was performed.

According to OSHA regulations, all combustible material closer than 35 feet to the hot work in either the horizontal or vertical direction that cannot be removed had to be protected with flameproofed covers or otherwise shielded with metal or asbestos guards or curtains. This task was not performed over two known areas of combustibles.

The NTSB determined the probable cause of the fire was the failure of contractor and vessel personnel to identify and then either remove or adequately protect these combustible material that were stored near where the hot work was taking place.

## Owner, contractor lacked fire safety plans

Investigators also found that Dixie Marine and the owner of the *Natchez* didn't have written safety policies or procedures in place regarding hot work on the vessel. Fire safety plans are required by OSHA regulations.

The vessel owner's director of operations told investigators that his company always relied on the contractor conducting hot work on their vessels to have a hot work policy in place and enforce it.

NTSB investigators found Dixie Marine's directions regarding safety preparation for hot work were passed verbally to employees by the project superintendent. The project superintendent told investigators his evaluations of the generator space on the *Natchez* were based on his 40 years of experience conducting hot work.

The Dixie Marine superintendent, the employee conducting the hot work and the employee who served as the fire watch told investigators they were unaware of the OSHA regulations concerning the risk of having combustible materials closer than 35 feet from hot work.

With the investigation's findings in mind, here are four tips to remember regarding hot work:

## 1 Have a fire safety plan

Fire safety plans are required by OSHA. They're meant to identify significant fire hazards such as those present when conducting hot work.

Having a fire safety plan in place and following the plan as instructed reduces risk of fire from hot work.

While the Dixie Marine employees conducted a safety evaluation, had a dedicated fire watch and placed a piece of sheet metal to protect an area near the hot work, they failed to identify the risk from the combustible materials in the nearby storage room.

If there had been a fire safety plan, these employees would've known to take steps to mitigate the risk from the combustible materials.

## 2 Don't forget about the dangers of smoldering fires

The NTSB report mentioned that the board has investigated multiple fires following the completion of hot work that were determined to be caused by a smoldering fire.

A smoldering fire is formed when combustible material ignites, but the combustion proceeds slowly on the material's surface with little heat and no smoke or flame. Fires like this are not easily detected and can last for hours after the initial ignition. They can quickly grow into a flaming fire with no warning.

Smoldering fires "can long outlast the time a fire watch observes an area following hot work." That means it's critical to evaluate work areas for fire hazards and ensure combustibles are relocated or protected with flameproofed covers or otherwise shielded with sheet metal.

## 3 Make sure employees are properly trained

Safety professionals know employees who are expected to fight fires need to be properly trained.

Not only do they need to know how to fight a fire if one occurs, but they also need to be trained to identify hazards, including combustibles, and how to address them to prevent a fire from breaking out.

## 4 Don't be afraid to ask about a contractor's fire safety plans

If it's a contractor doing the hot work, don't be afraid to ask them for the details of their fire safety plan.

In the *Natchez* incident, if any of the representatives of the vessel's owner had asked the Dixie Marine workers about the details of their fire safety plan, they may have realized the contractor didn't actually have one.

Instead, the vessel's owner assumed Dixie Marine had one with the end result being $1.5 million in damages to the *Natchez*. Since there were no injuries, it could have been much worse.

The point is, the owner had a right to ask. Its employees and property shared the same risk as the contractor's employees, after all.

Read this story online

Case Study

# Workers finding your safety training boring? Try these 3 tips to spice things up

PowerPoint presentations and lectures are informative, but they can also be extremely boring, especially if your trainees are even a little familiar with the topic.

Experienced workers who've sat through countless safety trainings on forklifts, falls and chemical hazards are going to have a hard time retaining valuable, potentially life-saving information if they have to go through the same old presentation every time.

So how do you make required safety training more exciting? Try adding these three things to your training repertoire:

## Change it up

While lectures are still useful in safety training, you can help keep them from becoming overbearing by mixing in other training methods.

For example, you could start a training session with a video, switch over to a short lecture and then open up a discussion on the topic to keep workers involved.

Reference handouts, hands-on activities and guest speakers with experience in the training topic can also help add variety and make the training session more memorable.

And when training is memorable, it will help trainees remember the valuable information you want them to retain.

## Inventive props can help

Human beings learn through a variety of ways. Some people learn better from watching and doing than they do from listening to lectures and reading documents.

Engaging as many senses as possible in a training is a good way to cover all the bases and add a little excitement to what would otherwise be just another boring lecture.

One good way to engage the senses in your safety training is to use props.

If you're discussing a specific kind of PPE, tool or piece of equipment, bring an example to the training session.

When you're talking about the subject, use the prop to demonstrate what you're talking about and be sure to let trainees come up to inspect the prop and see how it works. If there's a worker outside of the training session who's an expert in using whatever the subject may be, invite them to join you and your trainees to demonstrate.

However, props don't necessarily have to be that straightforward.

For example, safety speaker Richard Hawk once told a story at a National Safety Council Congress & Expo about how he used cookies to demonstrate the difference between radioactivity and radiation to painters at a nuclear power station.

Hawk was trying to think of a way to approach this training while he was grocery shopping when he saw a box of butter cookies on a shelf.

"Then it came to me – Beta butter cookies! Gamma wafers!" Hawk said. "I bought a bunch of boxes of cookies and turned them into a way to meet the goal of the training."

"I'd have a painter eat a cookie and describe what was going on as he was eating," he explained. "Then we'd discuss the difference between the cookie itself and its smell or taste to demonstrate the difference between a radioactive object (the cookie) and the radiation it emits (the taste or smell).

"It helped. And it was fun too."

## Games can be fun teaching aids

People learn better when they're curious about the topic. Curiosity inspires people to be open and makes them feel safer to ask questions without feeling judged.

Curiosity also inspires critical thinking. How? By giving trainees information to actively analyze rather than just cramming them full of information to be regurgitated on the quiz at the end of the session.

## Case Study

### Workers finding your safety training boring? Try these 3 tips to spice things up (continued)

Games are an excellent way to create curiosity. This is because games provide a way for trainees to apply the knowledge themselves, which promotes critical thinking and helps the information stick in their minds.

The games you use obviously need to be of the type that teach rather than just be fun. But they can still be a really powerful training tool and a great way to build curiosity about your topic.

While games are often used for review – HAZWOPER Jeopardy, anyone? – they can also be used in a microlearning context for a little burst of learning that's built into the game.

This is because what comes right before and right after you discuss something you're curious about generates the most memorable information.

Games of this kind, when woven into a lecture, will also contribute to adding more variety to a training session, which further contributes to a better learning experience for trainees.

*(Adapted from conference sessions by Becky Pike Bluth, CEO of The Bob Pike Group and Richard Hawk, safety speaker for Richard Hawk Inc. at the NSC Congress & Expo and from an interview with Dennis Duryea, Plant Manager at Kiski Valley Water Pollution Control Authority).*

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# 5 lessons learned from 2 fatal farming, mining rollovers that can be applied in any industry

by Merriell Moyer


Two fatal rollovers involving powered industrial trucks in farming and mining demonstrate the reasons why it's important that operators are properly trained, wear seat belts and follow safety rules.

## Worker on family farm killed when tractor rolls onto him

On July 28, 2020, a 56-year-old worker who was operating a tractor on his family's farm died when his tractor rolled down an embankment and its three-point hitch pinned him to the ground.

The tractor, which had been built in 1971, didn't have a rollover protective structure (ROPS) or a seatbelt, according to an investigation report by the Washington State Fatality Assessment and Control Evaluation (FACE) program. However, aftermarket ROPS and seatbelts that met state safety standards were available for the tractor.

## He disliked using the tractor

This tractor was purchased by the worker's father at an auction in 2019 as a training tractor for the worker's son. The worker began using the tractor two days before the incident after the farm's primary tractor developed engine problems.

Whether or not the worker was trained on the tractor was unknown, although he had expressed a dislike for it to some relatives.

The worker, who was considered a full-time employee under state law, had decades of experience in farm tractor and machinery operation on his father's farm, a 50-year-old business that the worker's wife and son also helped to operate.

Despite state requirements for small businesses, the farm didn't have formal, written accident prevention or safety programs.

## Front wheel caught unseen rut

The incident occurred when the worker was towing a 25-foot steel, single-axle lagoon pump trailer with an impeller mechanism that was used to agitate the farm's manure pond. The pond had to be agitated at several different locations where the worker had to drive the tractor on a narrow, bumpy and rutted dirt track road on the crest of an earthen embankment that surrounded the pond. This task was often performed at night, which was the case on the date of the worker's death.

On the morning of the incident, the worker's wife and teenage son had been helping him perform this job. However, since it was early morning, he sent them both home before the task was complete.

It was about two hours before sunrise with the only light coming from the tractor and the nearby farm. As the worker turned the tractor sharply near the final agitation point, the tractor's front left wheel caught a rut, causing the tractor to roll over the edge of the embankment. This caused the worker to fall to the ground as the tractor fell onto him.

## Lack of seat belt, roll cage contributed to incident

The tractor's three-point hitch fatally pinned him against his back. His wife and son found him crushed to death about four hours later. The worker's father, the owner of the farm, had to use another tractor to lift the rolled tractor off of his son's body so the coroner could take custody of it.

Investigators found that the key contributing factors to this incident were:

- failure to install ROPS and a seat belt, which are required by state and federal regulations
- lack of an accident prevention program or safety training, and
- operation of the tractor near the edge of a dark, narrow and rutted embankment road.

## Maintenance tech dies when lube truck falls into excavation

On Feb. 14, 2022, Marissa Hill, a 34-year-old maintenance technician with 10 years of mining experience, was killed when the lube truck she was driving rolled over the edge of an open mining excavation.

The lube truck fell 60 feet to a lower level where it came to a rest on its cab.

On the day of the incident, Hill was assigned to operate the lube truck to lubricate and refuel mobile equipment in the underground mine.

## No berm, broken backup camera

She conducted a pre-operational inspection of the lube truck before driving the vehicle underground. The only safety issue she, and previous operators, noted on the inspection form was a crack in the right cab window. However, investigators found that the vehicle's backup camera hadn't been working for a long time prior to the incident.

Based on data from the mine's electronic tracking system, Hill stopped at a maintenance bay inside the mine for supplies before driving to a lower level. After getting to the lower level, she stopped to turn around after finding there were no vehicles to lubricate or refuel in that area.

As she was in the process of backing into a crosscut to turn around, the lube truck over-traveled the edge of the open mining excavation because there was no berm and fell 60 feet to a lower level of the mine.

Several hours later, two other miners were passing near the area where the lube truck fell and noticed that barrier chains were hanging down as if a vehicle had fallen off the edge. They looked over the edge and saw the bottom and tires of Hill's lube truck facing upward.

## Truck lands on unsupported ground

The two miners drove to the lower level where the lube truck landed but couldn't approach it since it was in an area of unsupported ground. They called out to the driver – they didn't know it was Hill at the time – repeatedly but didn't receive a response.

In order to find out if the driver was OK, the two miners called a safety standdown, which compelled all miners to gather outside. They determined that Hill was missing and after ending the standdown, the mine operator scouted the area around Hill's lube truck using drones because of the unsupported ground.

In the early morning of the next day, the mine operator recovered the lube truck. Hill was found dead in the cab. The lube truck had a functional seat belt but it hadn't been in use when the incident occurred.

## Seatbelt was functional but wasn't worn

Investigators with the Mine Safety and Health Administration (MSHA) found that the lube truck was too damaged to determine if there were any safety defects that contributed to the incident. They were able to confirm that the truck had a functional seatbelt.

MSHA investigators reviewed the lube truck's safety inspections for the several months prior to the incident. They found the only reported safety defect was the cracked window, which didn't contribute to the incident. They also learned that, because of poor visibility through the rear window, the lube truck used a backup camera, which had been inoperable for several years.

The camera was difficult to maintain in a functional condition due to vibration that would dislodge the wiring, and wet, muddy conditions around the mine. Because the camera was always needing repairs, the miners stopped reporting the defect for more than two years. This did contribute to the incident, according to investigators.

MSHA found that the key contributing factors to this incident were the mine operator's failure to:

- follow its procedures on placing berms at all open excavations
- conduct adequate workplace examinations, and
- maintain the lube truck's backup camera.

## What do these incidents have in common?

So what do these two incidents have in common? Obviously, they both involve fatalities, powered industrial trucks that rolled over in some way and a failure to use safety devices.

They also involve failure to perform adequate inspections of the area where the industrial trucks were being operated and either the employer's complete lack of a safety program or an employer's failure to follow the rules of its existing program.

There are five lessons to learn from these tragic incidents:

## 1 Make sure industrial trucks are equipped with ROPS, seat belts

This seems like a no-brainer, but there are employers out there who don't pay attention to this obvious safety requirement.

Yes, there are certain types of powered industrial trucks that may not need ROPS or seat belts depending on certain factors – obviously a standup forklift won't need a seat belt, for example. However, these exceptions have other safety equipment and requirements regarding the specific vehicle.

No matter what kind of powered industrial truck it is or what industry it's being used in, ensure that at least the minimum required safety equipment is installed.

## 2 Ensure operators are properly trained

Another seemingly obvious point, but it boggles the mind how often this isn't done.

Safety professionals know that powered industrial trucks often perform very differently to cars and trucks that are used for personal transportation. Since that's not common knowledge, the people who are expected to operate these vehicles need to know the differences.

That includes being shown how to use seat belts and any other safety devices. The reason is because the seat belts and other safety devices on an industrial truck can function differently than those in an ordinary vehicle. Again, an operator needs to know the difference because, as detailed above, seat belt use could mean the difference between life and death.

Annual refresher training should be conducted to ensure all of this information stays fresh in an operator's mind.

## 3 Get specific in accident prevention or safety program

Being a safety professional, you know why having an accident prevention or safety program is important. You also know why that program should have a specific section covering the powered industrial trucks your employees are expected to use.

The program should include:

- performing pre-operation inspections
- rules regarding seat belts and ROPS
- avoidance of driving near ditches, holes, embankments and steep slopes
- driving slowly on sloped, bumpy, slippery or muddy terrain
- driving smoothly, without jerky starts, stops or turns
- staying alert at all times and especially at row ends, on roads and near trees or other obstacles
- following manufacturer recommendations on how the industrial truck is meant to be used
- never carrying passengers (unless the specific industrial truck is meant to do so), and
- when parking, always set brakes securely and use a park lock if possible.

Further, if the safety program specifically points out doing things like ensuring berms are placed at the edge of a mining excavation, then the employer needs to make sure it's done. Stopping such a practice without warning or reason, as the mine operator did in the lube truck incident, can lead to tragedy.

## 4 Make sure they're well maintained

If a safety device, like a seat belt or backup camera, is broken then it's useless in preventing an injury or fatality.

Operators need to pay attention during their pre-operation inspections and make sure to note any deficiencies that need addressed.

Employers and maintenance staff then need to pay attention to the inspection reports and make sure they take equipment out of service until it has been properly fixed. If employees notice that they're making the effort to report maintenance issues but nothing is being done about it, they'll eventually just stop reporting.

## 5 Stress the need to examine the work area

In both of these incidents, the operators and the employers failed to take the time to properly inspect the area where powered industrial trucks were supposed to operate.

Thorough examinations of the area before work starts will help operators catch and correct hazards. Things like ruts, bumps, debris, holes and the like will be found and then can be marked for the operator to avoid or removed altogether.

Read this story online

**Test Your Knowledge**

# Treatment & best practices for sprains

All too often, the diagnosis of a sprain is treated as a good thing: "Thank goodness it's not broken!"

**The truth is these are significant injuries – and need to be treated as such. See how much you know about treatment by answering *True* or *False* to the following.**

**1** **TRUE OR FALSE:** It's normal for sprains to be swollen with red streaks that spread out from the injured area.

**2** **TRUE OR FALSE:** Untreated or incorrectly treated sprains can have lasting health results.

**3** **TRUE OR FALSE:** You should be back to your normal range of motion and physical activity within a day of suffering a sprain.

**4** **TRUE OR FALSE:** The most common body parts for sprains are ankles and knees.

*Go to the following page to see if you are correct.*

## Test Your Knowledge

1. **FALSE:** Swelling is normal, however red streaks could indicate that the area is infected and needs immediate medical treatment.

2. **TRUE:** Delaying or going without treatment can lead to permanent joint problems or chronic pain.

3. **FALSE:** Wait two days until testing the injured area. Then gradually build up to your normal routine, observing for pain or worsening symptoms along the way.

4. **TRUE:** You can generally judge the level of severity by the amount of swelling and pain.

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Read more Test Your Knowledge in your Membership Dashboard

## Training Tips

### Stay on top of hazardous chemical container labeling

Reminder: Facilities can abide by EPA, OSHA or Department of Transportation guidelines for labeling containers of hazardous chemicals.

The key is to label, tag or mark containers either with:

- required shipping info if they're shipping containers, or
- product identifiers and words, pictures, symbols or combination that provides at least general information about the chemical hazards (ignitable, corrosive, etc.).

Workplace labels must be legible, in English, and prominently displayed on the container. Info can also be provided in other languages but English is mandatory.

For process containers: signs, placards, process sheets, batch tickets or operating procedures may be used in lieu of affixed labels to alert occupants to the contents of containers and associated hazards.

### Getting your safety message out to new hires

Workers who are new to the job have a lot to learn about safety. But these newbies could teach supervisors a thing or two as well.

Try talking with new workers as soon as possible – preferably on their first day – to find out a little about their experiences with safety.

Ask them what they thought of their safety program at their last job: Was there anything particularly helpful about it? Anything they would've liked to see change?

If this is a first job, ask about personal safety experiences: whether they've been trained in CPR or have taken any first aid classes, etc.

Then explain your safety program, hitting on some of the similarities to their experiences.

This shows you take safety seriously and you're open to their input from the get-go.

### A body part has been severed: Now what?

You've already covered what to do if a finger is amputated on the job.

But that's not the only sort of amputation injury workers can suffer. Here are two more injuries – and how to respond to them:

- **Tooth.** If a worker loses a tooth on the job, it's crucial to keep the ligament trailing from the end of the tooth moist. Rinse the tooth with water immediately and put it back in its socket. Once the tooth is back in, have the worker bite down to make sure it's correctly in place. If you can't get the tooth back into the socket, keep it between the cheek and the gum and get to a dentist ASAP.
- **Eye.** It's not common, but eyes can become dislodged, even if attached optic nerves keep them from falling out. Never try to push the eye back in, as it can only cause more problems. Instead, get to the emergency room ASAP, and call ahead so an ophthalmologist will be waiting.

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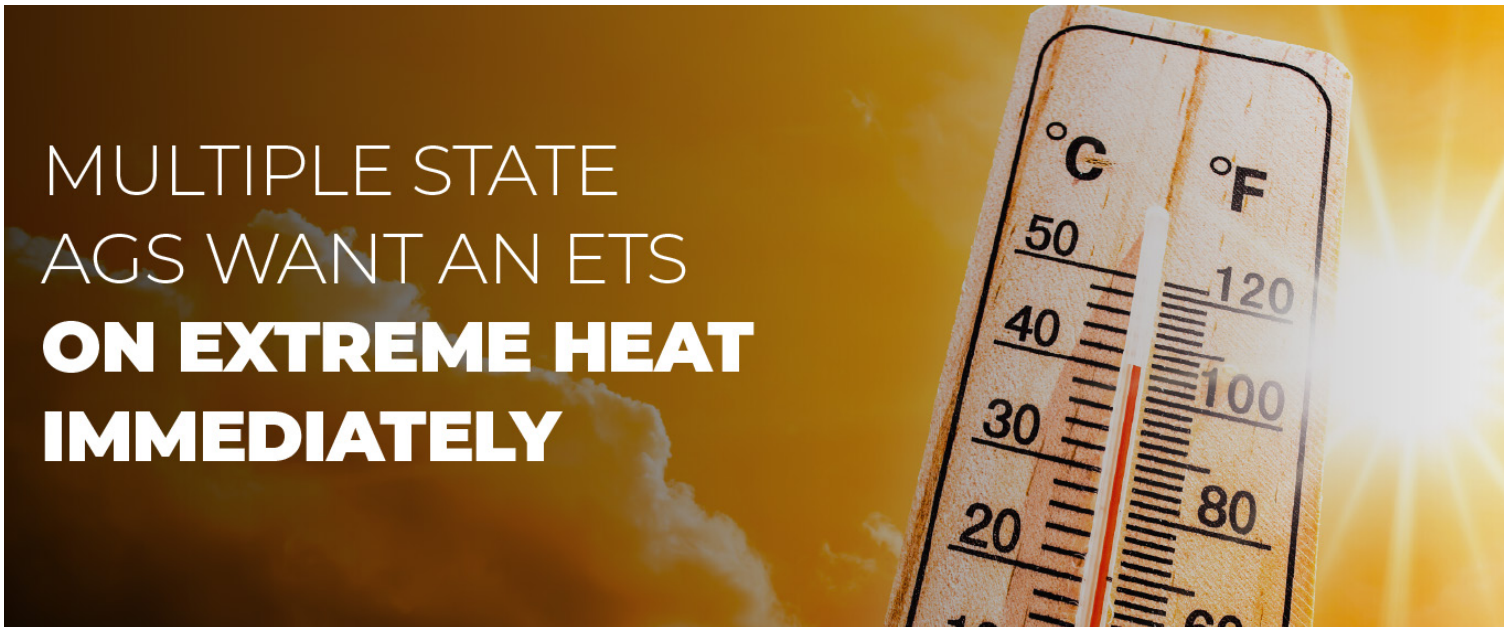
Read more Training Tips in your Membership Dashboard

# 3 reasons state attorneys general are asking OSHA to quickly adopt heat safety standard

by Merriell Moyer




The attorneys general of several states wants OSHA to move quickly to adopt a federal heat safety standard, citing the "grave danger" of extreme heat that workers are increasingly exposed to.

Attorneys general of California, Illinois, Maryland, Massachusetts, New Jersey, New York and Pennsylvania issued a petition Feb. 9 to federal OSHA asking the agency to move quickly to adopt an emergency heat safety standard and issue an emergency temporary standard (ETS) in the interim.

OSHA is required to create an ETS if it finds that:

- workers are exposed to a grave danger in the workplace, and
- an emergency standard is necessary to protect workers from such danger.

## 1 Extreme heat poses grave danger to workers

Tens of millions of outdoor and indoor workers across the U.S. are exposed to what the attorneys general call the grave danger of extreme workplace heat.

"Exposure to extreme heat can cause a range of acute and chronic heat-related illnesses, and extreme heat is responsible for dozens of workplace deaths each year, a number that is likely significantly undercounted," the petition states.

The petition points out that while all outdoor and many indoor workers are susceptible to occupational heat illness, workers in the agricultural, construction, postal and delivery services, warehousing, and food industries are particularly vulnerable. This is due to "the combined effects of their work environment, the physical nature of their work, and prevailing socioeconomic factors."

## 2 ETS needed now to protect workers from immediate hazard

Federal OSHA has a duty to issue an ETS on extreme heat in 2023, according to the attorneys general.

The petition said, "In 27 states and territories, OSHA is the only entity authorized to issue workplace health and safety standards that cover both public and private sector workers." Further, OSHA has exclusive authority to regulate private sector health and safety in many states.

California, Oregon, and Washington, which all have state OSHA plans, have already identified extreme heat as a grave danger and have promulgated emergency standards, and ultimately permanent standards, according to the attorneys general.

They mention that while they strongly support OSHA's efforts toward rulemaking for a permanent standard, they also know that process could take years to complete.

Instead of waiting, the petition urges OSHA to issue an ETS that would go into effect "when the heat index reaches 80°F – a temperature associated with increased rates of serious heat-related illnesses – and requires employers to take targeted steps to prevent harm to their workers, such as providing ample water, rest breaks, and access to cool or shaded areas."

The petition states that this ETS should be promulgated by May 1, 2023, to be in place by the beginning of summer.

OSHA introduced its first ever National Emphasis Program on extreme heat in April 2022.

## 3 Enforcement under GDC is insufficient

The petition states, "As OSHA has acknowledged, enforcement actions under the General Duty Clause (GDC) are almost always unsuccessful because without a regulatory standard for heat, it is difficult for the Agency to prove in an enforcement proceeding that working in extreme heat is hazardous."

This refers to an Occupational Safety and Health Review Commission case that saw an administrative law judge rule that "OSHA's use of the National Weather Service's heat index chart in heat stress cases lacks a scientific basis."

The July 2020 ruling had a big impact on OSHA's ability to successfully use the GDC to enforce violations involving extreme heat.

In past heat illness cases, OSHA would use the GDC and the heat index chart together in its attempt to prove that a violation existed, but after the 2020 decision it has become much more difficult.

Read this story online

**Real Life Safety**

# Company appeals $5.5 million jury award: Must it pay injured contractor?

"Mr. Jackson, can you please tell the jury what your former occupation was?" asked the defense attorney.

Jerry Jackson took a deep breath to answer. It hurt to speak loudly or at length. "I was … a roofer," said Jerry. "Until I … got hurt."

Members of the jury could plainly see Jerry's walking cane to the side of the witness chair.

"And on the morning of July 7, 2018, you were working for O'Doul Roofers. Is that correct?" the attorney asked. Jerry quietly answered "yes."

"Your employer was subcontracted to replace a roof by ABC Contracting, is that also correct?"

"Yes. My job … was to carry … insulation boards … to the crew."

"Your honor, I'm showing photo evidence of the roof work that morning to the members of the jury," said the defender. "I'd like to draw the jurors' attention to red flags clearly visible on the roof. Mr. Jackson, can you please tell the jurors what the flags were supposed to signify?"

Jerry took a few seconds to get his breath. "They mean … it's safe. Safe to work."

"So ABC Contractors and your employer said the roof was safe to work on. Can you explain what happened that morning you worked up on the roof?" the defender asked.

"I stepped … through a hole … didn't know was there," Jerry concluded.

"You thought the roof was safe and you stepped through an unmarked hole, falling more than 20 feet to the ground, isn't that correct?" the defender asked.

"Yes," said Jerry. "I remember … falling not … much else."

"And that was your last day of working, isn't that correct?" said the defender.

"Yes … I want to … but can't," said Jerry.

"Thank you, no further questions," the attorney said.

## Company tries a Hail Mary after jury hammers it

The injured roofer's testimony swayed the jury, to say the least. Jurors awarded $5,590,650 against the general contractor (ABC) at the trial's conclusion.

The roofer suffered multiple bone fractures that prevent him from working in manual labor. He suffers from chronic pain that requires him to take medications as well as arthritis.

Looking at a close to $6 million payout that could eventually put it out of business, the company appealed the jury award.

Its argument? The company qualified as a statutory employer under the Workers' Compensation Act, thereby making it immune to the negligence lawsuit. Winning the appeal would make the company responsible for comp payouts facilitated by its insurance provider.

**Result:** The court found in favor of the company, as a result stripping the injured roofer of the $5.6 million award. (His medical costs will be covered by comp payouts instead.) The court concluded the general contractor exercised sufficient control of the job in which the accident occurred to qualify it as a statutory employer.

*(Based on Yoder v. McCarthy Construction.)*

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## Who Got Fined & Why

# Why did company and supervisors let workers disable a safety lock with duct tape?

No one stopped or spoke up about shoddy safety management until it was too late.

**What went wrong:** FabPro Polymers in Kingman, Kansas was the site of a gruesome machine-related fatality. At some point, duct tape was affixed to the safety interlock on a bagging machine that prevented the machine from shutting down. An employee tried clearing a jam while the machine was operating and he became entangled in a rotating part. He died from crushing injuries.

**Result:** FabPro received OSHA fines of $292,421 and stands to pay a lot more to the family of the deceased worker. Deliberately disabling a safety device won't play well in front of a jury so count on the company settling out of court. The company was cited for absence of adequate machine guarding, not using lockout/tagout procedures, and slip-and-fall hazards from plastic particles and hydraulic fluid leaking onto floors.

# Arc flash kills electrician, employer's training practices called into question

An electrical crew didn't fully deenergize high-voltage equipment before reinstalling it.

**What went wrong:** Employees of Eversource Energy Service were doing maintenance work on electrical equipment located inside an underground electrical vault in Boston. As an employee set the equipment back into place, an arc flash and blast occurred. The worker died soon after from severe burns.

**Result:** OSHA investigated the fatal accident and fined Eversource $333,560 for:

- not fully deenergizing high-voltage equipment or following the manufacturer's maintenance recommendations
- failing to make a reasonable estimate of the heat energy to which employees would be exposed if an arc flash and blast occurred
- not adequately training the crew on electrical hazards
- providing rescue equipment nor testing oxygen levels for working in an enclosed space.

**Note:** "Eversource could have prevented this arc flash and blast – and its tragic outcome – by ensuring effective and necessary training, procedures and work practices were provided and followed," said OSHA.

## Who Got Fined & Why

# $2.4 million penalty for lead paint gaffes is a red alert warning!

Companies that renovate homes and facilities built before 1978 must factor in lead paint hazards. They can't afford not to, as this fine illustrates.

**What went wrong:** Logan Square Aluminum Supply, a home accessory store that sells to contractors in the Chicago area, violated the lead paint renovation, repair and painting (RRP) rule. EPA learned Logan Square frequently subcontracted work to uncertified firms that didn't:

- use lead-safe work practices as spelled out in the lead paint renovation, repair and painting rule
- perform post-renovation cleaning
- provide lead paint pamphlets to occupants, or
- keep compliance records.

**Result:** EPA fined the company $400,000. In addition to its $400K fine, Logan Square will perform $2 million of abatement work at low-income Chicago homes with high rates of childhood lead poisoning.

**Note:** The RRP rule falls under the Toxic Substances Control Act. For help with RRP compliance, click here.

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Read more Who Got Fined & Why in your Membership Dashboard

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**Safety News & Training Alert**, part of the **Success*Fuel*** Network, provides the latest Safety and employment law news for Safety professionals in the trenches of small-to-medium-sized businesses.

Rather than simply regurgitating the day's headlines, Safety News Alert delivers actionable insights, helping Safety execs understand what Safety trends mean to their business.

But we don't stop there.

Our editors read and vet hundreds of sources and hand-select the most relevant, practical content. Then we add our seasoned perspective and deliver actionable insights to help you understand what today's trends mean for your business.

## Meet Our Editors

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