



News & Training  
**SafetyAlert**

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October 2022

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# Best practices for dealing with unseen, unexpected hazards



# News & Training SafetyAlert


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October 2022


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# News Briefs

## Safety Stories You Might Have Missed

### Newspaper in trouble after firing whistleblower who complained about fleas in workplace

August 30, 2022

A Texas newspaper is in hot water with OSHA after firing a whistleblower who complained about an insect infestation in the workplace.

The *Killeen Daily Herald* is being sued by OSHA for allegedly firing a reporter after they told management they believed fleas had infested the workplace, leaving them with bug bites.

[Read more](#) 

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### Construction laborer suffers fatal fall while climbing scaffold cross braces

August 31, 2022

A 42-year-old construction laborer died when he fell 25 feet as he was climbing the cross braces of a scaffold, according to a new report on the incident.

The laborer was new to the trade and had only received informal on-the-job training, the Aug. 29 Washington State Fatality Assessment & Control Evaluation (FACE) Program report states. He had worked for his employer, a construction contractor, for about five months and had spent two months on the worksite.

[Read more](#) 

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### Court upholds \$96K fine against mine that continued work during methane incident

September 2, 2022

The U.S. Mine Safety Commission ruled Aug. 24 that an Indiana coal mine violated federal safety standards when it continued to operate an energized drill with explosive amounts of methane present.

This resulted in the commission upholding a \$96,000 Mine Safety and Health Administration (MSHA) fine against the mine operator, Peabody Midwest.

[Read more](#) 

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### CSB releases new guidance on Accidental Release Reporting Rule

September 2, 2022

The U.S. Chemical Safety and Hazard Investigation Board (CSB) has new guidance on its Accidental Release Reporting Rule, clarifying when employers should submit a report after an accidental release.

This guidance is also meant to help employers better understand the rule in general.

[Read more](#) 

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### Worker's repetitive stress injury claim denied over lack of medical evidence

September 6, 2022

A New York Transit Authority worker can't collect workers' compensation benefits after an appeals court found his repetitive stress injury claim from years of working on tracks was unsupported.

The New York Court of Appeals found the worker didn't provide sufficient medical evidence tying his repetitive stress injuries to his job duties.

[Read more](#) 

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## **Tougher OSHA lead standard could be a reality soon for industry and construction**

September 7, 2022

OSHA may toughen its workplace exposure to lead standard for the first time since 1978.

The safety agency proposes to lower the blood lead levels (BLLs) for medical removal and for returning to lead-exposed work for both general industry and construction.

[Read more](#) 

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## **OSHA joins task force to raise awareness about high suicide rate in construction industry**

September 7, 2022

OSHA has joined with a task force of construction industry employers, unions and educators to help raise awareness about the high rate of suicide among construction workers.

The task force seeks to highlight the work stresses seen as the causes of depression and suicidal thoughts and acts among workers in the construction industry, according to the Department of Labor.

[Read more](#) 

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## **California workers' compensation fund reports significant decrease in opioid use**

September 8, 2022

The California State Compensation Fund (State Fund), the state's main provider of workers' compensation insurance, reports that it has seen a significant decrease in opioid use by injured workers since 2014.

State Fund said its efforts have reduced the number of opioid prescriptions for injured workers it provides care for by 82% between 2014 and 2021. Further, State Fund reports a 14% decrease between 2020 and 2021, despite a national increase in opioid use and overdose deaths throughout the COVID-19 pandemic.

[Read more](#) 

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## **Tree company in hot water for letting teen workers operate woodchipper**

September 8, 2022

An Idaho tree services company is in hot water with the U.S. Department of Labor (DOL) for allowing teen workers to operate a power-driven woodchipper.

Done-Rite Tree Co. has to pay \$10,747 in penalties after an investigation by the Wage and Hour Division found two 17-year-old workers were regularly loading and operating the woodchipper. Operating power-driven woodchippers is considered a hazardous occupation for minors under the Fair Labors Standard Act.

[Read more](#) 

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## **Employer must pay workers' compensation for procedure from decade-old injury**

September 9, 2022

An employer must pay workers' compensation benefits for a spinal cord stimulator for a worker who injured his back on the job more than 10 years earlier.

The Court of Appeals of Iowa upheld a lower court decision that found the worker's continuing back pain was caused by his work injury despite one doctor's claim to the contrary.

[Read more](#) 

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# OK to let workers deviate from safety plan due to unexpected situation?



"Wow, it's busy out here today," Manage Mike Kelly said as he walked up to Ken Dawson, the manufacturing supervisor.

"Yeah," Ken said. "Some really big orders came down. The warehouse and shipping departments are also full steam ahead."

"I wonder how that's working out in the warehouse considering all the roofing work that's being done over there," said Mike.

"What do you mean?" Ken asked.

"They weren't banking on being this busy so a contractor was scheduled to work on a large area of the warehouse roof," Mike explained. "Certain sections of the warehouse floor are inaccessible to our employees because of safety concerns over falling debris."

"I better go check on that," Mike added.

## Supervisor said they could go into restricted area

As Mike was making his way to the warehouse, Sara Wood, an order filler, stopped him.

"Do you have a minute?" she asked.

"Sure," Mike replied. "I was just on my way to check on the warehouse roofing work."

"That's what I wanted to talk to you about," said Sara. "We're super busy but we're not allowed to go into parts of the warehouse we need to get to."

"I know," Mike said. "That's what I wanted to check on. I'll have to check in with the contractor to see if we can make some adjustments to our plan so you and the other order fillers can work safely."

"That's just it, Mike," Sara said. "Management said we could go into the closed-off areas if we don't see anyone working on the roof, but I'm afraid to do that. What if it only seems like no work is being done? Or what if the area is unsafe even though they're not actively working?"

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

## Keep them out of the restricted areas

As Sara pointed out, there are plenty of good reasons to stick to the plan and keep employees from entering the area where the roofing work is being done. Even if it may look safe to enter, there's no way to be sure, so Mike should put a stop to anyone going into the restricted areas.

Also, the fact that the roofers weren't expecting anyone to be working in the area below could mean they didn't take precautions they may have otherwise taken.

Further, Mike should find out what the other managers were thinking in allowing employees to enter restricted areas, in direct contrast to the agreed-upon plan.

## Did the supervisor already talk to the contractor?

On the other hand, management may have already had a conversation with the contractor, unknown to both Sara and Mike.

Even if that was the case, it should have been communicated to all the affected employees as well as to Mike. That way, everyone is on the same page and the changes to the plan can be properly documented and agreed upon.

Further, did management know the full extent of the plan? If they weren't fully in the know about what the plan required, that's an oversight that would definitely need to be addressed.

## Failing to adhere to plan caused 2 deaths in mine

On December 14, 2020, two miners at the Avery Island Mine in Iberia County, Louisiana, died when a section of the mine's ceiling fell on top of them. They were drilling holes in the ceiling to inject grout

## What Would You Do?

### OK to let workers deviate from safety plan due to unexpected situation? (continued)

to prevent water inflow at the time of the incident.

The two men, who both only had a few months of mining experience, were assigned to perform the drilling even though there was evidence that the area was unsafe due to adverse ground conditions, including a massive sinkhole nearby.

According to U.S. Mine Safety and Health Administration investigators, in the days leading up to the incident, multiple warning signs were recorded indicating that the ceiling could collapse. However, the mine operator didn't follow its Ground

Control Plan, which required more in-depth monitoring. This caused supervisors and other miners to miss obvious signs that would have led to the area being barricaded and signs posted warning workers to stay out due to the dangerous conditions.

The mine has since changed its Ground Control Plan to emphasize and address testing and monitoring of adverse ground conditions.

### Plans are meant to be followed

Safety plans are in place for a reason, and they should be followed.

If conditions dictate a change to the plan, then that change should be discussed with all relevant parties, the written plan adjusted to reflect the change and that change communicated to everyone who needs to know.

A safety plan that's only loosely followed, or not followed in any way, is as useless as having no plan at all.

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

## Sharpen Your Judgement

### Was injury caused by LOTO violation or completely unexpected worker misconduct?



*I can't wait to get home today,* Safety Manager Pete Travers thought as he finished some paperwork. *It's just been one thing after another all day long.*

He had meetings all morning followed by a safety training he had to conduct. Then, in the afternoon, there was a minor emergency when a water pipe in a bathroom burst. After that he found a trail of oil coming from a forklift, which he had to track down, clean up after and put out of service.

*Just one of those days, I guess,* he thought. *At least it's almost time to go home.*

The phone on his desk rang.

"Hello," he said, certain this call was something that would prevent him from getting home on time.

"It's John Jenkins," the company attorney said. "I need to talk to you right away. We just got an OSHA citation."

*Definitely one of those days,* Pete thought.

### 'He tried to adjust moving wire mesh by hand'

"OSHA claims we violated the lockout/tagout (LOTO) standard when an employee was injured while adjusting product on the coating line," John said. "Can you explain what happened?"

"Alex Turner, the injured employee, was trying to help another machine operator, Jim Rogers, realign the wire

## Sharpen Your Judgement

### Was injury caused by LOTO violation or completely unexpected worker misconduct? (continued)

mesh fencing that was going through the coating process," said Pete. "Apparently Jim was trying to adjust the moving wire mesh with his foot while hanging down from a walkway."

"I don't need you to tell me that's unsafe," John said.

"Exactly," Pete replied. "Alex saw Jim attempting it with his foot, so for some reason he decided to help by reaching in and adjusting the moving wire mesh by hand."

"As Alex reached down, his right arm was pulled into the rollers," Pete continued. "Several bones were broken in his arm and his skin was degloved from his hand to his bicep."

John cringed at the thought of the gruesome injury. "That's horrible," he whispered.

"I honestly don't know what possessed him to do that," Pete said. "We've got a problem with workers trying to take shortcuts here, which I'm trying to correct, but this was extreme."

### 5 different safe methods to make adjustments

"I mean, they had to go through a fenced-off area, complete with signs warning people to stay out when the line is running, just to get to the walkway," Pete continued. "Then Jim straddled the walkway in a way that he could get his foot down to the mesh before Alex ran

in and lowered his upper body down to the moving line.

"I've seen people do some crazy stuff before, but I'd have never expected anyone to be that reckless," said Pete. "We literally have five different safe methods to fix the alignment on the mesh without having to shut down the line."

"And that's how we can beat this citation," John said. "There's no way this company could have expected someone to bypass a closed gate with a warning sign and hang from an elevated walkway to adjust an active line."

"This isn't even a LOTO violation. Since the machine was already running there was no unexpected start up to worry about," John added. "We can definitely win this."

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

### The decision

The company won, on this violation at least. An administrative law judge with the Occupational Safety and Health Review Commission found that there was no way the company could have anticipated the employee's actions in this particular case.

OSHA claimed the incident was a violation of the LOTO standard because the two employees were required to service the line during normal production operations. The standard only applies, however, if employees are required to remove

or bypass a guard, which OSHA said was the case since the two workers had to bypass the closed gate.

The company argued it wasn't a LOTO violation since it didn't require employees to bypass the gate to straighten the wire mesh on the coating line. Instead, there were five different methods employees were trained to use for safely straightening the mesh on the line while it was active. Further, the company said there was no way it could have anticipated that any employee would go to such extremes to straighten the wire mesh when it provided safer alternatives that were also far easier to perform.

### Employees weren't required to bypass guards

The judge agreed with the company that sections 1910.147(a)(2)(ii) (A) and (B) of the LOTO standard applied to "servicing work during normal production operations 'only if' employees are 'required to remove or bypass a guard' or they are 'required to place any' body part in the 'point of operation' or 'where an associated danger zone exists during a machine operating cycle.'"

And in this case, the judge said the standard didn't apply since the company didn't require employees to bypass guards or place any body parts in the point of operation.

Testimony from former and current employees revealed that



## Sharpen Your Judgement

### Was injury caused by LOTO violation or completely unexpected worker misconduct? (continued)

the company in no way condoned the method the two employees attempted and was completely unaware it existed. The method of going beyond the closed gate and straightening the mesh by foot was a bad habit the uninjured worker had

picked up from a former employee who trained him. In fact, all of the employees who testified were astonished to learn that anyone would attempt to straighten the mesh with feet or hands.

With that in mind, the judge found OSHA also failed to prove that employees were exposed to the hazard.


### Analysis: Looking out for employee bad habits, shortcuts

In this case, it was one former employee who showed one of the employees involved in this incident the “foot trick” to straighten the wire mesh on the active line. The former employee felt this trick worked better than the safer, more efficient methods the company trained employees to use. This former employee claimed in court that he never told or trained the other worker to use this dangerous trick, but he did it in front of him several times and said, “This is how I do it.”

The supervisor in charge of that department and multiple current and former employees who testified were shocked to learn anyone would do something so dangerous when there were safer, faster methods to accomplish the task.

As safety professionals know, it’s important to keep an eye open for these tricks or shortcuts that can quickly become widespread bad habits among employees. If the shortcut is subtle enough, it could fly under the radar of supervisors and management long enough to become a major problem. Once they’re found out, it’s best to address them immediately.

**Cite:** *Secretary of Labor v. Riverdale Mills Corporation*, Occupational Safety and Health Review Commission, Nos. 19-1566 and 19-2011, 7/18/22. Dramatized for effect.

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

Thursday,  
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## TRAINING

# Situation awareness: Key to keeping workers safe, more complex than you may think



by Merriell Moyer

## How to prevent workers from getting tunnel vision



**S**afety professionals want employees to have good situation awareness and notice hazards before they're affected by them, but sometimes it seems that the most obvious things get overlooked.

Why? The simple answer is tunnel vision, but what tunnel vision actually means is a bit more complex.

The American Psychological Association (APA) defines situation awareness as:

“(C)onscious knowledge of the immediate environment and the events that are occurring in it. Situation awareness involves perception of the elements in the environment, comprehension of what they mean and how they relate to one another, and projection of their future states. Situation awareness is influenced by a number of factors, including stress; it may be

impaired by cognitive tunneling or social tunneling.”

Being able to perceive different elements and events in the environment, comprehending what they mean, how they relate and what they may lead to is important to workplace safety. To put it simply, if you don't smell the gasoline or see the lit match, and fail to understand what the two mean in relation to each other, then you're going to be in trouble.

### What is tunnel vision?

While it may seem silly to think that an adult worker would walk into a situation where they wouldn't take notice of an obvious danger like gasoline in the vicinity of an open flame, tunnel vision in the form of cognitive or social tunneling can affect a person's situation awareness.

Cognitive tunneling is defined by the APA as “a psychological state, typical of people concentrating on a demanding task or operating under conditions of stress, in which a single, narrowly defined category of information is attended to and processed. Cognitive tunneling involves the processing of highly critical task-relevant information, with limited or no processing of secondary information that may also be important to the task.”

The APA says social tunneling is “a psychological state, usually associated with a demanding task or stressful environment, characterized by a tendency to ignore social cues that may be relevant to a task, such as spoken commands or alert signals from other people.”

In short, if a worker is performing a task that requires a great deal of focus they could easily miss an obvious hazard. Likewise, if they're feeling stressed to perform a certain

task – for example, “We need that truck loaded yesterday!” – that can narrow their focus and cause them to miss important details.

A July 13, 2021, incident at the Nyrstar Tennessee Mines in Knox County, Tennessee, illustrates how this sort of tunnel vision can affect workers and lead to fatal consequences.

## **Rocks, debris on mine floor**

Gerald Turbyville was a miner with 10 years of experience at the Nyrstar mine. He and another miner, Kevin Norton, were assigned to work in an area of the mine designated as 17W-3. They took a telescopic boom lift with them to perform their work on the mine’s ceiling.

When the two men arrived at 17W-3 they found they couldn’t get the boom lift into position because the mine floor was covered with large rocks and mud. Another miner in the area said that rocks and mud had fallen from the ceiling the day before, which he moved before he could work. More rocks and debris had fallen since then. Some of the rocks were large enough that explosives had to be used to reduce their size before being moved by equipment.

They reported this to a supervisor who instructed the other miner to use explosives and a large front-end loader to once again remove the rocks and debris.

## **Concerns over task, not hazard**

Turbyville and Norton reported concerns about the work they were to do on the ceiling of 17W-3 to two other supervisors, but none of their concerns involved the rocks that

had been falling in the area. Instead, they were worried about where to position their boom lift to properly do their assigned work.

The two miners returned to 17W-3 before the rocks had been completely blasted and cleared to assist before beginning their own work.

With a member of the blasting crew onboard, Turbyville raised the lift basket so the other miner could attach explosives to a large rock. Turbyville raised the basket to about 11 feet when the blasting crew member felt small rocks hitting him from the ceiling. He laid down in the basket just as a large rock fell from above and struck Turbyville and the right side of the basket.

The blasting crew member was thrown from the basket with his legs contacting the mine floor and his upper body hanging by his fall harness and lanyard, which were attached to the basket. Norton and the other miners in the area ran for cover from the falling rocks.

Norton told another miner to get help. They then helped free the blasting crew member from his harness and got him to safety before checking on Turbyville. Norton found that Turbyville didn’t have a pulse.

Turbyville was later declared dead on the scene.

## **Warning signs were easily seen**

Investigators with the U.S. Mine Safety and Health Administration (MSHA) found that mining had started in 17W-3 in 1975 and occurred only sporadically thereafter. Over 45 years, the area had deteriorated due to age and excessive mining. During the five years before the fatal incident, 17W-3 hadn’t been mined, with

the exception of some exploration drilling. Mining resumed in June 2021, just one month prior to Turbyville’s death.

Interviews with miners revealed that they knew rocks had fallen in 17W-3. The broken, loose and hanging rocks were visible from the mine floor and could be seen more clearly when viewed from an elevated idle working place nearby.

There were clear warning signs regarding the hazard but none of the miners or supervisors working in the area noticed them. Everyone was so focused on the work at hand – clearing the debris and moving on to the actual job – that they overlooked clear signs of danger.

## **Train workers to pause, engage their brains**

What can be done to prevent this sort of tunnel vision? According to Donald Groover, an Industrial Hygienist with Dekra Consulting, the answer lies in training workers to pause and take in their environment.

“This is about stepping back, engaging the brain and thinking about the level of exposure,” Groover said.

Workers shouldn’t rush into a job without first stopping to think about what they’re about to do and where they’re going to be doing it. They should take just a few moments to think things through and make themselves aware of any new exposures they’re about to get into.

Those few moments should be enough to allow them to think things through rather than just running on autopilot.

[Read this story online](#) 



# Chemicals: Who's on the hook for greater process safety and risk management oversight?

Chemical safety rules and enforcement are about to get a lot tougher for some but not all regulated industrial sites.

The catch? It all depends on where the facility's located.

EPA is strengthening its Risk Management Plan (RMP) regulations to protect poor and/or minority communities. President Biden signed an executive order in January 2021 instructing EPA to correct disproportionate effects of pollution as part of an environmental justice initiative.

Long story short: Doing business near "overburdened" communities will involve more regulatory "red tape" and higher compliance costs for facilities that manufacture, process, import or store hazardous chemicals.

Proposed changes to RMP regs relate to:

- addressing natural hazards and power loss in hazard reviews and analyses
- facility siting requirements (which will make it more difficult to obtain building permits)
- mandatory safer technologies and alternatives analysis for petroleum & coal products manufacturing and chemical manufacturing processes (North American Industry Codes 324 and 325)
- root cause analysis for RMP-reportable accidents
- third-party compliance audits following accidents, and
- requiring employee participation and giving employees opportunities to report RMP-reportable accidents or non-compliance issues.

Most of these changes were proposed at the tail end of the Obama administration and were rescinded by the Trump administration because of high compliance costs for industry.


## EPA's move gives a boost to OSHA enforcement

EPA's RMP regs and general duty clause, both under the Clean Air Act (CAA), are generally considered to be "outside the facility" rules meant to address impacts of a chemical release.

OSHA's process safety management (PSM) rule primarily addresses "inside the facility" impacts of chemical safety – the well-being of employees, along with nearby neighbors and emergency responders, that can be hurt via a chemical release.

Keep in mind OSHA can refer egregious PSM violators to EPA for more strenuous enforcement under the CAA.

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

## Who Got Fined & Why



### Nailed for fall, burn and lockout/tagout hazards: \$480K fine could balloon if fixes aren't made

OSHA found a handful of hazards at a manufacturing facility. A few weeks later it checked in on one of the company's other locations and found even more problems!

**What went wrong:** General Aluminum has facilities in Wapakoneta, Ravenna and Conneaut, Ohio. Inspectors found a variety of safety violations at one or more locations within a six-week period. Infractions included:

- a band saw and quench tank that lacked adequate machine guarding
- failure to train workers performing service and maintenance tasks on industrial machinery on energy control procedures aka lockout/tagout
- exposing workers to fall hazards while working on top of casting machines
- burn hazards due to water accumulation around casting machines
- permitting the use of improper PPE
- exposure to electrical and arc flashes
- confined space hazards, and
- powered industrial vehicle hazards.

**Result:** The company was fined \$480,240 for one repeat, two willful and 10 serious violations. OSHA placed the company in its Severe Violator Enforcement Program which makes it vulnerable to frequent inspections and higher fines. General Aluminum produces engineered automotive castings and employs about 1,200 workers nationwide.



### Year in the clink for supervisor who skimped on asbestos safety

**What went wrong:** Babak Khalili of Los Angeles oversaw renovations made by the company Las Vegas Apartments. He admitted to knowing asbestos-containing materials were in both buildings, and that he hired untrained individuals to tear out those materials. Workers violated Clean Air Act requirements such as keeping asbestos materials wet and sealed in leak-proof bags.

**Result:** Khalili assured himself of jail time by lying to law enforcement about throwing asbestos-containing materials in outdoor dumpsters, then blaming work conditions on the contractor he hired. He was sentenced to one year in prison for endangering workers' health and safety and then trying to cover it up.

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[Read more Who Got Fined & Why in your Membership Dashboard](#) 



# Electrical shocks: Knowing the facts and risks



When electrical currents run through your skin, the resulting shock can be serious.

Have your people test their knowledge of this hazard by answering True or False to the following questions.

**check answers on the next page**

- 1 TRUE OR FALSE:** Electric shocks can range in severity from minor tingling sensations to death.
  
- 2 TRUE OR FALSE:** Live parts of electrical equipment operating at 15 volts or more need to be guarded.
  
- 3 TRUE OR FALSE:** Do not make simple electrical repairs unless you have already shut the power down and have the proper PPE and documents outlining how to fix the equipment.
  
- 4 TRUE OR FALSE:** Even if you aren't touching anything metallic, you're still at risk of getting an electric shock.

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



## Test Your Knowledge

### Answers from previous page



- 1 TRUE:** A shock of 1 milliampere (mA) will be barely perceptible at all, whereas a shock of 17 mA or more is likely to result in death.
- 2 FALSE:** Live parts that operate at 50 volts or more need to be guarded. They should be located in areas where workers can't accidentally come into contact with them and be marked with warning signs.
- 3 FALSE:** Unauthorized fixing of electrical equipment is like asking to be shocked. Never attempt to fix electrical equipment unless you've been specifically trained, authorized and instructed to do so by your Supervisor.
- 4 TRUE:** The human body can conduct electricity when a current enters and exits through two live wires, one wire and the ground or a metallic part touching a live wire and the ground.

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# FATAL INCIDENT SHOWS NEED TO ADDRESS HAZARDS THAT AREN'T OBVIOUS



## TRAINING

# When a job hazard analysis isn't enough: Training workers to expect the unexpected



by Merriell Moyer

**S**afety professionals rely on regular, routine training to help keep workers safe from hazards they face on the job. But training only on the normal, everyday hazards isn't enough.

As a safety professional, how can you possibly prepare employees for hazards that may occur outside of their regular training?

The answer is actually simple: training. That's right, you train them to be prepared for the unexpected.

For example, a Washington State Fatality Assessment and Control

Evaluation (FACE) program investigation recently found that a worker's tragic death could have been prevented if, among other things, he'd been trained to identify unexpected situations that weren't specifically addressed in a job hazard assessment (JHA).

### **Forklift was parked on power cord**

On Sept. 16, 2021, a 54-year-old forklift operator and a co-worker were installing large metal storage racks in a customer's warehouse.

They were in the process of placing shims under the uprights to level the racks.

The operator was using his forklift to raise the racks so the shims could be installed. At the same time, the co-worker was drilling holes in the concrete floor to anchor the uprights.

The operator shut off the lift's engine and set the parking brake, leaving the forks raised to about 39 inches.

However, he unknowingly parked on top of the cord for the drill his co-worker was using, so the co-worker got into the forklift to move

it and free the cord. The co-worker started the engine and put the lift into forward gear, but since the co-worker wasn't trained to operate the forklift, he didn't know how to release the parking brake.

The co-worker asked the operator for help, so the operator reached into the cab of the forklift and released the parking brake, which caused the forklift to begin moving toward the metal racks.

In a panic, the co-worker swerved to avoid the racks and struck the operator, crushing him between the rear of the forklift and one of the metal uprights. The co-worker jumped from the forklift, which came to a stop when its forks ran into a wall.

The operator was pronounced dead shortly after arriving at the hospital.

## Forklift was parked on power cord

Safety professionals, like the FACE Program investigators, can surely identify multiple root causes for this incident. Investigators specifically found that:

- a JHA had been conducted for this task, but this situation was not an expected hazard
- the operator and co-worker hadn't completed a required operator training program before operating the forklift, and
- the operator had received on-the-job training and was authorized by the employer to operate the forklift, but

the co-worker had no training and wasn't authorized to operate the forklift.

## Workers had blinders on

Quite obviously, the lack of proper forklift training is another major red flag to add that, if addressed, may have prevented this tragic incident.

One thing that's not so obvious – and something the FACE investigators took note of – is that one of the contributing factors was the JHA didn't prepare the workers for the unexpected situation they found themselves in with the forklift parked on the cord.

Instead of thinking through the situation and identifying possible hazards before attempting to free the cord, the co-worker focused on one thing: moving the forklift off the cord. And the operator followed suit, blindly helping without first assessing the situation.

## Train them like they're emergency responders

In addressing unexpected situations, the FACE investigators recommended training workers to:

- identify unexpected situations not specifically addressed in a JHA
- evaluate the hazards associated with unexpected situations, and
- control the hazards safely if possible and check with a supervisor if they cannot or if they have questions.

Unexpected situations are typically addressed in training for employees who volunteer to be emergency responders, such as your HAZWOPER-trained individuals. After all, emergencies are full of unexpected situations, so it makes sense to train emergency personnel how to react to them. But the day-to-day workplace can also throw regular workers the occasional curveball too, so it's best to prepare them for it.

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# Trouble getting C-suite to pay attention? Learn context of safety role within organization



As safety professionals, we all approach our jobs based on our own personalities and experiences.

Some are extroverts. Some are introverts. Some like to fly solo while others like to work in a team.

And the years we've spent in safety roles will definitely shape our approach to our jobs.

It has to do with life lessons. Not everyone has experienced the ugly side of safety. But those who have dealt with a fatality or have witnessed a traumatic event certainly have a different outlook and approach.

Safety professionals, just like anyone else, are shaped by their biases, stereotypes and assumptions about other people. This impacts the way we welcome ideas from others, form conclusions, connect with others and how we view ourselves within an organization.

As many different approaches to safety as there are, all safety professionals have one thing in common: We all want to make our workplaces as safe as possible.

## Easy to get stuck on opinions, biases

At some point in our careers, especially during those early years, safety professionals are stuck

on whatever opinion we have formed in our heads about what it means to be a safety and health professional. We are usually too quick to form conclusions at this point in time, consequently get results we don't expect and then find a coping mechanism to deal with it all.

Some become enforcers, writing rules and expecting everyone to follow. Others take different approaches. Some become cautious, afraid of saying the wrong thing or venturing out to try new things. Others may become the technical know-it-all, somewhat disconnected from the dynamics of the organization, but still trying to show value through technical expertise. Some may try to win workers over with charm and become the social butterfly, thinking that learning everyone's name or remembering everyone's birthday will magically contribute to having safe employees.

And when things don't go as planned, there is a tendency to blame it all on lack of support from the organization.

## Reality check: Safety program = management system

Here's a reality check: Even the most talented safety and health professional can't magically change anyone just with an inspirational talk. Or a rule. Or a warning. Or a smile in the morning.

The thing safety professionals have to realize is that it isn't all about your safety record, rules or even your safety and health program.

A successful safety and health management program is first and foremost that: a management system.

This sort of management system requires the leader, the safety professional, to leap out of the comfort zone into that management take-charge role. The way in which you view your role in an organization and how you understand safety's impact to the bottom line of the business will have a lot to do with your motivation and success.

## Understanding role in business will lead to better safety results

As a safety professional, you've signed up to be a business leader and your mission is to bring attention to matters related to safety within the business. Becoming familiar with internal dynamics and how these impact one another and what the organization's priorities are should be at the forefront of a safety professional's list of priorities.

Safety professionals need to be in a position where they understand

## Case Study

### Trouble getting C-suite to pay attention? Learn context of safety role within organization (continued)

their business management role as much as their technical knowledge.

When you accomplish this, safety impact in an organization is immediately a topic of focus since you are now communicating based on the motivation of your customer, the organization that hired you.

Our customer's motivation is frequently triggered by


various financial, efficiency, quality and safety metrics. That's the business world plan: the type of accomplishments that trigger people's raises and bonuses. Those factors influence day-to-day business decisions and available budgets.

Knowing this information will help you increase your level of empathy for what the rest of the business management team is

facing and will allow you to find opportunities where you can have a higher impact.

*(Adapted from "Safety Strategies and Initiatives: Are You Hitting the Mark?," a presentation by Vanessa Barrios-Galvan, Global EHS Segment Leader, PENTAIR, at the ASSP Safety 2022 Conference + Expo)*

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## Training Tips

### Checklist: Pass a hazardous waste inspection with flying colors



EPA's Resource Conservation and Recovery Act (RCRA) permits quite a bit of flexibility for facilities that generate small quantities of one or two hazardous or universal waste items per year.


Keep in mind you don't necessarily have to spend a lot of money on special EPA-approved containers to comply with RCRA.

EPA and state environmental inspectors will accept the following items as waste containers: metal drums, totes, cans, bottles and jars, beakers or test tubes, portable frac tanks, roll-offs, boxes, crates, buckets and pails.

Inspectors consider a variety of factors when it comes to containers and the soundness of your central or satellite accumulation areas:

- "Is there a reasonable chance of a container tipping over or breaking and releasing a dangerous waste to the environment?"
- "Are incompatible wastes being kept in separate containers?"
- "Are containers free of holes, corrosion or other damage?"
- "Do facility personnel keep lids securely on top of containers except when removing or adding waste?"
- "Is the facility properly training staffers on how to handle hazardous, universal or electronic wastes?" If records don't prompt a confident "Yes" response, inspectors are more likely to take a closer look at the site's RCRA program, including containers.

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## HAZARDS

# Relying too much on technology leads to \$1.5M shipwreck



by Merriell Moyer



BLIND SPOTS  
CREATED BY  
**OVERRELIANCE**  
**ON ONE DEVICE**

**T**echnology can be used to make a workplace safer, but relying on it too much could have the opposite effect.

An Aug. 9, 2022, investigation report by the National Transportation Safety Board (NTSB) is a perfect illustration of that fact as it explores how a ship crew's overreliance on electronic information systems led to a collision between the ship

and an out-of-service oil and gas production platform.

### **Failed to notice hazard despite seeing it**

On Jan. 7, 2021, the bulk carrier *Ocean Princess* and its 24-person crew struck the out-of-service oil and gas production platform

SP-83A while operating in the Gulf of Mexico, 24 miles south of Pilottown, Louisiana. There were no injuries and damages were estimated at \$1.5 million.

Investigators found the probable cause of the incident was poor bridge resource management, resulting in the bridge team failing to identify the platform and recognize the risk it posed

## Relying too much on technology leads to \$1.5M shipwreck

despite seeing its lights 10 minutes before the incident occurred.

### Platform was on paper charts, not electronic display

SP-83A wasn't shown on the ship's electronic chart display and information system because of a charting error. Paper charts showed the location of the platform and several crew members saw visual cues of the platform's presence, but no one informed the bridge personnel. This was mainly because the other crew members assumed the platform had already been seen by the bridge team. If the bridge team would have used the ship's

radar systems, it also would have detected the platform.

Bridge teams should use all available resources – paper charts, electronic charts, radar and visual cues – to conduct safe navigation, the NTSB states. Using all of these resources increases the team's collective situational awareness.

### Avoiding blind spots

Overreliance on a single data source should be avoided when identifying hazards because it can cause blind spots, just as it did for the bridge team of the Ocean Princess.

This can apply to just about any technology in any industry, as overreliance can lead workers and

supervisors to depend too much on the tech and not enough on their own senses or the other resources they may have available. And that can lead to blind spots.

"Increasing operator vigilance and combatting overreliance requires healthy skepticism about situations and information sources regardless of how accurate they could be, or how confident one is in their own assessment," the NTSB states in the report.

This doesn't mean technology shouldn't be used or that it's detrimental in any way, just that it should be used with other resources to ensure safer results.

[Read this story online](#) 

SafetyNewsAlert

## Handling an Aging and Obese Workforce

injury



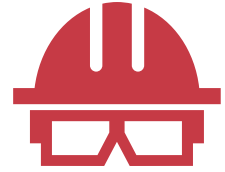
### Exclusive Safety News Alert Guide

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This Essential Insights is filled with actionable tactics and proven strategies to merge wellness, safety and ergonomics into one highly effective program best suited to today's employees.

get the guide 





# Was painful forklift injury due to a simple error or failure to train?

"Hey Oliver, could you give me a hand here?" Supervisor Chris Welsh called out to one of his workers from the loading dock.

Chris was tying down six long sections of pipe across a pallet. He tossed one of the straps over the top and Oliver secured it to the other side.

"Didn't know we were sending any more shipments out today," Oliver said.

"We weren't supposed to," Chris said. "But a customer just called us in a panic. Seems his supplier fell through."

"That's good news for us, I guess," Oliver said.

"You bet," Chris said. "As long as the competition keeps over-promising, we're going to keep stealing all their customers from them."

"I'm going to pull the forklift around," Chris said. "Would you be able to help me load this on the truck?"

"Sure thing," Oliver said.

## Supervisor decides to take over

Oliver heard the horn on the forklift as his Supervisor turned the corner. He stepped out of the way.

Chris pulled the forklift up to the pallet. "It's been a while since I've driven one of these things," he said.

"Do you want me to go grab another driver?" Oliver asked. "I think I saw Donny hanging around a little earlier."

"No. He just went on break," Chris said.

"We could call him," Oliver suggested.

"Don't bother," Chris said. "I wasn't always a Supervisor. I'm no stranger to driving a forklift."

"Besides, we have to get this order out ASAP. It could be a big deal for us."

"Good point," Oliver said.

"Just hang close and make sure the load is balanced," Chris said.

"OK," Oliver said.

# Was painful forklift injury due to a simple error or failure to train? (continued)

## Lifting the pallet becomes a problem

Chris navigated up to the load and positioned the forks to lift the pallet.

"Still a pro after all these years," he said. "You ready to go?"

Oliver stood to the side. "Ready when you are," he said.

Chris lifted the load carefully. He began driving it forward toward the truck waiting at the end of the loading dock.

"Careful," Oliver said. "It looks like that pallet is sitting a little toward the front of the forks."

"OK," Chris said, slowing to a stop. "Let's adjust it. Hold the pallet steady while I lower the forks."

Oliver walked over to the front of the forklift. As he did, he noticed the pallet was inching forward on the forks.

"Chris, I think we should ... "

The heavy load had reached a tipping point and slid forward, onto Oliver.

Workers rushed from all around to help their pinned colleague.

## It ends up going to court

Oliver's injuries resulted in huge medical bills. He was unable to return to work.

He sued the company for negligence.

Oliver argued OSHA standards require workers to receive training on how loads should be transported on forklifts and to protect workers from falling loads.


He said the company acted "intentionally and maliciously" when it ignored those standards.

Result: A judge threw out Oliver's lawsuit. He said the worker was entitled to workers' comp for his injuries. But he couldn't prove that the company had any ill will or intended for its worker to be hurt.

Key: Workers should remain clear of forklifts in use at all times.

Never allow workers to stand under elevated forks – even if there's nothing on them.

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

# Truck in fatal crash was noted as unsafe: Why did it remain in service?



by Merriell Moyer

## FAULTY BRAKES MARKED ON PRE-OP INSPECTION, NOTHING DONE ABOUT IT

**T**his may feel like it doesn't need to be said but if a piece of equipment is in need of maintenance for safety reasons then it needs to be fully taken out of service until it's fixed. Otherwise, it could have fatal consequences.

Safety professionals, supervisors, managers and even workers know this, yet injury incidents and fatalities still happen because the equipment remained operational when it should have been removed from duty.

For example, one worker was killed and another severely injured when the cement mixer truck they were operating crashed while traveling down a ramp at a mine.

Why did it crash? Because the brakes were defective, which was noted on pre-operational inspections. Despite the fact that employees and

management knew the vehicle had defective brakes, it remained in service and eventually caused a fatality.

### Brakes fail, speed increases

At 4:30 a.m. on Jan. 28, 2022, Monroe Caston, Jr., a 56 year-old cement mixer driver, and David Butler, a 24 year-old mixer driver in training, began their shift at Tri County, a concrete hauling and pumping contractor that was hired by the Freeport-McMoRan Morenci mine in Greenlee County, Arizona.

They retrieved their mixer and drove it to the concrete batch plant for their first load of the day. At 8:35 a.m., when they got to the mine, the load of concrete was rejected because it was too wet, so they were

told to take the load down a ramp to another batch plant for disposal.

An escort vehicle was assigned to guide the mixer to the appropriate area. As they began to descend the ramp, Caston and Butler lost the use of their brakes and the truck's speed rapidly increased. By 9:03 a.m., they passed the escort vehicle and a haul truck that was also descending the ramp at the time.

The driver of the haul truck radioed that the cement mixer had passed her and was traveling faster than the speed limit. The mixer continued to accelerate as it descended the ramp then veered out of control on a curve before rolling onto its side and sliding into a berm. Caston and Butler were ejected from the mixer since neither of them were wearing seatbelts.

At 9:12 a.m., an emergency medical technician arrived on scene and began administering first aid, with more arriving within the next few minutes. Caston and Butler were transported to a local hospital. Caston was pronounced dead from his injuries at 6:58 p.m.

### Defective brakes mentioned on pre-op inspection

Investigators with the U.S. Mine Safety and Health Administration found the cement mixer truck had a third axle that wasn't lowered while the truck was in use and

## Truck in fatal crash was noted as unsafe: Why did it remain in service?

was therefore unable to provide additional braking assistance.

The following defects were also found in the braking system:

- three of the four brakes were out of adjustment
- the rear drive axle had mismatching brake chambers resulting in unequal brake force and less effective braking
- the brake shoe on the driver side wasn't correctly positioned
- one brake actuator had an air leak, and
- five of six braking components were worn beyond requirements.

All of these defects combined to make operation of the truck

hazardous. Tri County management was notified of the defective brakes on a pre-operational inspection record from Jan. 20, 2022, but failed to take the truck out of service.

One root cause investigators pointed out was that the employer didn't remove defective equipment from service until those defects could be corrected.

### Workers trained to recognize, remove defective equipment

Tri County has since taken all of its trucks out of service and inspected the braking systems on each one before putting them back in service.

The company then developed written criteria for removing

defective equipment from service along with a standard operating procedure for inspecting brakes before each vehicle use.

All employees were also trained to recognize and remove defective equipment from service.

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## Training Tips

# Are workers doing the right stretches? Try this idea



An Olympic weight-lifter and sprinter both will stretch before competing. But they're certainly not doing the same stretches.

So which stretches are appropriate for your line of work?

Try this: Invite a physical therapist to your facility to observe your workers in action. (Your workers' comp or healthcare provider could be a good place to get started.)

Have them come up with a stretching program specific to the kinds of things your workers do.

This way, your stretching program will be targeting the muscle groups most likely to be injured.

## Who Got Fined & Why



### Worker loses part of his arm trying to dislodge debris from an energized machine

Workers at this cushion manufacturing plant dodged OSHA hazards on a daily basis and no one ever got seriously hurt. That winning streak came to an end in the worst way.

**What went wrong:** During normal production hours at the Carpenter Company in Temple, Texas, an employee tried to clear debris from a hot laminating machine when his right forearm became caught. He needed to have part of his forearm removed due to the grievous injuries suffered. The laminating machine lacked machine guards at entry points and adequate locking devices to prevent injury.

**Result:** In addition to lacking machine guards and locking devices on the laminating machine, OSHA found the company didn't conduct periodic inspections, apply a personal lock to a group lockout procedure to verify energy sources were isolated, and exposed workers to falls into dangerous equipment. The company faces \$227,907 in fines.

**Note:** Close to 60% of amputation injuries suffered annually are related to machinery use and maintenance.

[Read more Who Got Fined & Why in your Membership Dashboard](#) 

# about <sup>News & Training</sup> SafetyAlert

**S**afety News & Training Alert, part of the *SuccessFuel* 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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