

September 2022

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Fatal incidents show why safety must be priority for workers, management

News & Training SafetyAlert


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September 2022


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News Briefs

Safety Stories You Might Have Missed

California updates definition of COVID-19 'close contact'

July 25, 2022

Cal/OSHA updated its COVID-19 Emergency Temporary Standard (ETS) FAQ page July 18 to address the California Department of Public Health's (CDPH) revised definition of the term "close contact."

The CDPH updated the definition in early June, stating that close contact was "someone sharing the same indoor airspace (e.g., home, clinic waiting room, airplane, etc.) for a cumulative total of 15 minutes or more over a 24-hour period."

[Read more](#) 

Owner caught in workers' compensation scam for 2nd time in 6 years

July 26, 2022

A Washington auto repair shop owner was caught in a workers' compensation scam for the second time in six years and has pleaded guilty to the crime.

Rodney Dietrich, owner of Rod's Cars, was sentenced to 30 days of electronic home monitoring after pleading guilty to doing business without workers' compensation insurance for the second time, a felony offense.

[Read more](#) 

Feds release final rule to streamline transport of hazardous materials

July 26, 2022

A final rule was released July 25 amending the Federal Hazardous Materials Regulations (HMR) to harmonize U.S. laws with international standards to improve safety and streamline transport of hazardous materials.

The U.S. Pipeline and Hazardous Materials Safety Administration (PHMSA) introduced the rule to "streamline international shipping, untangle supply chains and reduce costs for Americans."

[Read more](#) 

White House: OSHA conducted 564 heat-related inspections so far in 2022

July 27, 2022

With temperatures in the U.S. nearing or reaching triple digits in most states at this point in the summer, the White House issued a fact sheet July 20 including statistics on OSHA's heat-related inspections for 2022.

The agency has "already conducted 564 heat-related inspections, which are focused on over 70 high-risk industries across 43 states," as part of a national emphasis program (NEP) that began in April.

[Read more](#) 

NIOSH releases new guidebook on keeping temporary workers safe

July 27, 2022

Use of temporary workers continues to increase in the U.S. – there was already a 682% increase in temporary workers between 1992 and 2017, jumping from 341,884 to 2.7 million – and now there's a new guidebook for protecting them.

On July 18, the National Institute for Occupational Safety and Health (NIOSH) released "Protecting temporary workers: best practices for host employers," a new guidebook to ensure temporary workers stay safe on the job.

[Read more](#) 

Widow gets comp benefits since husband's travel gave 'special benefit' to employer

July 28, 2022

If an employee is killed in a crash on their way to an employer-sponsored class, is their spouse entitled to benefits through workers' compensation? Yes, if the employer derives a special benefit from the employee's activities.

In *Lewis v. LexaMar Corp.*, the Michigan Supreme Court reversed a Dec. 17, 2020, appeals court decision that denied benefits to the widow of a worker who was killed on his way to a community college to take a class paid for by his employer.

[Read more](#) 

New NSC collaboration focuses on using technology to combat MSDs

July 29, 2022

A new collaboration between the National Safety Council (NSC) and a dedicated technology accelerator with a focus on industrial safety will focus on creating technology to combat MSDs, or musculoskeletal disorders.

NSC's MSD Solutions Lab has partnered with Safetytech Accelerator, a fully dedicated technology accelerator focused on safety and risk in industrial sectors, to build and run an open innovation lab to help facilitate development of next generation MSD prevention technology.

[Read more](#) 

Do employers need to make the workplace safe from monkeypox?

July 29, 2022

With the World Health Organization (WHO) and U.S. Centers for Disease Control and Prevention (CDC) declaring monkeypox a "public health emergency of international concern," do employers need to take action?

According to law firm Seyfarth Shaw, the answer is, "Not at this time."

[Read more](#) 

CSB: Inadequate process safety culture led to 2017 boiler explosion that killed 4

August 1, 2022

An inadequate process safety culture and a lack of proper inspection programs led to the 2017 industrial boiler explosion that killed four people at the Loy-Lange Box Company in St. Louis, according to the U.S. Chemical Safety and Hazard Investigation Board (CSB).

The CSB released its final investigation report on the incident July 29, finding that the fatal explosion was the result of the catastrophic failure of a severely corroded pressure vessel inside the boiler.

[Read more](#) 

DOL is cracking down on child labor law safety violations

August 1, 2022

After seeing an increase in child labor law violations in 2021 and 2022, the U.S. Department of Labor (DOL) is cracking down on employers who jeopardize the safety of teen workers.

DOL's Wage and Hour Division investigated three teen worker fatalities in 2021 and another in May 2022. In fiscal year 2021 alone, the division found 2,819 minors employed in violation of the law and assessed employers with nearly \$3.4 million in civil money penalties.

[Read more](#) 



FREE REPORT FROM  **Avetta**

Global Performance Indicators for Safety and Compliance

How Organizations Can Prioritize and Implement Better Safety Measures

Now more than ever, organizations need to implement a proactive approach to workplace safety. But better workplace safety is more than just productivity and compliance – it's a demonstrated commitment to employees, families, and consumers.

Download this whitepaper to get the latest insights into workplace safety, better risk management, and how to protect your employees.

[get the white paper](#) 



What can be done when workers begin taking safety shortcuts?

Manager Mike Kelly was neck deep in paperwork, preparing for budget discussions with the C-suite. He was so focused he didn't hear the knock at his office door.

"Earth to Mike," Supervisor Janet Costello said, causing Mike to startle. Another supervisor, Ken Dawson, chuckled.

"Wow, I must have really been in the zone," Mike said, grinning sheepishly. "I didn't notice you there."

"No problem," said Ken. "Honestly, we're sorry we have to disturb you at all, but we've got a problem we need to discuss."

"What's going on?" Mike asked.

Trying to get away with shortcuts on the sly

"You know how we hired a ton of new people for our two departments about six months ago because of how busy we are?" Janet asked. "Well, we think some of those employees are trying to get away with safety shortcuts."

"Yeah, and we think some of the employees who've been here longer are following along," Ken added.

"We've overheard other workers talking about it, but no one has come forward so far," said Janet. "And

we've thought we've seen things from a distance – someone on a forklift not wearing a seat belt, for example – but when we get closer, they quickly correct the issue."

"So you're hearing rumors and have your own suspicions, but you haven't outright caught anyone, is that correct?" Mike asked.

"Yes," Ken said, followed by, "You got it," from Janet.

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

Reminders via refresher training, meetings

This may be a sign that it's time to start doing some safety refresher training, have more frequent safety meetings and/or have supervisors take time to zero in on relevant safety topics during daily pre-shift meetings.

These extra training sessions and meetings will remind everyone what is expected of them and maybe give them a hint that certain employees' shortcuts have been noticed.

Unannounced spot checks

Of course extra training and safety meetings may not be enough, so doing unannounced spot checks to make sure employees are complying

with requirements is another measure that can be taken.

This doesn't mean sneaking around trying to catch them, either. It's as simple as just being out on the floor at unexpected times to see if anyone is taking a shortcut because they think no one will notice.

Case in point: Framer injured in fall, didn't use PPE

Safety professionals know that sometimes they have to go to these lengths to ensure employees follow safety protocols. This is because employees may view such rules as inefficient or unnecessary and then attempt to bypass them.

For example, the Washington State Fatality Assessment & Control Evaluation (FACE) Program issued a report on a November 20, 2019, incident that saw a framer seriously injured after falling 25 feet from a low-pitched roof of a house that was under construction.

The framer had 30 years of experience and was trained on fall protection. He had been working on the inside of the house and then went out onto the roof for an unknown reason. Despite knowing he needed fall protection when he went onto the roof, his fall protection harness was in his truck and he didn't bother retrieving it.

What Would You Do?

What can be done when workers begin taking safety shortcuts? (continued)


He was working during the early morning and the roof was wet with dew when he fell. He was hospitalized with serious injuries. There were no witnesses and the framer had no memory of the incident.

This contractor had been previously cited for failing to ensure employees used fall protection when required.

FACE Program investigators listed similar steps to those mentioned above to avoid a similar incident, stating that employers should:

- conduct pre-shift safety meeting to determine if workers will be doing tasks that put them at risk of fall and reinforce the need for fall protection

- perform unannounced fall protection spot checks to ensure workers maintain 100% tie-off, and
- effectively enforce their written safety program.

[Read more What Would You Do? in your Membership Dashboard](#) 

You Be The Judge

Was fatal incident result of outdated procedure or employee misconduct?



Safety Manager Pete Travers took a deep breath and prepared himself for what he had to do.

"It's OK, Pete," John Jenkins, the company attorney, said. "This whole situation is difficult, I know. Just continue when you're ready."

Pete took another deep breath.

"I'm not sure why they decided to loosen the bolts on that high-pressure steam pipe," Pete said. "They knew better. They made one mistake. One mistake. Now two of them are dead and one may never work again."

"I'm sorry, but can you start over from the beginning?" John asked. "OSHA is citing the company for

this incident and I need as much information as possible."

'No rush to fix it'

"There was a clog in Hydrolizer A – that's the steam system that breaks down chicken feathers in the processing plant – and the three maintenance men were assigned to fix it," Pete said. "Ralph, Jake and Curtis tried a variety of methods to clear the pipe, but none of them worked."

"If it wasn't fixed right away, would that hold up production?" John asked.

"That's just it, there was no rush to fix it," said Pete. "We have a backup Hydrolizer and even if we didn't, the product can sit in there for days without going bad."

"Typically, if troubleshooting doesn't work, we just wait for everything to cool and pressure down before tearing it apart and fixing it," Pete explained. "That's the procedure. If you've tried everything else, you walk away, come back later and fix it when it's safe to do so."

"But they didn't do that?" asked John. "No, they didn't," Pete replied.

You Be The Judge

Was fatal incident result of outdated procedure or employee misconduct? (continued)

"Instead, they began loosening bolts on one of the pipes in an attempt to slowly release steam and system pressure. With all that pressure and the loosened bolts, it was only a matter of time until the pipe blew,

releasing hot steam and product into the room."

"If they didn't follow the procedure, then this is clearly a case of unpreventable employee

misconduct," John said. "We can definitely fight this."

Pete's company fought the citation.

Did it win?

The decision

No, Pete's company lost when an administrative law judge with the Occupational Safety and Health Review Commission found the company's lockout/tagout procedure for the Hydrolizer didn't "clearly and specifically outline the steps for shutting down, isolating, blocking and securing machines or equipment to control hazardous energy."

OSHA cited the company for failing to comply with the agency's LOTO standard, which states that procedures must include specific procedural steps for controlling hazardous energy by shutting down or otherwise isolating machinery.

In this case, the company had six steps for clearing a clog in the

Hydrolizer, with step No. 6 stating:

"Make all of the following sources of stored energy (capacitors, flywheels, springs, pressure lines of hydraulics/steam/air/water/grease) safe by relieving pressure, restraining, disconnecting, or discharging."

Subpart "a" to this step states, "Relieve internal pressure."

Procedure differed from common practice

However, the company's corporate safety director testified that "if you've got internal pressure and you have already gone through the normal processes of shutting the gates and trying the pressure relief valve, you cannot accomplish step No. 6. There are no procedures that are applicable."

The safety director asserted that the maintenance employees knew "if you get there and there's still pressure there, you're done. And you've got to wait for that thing to cool down and get rid of the pressure."

But, as the judge noted in upholding the OSHA citation, that's not what the company's LOTO procedure states. It

says, under the final part of step No. 6 to relieve internal pressure, which means the procedure wasn't clear or specific. This is especially true when considering what the procedure states in context with the incident that killed two workers and severely injured another.

Analysis: Re-evaluate procedures regularly

Safety procedures should be specific, clear and "written in stone," so to speak, but that doesn't mean they can't become outdated. They could also contain mistakes which may have slipped through the cracks in the first draft.

That's why it's important to regularly re-evaluate a procedure to make sure it's correct, still relevant and safe for employees to follow.

While reviewing a procedure, it's best to ask questions such as, "Do these steps still make sense?" and "Is this exactly how employees are doing this?"

If the answer is no, then it's probably time to make some revisions.

Cite: *Secretary of Labor v. Darling Ingredients*, Occupational Safety and Health Review Commission, No. 16-1587, 6/2/22. Dramatized for effect.

[Read more You Be The Judge in your Membership Dashboard](#) 

HAZARDS

Fatal engulfment in mine demonstrates importance of workplace examinations



by Merriell Moyer



Safety professionals know that workplace examinations are important so hazards can be identified and corrected before employees start working.

Regular workplace safety exams can catch hazards that may otherwise be missed. And when those hazards are found they need to be corrected as soon as possible. Why? Because the longer the hazard is present the more likely an employee could be exposed to it, resulting in injury or even death.

For example, the U.S. Mine Safety and Health Administration (MSHA) investigated an incident involving an experienced lead technician who died when he became engulfed in crushed limestone. The incident occurred because of an unidentified hazard that a good workplace

examination would have caught months prior.

Gate couldn't close completely

Omar Thomas was a lead technician with 17 years of experience at the Palm Beach Aggregates (PBA) mine in Palm Beach County, Florida. PBA is a surface limestone mine that sees materials transported via overland belt conveyor to an onsite processing plant where the rock is crushed and sized before being stockpiled for sale.

Thomas' regular duties at the mine involved leading a six-member crew to perform maintenance, repair and clean-up tasks.

At 4 p.m. on Dec. 6, 2021, Thomas and his crew were assigned to replace damaged wear plate liners in the processing plant's vibrating pan feeder. The production shift had already emptied the belt conveyors and shut down the plant in preparation for the maintenance shift to perform these repairs.

The crew assembled at 5 p.m. in the tunnel under the surge pile to begin working on the feeder, with several members attempting to close the slide gate in the chute above the feeder by using its hydraulic cylinder levers. The slide gate isolates the feeder from the stone surge pile to prevent material from falling into the feeder during maintenance work.

However, the crew members could see that the slide gate was less than halfway across the four-foot opening,

leaving a gap, and that there was still material in the feeder. They tried closing the slide gate again by opening it fully and then closing it, but it still wouldn't close the whole way.

Bent piece of angle iron in the way

Thomas manually raked some material out of the feeder and saw a bent piece of angle iron blocking the slide gate. At 5:45 p.m., he directed another crew member to run the feeder to empty it out, but this didn't correct the problem. He then told another crew member, Christopher Case, to climb inside the feeder and cut the angle iron with an oxygen acetylene torch.

Case climbed into the feeder and began to cut the angle iron. As he worked, material began to fall on him and he noticed the piece of angle iron begin to bend downward from the weight of the material. He climbed back out of the feeder and told Thomas it was unsafe to continue.

Instead of continuing to cut the angle iron, Case suggested they operate the plant and feeder to remove all the rock from the surge pile above the feeder and empty out the draw hole. Thomas agreed, opened the slide gate completely and had another crew member operate the plant and feeder. He dismissed the rest of the crew to go take care of other assignments.

Dangerous conditions inside feeder

After 20 minutes, they turned off the plant. Case suggested they continue operating the feeder for a little longer to ensure any loose material was knocked down, but Thomas disagreed. The two men

tried to close the slide gate again, but without success.

Thomas told Case to climb into the feeder and attempt to cut the angle iron again, but when Case looked inside he could see a hole, four feet in diameter, extending upward through the surge pile for about 30 feet. This was a dangerous condition known as "coning-out" where material in the pile over an opening flows out and leaves a cylindrical void with almost vertical walls. Coning-out means the material in the surge pile is unstable and can collapse into the void without warning.

After taking all of this in, Case refused to do the work. Thomas told him to get out of the feeder and then climbed inside to cut the angle iron himself. While cutting, the tip of the torch got clogged up and Thomas told Case to go get a new tip from the truck parked outside of the tunnel.

Cone-out causes collapse

As Case turned to leave, he heard a loud crash in the feeder. He turned to see that a mass of material from the surge pile had collapsed, fallen through the draw hole, filled the chute and feeder and engulfed Thomas.

Case began to remove material from the feeder by hand while yelling for Thomas and for help. Ten minutes later other members of the crew arrived. They dug with shovels, but when they still couldn't uncover Thomas, they decided to run the feeder to help remove more material. At 6:57 p.m., the crew member who went to the control center to run the feeder called 9-1-1.

Eventually, running the feeder discharged enough material to expose Thomas. He had no pulse and wasn't breathing, so the crew

members took turns performing CPR. Emergency responders arrived at 7:11 p.m. and transported him via ambulance to a helicopter pad. He was resuscitated during transport but died from his injuries four days later.

Damage never reported, caught by examination

MSHA investigators found the piece of angle iron, which may have been bent months before the incident by the teeth on the bucket of an excavator, was a contributing factor to the incident. No report was made of this damage prior to the surge pile being resupplied, which concealed the damage.

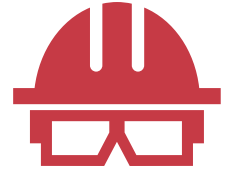
Investigators found the mine operator wasn't conducting adequate workplace examinations because good exams would have caught the slide gate that wouldn't close and the hazard presented by the coned-out, 30-feet-high surge pile. After identifying such a hazard, the mine operator would've been required to barricade the feeder from entry and withdraw all workers from the area.

One of the root causes identified in the investigation was that the mine operator didn't identify and correct hazards in the workplace before work began.

To correct the problem, the mine operator has since implemented a training and tracking process on workplace examinations, along with an on-site audit program.

This will assure that competent individuals are conducting workplace examinations, correcting hazards and eliminating exposure to identified hazards before work begins at a jobsite.

[Read this story online](#) 



Chemical Safety Board drops scary stats on facility accidents

Industry just received a jolt from the U.S. Chemical Safety and Hazard Investigation Board (CSB).

Since March 23, 2020, regulated facilities reported 153 reportable releases. Ninety of these incidents caused serious injury, and 62 resulted in substantial property damage.

Nearly one-sixth of reported releases resulted in the death of one or more facility employees or emergency responders.

CSB needs to know the scoop

These sobering statistics represent the worst outcomes for accidental releases at facilities already regulated under EPA's Risk Management Plan and OSHA's Process Safety Management standards, plus other rules for pipelines, refineries and chemical plants.

CSB finalized a first-ever reporting requirement for a releases resulting in death, serious injury or substantial property damage in 2020. Facilities must notify CSB within eight hours of a disastrous release.

Note: Facilities can satisfy CSB's reporting requirement by providing their National Response Center (NRC) ID number to CSB within 30 minutes of submitting a report to the NRC.

Keep reporting data current!


In an emergency situation, people are hurrying to contain a release, respond to a fire and help co-workers escape from the building.

Reporting can get lost in the shuffle. Facilities often neglect to report releases until several hours later.

Make sure the designated point people on your compliance team have current phone numbers of your local and state emergency planning committees, local fire department and the NRC.

A report to the CSB for a destructive release should include:

- name and phone number for the owner/operator and contact person making the report
- location and EPA facility ID
- approximate time and brief description, including occurrence of fire, explosion, death, serious injury or property damage
- name and Chemical Abstract Service number of substances, and
- evacuation radius zone and number of people evacuated if applicable.

[Read more Real Life Safety in your Membership Dashboard](#) 

Stretching strategies that alleviate back pain



Whether your workers do their jobs standing or sitting, one thing that can plague them is back pain.

They can minimize it by stretching, which relaxes and lengthens muscles. And relaxed muscles hold up to stress better than tight muscles.


In addition to stretching, people need to be aware of how to reduce stress on the lower back and keep the spine in a neutral position.

When sitting:

- use a small pillow to support the lower back if your chair doesn't provide it
- lean back slightly
- keep feet flat on the floor
- make sure your knees are level or slightly lower than your hips
- don't keep a wallet in your back pocket because it places stress on the back and nerves

When standing:

- try not to lean forward
- keep heavy objects at waist level
- if a task requires a lot of force, keep it at waist level
- if the work is light, keep it slightly above waist level
- avoid twisting

[Read more Training Tips in your Membership Dashboard](#) 

TRAINING

Confined space fatality shows why just having a safety procedure isn't enough



by Merriell Moyer

Procedures are only effective when they're followed



Just having a safety procedure in place is not enough. Procedures have to be followed to be effective and failing to do so can result in fatal consequences, as a recent Mine Safety and Health Administration (MSHA) investigation illustrates.

MSHA investigators were called to the Freeport-McMoRan Morenci mine in Greenlee County, Arizona, on Sept. 15, 2021, to investigate a fatality involving a contract welder who died while working with argon gas in a confined space.

The contract company, PVB Fabrications, had a confined space

safety procedure created jointly with the mine operator, but much of it had been ignored, leading to the welder's death.

Argon gas used to purge ambient air

At 6 a.m. on Sept. 15, 2021, Cleveland Sloan, a 33-year-old contract welder with more than 10 years of mining experience, traveled with the rest of his PVB crew to work on a pipe project at the mine. The crew attended a general safety meeting and a Job Risk Assessment, a pre-work

meeting on potential safety hazards and mitigation methods.

Sloan and Laroy Smith, another welder, then went to work welding a 30-inch pipe. This involved placing a dam inside the pipe on each side of the joint, less than 5 feet apart, and then filling that space with argon gas to purge the ambient air.

With the purging complete, Sloan and Smith began to lay down a root weld, which is the first pass on the pipe, meant to seal the joint. As they were about to make an additional pass to strengthen the connection, the two welders noticed "sugar" on the weld, an

indication that the argon gas didn't fully purge the ambient air, resulting in contamination. Sloan exchanged the argon gas bottle with a new, full bottle, which meant both men had to wait for the purge to finish before work could continue.

Asphyxiated after entering pipe

At one point, Smith noticed Sloan's hard hat at the end of the pipe, so he went to check on him. He didn't see Sloan around, so he called out. There was no response. Smith sent a helper for a flashlight, which he used to look deeper into the pipe. He saw Sloan about 40 feet inside. Smith, the helper and other workers shouted and banged on the side of the pipe to get Sloan's attention, but he didn't respond.

At 9:15 a.m., the mine's emergency response team arrived and one of the first responders donned a self-contained breathing apparatus and went into the pipe to retrieve Sloan. However, the responder couldn't pull Sloan out by himself, so he tied a rope to Sloan's ankle and with help from several other miners, pulled him out of the pipe.

Sloan didn't have a pulse and emergency responders couldn't resuscitate him. He was pronounced dead at a local hospital at 10:02 a.m.

MSHA investigators found that Sloan likely entered the pipe to check on, or reposition, the argon gas dam,

which lead to his asphyxiation due to the argon gas, which displaced the oxygen in the confined space. There were no warning signs posted regarding the confined space and its oxygen-deficient atmosphere and no physical barriers to prevent workers from entering the pipe.

Entry procedure was in place, but not followed

PVB welders didn't enter pipes on a regular basis, but when they did there was a confined space entry procedure established jointly by the mine and the contract company, which stated the:

- PVB welder must notify their supervisor
- supervisor must obtain a confined space entry permit
- supervisor must request and obtain ambient gas detection equipment from the mine operator, and
- welder must wear safety belts and lines, which an additional worker could monitor and make adjustments to, as necessary.

In this case, there was no permit and no request for ambient gas detection equipment.

Sloan was an experienced welder and miner who had some training on confined spaces, including task training on the confined space entry procedure. The exact reason why he

and Smith failed to follow the safety procedure is unknown.

Company updated training on procedure

MSHA investigators found PVB's hazard communication program didn't include argon gas and that the company failed to adequately train its welding crews and supervisors on the safe use of argon gas in confined spaces.

PVB has since updated its hazard communication program to include argon gas. The company also developed more thorough programs and training to:

- provide warning signs and barricades for workers entering confined spaces
- verify a respirable atmosphere before entering confined spaces, and
- ensure workers knew and practiced the safety procedures for entering a confined space, including wearing safety belts and lines and having an additional worker to monitor and adjust lines as needed.

[Read this story online](#) 

Navigating the dangers of shift work



Not every worker punches the clock in the morning and heads home for dinner. Workplaces are often all-day and all-night operations.

For those who have to work outside of the nine-to-five, there are concerns. Find out more about shift work safety by answering **True** or **False** to the statements below.

- 1 TRUE OR FALSE:** The first hour of night shift work is statistically the most dangerous.
- 2 TRUE OR FALSE:** The term shift workers refers to people who work overnight hours.
- 3 TRUE OR FALSE:** Shift work is only dangerous when people are tired, which could lead to workplace accidents.
- 4 TRUE OR FALSE:** When someone is going to start working nights, it's best to adjust them slowly.
- 5 TRUE OR FALSE:** Even though night shift workers do their jobs at a different time, they generally sleep about as well as day shift workers.

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

Test Your Knowledge

Answers from previous page



- 1 TRUE:** According to studies, safety incidents were more likely to occur from the first to second hour of night shift work. There is also a small increase in incidents between 3 and 4 AM.
- 2 FALSE:** This term includes anyone who works outside of a steady nine-to-five schedule.
- 3 FALSE:** There are many health effects to shift work as well. These workers are more prone to health issues like stomach problems, ulcers and even depression.
- 4 TRUE:** Experts recommend giving workers' bodies a chance to adjust by having them shift forward from day shift, to afternoons and evenings, to the night shift.
- 5 FALSE:** Night-shift workers get between 10% and 30% less sleep than day-shift co-workers. No matter when they work, it's important the crew is well-rested.

[Read more Test Your Knowledge in your Membership Dashboard](#) 



Using Total Worker Health to keep remote workers safe



Because of the COVID-19 pandemic, the workforce has changed significantly with many employees now working from home at least part of the time. But how do you keep remote workers safe when they're not in the office?

Prior to the pandemic, only 6% of the workforce worked full time remotely with about a quarter of the workforce working remotely only on occasion. Now, more than one third of the workforce has shifted to remote work, making it a new experience for many.

This is especially true of office-based occupations, which are much more likely to have the ability to work from home.

And while the world is transitioning back to more normal routines and work environments, workers and employers seem to appreciate the benefits of remote work, resulting in many office employees working a hybrid schedule at the very least. Additionally, studies conducted prior to the pandemic revealed there had already been an increase in remote work.

In short, it doesn't seem remote work is going away anytime soon.

Remote work has its own set of risks, hazards

With this change in work arrangement there are bound to be impacts on both the employer and the employee with advantages and disadvantages for both. But the cost savings for both, along with other advantages, often outweigh the negatives.

However, remote work does come with its own set of risks and hazards including ergonomics; slips, trips and falls; electricity; and fatigue.

So, as a safety professional, how do you address these issues with employees who aren't in the office? By applying the total worker health approach.

The total worker health approach is defined by the U.S. Centers for Disease Control and Prevention as "policies, programs and practices that integrate protection from work-related safety and health hazards with promotion of injury and illness-prevention efforts to advance worker well-being."

Technology can be used in multiple ways

With that approach in mind, we can begin by addressing a remote employee's safety exposures by using technology solutions.

Case Study

Using Total Worker Health to keep remote workers safe (continued)

There are several ways to use technology to address ergonomics issues in a worker's home office.

For example, a safety professional could use a virtual conferencing app such as Zoom or Skype to evaluate an employee's home office and make recommendations to address any ergonomics issues the employee may have.

There are also software solutions and wearables that can remind employees when they should take a break and stretch or adjust their posture.

Sit-stand desks are also readily available and can help with an employee's ergonomics needs.

Zoom and Skype can also help employees keep in touch with co-workers and help with stress and feelings of isolation that can come with working from home.

Flexible schedules, limited metrics reduce stress, fatigue

Employers should develop policies allowing for the development of flexible schedules for work-at-home employees. They should also encourage and remind employees to stick to those schedules as if they were in a traditional office setting to help reduce overwork, stress and fatigue.

Implementing policies that focus on limiting metric tracking or monitoring for productivity can also help ease stress and overwork for remote workers.

Enhancing existing employee assistance programs to take remote work into consideration could provide benefits which support employees' needs such as monetary supplements for child care, paid time off, wellness days, health benefits and even allocation of funds for office equipment.

Communicate with workers regarding at-home hazards

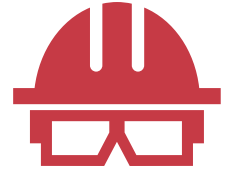
Remote workers should be trained regarding the hazards they may encounter while working from home, just as they would be in the traditional office setting.

To continue to reinforce the training, a daily remote or home office safety checklist could be provided to remote workers that would cover things like fire protection; emergency procedures; electrical safety; slips, trips and falls; stress; and mental health.

Remote workers should also be made aware of the impact working from home could have on workers' compensation and federal and state occupational health and safety laws.

(Adapted from "Remote Working Capabilities: The Impact on Total Worker Health," a presentation by Justin Francini, Risk Control Consulting Director, CNA Insurance, at the ASSP Safety 2022 Conference + Expo)

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Cluttered work area leads to fall and lawsuit: Did Supervisor act quickly enough?

Peter Harvard looked around at the worksite and shook his head. "Do you think we could get some of these work crews to be adults and clean up after themselves?" he asked.

"I'll see what I can do," Supervisor Jim Blatchey said. "Some of those contractors are really careless. But I'll have a word with their Supervisor when he gets in."

"Thanks," said Peter, strapping on his drywall installation stilts. "Sorry to make a big deal out of it. I'm kind of a neat freak."

"Nothing to apologize for," Jim said. "They should be cleaning up the work area."

Scanning for danger while trying to get work done

Peter was installing drywall on the site. To reach the ceilings of the construction area, he wore 18-inch-high stilts.

He'd been doing this job for years, and was so comfortable working on stilts he would sometimes forget he had them on.

But today, Peter was moving slowly and scanning the ground frequently.

He barely avoided stepping on a tool one of the workers had left in the middle of the room. *I'm going to strangle these guys*, he thought stepping aside.

But that step put him in even more danger. He tripped over an electrical box, falling forward. His face smashed into the hardwood floor.

When Jim heard the noise, he rushed in and unstrapped Peter's stilts.

Worker sues after painful fall

Peter sued the company. He claimed it should've kept the work area clean and free from debris or provided scaffolding to safely install drywall on the ceiling.

Result: A court initially threw out the case, saying the worker hadn't given enough time for the hazard to be fixed. But on appeal, it was upheld – meaning a settlement or costly trial.

Cleaning up a work area can't wait. Every second it's messy puts workers' safety at risk. Clutter isn't just unsightly – it puts workers in serious risk of injury.


Real Life Safety

Cluttered work area leads to fall and lawsuit: Did Supervisor act quickly enough? (continued)

Make sure to:

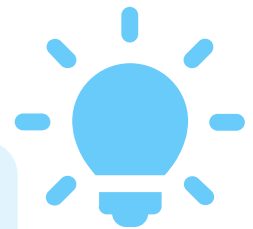
- enforce rules that workers remove any items they bring into the work area when they're done with them
- not have work begin until the area is clean
- mark off any temporary hazards that can't be moved, and
- keep aisles and passages clear from debris or other objects at all times.

Based on *Lederer v. Executive Construction*

[Read more Real Life Safety in your Membership Dashboard](#) 

Training Tips

Quick reminders for using cutting tools




You'd be hard-pressed to find a workplace that doesn't use sharp and/or cutting tools.

While they're common, they're also dangerous if not used properly.

Make sure your workers:

- inspect all tools before use
- don't substitute the wrong tool for the job just because it's there
- don't use dull or damaged tools
- don't rock, pry or twist a tool to cut or open something
- don't use excessive force/pressure which can cause slippage, and
- don't try to catch a dropped tool.

[Read more Training Tips in your Membership Dashboard](#) 



Having rules for each piece of equipment may have prevented tragedy

HAZARDS

Caught-in fatality due to lack of specific LOTO procedures?



by Merriell Moyer

Safety professionals know why lockout/tagout (LOTO) procedures need to be specific to individual pieces of equipment: because there can be big differences from one machine to the next.

Beside being an OSHA requirement, it's important to have specific LOTO procedures in place for individual machines since general rules that apply to all the equipment could lead to confusion, and injuries, for workers.

A fatal incident at a compost plant in Washington State serves as a reminder why specific LOTO rules are a requirement.

Head, shoulder, arm pulled between roller, belt

On the morning of September 10, 2020, a lead operator and his assistant at an outdoor compost manufacturing facility, or screen plant, were operating the plant's biomass screening system. This system, which is made up of several pieces of equipment, processes organic yard and food waste into compost, topsoil and mulch.

The final stage of this system used a radial stacker conveyor that carried and discharged finished compost into stockpiles.

At 8:15 a.m., the assistant informed the lead that plastic debris was

escaping from a waste container near the stacker, and the lead told his assistant not to worry about it. Instead, he instructed him to get a backpack leaf blower to clean up the debris since company safety rules prohibited getting too close to the machine while it was energized.

As the assistant was getting the leaf blower, he heard the stacker shut down. He called out for the lead but received no response.

When the assistant walked up to the machine he saw the lead under it with his head, left arm and shoulder caught between its unguarded steel return idler roller and rubberized conveyor belt. The lead's sweatshirt hood had become entangled in the roller along with a metal scraper

spade with a long wooden handle, which was caught between the roller and belt and pressed against the lead's throat.

The assistant found he couldn't pull the lead out, so he ran to an operations trailer 75 feet away while shouting for help. The crew supervisor and facility manager responded and released the lead by cutting his sweatshirt and the conveyor belt along with breaking the scraper's handle. They performed CPR until emergency responders arrived. The lead died at the hospital after nine days on life support.

Worker was trained, authorized on LOTO procedure

At the time of the incident, the employer had a formal, written accident prevention program, including LOTO procedure requirements. This LOTO program didn't have specific training for the radial stacker conveyor and only restricted workers from walking under energized conveyors, according to a Washington State Fatality Assessment & Control Evaluation (FACE) Program report.

The radial stacker conveyor had an emergency stop located in a central control panel shed and a plastic guard that partially covered the return idler roller to prevent workers from being pulled between the roller and belt. Only mechanics were allowed to remove this guard, but it was missing on the day of the incident. Employees interviewed during the investigation couldn't

recall how long it was missing or why it had been removed.

Screen plant operators, including the lead, performed and documented daily inspections on the stacker before using it. Only visual inspections were allowed when the machine was energized. Only trained and authorized workers could perform LOTO procedures on the stacker, with the lead being one of the few with authority to do so.

The LOTO procedure wasn't specifically designed for the stacker. Instead it offered general steps for shutting down a machine, deactivating and locking out an energy isolating device, dissipating or restraining stored or residual energy and disconnecting a machine from an energy source. A LOTO station was kept in the operations trailer.

Despite having refresher training in 2019 and 2020, the lead didn't perform the LOTO procedure on the stacker prior to the incident. Investigators believed he had walked under the energized stacker to clear debris off the belt, which was only to be done after the machine was de-energized. On the day of the incident, the machine shut down because an amperage spike tripped its conveyor motor's protection switch when the lead became caught in the machine.

Specific procedures would've highlighted deficiencies

Investigators found several key contributing factors for this incident, including:

- a conveyor belt safeguard that wasn't in place
- LOTO requirements that weren't followed
- inadequate LOTO training and enforcement of policies and procedures, and
- periodic reviews of the hazardous energy control program weren't conducted.

The program deficiencies that led to these contributing factors come back to the lack of LOTO procedures for each specific piece of equipment in a system, according to the FACE report.

Why is that? Because, as the report states, "While a system's different types of equipment may appear to share certain hazardous energy features, each separate piece may be made by different manufacturers and have unique hazards and LOTO requirements that should be recognized."

Instructing workers to use the same LOTO procedures across different types of equipment:

- raises injury risk because the procedure may be missing steps that are required to safely de-energize specific equipment, and
- may lead workers to perform other safety procedures incorrectly if they see that management hasn't developed safety instructions adapted for specific equipment.

[Read this story online](#) 

21-year-old roofer falls to death through skylight – firm warned by OSHA 1 month earlier

D&G Quality Roofing faces \$223K in OSHA fines following a fatal accident.

What went wrong: A 21-year-old worker fell through a skylight to his death. The company didn't provide fall arrest systems or train workers on using fall protection. The tragedy could've been easily avoided – OSHA cited the company for lack of fall protection at a job site in Austin just a month earlier.

Note: Nearly a third of all construction deaths are the result of falls from heights. Skylights are a particular problem for builders as workers put their weight onto them accidentally or fall through open spaces, typically while not wearing a harness and lanyard.

Fatal refinery blaze tied to process safety deficiencies

A fatal accident at an oil refinery was tied directly to safety mistakes made over the years.

What happened: In 2014, HollyFrontier El Dorado Refining in El Dorado, Kansas, was fined for failure to evaluate hazards and compile safety information regarding hazardous materials it uses and stores. Three years later, a heater tube ruptured, resulting in a fire. An employee was killed in the blaze.

Result: A subsequent investigation found HollyFrontier failed to design and maintain a safe facility and inspect and replace heater tubes. EPA fined the company a whopping \$1.6 million for violating the Clean Air Act's general duty clause and Risk Management Plan guidelines.

Wide range of safety hazards & 3 repeat citations: Facility rung up for \$311K

An Atlanta-based recycling company didn't keep safety data sheets (SDS) up to date and easily accessible so staffers could protect themselves from chemical hazards.

What the company did wrong: TAV Holdings' facility in South Carolina underwent an OSHA inspection in 2021. Inspectors wrote the firm up for a lack of SDS. The company didn't make sure

Who Got Fined & Why

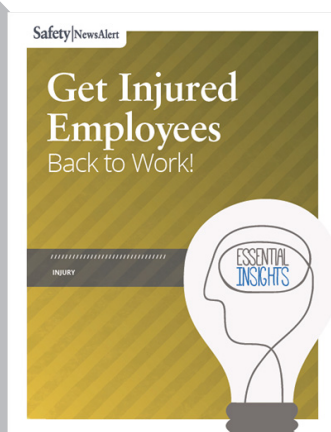
Wide range of safety hazards & 3 repeat citations: Facility rung up for \$311K (continued)

all of its locations were in compliance. Its Atlanta facility was inspected and fined for failing to:

- install a fall protection system around unprotected sides of a pit
- keep exit routes unobstructed
- post signs along obscured exits to show the correct routes
- isolate energy sources on machines
- train employees on lockout/tagout
- guard rotating parts and ingoing nip and pinch points on a drill press and conveyor
- mark electrical panel circuits
- enclose an electrical control panel.
- provide audiometric testing or annual training on noise
- provide hearing protection to affected employees
- conduct annual training on respirator use
- fit tests employees for respirators

Result: The company's reeling from just under \$312,000 in fines. Failure to correct all of these problems at its multiple locations are liable to result in higher repeat fines.

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TRAINING

Employer's reliance only on warning stickers leads to tragedy



by Merriell Moyer

Lack of
procedure
contributed
to fatality

A North Carolina city's reliance on warning stickers rather than safety policies for its sanitation crews contributed to the death of a worker who was struck by a sanitation truck, according to an investigation report.

The city had an extensive safety program, but it failed to have a written policy for sanitation workers riding on the backs of trucks, instead relying on clearly visible warning

stickers on the inside and outside of the trucks.

Jumped behind backing sanitation truck

On Feb. 14, 2020, a city public works department sanitation crew was picking up garbage along a residential route. The three-person crew consisted of a sanitation truck operator and two ground workers

who would ride short distances on the back rider steps of the truck.

The roadway the crew was collecting garbage on was a dead-end street that the truck would drive forward along to gather the trash, and would back out of to leave.

After the trash was collected, the truck began backing out of the dead-end street with both sanitation workers on their ride steps despite conspicuous warning stickers at each

ride step forbidding riders while the truck was in reverse. One worker was on a step on the right side of the truck, while the other was on a step on the left.

Before the truck backed completely out of the street, the worker on the right got off his step and was walking alongside getting trash cans on his side of the truck. At one point, the worker looked up and saw a pickup truck backing out of a driveway on the left at a high rate of speed toward the sanitation truck.

Believing the pickup was going to hit the sanitation truck, the worker on the right called out to the worker who was still standing on the left ride step, warning him about the incoming pickup. Startled, the worker on the left jumped off his step and ran behind the backing sanitation truck.

The worker on the right hit a button on the back of the sanitation truck that sounded a buzzer inside the truck's cab, but the operator didn't hear the buzzer and continued to back up.

Because of the pickup, which narrowly missed the sanitation truck, the operator did stop the truck, but it was too late as the sanitation truck ran over the worker who had jumped from the left ride step.

Emergency responders pronounced the worker who had been run over dead at the scene.

Near miss, some property damage prior to fatality

Investigators with the National Institute for Occupational Safety and Health (NIOSH) Fatality

Assessment and Control Evaluation (FACE) program found the following hazards were key factors that contributed to the incident:

- riding on an outside step of a backing sanitation truck
- lack of situational awareness of the driver and workers
- lack of written standard operating procedures for driving and riding positions on sanitation trucks, and
- lack of communication between the sanitation truck operator and the ground workers.

Prior to this incident, the city's sanitation department only had a few minor property damage incidents and one near-miss involving an employee on a ride step who brushed against a telephone pole.

Info from stickers incorporated into new procedure

Despite having an extensive safety program, the city failed to create and use a procedure for sanitation workers who had to use ride steps on sanitation trucks. FACE program investigators learned that the city considered clearly visible warning stickers placed in passenger compartments and on the sides of the trucks near the ride steps as the policy for operators and riders.

The stickers instructed workers not to use the ride step when the truck was:

- in reverse
- traveling above 10 mph, or

- traveling greater than 2/10 of a mile.

Since the incident occurred, the city developed and is now using a procedure for sanitation workers that incorporates what's written on the warning stickers into a more comprehensive program. That program includes training on vehicle blind spots, and instructs:

- operators to always know the locations of ground workers and establish visual contact with them before moving refuse trucks
- sanitation workers to load refuse from the sides of a truck and avoid walking or standing behind trucks, and
- operators and ground workers on how to use hand signals to allow consistent communication.

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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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