



Wiring a green tomorrow



Joint Safety Committee  
Oregon Pacific-Cascade Chapter, NECA  
IBEW Local 280  
Thursday November 16, 2023  
Meeting MINUTES

Roll call: meeting called to order, In-Person and Zoom  
Approval of previous Meeting Minutes

**Communications**

We discussed Asbestos and Lead. Making sure everybody know of the rule change that happened in 2018. Clarifying what it means for commercial and residential. In addition we discussed lead in construction.

Also discussed two sections of the packet.  
Discussed LOTO and having written procedures for multiple sources of energy.

**OSHA Injury/Incidents (July-December)**

Recordable

- 1.1
- 1.2

First Aid/Near-miss

- 1.3 8.19 Worker moved a step ladder and strained back probably not a recordable
- 1.4

**Class Schedule-** Posted online

**Next Meeting** – December 28, 2023

**Adjournment**

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Vaughn Pugh  
Integrity Safety-Consultant

November 16, 2023



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Joint Safety Committee  
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Meeting AGENDA

Roll call: meeting called to order, In-Person and Zoom

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**1.0 Communications**

- 1.1 7 Holiday Safety Concerns in the Workplace
- 1.2 How we doing on any needs you might have that I can help?

**2.0 New Business- (safety packets distributed)**

- 2.1 Holiday Blues
- 2.2 Excerpt from Packet
- 2.3 Other items

**3.0 OSHA Injury/Incidents (July-Dec)**

Recordable

- 3.1 10.11 While drilling, drill bit slipped and penetrated other hand in the palm

First Aid/Near-miss

- 3.2 8.19 Worker moved a step ladder and strained back
- 3.3 9.25 Worker got dust in eye- no safety glasses worn

**4.0 Class Schedule- Posted online**

*All NECA Contractors are reminded that work related accidents and incidents should be reported via the Accident/ Incident report to the NECA office for consideration by the committee. If you need a copy of the report, contact the Chapter office.*

***IMPORTANT REMINDER:** The variance granted to NECA/IBEW by OR-OSHA requires participation by both Labor and Management Representatives at the Joint Innovative Safety Committee. For the Committee to be viable and provide assistance to Contractors and IBEW Members we need to have consistent attendance of all committee members.*

**Next Meeting: January 25<sup>th</sup>, 2024**



POWERFUL TRADITION ELECTRIFYING FUTURE  
OREGON PACIFIC-CASCADE CHAPTER

# **Safety Meeting Packet**

## **December 2023**

1040 Gateway Loop, Suite A ♦ Springfield, OR 97477

541-736-1443 Office ♦ 541-736-1449 Fax

**2023 LABOR HOURS RECAP  
ALL SIGNATORY CONTRACTORS**

Local#	Contract Type	Annual Total	Average Hrs/Mo	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
280	Inside	1,102,564	10	110,256	103,945	111,251	122,872	113,682	104,669	127,371	94,109	116,444	101,929	106,292	
280	Inside Appr.	352,922	10	35,292	33,080	36,178	41,949	39,430	34,323	42,315	29,202	35,810	30,125	30,510	
280	MAI	0	10	0	0	0	0	0	0	0	0	0	0	0	
280	Material	94,919	10	9,492	11,230	10,956	11,319	10,906	9,145	9,254	8,711	8,165	7,288	7,945	
280	Residential	86,294	10	8,629	7,215	8,641	9,630	7,955	8,324	10,667	7,218	9,383	8,993	8,268	
280	Resi. Appr.	55,223	10	5,522	4,753	5,536	6,370	4,780	5,597	7,155	4,396	5,849	6,053	4,734	
280	S & C	195,965	10	19,597	17,028	18,882	23,246	19,379	19,893	22,944	17,975	21,008	18,966	16,644	
280	S & C Appr.	65,055	10	6,506	4,879	5,741	7,610	6,606	6,317	7,806	6,256	7,395	6,952	5,493	
280	Support Tech/MOU	164,073	10	16,407	17,393	23,084	23,217	17,512	15,932	17,087	13,891	13,276	13,526	9,155	
	<b>TOTAL 280</b>	<b>2,117,015</b>	<b>10</b>	<b>211,702</b>	<b>199,523</b>	<b>220,269</b>	<b>246,213</b>	<b>220,250</b>	<b>204,200</b>	<b>244,599</b>	<b>181,758</b>	<b>217,330</b>	<b>193,832</b>	<b>189,041</b>	<b>0</b>
	<b>Total NECA</b>	<b>1,902,752</b>	<b>10</b>	<b>190,275</b>	<b>180,657</b>	<b>197,877</b>	<b>223,078</b>	<b>202,674</b>	<b>182,267</b>	<b>220,111</b>	<b>159,647</b>	<b>192,698</b>	<b>174,989</b>	<b>168,754</b>	<b>0</b>
	<b>% NECA</b>	<b>89.88%</b>		<b>90.54%</b>	<b>89.83%</b>	<b>90.60%</b>	<b>92.02%</b>	<b>89.26%</b>	<b>89.99%</b>	<b>87.83%</b>	<b>88.67%</b>	<b>90.28%</b>	<b>89.27%</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>

Local#	Contract Type	Annual Total	Average Hrs/Mo	Jan	Feb	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
659	Inside	239,823	10	23,982	18,216	22,795	28,225	23,379	23,263	27,100	22,988	23,878	26,008	23,971	
659	Inside Appr.	112,295	10	11,230	9,251	11,148	14,290	11,477	10,362	12,357	10,493	11,508	11,707	9,702	
659	Material	6,109	10	611	930	846	772	556	511	361	321	432	752	628	
659	Residential	6,613	10	661	634	756	929	609	652	793	502	650	565	523	
659	Resi. Appr.	2,890	10	289	287	413	228	229	303	302	264	312	292	260	
659	S & C	10,168	10	1,017	953	1,033	1,139	999	1,144	1,229	836	939	1,112	784	
659	S & C Appr.	2,420	10	242	228	315	358	289	306	407	300	154	63	0	
	<b>Total 659</b>	<b>380,318</b>	<b>10</b>	<b>38,032</b>	<b>30,499</b>	<b>37,306</b>	<b>45,941</b>	<b>37,538</b>	<b>36,541</b>	<b>42,549</b>	<b>35,704</b>	<b>37,873</b>	<b>40,499</b>	<b>35,868</b>	<b>0</b>
	<b>Total NECA</b>	<b>310,258</b>	<b>10</b>	<b>31,026</b>	<b>24,825</b>	<b>30,539</b>	<b>37,842</b>	<b>31,042</b>	<b>29,928</b>	<b>35,556</b>	<b>29,498</b>	<b>30,822</b>	<b>33,306</b>	<b>26,900</b>	<b>0</b>
	<b>% NECA</b>	<b>82%</b>		<b>81%</b>	<b>82%</b>	<b>82%</b>	<b>83%</b>	<b>82%</b>	<b>84%</b>	<b>83%</b>	<b>81%</b>	<b>82%</b>	<b>75%</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>

Local#	Contract Type	Annual Total	Average Hrs/Mo	Jan	Feb	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
932	Inside	102,150	10	10,215	8,218	9,082	9,687	10,250	10,240	10,277	10,229	11,022	11,671	11,474	
932	Inside Appr.	44,682	10	4,468	3,957	4,342	4,655	5,178	4,842	4,652	4,096	4,415	4,012		
932	Residential	1,197	10	120	114	108	31	119	152	160	126	129	155		
932	Resi. Appr.	2,790	10	279	0	0	79	151	168	318	349	519	689	517	
932	S & C	4,603	10	460	486	393	558	514	435	586	310	462	412	447	
932	S & C Appr.	137	10	14	0	0	0	35	0	45	40	0	17	0	
	<b>Total 932</b>	<b>155,559</b>	<b>10</b>	<b>15,556</b>	<b>12,775</b>	<b>13,925</b>	<b>15,010</b>	<b>16,247</b>	<b>15,837</b>	<b>16,038</b>	<b>15,564</b>	<b>16,225</b>	<b>17,333</b>	<b>16,605</b>	<b>0</b>
	<b>Total NECA</b>	<b>119,971</b>	<b>10</b>	<b>11,997</b>	<b>10,320</b>	<b>11,135</b>	<b>11,436</b>	<b>12,829</b>	<b>12,341</b>	<b>11,988</b>	<b>11,933</b>	<b>11,867</b>	<b>13,686</b>	<b>12,436</b>	<b>0</b>
	<b>% NECA</b>	<b>77%</b>		<b>81%</b>	<b>80%</b>	<b>76%</b>	<b>79%</b>	<b>78%</b>	<b>75%</b>	<b>77%</b>	<b>73%</b>	<b>79%</b>	<b>75%</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>
	<b>Grand Total</b>	<b>2,652,892</b>	<b>10</b>	<b>265,289</b>	<b>242,797</b>	<b>271,500</b>	<b>307,164</b>	<b>274,035</b>	<b>256,578</b>	<b>303,186</b>	<b>233,026</b>	<b>271,428</b>	<b>251,664</b>	<b>241,514</b>	<b>0</b>
	<b>Total NECA</b>	<b>2,332,981</b>	<b>10</b>	<b>233,298</b>	<b>215,802</b>	<b>239,551</b>	<b>272,356</b>	<b>246,545</b>	<b>224,536</b>	<b>267,655</b>	<b>201,078</b>	<b>235,387</b>	<b>221,981</b>	<b>208,090</b>	<b>0</b>
	<b>% NECA</b>	<b>88%</b>		<b>89%</b>	<b>88%</b>	<b>89%</b>	<b>90%</b>	<b>88%</b>	<b>88%</b>	<b>86%</b>	<b>87%</b>	<b>88%</b>	<b>86%</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>

## 2023 LABOR HOURS RECAP NECA MEMBERS

Local#	Contract Type	Annual Total	Average Hrs/Mo	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
280	Inside	993,633	10	99,363	95,278	102,203	112,045	104,305	93,306	115,038	82,902	102,867	90,898	94,791	
280	Inside Appr.	317,844	10	31,784	29,792	32,555	37,851	36,003	30,258	38,610	25,954	31,914	27,908	26,999	
280	MAI	0	10	0	0	0	0	0	0	0	0	0	0	0	
280	Material	84,710	10	8,471	10,866	10,385	10,760	10,501	8,565	6,186	5,990	7,318	6,746	7,393	
280	Residential	61,178	10	6,118	4,831	6,092	7,221	5,616	5,543	7,955	4,781	6,692	6,676	5,771	
280	Resi. Appr.	38,758	10	3,876	2,962	3,932	4,437	3,293	3,789	5,411	2,906	4,143	4,444	3,441	
280	S & C	192,180	10	19,218	16,637	18,571	22,755	19,785	19,368	22,498	17,526	20,497	18,349	16,194	
280	S & C Appr.	64,276	10	6,428	4,879	5,741	7,490	6,437	6,189	7,636	6,098	7,105	7,208	5,493	
280	Support Tech/MOU	150,173	10	15,017	15,412	18,398	20,519	16,734	15,249	16,777	13,490	12,162	12,760	8,672	
<b>Total 280</b>		<b>1,902,752</b>	<b>10</b>	<b>190,275</b>	<b>180,657</b>	<b>197,877</b>	<b>223,078</b>	<b>202,674</b>	<b>182,267</b>	<b>220,111</b>	<b>159,647</b>	<b>192,698</b>	<b>174,989</b>	<b>168,754</b>	<b>0</b>

Local#	Contract Type	Annual Total	Average Hrs/Mo	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
659	Inside	198,398	10	19,840	14,919	18,446	23,075	19,368	19,455	23,224	19,565	20,044	21,825	18,477	
659	Inside Appr.	92,984	10	9,298	7,726	9,770	12,221	9,767	8,511	10,206	8,502	9,278	9,806	7,197	
659	Material	2,848	10	285	478	366	443	307	244	114	153	153	314	276	
659	Residential	3,183	10	318	397	443	606	312	268	376	163	254	198	166	
659	Resi. Appr.	290	10	29	124	166	0	0	0	0	0	0	0	0	
659	S & C	10,135	10	1,014	953	1,033	1,139	999	1,144	1,229	815	939	1,100	784	
659	S & C Appr.	2,420	10	242	228	315	358	289	306	407	300	154	63	0	
<b>Total 659</b>		<b>310,258</b>	<b>10</b>	<b>31,026</b>	<b>24,825</b>	<b>30,539</b>	<b>37,842</b>	<b>31,042</b>	<b>29,928</b>	<b>35,556</b>	<b>29,498</b>	<b>30,822</b>	<b>33,306</b>	<b>26,900</b>	<b>0</b>

Local#	Contract Type	Annual Total	Average Hrs/Mo	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
932	Inside	76,855	10	7,686	6,454	7,088	7,119	7,986	7,755	7,444	7,619	7,833	9,072	8,485	
932	Inside Appr.	37,456	10	3,746	3,380	3,654	3,759	4,294	4,151	3,913	3,884	3,332	3,785	3,304	
932	MAI	0	10	0	0	0	0	0	0	0	0	0	0	0	
932	Residential	0	10	0	0	0	0	0	0	0	0	0	0	0	
932	Resi. Appr.	920	10	92	0	0	0	0	0	80	240	400	200		
932	S & C	4,603	10	460	486	393	558	514	435	586	310	462	412	447	
932	S & C Appr.	137	10	14	0	0	35	0	45	40	0	17	0		
<b>Total 932</b>		<b>119,971</b>	<b>10</b>	<b>11,997</b>	<b>10,320</b>	<b>11,135</b>	<b>11,436</b>	<b>12,829</b>	<b>12,341</b>	<b>11,988</b>	<b>11,933</b>	<b>11,867</b>	<b>13,686</b>	<b>12,436</b>	<b>0</b>

<b>Grand Total</b>		<b>2,332,981</b>		<b>233,298</b>	<b>215,802</b>	<b>239,551</b>	<b>272,356</b>	<b>246,545</b>	<b>224,536</b>	<b>267,655</b>	<b>201,078</b>	<b>235,387</b>	<b>221,981</b>	<b>208,090</b>	<b>0</b>
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# **Safety Training Topics**

January 2024

Accident Investigations

OSHA Recordkeeping

OSHA Reporting

Reporting Incidents

Fall Protection

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# SAFETY TRAINING TOPIC

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## Accident Investigations

Accidents can be defined as unplanned events that result in personal injury or property damage. By this definition, a worker who slips on a scaffold, but catches himself before falling, did not have an accident. Although there was no injury as a result of this incident, a means of reporting and investigating these near misses, as well as accidents, should be established. By investigating both near-misses and accidents we can do a better job of eliminating or controlling hazards.

Unsafe acts and unsafe conditions cause 98% of all accidents and near-misses. Of that number, 88-90% of the accidents result from unsafe acts, with unsafe conditions making up the other 10 %. Less than 2% of accidents go unexplained or are called "Acts of God." Unsafe acts are often identified by their immediate cause. Carelessness, poor judgment and bad attitudes are all examples of unsafe acts.

In an investigation we must look beyond the immediate cause to determine what underlying causes may have been involved. Poor training, lack of supervision and inadequate maintenance may all be contributors to accidents. Unsafe conditions in the work place may also be at fault. An oil spill may be the immediate cause of a fall. Poorly maintained equipment may have caused the spill and would thus be an underlying cause. A thorough accident investigation should reveal both.

Many accidents are caused by assigning workers to jobs that are too difficult to perform. If you don't have the skills or training to do a job, let your supervisor know. Performing a job that you know is beyond your ability is simply poor judgment, otherwise known as an unsafe act.

### THE ACCIDENT INVESTIGATION

Accidents may be investigated by an individual or team. In either case, it should be reviewed and used as a learning experience. Both management and workers should review the results of investigations and be free to make comments. While a report might indicate names of people involved, results used for discussion and training should not include these names. The intent of an investigation report should be to find solutions, not cast blame.

## **ACCIDENT INVESTIGATION PROCEDURES USUALLY CONSIST OF 5 STEPS:**

1. Collect the facts. (Use interviews and inspections.)
2. Determine the causes-both immediate and underlying.
3. Recommend actions to prevent future occurrences.
4. Communicate the results of the investigation.
5. Verify that recommendations are implemented.

Facts must be collected immediately. Don't change anything at the scene. Whenever possible, the injured worker(s) will be interviewed first and witnesses second. In most cases, interviews should be conducted separately to avoid confusion and omissions; witnesses may be influenced by what they hear from others. If you are interviewed, try to relax. If necessary, ask to go to surroundings that are more comfortable. Stick to the facts. Tell the interviewer what you saw, not what you think he wants to hear.

Following the interviews, the equipment and work areas should be inspected. If you have any knowledge or records which would be pertinent, such as maintenance records or written procedures, provide them to the inspector. When the results are posted, if you feel that certain causes weren't identified, be sure to let your supervisor know. Be sure to follow any new policies which are developed as a result of the investigation.

## **REVIEW QUESTION**

What are the leading causes for all accidents?

## **ANSWER**

Unsafe acts cause 90% of all accidents.



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# SAFETY TRAINING TOPIC

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## OSHA Recordkeeping

The Occupational Safety and Health Act of 1970 requires certain employers to prepare and maintain records of work-related injuries and illnesses. Separate records must be kept for each establishment or site that is expected to be in operation for one year or longer. Some employers are partially exempt from these requirements because of their size or the industry classification of the business.

Employers must decide if a case is recordable within 7 calendar days after they have been notified that an incident has occurred. Employers must also determine whether the incident is a new case or a recurrence of an existing one, and if the case was work-related. Flowcharts and other documents have been prepared by OSHA to assist your employer in the decision making process.

Specific forms have been developed and must be used to record work-related injury and illness information. If the case is recordable, your employer must first complete the Injury and Illness Incident Report form (OSHA 301). Some state workers compensation, insurance, or other reports may be acceptable substitutes, as long as they provide the same information as the OSHA 301.

The Log of Work Related Injuries and Illnesses (Form 300) is used to classify work-related injuries and illnesses and to note the extent and severity of each case. When an incident occurs, your employer should use the log to record specific details about what happened and how it occurred.

A separate form, The Summary of Work-Related Injuries and Illnesses (Form 300A) tracks the total incidents for the year in each category. The Summary must be posted in a visible location from February 1 to April 30. A "Company Executive" must examine and sign the summary certifying the accuracy of the information. All workers are encouraged to review the Summary and be aware of the types of injuries that are occurring in the workplace.

### **What is a work-related incident?**

An injury or illness is considered work-related if an event or exposure in the work environment caused or contributed to the condition or significantly aggravated a preexisting condition. Work-relatedness is presumed for incidents resulting from events or exposures occurring in the workplace, unless an exception specifically applies. The work environment includes the establishment and other locations where one or more employees are working or are present as a condition of their employment.

## **What incidents get recorded?**

Employers must record all work-related injuries and illnesses that result in:

- Death
- A loss of consciousness
- Days away from work
- Restricted work activity or job transfer
- Medical treatment beyond first aid

Your employer must also record any work-related case involving cancer, a chronic, irreversible disease, a fractured or cracked bone or a punctured eardrum. An additional recording criterion includes:

- Any needle-stick injury or cut by a sharp object that is contaminated with a potentially infectious material;
- Any case requiring an employee to be medically removed under the requirements of an OSHA health standard;
- Cases of tuberculosis infection as evidenced by a positive skin test or diagnosis by a physician or other licensed health care professional after exposure to a known case of active tuberculosis.

Workers have the right to review the injury and illness records. However, under certain conditions information will not be provided on the forms to protect the "privacy concerns" of affected workers. A separate report containing the omitted information must be kept by your employer and provided to OSHA upon request. Workers should also be aware that cases listed on the forms are not necessarily eligible for workers' compensation or other insurance benefits. Listing a case does not mean that the employer or worker was at fault or that an OSHA standard was violated.

## **QUESTION**

What are the posting requirements of the recordkeeping regulation?

## **ANSWER**

The Summary of Work-Related Injuries and Illnesses (Form 300A) must be posted in a visible location from February 1 to April 30. A "Company Executive" must examine and sign the summary certifying the accuracy of the information.

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# SAFETY TRAINING TOPIC

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## OSHA Reporting

Unfortunately there are times when work-related incidents result in the death or hospitalization of workers. OSHA has established criteria for the immediate reporting of these catastrophic events. OSHA will investigate these incidents to ensure the safety of the existing workforce.

Your employer must report to OSHA, within eight hours, the death of a worker or the in-patient hospitalization of three or more employees. The report must be made orally by telephone, or in person, to the nearest OSHA Area Office. If an OSHA representative cannot be reached at the area office the report can be called into the OSHA Central Telephone Number (1-800-321-OSHA). The report must still be given to a person and not through an answering machine, e-mail or fax.

At the time the report is given, OSHA will need to know the following:

- Establishment name
- Location of the incident
- Time of the incident
- Number of fatalities or hospitalized employees
- Names of any injured employees
- Contact person and his or her phone number
- Brief description of the incident

Even work-related heart attacks need to be reported. In these cases the OSHA Area Director will decide whether to investigate the incident, depending on the circumstances of the heart attack. Some fatalities and multiple hospitalizations do not need to be reported. Motor vehicle accidents that occur on a public street or highway and not in a construction work zone do have to be reported. Incidents that occur on commercial airplanes, trains, subways or buses also need not be reported. However, these injuries must be recorded on the OSHA injury and illness records, if the employer is required to keep such records.

There are times when a fatality or hospitalization occurs long after the incident. Your employer is only required to report fatalities or multiple hospitalizations that occur within thirty (30) days of an incident. If your employer did not learn of a reportable incident at the time it occurred and the incident would otherwise be reportable, the report must be made within eight (8) hours of the time your employer is informed. Your employer depends on the supervisors to immediately report these incidents to management. Workers also play a key role in keeping their Supervisors immediately informed so that action can be taken to prevent a reoccurrence.

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# SAFETY TRAINING TOPIC

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## Reporting Incidents

If you were involved in a work-related incident, would you know what action to take? All incidents, and even near miss incidents, should be immediately reported to your supervisor. Injury and illness information serves many purposes. It assists management in meeting the requirements established by OSHA. More importantly, the information can be used to identify hazards in the workplace. Once the hazards are identified, corrective action can be taken. Management also uses this information to file worker's compensation claims, identify accident trends and compile reports requested by clients, insurance providers, and government agencies.

Most of the information contained in these reports comes from the affected workers. It is collected by the supervisors and then forwarded to management. Your supervisor depends on you notify him of work-related injuries, illnesses and near misses as soon as they occur. By promptly reporting these incidents to your supervisor you also protect your rights if a workers' compensation claim is filed. Prompt reporting will help establish the injury or illness as work-related. Prompt will also allow your supervisor to take immediate corrective action.

Management understands that some injuries and illness that occur in the workplace are of a private and personal nature. OSHA also recognizes that the "privacy concerns" of workers need to be protected. In "privacy concern cases" the employee's name and other information can be omitted from the reports.

The following types of injuries or illnesses are considered to be privacy concern cases:

- An injury or illness to an intimate body part or to the reproductive system,
- An injury or illness resulting from a sexual assault,
- A mental illness,
- A case of HIV infection, hepatitis, or tuberculosis,
- A needle-stick injury or cut from a sharp object that is contaminated with blood or other potentially infectious material,

Other incidents can be classified as "privacy cases" if the employee independently and voluntarily requests that his or her name not be entered on the log. Our workers can be sure that their rights to privacy will be respected and that all data collected will be used to assist supervisors, management and government agencies create a safer workplace.

### QUESTION

Why is it important to promptly report any accident?

## **ANSWER**

By promptly reporting an accident you:

- Help prevent future accidents from occurring
- Assist management in complying with OSHA regulations
- Establish the work relationship if a worker's compensation claim is filed

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# SAFETY TRAINING TOPIC

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## Fall Protection

### SOME FACTS

Fall-related accidents account for about 10% of all workplace fatalities. Nearly all of the fall accidents on record were preventable.

Ways of protecting yourself include hazard elimination, fall protection, and work procedures.

### HAZARD ELIMINATION

The most effective way to deal with fall hazards is to eliminate them. For example, if you can lower a light to replace its lamp and then raise the light back up, you have eliminated the hazard.

Partial elimination is the second most effective way. For example, if you can pre-assemble items before going up in a lift or up on a ladder, you will spend less time being vulnerable to a fall.

### FALL PROTECTION

You can't always eliminate a fall hazard, and partial elimination still leaves you with a hazard. Fall protection, as defined by the fall protection industry, is a passive way of preventing you from falling.

Fall protection examples are all around you. These include ladder cages, platform railings, and secured hole covers.

### FALL RESTRAINT

This is what most people think of, when they think of fall protection.

It involves the use of a secure anchorage and a lanyard connected to your full body harness. The lanyard allows you to reach the work area, but prevents you from falling too far.

Fall restraints require you to have training in the proper use and inspection of your equipment.

### WORK PROCEDURES

Some situations make fall protection and fall restraint measures impractical or impossible.

The idea of changing the work procedure is not to find a cheaper way of protecting against the fall. The idea is to rethink the work process so fall protection measures become practical, possible, or unnecessary.

You may need to help change the procedure or find a way to eliminate the task completely. Your input is valuable, as you are the one doing the work.

## **SAFETY HARNESS INSPECTION**

When using fall restraint devices, you must inspect them. Look for fiber damage, pulled stitches, or frayed edges. Examine D-rings, grommets, rivets, buckles, tongues, and straps.

## **LANYARD INSPECTION**

Look for fiber damage, pulled stitches, or frayed edges. Inspect the snaphooks, carabineer, and any other mechanisms.

If it is a retractable lanyard, ensure the back nuts and rivets are tight.

If it is a retractable lanyard, test for smooth operation and proper locking.

## **ANCHORAGE POINTS**

Before attaching to an anchorage point, look for cracks, sharp edges, or evidence of abuse.

In a particularly dangerous area, you will need to attach to a new anchorage point before un-attaching from the one you are attached to.

Do not attach to guardrails, C-clamps, ladders, conduit, light fixtures, rebar, plumbing, roof stack, or any object that you aren't sure can support your weight plus the force of your fall. Anchorage points must be capable of supporting 5,000 pounds per person because of the forces generated from the impact of a fall.

## **REVIEW AND DISCUSSION**

- If there are ten people in your crew, how many are statistically likely to die from a preventable fall accident?
- What are three ways of protecting yourself from falls?
- What are some examples of how might you eliminate or partially eliminate a fall hazard?
- What is fall protection, as defined by the fall protection industry, and what are some examples?
- What is fall restraint, and what are some examples?
- What kind of training do you need if you are going to use fall restraint equipment?
- What is the purpose of changing work procedures?
- How do you inspect a harness?
- How do you inspect a lanyard?
- What do you need to know about attachment points?



# News & Training SafetyAlert

Powered by SuccessFuel

December 2023

Communications, information  
key components to any effective  
emergency response..... 15

Report: 41% of Amazon warehouse  
workers have been injured while  
working for the company..... 22

Worker's fatal fall due to  
supervisor's failure to stay  
at the worksite ..... 31

## New report says Amazon's injury problem could be far bigger than previously thought





# News & Training SafetyAlert


Powered by  SuccessFuel


December 2023


## In This Month's Issue


News Briefs ..... **3**


### Insider Content


 **You Be the Judge**  
Was it the employer's fault that supervisors and workers failed to wear required PPE on jobsite? ..... **13**


 **Safety Case Study**  
5 climate change hazards safety pros need to know and tips on how to control them ..... **18**


 **Training Tips**  
Is there a right time for doing lockout/tagout refresher training? ..... **21**

 **Who Got Fined and Why**  
Sawmill worker crushed to death when stored energy causes infeed roller to close: \$184K fine ..... **24**


 **What Would You Do?**  
Was safety-focused supervisor being overbearing or simply doing his job? ..... **25**


 **Real Life Safety**  
Demolition worker crushed by concrete wall: Did employer overlook hazards? ..... **29**


 **Training Tips**  
Veterans can be the linchpin to improving safety buy-in ..... **30**


 **Who Got Fined and Why**  
Freight company fined \$379K for exposing workers to suspended cars, motorcycles ..... **33**

### Articles

 **Communications, information**  
key components to any effective emergency response ..... **15**

 **Report: 41% of Amazon warehouse**  
workers have been injured while working for the company ..... **22**

 **4 ways to ensure subcontractors'**  
mobile equipment is safely maintained on your worksite ..... **27**

 **Worker's fatal fall due to supervisor's**  
failure to stay at the worksite ..... **31**

# News Briefs

## Safety Stories You Might Have Missed

### Feds find worker's failure to wear fall PPE while cleaning front-end loader led to his death

A steam truck operator with 16 years of experience was fatally injured when he fell 9 feet from a front-end loader's deck while steam cleaning the machine. He wasn't wearing fall PPE at the time.

U.S. Mine Safety and Health Administration (MSHA) investigators determined that the root cause of the incident was the employer's failure to ensure use of fall PPE when a fall hazard was present.

#### He collapsed and fell through gap in machine's deck

Jeffrey Hudnall worked for Marfork Environmental as a steam truck operator whose job duties involved cleaning mining equipment.

On Aug. 4, 2021, Hudnall met with another employee who had already started cleaning the front-end loader at the ground level. Ten minutes later, Hudnall took the steam cleaner wand from the other worker and continued cleaning the machine from the ground.

Hudnall climbed up a ladder to the right-side deck of the front-end loader and continued steam cleaning. A few minutes later, he collapsed and fell through an opening in the deck between a handrail and the closed cab. He fell more than 9 feet to the concrete pad below.

Hudnall was transported to a local hospital. He was pronounced dead on Aug. 8, 2021.

#### Opening was designed by manufacturer for maintenance access

MSHA investigators examined the front-end loader after the incident and found no defects that would have contributed to Hudnall's death.

The machine had an 18-inch opening between the handrails and the cab when the door was closed, which was designed by the manufacturer to provide maintenance access. This is the opening Hudnall had fallen through when he collapsed.

#### Failure to wear fall PPE contributed to his death

Investigators determined that Hudnall's death was the result of his failure to wear fall PPE while working where a fall hazard was present.

MSHA found that Marfork failed to ensure its employees wore fall protection when there was a danger of falling, which contributed to the fatal incident.

#### MSHA Review Committee had to review case

Investigators submitted the facts of Hudnall's death to the MSHA Chargeability Review Committee following the investigation for a decision on whether the fatality should be charged to the mining industry. This was presumably because Hudnall collapsed for some reason before he fell, although MSHA doesn't make this clear in the incident report.

The committee reviewed the autopsy report and MSHA's investigation and concluded that Hudnall's death was the result of injuries he sustained in the fall. That meant his death was chargeable to the mining industry.

#### Employer revised safety procedures, modified equipment

MSHA determined that the root cause of the incident was Marfork's failure to ensure its workers wore fall protection when there was a danger of falling.

To prevent a similar incident, Marfork developed a new written procedure and modified its equipment.

The new procedure requires:

- fall protection consisting of a full-body harness or full-body vest-type harness with an anchored lanyard
- use of fall protection when working within 6 feet of a ledge or opening that lacks safety rail protection
- use of fall protection when working in precarious positions at any elevation, such as working while leaning or working inside an approved bucket, basket, man-lift, chute, bin, and all overhead hoist doorways or access points, and
- use of fall protection while performing work in an elevated position with exposure to falling 5 feet or more.

Marfork also installed an additional handrail closing the gap between the factory handrail and cab on all of its front-end loaders that had a gap similar to the one Hudnall fell through.

## Farm owner charged with felony manslaughter for worker's death in unguarded harvester

The owner of a California farm was charged with involuntary manslaughter for the death of a worker who was killed while servicing an unsafe spinach harvester.

Willoughby Farms and its owner, David Willoughby, were charged for causing the death of employee Carlos Jimenez Cruz.

On Oct. 15, 2020, Cruz was strangled to death when the hood on his clothing got caught in a spinning shaft on the 16,000-pound harvester, according to the Santa Clara County District Attorney's Office.

Willoughby was arraigned Nov. 7, 2023, on felony manslaughter charges. The company, which is based in Santa Clara County, was arraigned Nov. 8, 2023 on the same felony charges.

The allegations against Willoughby and his business include failing to:

- provide adequate training to employees, and
- cover the dangerous parts of a machine, resulting in the death of Cruz.

Willoughby is facing up to four years in prison while his company could see millions of dollars in fines for three related Labor Code violations.

"Employers have a basic responsibility to make sure their workers are safe," District Attorney Jeff Rosen said. "It is a tragedy and a crime when a person doing their job is injured or killed because an employer fails to pay attention to safety."

This isn't the first time an employer in Santa Clara County was charged for a workplace death. In 2015, an owner and project manager of a construction company were convicted of manslaughter after an unsupported trench collapsed and killed a worker. Both were sentenced to two years in prison.

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## Worker wins Labor Law case for fall from ladder covered in 'mud and grime'

Can a construction worker in New York get summary judgment on his Labor Law case for a fall from a grimy ladder?

### Slipped, fell from third rung as he was descending

Michael O'Shea was working at a construction site operated by general contractors Procida Construction Corp. and Cosan Construction when he slipped and fell from a ladder on the jobsite.

He slipped on the third rung of the ladder, which was covered in "mud and grime," and fell as he attempted to descend to ground level from the upper floors of the building that was being worked on.

O'Shea filed a Labor Law claim, arguing that the general contractors were liable for his injuries.

### Photos of ladder offered as evidence

In court, O'Shea testified about his incident and offered photographic evidence of the ladder at the jobsite.

Procida and Cosan argued that O'Shea caused his injury by losing his balance while climbing down the ladder. The two companies submitted O'Shea's workers' compensation form as evidence of this.

On Sept. 29, 2022, a lower court denied O'Shea's request for summary judgment. O'Shea appealed.

### No proof worker knew another ladder was available

The Appellate Division, First Department found that the evidence offered by the two general contractors "lacked probative value and failed to raise a triable issue as to whether (O'Shea's) alleged misstep was the sole proximate cause of his injury." This was because there was no authentication of the alleged statement made by O'Shea on the workers' compensation claim.

The general contractors also argued that O'Shea could have used another ladder that was available on the jobsite, but there was no evidence that he was ever instructed to use the other ladder or even knew of its existence.

In light of the evidence, the appeals court ruled that O'Shea should have been granted summary judgment and overturned the lower court's decision.

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## Study: Workers with critical jobs during COVID-19 pandemic had higher excess mortality rates

A new study has found that workers in critical occupations suffered a greater excess mortality rate (EMR) during the COVID-19 pandemic than other workers.

### Some critical occupations had higher EMR than others

Researchers at the University of Minnesota found, for example, that the 2021 EMR for workers in food processing, which is a critical infrastructure sector, was 9.6 per 10,000 workers compared to 1.9 per 10,000 for workers outside critical occupations.

Some critical occupations, like transportation and construction, experienced higher EMR than other critical occupations, such as health care and agriculture.

Workers of color experienced higher EMR than white workers, according to the study. That was particularly true in food processing, food service, construction, retail, and transportation and logistics. The EMR for people of color was 4.6 in 2020 and 5.6 in 2021 compared to white workers at 2.7 and 4.4, respectively.

### 'Vaccine eligibility system didn't prioritize vulnerable workers'

Minnesota's system of vaccine eligibility was also looked at by researchers. This system was designed to get limited supplies of the vaccine to workers with the greatest risk of death. It prioritized health care and child care workers. However, the study's findings "suggest this system insufficiently prioritized some vulnerable groups of workers."

### Death certificates, employment rates from 2017 to 2021 studied

The study examined the "occupational risk associated with COVID-19 among those working in areas essential to continued critical infrastructure operations as defined by the Cybersecurity and Infrastructure Security Agency."

To conduct the study, researchers examined death certificates and employment rates in Minnesota from 2017 through 2021. Then they estimated the EMR for critical occupations in 2020 and 2021. Researchers further detailed the rates by different racial groups and vaccine rollout phases.

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## Injured his leg getting into his work truck after clocking out: Can he get workers' compensation?

Can an employee collect workers' compensation benefits for a leg injury he suffered while getting into the cab of his work truck after clocking out for the day?

### He felt pain, weakness in leg throughout his shift

On Nov. 12, 2018, Robert Lewis was working in the equipment yard of Lehigh Asphalt Paving & Construction Company moving equipment to prepare for winter.

Throughout the day, Lewis felt pain and weakness in his left calf and ankle, almost as if it was "slowly giving out."

At the end of his shift, Lewis locked up the shop area, went to the time clock and punched out for the day. After punching out, he returned to the work truck he was driving and attempted to quickly get into the cab of the vehicle. As he pushed off with his left foot to step up into the cab, Lewis felt a popping sensation in his lower leg, which was later diagnosed as a tear in his Achilles tendon.

Lewis filed a workers' compensation claim for the injury, which Lehigh contested.

### Judge finds injury didn't occur in course of employment

The judge denied the claim on Oct. 11, 2019. However, the Pennsylvania Workers' Compensation Board remanded the case back to the judge because he failed to make a finding regarding whether Lewis met his burden of establishing that his injury occurred in the course and scope of his employment.

On remand, the judge determined that Lewis's injury wasn't caused by a condition of his employer's premises and that he wasn't doing anything to benefit his employer when the injury occurred. The judge again denied the claim and the board affirmed the decision on Dec. 3, 2021.

### 'He wasn't engaged in furtherance of employer's business'

Lewis appealed the decision with the Commonwealth Court of Pennsylvania. Like the judge, the court found that there was sufficient evidence proving that Lewis's injury wasn't work-related.

The court said that Lewis "was not actually engaged in furtherance of (Lehigh's) business or affairs; he had punched out and was entering his vehicle ... to go home."

That meant the injury wasn't work-related and therefore wasn't compensable.

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## Teacher's gunshot injury isn't barred by workers' comp exclusivity; \$40M lawsuit can proceed

An elementary school teacher's gunshot injury doesn't fall under workers' compensation exclusivity provisions, according to a circuit court judge, so her \$40 million lawsuit against the school district can proceed.

The judge ruled that the shooting by a six-year-old student at Richneck Elementary School in Newport News, Virginia was personal and didn't arise out of the teacher's employment

### 6-year-old student shot her in the shoulder

Abigail Zwerner was breaking her first-grade class into reading groups after recess at about 2 p.m. on Jan. 6, 2023, according to The Virginian-Pilot. A six-year old student pulled a handgun out of his front hoodie pocket and pointed it at Zwerner, who was sitting about 10 feet away from him. The boy fired a single shot that went through Zwerner's left hand and into her shoulder.

### 'Past behavior should have led to heightened safety precautions'

Zwerner filed a lawsuit against the Newport News school district on April 3, 2023, arguing that the student's "past behavior, such as choking another teacher and whipping other students with a belt, should have led to heightened safety precautions at the school."

The lawsuit contends that instead of taking extra precautions, the school's assistant principal ignored warnings that the boy had a gun the day the shooting occurred. Zwerner claims the assistant principal refused to allow the boy to be searched despite another student telling a teacher the boy showed him a gun at recess.

### Judge: Boy specifically targeted his teacher

The Newport News School Board fought the lawsuit, arguing that Zwerner's sole remedy was workers' compensation because the incident was job-related.

Newport News Circuit Court Judge Matthew Hoffman disagreed.

Hoffman ruled that the assault was personal to Zwerner, meaning that it didn't arise by nature from her employment.

"He did not at any time threaten any other student, teacher, or administrator at the school with the firearm," Hoffman said. "The shooting was 'personal' and was directed against Plaintiff."

## New NIOSH resource addresses lead exposure for workers removing, replacing underground pipes

Lead is an insidious hazard that can be carried home on workers' clothing and skin, exposing their families to its harmful effects.

A new resource from the National Institute for Occupational Safety and Health (NIOSH) aims to help combat the hazard of lead exposure, specifically for those working on lead pipes.

Workplace Solutions: Reducing Workers' Lead Exposure during Water Service Line Removal and Replacement is specifically meant to address the potential for lead exposure for workers replacing lead service lines. It also provides recommendations to reduce lead exposure.

### Based on 2019 hazard evaluation of city water workers

NIOSH chose to address this because of "recent efforts to improve municipal water systems and protect public health by removing and replacing lead water service lines in the U.S.," which leads to potential worker exposure to lead-contaminated pipes and soil.

The resource is based on a 2019 hazard evaluation among city water department employees who were tasked with replacing water service lines. Air samples that were collected at the worksites were below occupational exposure limits. However, NIOSH investigators found lead on samples collected from workers' hands and work gloves as well as the surfaces inside locker rooms and vehicles.

### Recommendations for reducing exposure

To reduce lead exposure, NIOSH recommended solutions based on the hierarchy of controls, including:

- developing a written lead monitoring and control program
- monitoring airborne lead exposures
- providing portable high efficiency particulate air (HEPA)-filtered vacuums to clean work vehicles
- improving training, testing and housekeeping.
- cleaning surfaces
- avoiding bringing their personal items into contaminated areas, and
- using PPE.



## Injured worker wins Labor Law case despite being unable to identify object that struck him

A New York construction worker injured by an unknown object was awarded summary judgment on his Labor Law claim despite being unable to identify the object that struck him.

The New York Appellate Division, First Department ruled that summary judgment was appropriate because the worker's testimony and a photo of a hole in protective netting above where he worked was sufficient evidence to prove liability.

### Lower court felt failure to identify object justified denial

Boaz Harsanyi worked on a construction site operated by Extell 4110 LLC. Harsanyi claimed he was struck on the head and neck by an unknown object while he was working on an outrigging platform on the 25th floor of a building that was under construction.

In court, Harsanyi testified that he could hear other workers stripping wood on the floors above him at the time of the incident. He submitted photos showing a large hole in the safety netting that served as overhead protection for the floor he had been working on.

On Dec. 23, 2022, a lower court denied Harsanyi's petition for summary judgment on his Labor Law claim that argued that Extell was liable for his injury. The court felt that Harsanyi's failure to identify the object that struck him precluded summary judgment. It also denied Extell's petition for summary judgment.

### Defective protective device enough to justify summary judgment

On appeal, the Appellate Division, First Department found that Harsanyi should have been granted summary judgment because a Labor Law claim involving a falling object "is not dependent on whether the plaintiff observed the object that hit him."

Also, an injured worker isn't required to show the "exact circumstances under which the object fell, where a lack of a protective device" caused the injuries.

The appeals court said the evidence was sufficient to prove that Harsanyi's injury was the result of a Labor Law violation. Further, Extell failed to provide "any version of the accident under which they could not be held liable."

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## Be on the lookout for NIOSH's new survey on employer respirator use, its first since 2001

Employers may soon receive an invitation from the National Institute for Occupational Safety and Health (NIOSH) to complete a survey on respirator use, the first to collect updated data since its initial survey in 2001.

The Survey of Respirator Use and Practices (SRUP) will be used to update the estimated number of U.S. companies using respirators, determine why the respirators are being used and reveal how employers are managing respirator use.

This is intended to help ensure that NIOSH's Respirator Approval Program can address all respirator uses and practices so it can continue to provide "crucial support to workers and the public."

NIOSH's Respirator Approval Program is the "most robust respirator certification and approval program across the globe" and is counted upon by many countries to provide workers with these protections.

### Survey meant to capture post-pandemic practices

New questions added since the 2001 survey are meant to help determine how the COVID-19 pandemic impacted respirator use across many industries.

NIOSH feels that the changes in respirator use throughout the pandemic make it important to capture current practices in:

- manufacturing
- mining
- agriculture
- healthcare
- public safety
- construction, and
- services.

Invitations to complete the survey were scheduled to start being sent out on November 2, 2023. Questions regarding the survey can be directed to [ODAdmin@cdc.gov](mailto:ODAdmin@cdc.gov).

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## MSHA: Company's failure to provide proper training led to mechanic's death

Failure to provide proper training and block equipment against hazardous motion resulted in the death of a contractor mechanic who was struck by the counterweight of a hydraulic excavator.

The U.S. Federal Mine Safety and Health Administration (MSHA) found that the contractor didn't task train the mechanic on how to disassemble the major components of the excavator and didn't have procedures in place for controlling potentially hazardous motion.

### Counterweight fell as last bolt was removed

On Dec. 16, 2022, Thomas Hild was working as a mechanic at the Signal Peak Silica of Atascosa mine in Atascosa County, Texas. Hild was employed by Stout Excavating Group LLC, a contractor that provided excavating and hauling services.

At 7:30 a.m., Hild, a co-worker and their supervisor began disassembling the major components of a hydraulic excavator for transportation to Kermit, Texas. They removed the tracks, upper boom and bucket earlier in the day. Later in the afternoon, Hild backed his service truck close to the rear of the excavator's 27,227-pound counterweight and then climbed onto the truck's back step. He did this so he could get access to the bolts securing the counterweight to the excavator.

At 4:29 p.m., the co-worker and supervisor stood out of sight about 10 feet away while Hild removed the last bolt from the counterweight. They heard a popping noise and went to where Hild had been working. The co-worker and supervisor found the counterweight lying on the ground near an injured Hild, who had been struck by the falling counterweight.

Police arrived at 4:32 p.m. Emergency medical services showed up at 4:51 p.m. Hild was pronounced dead at 6:18 p.m.

### Important anchor bolts were missing

The excavator involved in the incident was a Caterpillar 390F. MSHA investigators found a copy of the manufacturer's operating manual in the cab, which contained step-by-step instruction on how to remove the counterweight.

Investigators brought in representatives of Holt CAT, an authorized Caterpillar dealer, to aid in looking the

excavator over for defects. They found that two anchor bolts were missing from the counterweight, which were important for supporting the counterweight during the assembly and disassembly processes. No other defects were found.

MSHA investigators also determined that Hild didn't engage the lift cylinder on the excavator to block the counterweight from hazardous motion before removing the final mounting bolt.

### Co-workers felt mechanic lacked experience to perform task

Based on his training records and interviews with co-workers, investigators learned that Hild had more than one year of experience working as a mechanic for Stout. He participated in the assembly of the counterweight on the excavator in the past, but had a limited role and was more of an observer at the time.

The MSHA investigators also learned that Hild and his co-workers were called by two more experienced Stout employees and asked to wait for them to arrive before attempting to remove the counterweight. These more experienced employees were concerned because they knew Hild lacked experience with the disassembly process.

The supervisor told investigators that Hild was familiar with the disassembly procedure but wouldn't confirm that Hild had ever removed the counterweight from the excavator before.

MSHA interviewed Stout management and learned that their mechanics received no task training. Instead, the company relied on the mechanics to look at the manufacturer operating manuals for their training. None of Stout's management acknowledged assigning the counterweight removal task to Hild.

### Company now task trains all of its employees

Based on its investigation, MSHA determined that the root cause of the incident was that Stout:

- failed to provide task training on disassembling the major components of the hydraulic excavator, and
- didn't ensure that equipment was blocked against hazardous motion.

Stout has since properly task trained all of its employees on the duties assigned to them. The company has also held safety meetings with all of its employees to retrain them on existing procedures and requirements regarding blocking equipment against hazardous motion.

## Following President Biden's Executive Order on AI, NSC encourages its use in safety programs

Following President Biden's Executive Order establishing new standards for artificial intelligence (AI) safety and security, the National Safety Council (NSC) pointed out that use of AI can help with workplace safety.

The NSC believes "data and AI can be used to gain insights into workplace safety programs and that employers can apply those same insights and technology to reduce the risk of serious injuries and fatalities for workers."

### 'Promise of productivity, dangers of increased surveillance, bias'

President Biden's Executive Order was meant to ensure that the U.S. "leads the way in seizing the promise and managing the risks of AI" while protecting privacy, advancing civil rights, standing up for consumers and workers, and promoting innovation and competition.

The Executive Order points out that AI offers not only "the promise of improved productivity but also the dangers of increased workplace surveillance, bias, and job displacement" and to mitigate these risks the U.S. must "support workers' ability to bargain collectively, and invest in workforce training and development that is accessible to all."

### NSC: AI must be 'people centered, without bias, and correct'

The NSC agreed with the tenets of the Executive Order and issued a statement doubling down on its assertions that technology, including AI, can be used to improve worker safety. Through its Work to Zero initiative, the organization has been promoting the use of technology for workplace safety for the past five years.

AI has made an impact among U.S. jobs and workplaces, but there are several barriers to widespread adoption, according to the NSC. Investing in worker training on the use of AI to do jobs "safely and securely is the key, as AI has the power to help improve safety and health outcomes in the workplace."

This technology must be "people centered, without bias, and correct," the NSC said, while promising to support employers as they consider the safety and security of workers and other stakeholders "in this changing landscape."

## Feds find employer at fault for worker who died of carbon monoxide poisoning in his own vehicle

U.S. Mine Safety and Health Administration (MSHA) investigators determined that the mine operator and contractor didn't ensure that the worker's personal vehicle was maintained in a safe operating condition.

### Waiting in personal vehicles was common practice

On Dec. 22, 2022, Aidan Coon was working at the Wellmore No. 8 Prep Plant mine in Buchanan County, Virginia. Coon worked for SNF Mining, a contractor hired by the mine to spray train coal cars with an anti-freezing chemical during the winter months.

Coon began his shift at 12 a.m. That night, the mine was expecting a train to arrive, which would require Coon to apply the anti-freezing spray to the coal cars. However, the train didn't arrive on time. This led Coon to do what he normally did in such a situation: wait in his personal vehicle, a 2011 Ford Escape. Waiting for a late train in a personal vehicle was a normal practice among the SNF Mining workers.

At 12 p.m., another SNF Mining employee arrived to relieve Coon, who was still in his personal vehicle with the engine running and the doors locked. The other employee thought Coon was asleep and attempted to wake him, but could not.

### Damaged exhaust, failure to maintain contact led to fatality

During the investigation, MSHA found that Coon's Ford Escape had pre-existing damage to the rear passenger side, a missing light assembly and a damaged exhaust system, which allowed exhaust fumes to enter the interior of the vehicle. This directly led to the fatality, according to investigators who faulted both the mine and the contractor for failing to ensure Coon's vehicle was properly maintained.

Investigators also found that the mine operator didn't maintain constant communication with the SNF Mining workers. The standard procedure was to find them in their personal vehicles when they were needed.

### New procedure doesn't allow use of personal vehicles

The mine and SNF Mining have since developed a new written procedure that doesn't allow miners or contractors to stay in their personal vehicles. Further, the mine now provides an area for workers to monitor the coal belt and spray the railroad coal cars.



## OSHA, National Labor Relations Board agree to strengthen info sharing, whistleblower efforts

OSHA and the National Labor Relations Board (NLRB) have agreed to strengthen their information sharing efforts and outreach regarding workers' whistleblower rights.

The memorandum of understanding (MOU) will make it easier for OSHA and the board to cooperate more efficiently to enforce related laws and protect workers' rights.

This agreement, which was announced Oct. 31, 2023, will also "create mechanisms to increase overall awareness on the rights and remedies available under federal anti-retaliation and whistleblower protection laws."

"Workplace safety can be a matter of life and death for workers and so the ability to report workplace hazards without fear of retaliation is critically important," said NLRB General Counsel Jennifer A. Abruzzo. "Today's MOU will bolster protections for workers to speak out about unsafe working conditions by strengthening coordination between OSHA and the NLRB on our enforcement efforts."

A fact sheet, *Building Safe & Healthy Workplaces by Promoting Worker Voice*, has already been jointly produced by OSHA and the NLRB. This fact sheet is meant to help workers better understand their options when they've had their rights violated.

"Everyone should be able to exercise their legal rights in the workplace without fear of losing their job or other forms of punishment," Assistant Secretary for OSHA Doug Parker said. "Our partnership with the National Labor Relations Board will expand both of our agencies' impact and effectiveness in protecting workers who raise concerns about workplace violations or retaliation."

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## Mine slammed with significant and substantial citations for inadequate workplace exams

An Ohio mine was cited for 25 violations, including six deemed as significant and substantial, for failing to perform adequate workplace examinations and repeat violations relating to machine and fall hazards.

The inspection was one of nine impact inspections performed by the U.S. Federal Mine Safety and Health Administration (MSHA) at mines in seven states in September 2023.

Monthly impact inspections are conducted at mines "that merit increased agency attention and enforcement due to poor compliance history, previous accidents and injuries, and other compliance concerns."

Marblehead Aggregates quarry in Marblehead, Ohio was one of the mines that underwent an impact inspection in September 2023 "given its previous enforcement history."

The inspection identified 25 violations, including 6 considered to be significant and substantial, or S&S.

S&S violations are what MSHA considers "reasonably likely to cause a reasonably serious injury or illness." Another type of violation, called an unwarrantable failure, involves "aggravated conduct that constitutes more than ordinary negligence."

At the Marblehead Aggregates quarry, MSHA found:

- that the mine failed to conduct adequate workplace examinations, a failure that "contributed to fatal mine accidents and disabling injuries" in other mining incidents in 2023, and
- several hazards that led to S&S violations, including failure to install and maintain machine guards, provide safe access to work areas, and maintain work areas free from slip, trip and fall hazards.

### 35 mining fatalities so far in 2023

As of Oct. 31, 2023, there have been 35 mining fatalities this year, which makes it important for mine operators "to remain vigilant in ensuring the health and safety of miners," according to Assistant Secretary for Mine Safety and Health Chris Williamson.

"Given the troubling increase in fatalities this year, MSHA again calls on everyone in the mining community to pay close attention to hazards and conditions that put miners' health and safety at risk," Williamson said.

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## Update to OSHA Hazard Communication Standard submitted to White House for review

OSHA's final rule to update the Hazard Communication Standard (HCS) was submitted Oct. 11, 2023 to the White House Office of Management and Budget.

The final rule – which was intended to align the OSHA standard with the international seventh edition of the Globally Harmonized System of Classification and Labeling of Chemicals (GHS) – is expected to be finalized sometime in early 2024.

### Law firm says rule could introduce 'significant challenges'

This rule could introduce some “significant changes and challenges particularly for chemical companies and especially those exporting to the European Union,” according to law firm Reed Smith.

The main challenge comes from a requirement to include “any hazards” a chemical poses on warning labels. That includes the chemical in its current form as well as any combinations and reactions it could have with other chemicals as an end product.

Further, companies will have “to gather and evaluate data on the potential hazards of their chemicals in various scenarios and contexts, which could be costly, time-consuming, and uncertain.”

### Regs may force different labels depending on jurisdiction

An additional challenge for international chemical companies is that OSHA's final rule will be compatible with the European Union's more stringent and progressive chemical regulations. However, Reed Smith said that even with these changes, the final OSHA rule is still behind on some requirements when compared to the international GHS.

That means companies in the U.S. may be forced to have different labels for each of the jurisdictions in order to comply with both OSHA and European Union regulations. Separate labels could cause “confusion and mistrust among consumers and regulators, who may wonder why a product has different hazard warnings in different markets.”

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## Court says worker should have won Labor Law case since he proved scaffold lacked guardrails

An injured New York worker should have been granted summary judgment on his Labor Law claim because he proved that the scaffold he fell from lacked required safety equipment.

The New York Appellate Division, First Department ruled that a lower court erred by granting summary judgment to the general contractor and owner of the worksite.

Since the defendants offered no evidence that required further consideration in court proceedings, there was no reason not to grant summary judgment in favor of the worker, the appeals court said.

### Scaffold didn't have railings or other safety equipment

Juan Maillazhungo was a worker at a construction site operated by Pioneer General Construction Co. and owned by 94 E. 208 Street Partners LLC.

Maillazhungo was injured on the job when he fell from a scaffold. He filed a Labor Law claim, arguing that Pioneer and Street Partners were negligent for supplying a scaffold that lacked safety devices to keep workers from falling.

A lower court granted summary judgment to the defendants on Sept. 28, 2022 despite an undisputed affidavit Maillazhungo's provided as evidence that the scaffold lacked guardrails and other safety equipment.

### Worker's evidence wasn't contested

On appeal, Maillazhungo argued that the lower court erred in granting summary judgment to the defendants.

The appeals court agreed, finding that the defendants failed to show what further evidence was needed to make its case or what that evidence might reveal.

Instead, summary judgment was warranted in favor of Maillazhungo, whose affidavit evidence regarding the state of the scaffold on the day he fell wasn't contested by the general contractor or the worksite owner.

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## Port of Portland wins NIOSH Prevention through Design Award

The Port of Portland in Portland, Oregon received the third annual Prevention through Design (PtD) Award from the National Institute for Occupational Safety and Health (NIOSH).

NIOSH, the American Society of Safety Professionals (ASSP) and the National Safety Council (NSC) held a ceremony Oct. 23, 2023 at the NSC Safety Congress & Expo to present the award to the Port of Portland for its efforts on a project at the Portland International Airport.

The PtD award highlights an organization's real world success at "designing out" hazards, which according to the hierarchy of controls, is the most effective way to protect workers.

PtD methods used in the construction of a large parking and rental car center project is what earned the Port of Portland the nomination. This project involved a \$325 million construction of five facilities.

### Team used 'integrated design-safety process' on project

Success with PtD methods on smaller projects led the Port of Portland team to include those methods on this larger project. The team also included general contractor JE Dunn and design contractor YGH.

They used "an integrated design-safety process including the hierarchy of controls to reduce inherent risks at multiple stages of the facility life cycle, including construction, operations, and maintenance."

The design "took into account a smooth transition between constructing the parking facility and occupant use" with one key element of the project success being "that PtD requirements were placed in contract specifications."

Inclusion of a multidisciplinary team and its practice of meeting at least monthly was listed as another key practice to the team's success at incorporating PtD into the project. For example, the meetings helped the team come up with creative solutions to avoid the use of ladders.

### 'Designing out hazards most effective way to prevent injuries'

"Anticipating and 'designing out' hazards in tools, equipment, processes, materials, structures, and the

organization of work is the most effective way to prevent occupational injuries, illnesses, and fatalities," said NIOSH Director John Howard.

The Port of Portland has since shared its experience with the construction industry and provided consultation to Pennsylvania's Pittsburgh International Airport in its PtD efforts.

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## You Be The Judge

# Was it the employer's fault that supervisors and workers failed to wear required PPE on jobsite?



Safety Manager Pete Travers was on his way to the front office. He was on a mission.

During his safety walk, Pete noticed several employees making safety infractions. On top of that, there were supervisors who were blatantly ignoring the employees who were breaking the rules.

Pete was planning on calling the supervisors in for a quick meeting and addressing the issue in general with the group. Chats with individual violators, with formal documentation, would be the next step if it came to that.

However, before he could make the call over the P.A. system, John Jenkins, the company attorney, stopped him.

"We need to talk," said John. "OSHA is citing us."

### 'OSHA says no one was wearing hard hats'

Pete shook his head as if he was trying to clear it of what he just heard. "What? Why?" he asked.

"The citation says, 'Employees at the worksite failed to wear protective

headgear while working in an excavation,'" John said, reading from the document. "They were working in a trench that was more than 9-feet deep, replacing several lengths of pipe.

"Employees were exposed by struck-by hazards from tools, materials and spoil piles, according to OSHA," he added.

"Our safety rules require the use of hard hats anytime there's the potential for a head injury," said Pete. "Working in a trench that deep certainly warrants wearing them."

"From what I can tell from the citation, a supervisor was onsite," John said. "He wasn't wearing one either."

"Of course he wasn't," Pete said, obviously agitated. "He should've been wearing one. He also should've been telling his workers to get theirs on."

"This sounds like an obvious case of unpreventable employee misconduct," John said. "We should be able to 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 ruled that the supervisor's knowledge of the employees' violation could be imparted to the employer.

The company claimed that the head protection standard, 1926.100(a), didn't apply because there were no struck-by hazards present. It also presented the unpreventable employee misconduct defense.

OSHA argued that the supervisor's knowledge of the violation, and the fact that he also wasn't wearing a hard hat, meant that knowledge could be extended to the employer. The agency asserted that there was documented exposure to struck-by hazards on the worksite.

## You Be The Judge

### Was it the employer's fault that supervisors and workers failed to wear required PPE on jobsite? (continued)

#### Judge: Standard was violated even if 'hardhats were a nuisance'

The judge agreed with OSHA. Evidence presented by OSHA established that the supervisor and workers weren't wearing hard hats while in the trench on the day of the inspection. The company even admitted that was the case.

Despite the company's assertions that hard hats were seen by workers as "a nuisance and limited the

wearer's field of vision" that didn't negate a finding that the standard was violated, according to the judge.

Likewise, the company's argument that the possibility of being struck was remote didn't take away from the fact that the standard was violated. Especially considering that OSHA established that workers were exposed to the struck-by hazard since there was debris along the edge of the trench.

On the subject of employer knowledge, the judge found that OSHA successfully proved its case

against the unpreventable employee misconduct defense because the supervisor admitted he didn't wear a hardhat and didn't require workers to do so. That supervisor's knowledge could be legally extended to the employer, the judge said.

#### Analysis: PPE should fit properly and be comfortable to wear

The company in this case attempted to use uncomfortable hard hats as an excuse for why its workers weren't wearing the PPE.

While that's a poor excuse and an awful legal defense, it's still very likely the truth of the matter. Ill-fitting, uncomfortable PPE is miserable to wear when you're trying to get work done. If the hazard isn't readily apparent – meaning the worker doesn't see it as immediately dangerous to their life and health – then that PPE is likely coming off as soon as they're sure no one is looking. It's also likely that supervisors will at least sympathize with workers on that point.

That's why PPE needs to be offered in the right size for each individual employee who is required to wear it. A proper fit usually equates to better comfort, which means workers will be more likely to keep that protective equipment on..

**Cite:** [Secretary of Labor v. Arrow Plumbing](#), Occupational Safety and Health Review Commission, No. 21-0244, 8/21/2023. Dramatized for effect.

## HAZARDS

# Communications, information key components to any effective emergency response

 by Merriell Moyer



**G**ood communications and information are of the utmost importance when it comes to having an effective emergency response.

A response team that fails to communicate effectively and gather sufficient information on the details of an incident can put its members in danger and undermine response efforts.

For example, the emergency response effort to put out a fire aboard the passenger vessel *Spirit of Norfolk* in June 2022 was hindered by poor unified command communication and a failure to collect important information about the ship.

While no injuries were reported due to the mishandling of the response,

there was at least one close call and failure to properly control the fire resulted in the *Spirit of Norfolk*, valued at \$5 million, being declared a total constructive loss.

### Engine room fire leads to evacuation

On June 7, 2022, the 169-foot-long passenger vessel, *Spirit of Norfolk*, was underway on the Elizabeth River in Virginia near Naval Station Norfolk. The vessel was on a two-hour sightseeing cruise with 108 people on board, including passengers and crew.

At 12:04 p.m., the U.S. Coast Guard received a report of an engine room fire aboard the *Spirit of Norfolk*.

Thanks to the crew's quick response and with help from Good Samaritan vessels, everyone evacuated safely.

Due to certain exemptions, the *Spirit of Norfolk* wasn't required to have fixed gas fire extinguishing systems in its engine room. When the crew attempted to fight the fire, they found they couldn't safely enter the smoke-filled engine room.

### Incompatible equipment leads to poor communications

Eventually, the Coast Guard decided to have tugboats that were on scene tow the vessel to the nearby Naval Station Norfolk docks so a proper firefighting effort could be staged.



While the vessel was being towed, Coast Guard vessels and tugboats sprayed water into certain areas of the ship to help prevent the fire from spreading beyond the engine room. This continued throughout the response.

When the *Spirit of Norfolk* arrived at the dock, it was moored on the wrong side for firefighters to access the vessel's only entrance. Instead, access was gained via ladder, which National Transportation Safety Board (NTSB) investigators found impacted firefighter safety.

Further complicating response efforts, the unified command consisting of the U.S. Navy and City of Norfolk fire departments found they had incompatible communication equipment, meaning that the recon team was unable to properly communicate with the fire attack team.

### **Command didn't ask captain for help to locate hatch**

Unified command's original plan to fight the fire was to place foam in the engine room via an emergency hatch on the main deck of the ship. However, they couldn't find the hatch and no one thought to ask the ship's captain, who remained on scene, for help in locating it.

A four-person recon team went on board in an effort to find the hatch and gather other information, but instead had to enter the engine room via the door since the hatch couldn't be found. They found that the flames had spread across the ceiling of the engine room. After surveying the extent of the fire, the

recon team closed and secured the door, despite a significant accumulation of water in the room, before leaving the vessel to report their findings.

However, because they couldn't communicate via radio with the fire attack team, they could only report their findings to unified command. This resulted in the fire attack team not receiving information about the unlocated hatch and state of the engine room.

### **Fire spreads after attack team can't get door to close**

When the four-person fire attack team went onboard to deploy foam, its members also looked for and failed to find the emergency hatch. Like the recon team, the fire attack team decided to enter the engine room via the main door.

At this point, visibility had decreased and the heat from the fire had worsened. When a member of the fire attack team turned the wheel on the watertight door to the engine room, the door exploded open causing a minor backdraft into the galley. Further, thousands of gallons of water that had been sprayed into the engine room rushed out. This rush of water separated the team and trapped one member behind the door.

At the same time, emergency responders on shore heard a loud noise and saw the *Spirit of Norfolk* shift hard to one side as if it was going to roll over. The fire attack team called a mayday and the unified command ordered them to evacuate, which they did. No injuries were reported.

Because the fire attack team was unable to close the engine room door due to about 4 feet of water in the area, the fire was able to spread throughout the vessel.

In its review of the response to the fire, the NTSB identified several safety concerns, including the following:

### **Personnel familiar with the vessel weren't in the unified command**

There were personnel on scene who could have helped the firefighting teams find the emergency hatch. The captain and another representative of the *Spirit of Norfolk* told unified command about the hatch, but since they weren't part of the command they were unable to provide additional guidance. This failure to gather more information about the location of the hatch put firefighters at risk and ultimately undermined the response.

### **Poor communications**

The recon and fire attack teams that boarded the vessel both wore respirators to protect against smoke and would have relied on radios for communications between the members of each team.

However, the incompatible communication equipment between Navy and City of Norfolk firefighters meant that the two teams couldn't communicate from team to team. That resulted in poor communications between both teams and the unified command and important information didn't

get passed effectively between all three parties.

### **Failure to communicate regarding specific hazards**

Because land-based firefighting departments weren't included in Coast Guard contingency plans, City of Norfolk firefighters were unaware of the risks inherent with maritime firefighting. They didn't realize the specific risk associated with opening the door to the engine room, where all the water from ship-based firefighting efforts were contained along with the fire. Not only did the land-based firefighters not have the training they needed for a ship-based incident, they also weren't told about the hazards by their Coast Guard counterparts.

- make extra efforts to ensure communications equipment is compatible with that equipment used by land-based responders
- create procedures that ensure personnel with vital information get placed within the unified command structure, and
- communicate with land-based responders regarding the hazards associated with maritime-specific incident response.

[Read this story online](#) 

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### **Importance of gathering and sharing vital information**

To avoid future problems with joint firefighting efforts between the Coast Guard and City of Norfolk fire departments, the NTSB recommended that the Coast Guard use this incident and the findings in the NTSB report to improve its contingency plans related to fighting fires on passenger vessels.

The NTSB recommendations didn't go into specific details, but considering the context of the report, the NTSB likely means that the Coast Guard should:



# 5 climate change hazards safety pros need to know and tips on how to control them



While there may still be some skepticism around climate change, the fact is safety professionals are uniquely suited to deal with many of the hazards experts say will be exacerbated by global warming.

Addressing indoor and outdoor air quality issues, emergency response to extreme weather events, heat illnesses and mitigating diseases all fit into a safety professional's wheelhouse.

"Climate change is a very broad topic that exacerbates several hazards and impacts multiple industries," Clint Smith, a project consultant at Colden Corporation, said during a presentation at the 2023 American Industrial Hygiene Conference & Expo in Phoenix, Arizona. "You may think that climate change hazards are only the focus of environmental or emergency management response professionals. They do have a large role to play with these hazards, but we as safety professionals and industrial hygienists have a unique experience and expertise for mitigating these climate change-related hazards."

Smith; Doug Fallon, another project consultant with Colden Corporation; and Sadie Daffer, an industrial hygienist with the U.S. Army Public Health Command, discussed how climate change will impact safety professionals.

Just as with the COVID-19 pandemic, some of these hazards may not seem to fall fully within

a safety professional's expertise, but they are hazards safety professionals actually are prepared to address.

## What is climate change and why is it happening?

In broad terms, climate change occurs when there's an overabundance of greenhouse gases, such as carbon dioxide, in the Earth's atmosphere. These gases are good absorbers of infrared radiation.

The Earth receives solar radiation from the Sun, which is re-emitted from the Earth as infrared radiation. That infrared radiation is absorbed by the greenhouse gases, creating a warming effect for the planet. The more greenhouse gases in the atmosphere, the greater the warming effect will be with a steady increase in temperature. Temperatures have been increasing in this manner since at least the 1980s, according to Smith, Fallon and Daffer.

An important note is that although the overall global average temperature increase of a few degrees doesn't seem all that significant, it actually affects more than what one may think. That slight overall increase in average temperature means more energy in our climate system resulting in more extreme weather events because the energy doesn't distribute itself evenly and equally.

## These hazards often overlap

Climate change is expected to mostly impact industries involving outdoor workers such as agriculture, construction and tourism, although it will likely affect others over time.

When it comes to climate change hazards, it's important to remember that they often overlap. For example, wildfires often occur during droughts that are brought on by heatwaves. In that situation, you'll have air quality issues and heat illnesses to deal with simultaneously.

The five major hazards that safety professionals will have to deal with as climate change worsens is vector-borne infections, wildfires, indoor air quality, severe weather and heat stress.

Here's a breakdown of each hazard along with some controls to help mitigate them:

### 1. Vector-borne infections

Lyme disease is a good example of a vector-borne disease that's being exacerbated by climate change. It's actually the most commonly diagnosed vector-borne disease in the U.S. There are almost half a million cases diagnosed per year.

Symptoms can range from mild, like fevers and rashes, to severe,

## Case Study

### 5 climate change hazards Safety Pros need to know and tips on how to control them (continued)

such as heart problems. These symptoms are why the disease warrants attention from safety professionals.

Lyme disease is spread by the black-leg tick that carries the bacteria. The range of these ticks has expanded a lot over the last 20 years, and as temperatures warm more tick activity is expected for longer periods throughout the season.

Occupations that are most at risk from Lyme disease involve outdoor occupations working in or around a forested area. That includes workers involved in construction and utilities.

Most of the controls for Lyme disease are either administrative or involve PPE.

From the administrative side, training is always important. Employees need to know how the disease is transmitted and how to prevent it.

As for PPE, light clothing makes ticks easier to see so they can be picked off before they bite. Obviously, the more coverage the better. There are tick repellants available as well as a type of clothing that's treated with an insecticide that's effective against both ticks and mosquitos.

#### 2. Wildfires

There have been numerous headlines regarding the increase in wildfires, especially in California, Oregon and Washington. These events are growing larger and lasting for longer periods of time.

The United Nations have recently published a report stating that there's an anticipated increase in wildfires by 30% in the year 2050 and an anticipated increase of 50% by 2100.

Outside of being directly in the path of the fire, the primary concern safety professionals will encounter is particulate matter in wildfire smoke generated from these events. Some of these particulates are comprised of hazardous chemicals and inorganic compounds. This particulate matter can penetrate deep into the lungs and cause health and respiratory issues.

Outdoor workers will typically be the most affected, but it's important to remember that workers with underlying health conditions will be more susceptible to the effects of wildfire smoke byproducts.

It's also important to note that the California, Oregon and Washington state OSHA programs have regulations covering wildfire smoke.

As far as controls are concerned, if the outdoor air quality is too poor to work then workers can either be pulled from the worksite or, if one is in place, the respiratory protection program can come into play.

If the choice is respirators, then keep in mind that this involves a written program, medical surveillance and fit-testing. This isn't something that can be put into place overnight, so establishing the program before the poor air quality event occurs is a good idea.

Of course, preventing the fire in the first place is also important. The U.S. Forest Service has resources available on what workers can do to help prevent wildfires.

#### 3. Indoor air quality

Wildfire smoke and other contaminants also affect indoor air quality. Most people spend about 90% of their time indoors, and they rely on HVAC systems to bring in fresh air as well as for indoor climate control.

Researchers usually say that indoor air quality mirrors the quality of the air outside, but that isn't always the case. There is less research on the effects of poor indoor air quality compared to outdoor air quality.

Administrative workers are typically stuck in their offices and don't get to go out to worksites or work with chemicals. They're not used to working in hazardous environments, but as climate change progresses they'll face increased risks of additional hazards in their workplaces.

Climate change means more air quality issues from carbon dioxide. Warmer temperatures mean more plants growing and more pollen being produced, which means longer and stronger allergy seasons. Particulates from wildfire smoke will also affect indoor air quality. Extreme weather events like hurricanes and severe flooding will cause potential water intrusion events, creating the perfect environment for mold to grow, which is another issue for indoor air quality.

### 5 climate change hazards Safety Pros need to know and tips on how to control them (continued)

So what can safety professionals do to control this hazard? A good start is with a facility's HVAC systems. There are even recommendations specifically for wildfire smoke. The American Society of Heating, Refrigeration, Air Conditioning Engineers (ASHRAE) has a document that specifically covers recommended modifications for HVAC systems in commercial buildings to reduce worker exposures to wildfire smoke particulates.

HVAC systems should also be well maintained. It's important that ventilation systems get maintenance and have their filters changed out on a regular basis.

Removal of gas-powered water heaters or ovens from the worksite can help in reducing carbon dioxide emissions.

The U.S. Environmental Protection Agency has some great information regarding indoor air quality, as well.

#### 4. Severe weather

When it comes to severe weather, hurricanes are typically the first thing that comes to mind. In the U.S., the Atlantic and Gulf coasts are typically the most at risk. Hurricanes can occur in the Pacific but they're much more rare.

There has been a trend from the 1980s to the present with hurricanes becoming more frequent and more severe. That trend is expected to continue.

Essentially, all of the areas that are currently at risk of hurricane

impact should expect to receive more and stronger storms. As the water warms through climate change it feeds the hurricanes and allows them to build faster with higher winds and more water.

When it comes to controls, a facility's Emergency Action Plan is extremely important. Most workplaces are required to have some kind of plan that covers different emergency situations, especially the ones that are more likely to occur.

Safety professionals should be sure to do training based on the emergency action plan. If the plan is just sitting on a shelf, it isn't doing anyone any good. Employees need to know what they need to do during an emergency.

It's also important to work with local emergency management departments to understand what they can do for your site and also what their limitations are. Their capabilities and limitations need to be factored into the facility's risk assessment.

#### 5. Heat stress

Heat waves lead to heat stress, which occurs when the body's core temperature rises above 99 degrees Fahrenheit.

Lately, each summer seems to be hotter and longer than the one before it, and the data supports this. The eight hottest years on record have all been within the last eight years, according to the National Oceanic and Atmospheric Administration, National Aeronautics and Space

Administration, and the European Union Climate Group.

Obviously, outdoor workers are most at risk for heat stress, but as climate change worsens it could affect indoor workers as well. Just walking out to get lunch or in the car to go home could cause a heat injury if an indoor worker isn't acclimated to the extreme heat outside.

Keep in mind that heat illnesses are recordable for OSHA purposes and that extreme heat standards exist in California, Oregon and Washington. Federal OSHA tends to use the General Duty Clause when it comes to extreme heat.

Controls for extreme heat are typically administrative or involve PPE.

For administrative controls, work schedules can be adjusted so work takes place at a time of day when the temperatures are cooler.

As for PPE, there are clothes that allow for thermal regulation, such as cooling vests.



### Is there a right time for doing lockout/tagout refresher training?



To answer this question, note that we're not talking about a particular time of day or day of the week. Although some safety studies show workers are more apt to absorb info in the morning, and minds are wandering come Fridays.

For refresher training, we're talking about times over the course of the year when it's crucial to dig into LOTO rules and practices.

Those four times are:

1. Whenever there's a change in machines or equipment that presents a new hazard
2. When there's a change in job assignments
3. Any time your or another supervisor catches workers breaking the lockout/tagout rules or skipping safety steps, and
4. When there's a change in your company's lockout/tagout steps.



### Need to boost forklift safety awareness? Try these 2 ideas

Getting staffers to remember – and follow – forklift safety rules can be challenging.

To make the info stick, get hands-on in your next training session with these tips:

- Have workers go through an obstacle course of common hazards by setting up cones that represent co-workers on foot. Note when they violate a safety rule. For example, note when they come too close to one of the cones/co-workers.
- Try having workers use a forklift to move barrels full of eggs. Can they put these barrels in the right area without breaking the eggs?.

Two great ways to challenge workers on how fast they can get the goods to the right spot without breaking them – or any safety rules.



# LOGISTICS SYSTEM GEARED TOWARD **UNRELENTING SPEED EXACTS HEAVY TOLL ON WORKERS**

## INJURIES

### Report: 41% of Amazon warehouse workers have been injured while working for the company

 by Merriell Moyer

**F**orty-one percent of Amazon warehouse workers reported being injured while working at an Amazon facility. Fifty-one percent who worked for Amazon for more than three years reported being injured.

That's according to a recent report based on a survey of 1,484 frontline Amazon warehouse workers across 451 facilities in 42 states.

The study, conducted by the University of Illinois Chicago Center for Urban Economic Development, found that 69% of Amazon warehouse workers reported having to take unpaid time off in the past month due to pain or exhaustion from working at the company; 34% had to do so three or more times.

Fifty-two percent reported feeling burned out from their work for the online retail giant. Among those who worked for Amazon for more than

three years, 60% reported feeling burned out.

Researchers found that 41% of these workers typically feel a sense of pressure to work faster with 30% reporting that they sometimes do. Those who felt pressured to work faster reported elevated levels of injury (53%) and burnout (78%).

Sixty percent of the Amazon warehouse workers surveyed reported experiencing more workplace monitoring at Amazon than at previous jobs. Nine percent said they experienced less monitoring, and 17% said the level was about the same.

#### **'Unpaid time off for pain is tacit condition of working at Amazon'**

"Together, these findings indicate that a logistics system geared

towards unrelenting speed and maximum customer convenience exacts a heavy toll on the health and wellbeing of many Amazon warehouse workers," the report states. "In turn, this health toll brings unmeasured economic impacts, given the immediate costs of unpaid time off from work and the potential long-term effects of pain, injury, and burnout on workers' livelihoods."

"It is concerning that most Amazon warehouse workers need to take unpaid time off due to pain or exhaustion as a kind of tacit condition of working at the company," said Dr. Sanjay Pinto, a co-author of the report. "This reduces workers' paychecks in the immediate term. The magnitude of the health toll captured in the data should also raise concerns about potential long-term effects on well-being, medical costs, future employment, and overall economic security."



Pinto and the other researchers feel that “stronger regulatory guardrails and advances that afford workers greater voice and input could help to improve working conditions at Amazon.”

The study was conducted because the researchers “were motivated to ... provide a clearer picture of how Amazon’s workplace practices impact frontline workers” after federal and state investigations of the company that began in 2022.

Amazon pushed back against a previous report by the Strategic Organizing Center that criticized the safety of the company’s warehouses, telling CNBC that the “safety and health of our employees is, and always will be, our top priority, and any claim otherwise is inaccurate.”

The company said the University of Chicago study wasn’t a study at all, rather it was “a survey done on social media by groups with an ulterior motive.”

## Participants screened to target only current warehouse workers

Researchers issued a 98-question survey to current frontline Amazon warehouse workers across the U.S. between April and August 2023. The survey covered a range of topics, including:

- employment and personal background
- work intensity and worker monitoring
- health and safety
- workplace fairness
- worker voice and input, and
- economic security.

Survey participants were recruited using a “Meta/Facebook targeting method” approved by the University of Illinois Chicago Institutional Review Board. As an incentive, participants were offered the chance to win one of 15 gift cards valued at \$175.

The researchers, with the aid of a media firm, ran advertisements to individuals who listed Amazon as their employer. Various methods were used to screen out Amazon employees who didn’t work in warehouses, such as drivers and management staff, as well as fraudulent surveys. Former Amazon employees were also screened out.

“In all, 3,700 people came into the survey, including 2,605 current workers, 466 former workers, and 629 individuals who said that they had never worked at the company,” according to the report. Those who said they never worked for Amazon were immediately screened out of the research.

Out of those who identified as current workers, 2,369 were frontline warehouse workers. That number was whittled down to 1,558 who reached at least the midpoint of the survey.

“In all, 1,484 individuals provided sufficient information to be included in the weighting variable,” the report states.

## Who Got Fined & Why



### Sawmill worker crushed to death when stored energy causes infeed roller to close: \$184K fine

OSHA cited an Alabama sawmill after a 20-year-old worker was crushed to death when stored energy caused the infeed unit of a jammed conveyor roller to close on him.

The agency found a willful citation for allowing workers to perform maintenance on equipment without controlling hazardous energy sources, along with several related violations.

This same employer was cited by OSHA in 2020 and 2021 at two different sawmills it owns in Florida for similar machine operation issues. One of those citations was the result of an amputation injury that resulted in the worker's death. The other came about following a worker's non-fatal crushing injuries from being caught in a machine's wheels and pulleys.

**Fine:** \$184,385

**Company:** Rex Lumber LLC, Troy, Alabama

**Business:** Sawmill

**Reasons for fine:**

*Two willful violations for failing to:*

- clearly outline steps for shutting down, isolating, blocking and securing equipment against hazardous energy
- ensure energy isolating devices were operated in a manner to isolate equipment from energy sources

*Two serious violations for failing to:*

- conduct periodic inspections of energy control procedures
- train authorized employees on the recognition of hazardous energy sources and how to control them

## What Would You Do?

# Was safety-focused supervisor being overbearing or simply doing his job?



"Good morning," Manager Mike Kelly said as the first shift employees shuffled past him into the conference room.

Maria Maldonado and Jason Williams from Manufacturing stopped to talk to Mike as they entered.

"Can we talk to you after the meeting?" Maria asked.

"We've got a big problem in our department," Jason said.

"OK, sure," said Mike. "Meet me in my office as soon as we're done here."

After the meeting, Maria and Jason followed Mike to his office.

As soon as Mike shut the door, Jason said, "Something needs to be done about Ken Dawson."

Ken was the supervisor in charge of the manufacturing department.

### 'He doesn't shout, he lectures'

"What exactly is Ken doing that needs to be addressed?" Mike asked.

"He's constantly riding us about safety," said Maria. "If we don't do things exactly according to procedure then he's right there telling us the right way to do it."

"I'm sorry," Mike said. "But it sounds like Ken is just doing his job. He's supposed to make sure employees are following procedures."

"There's a big difference between making sure we follow procedures and shouting down the way we troubleshoot problems," Jason said.

"He shouldn't be shouting at anybody," Mike said. "That's definitely a problem."

"Well, he doesn't shout exactly," Maria explained. "It's more like he gives thorough lectures, but sometimes they can be a little - I don't know - aggressive, maybe?"

If you were Mike, what would you do?

### Sounds like Ken is doing his job

These complaints seem to be coming from employees who are upset because they were caught not following procedures as closely as they should have been.

The way they make it sound, Ken is doing his job quite thoroughly. He's keeping an eye on his employees and he's not afraid to correct them if he needs to.

Notice that neither employee complained about being written up. Their infractions were probably minor shortcuts that Ken felt didn't warrant a write-up for a single instance. However, if those little shortcuts don't get addressed quickly, they can turn into bad habits that can lead to injuries.

### Probably nothing to worry about, but talk to him anyway

Yes, Ken is probably just doing his job and hasn't done anything wrong. After all, the two employees did change "shout" to "lecture."

However, they did use the word shout first, so maybe it's worth checking up on Ken just to be sure. Being focused on safety is a good thing, but if he's getting that aggressive he should probably be reined in a little.

### Fatal tractor rollover shows 'ample supervision' is recommended

Following the death of a 22-year-old tractor operator in a rollover incident, the Washington State Fatality Assessment & Control Evaluation (FACE) Program offered a recommendation to avoid a similar incident:

"Provide ample supervision of tractor operators and always enforce tractor safety policy requirements."

Why did FACE investigators make that particular recommendation? Because a manager had seen the operator driving unsafely just before the incident occurred but failed to properly address the issue.



## What Would You Do?

### Was safety-focused supervisor being overbearing or simply doing his job? (continued)

#### Operator was driving too fast and didn't use safety equipment

The operator was working at an apple orchard on Sept. 28, 2022. He was operating a low-profile utility tractor to pick and move wooden bins full of apples that were being harvested. The tractor had a set of forks attached to the rear three-point hitch. It also had a rollover protective structure (ROPS) and a seat belt, but neither was being used.

When the operator tried to make a right turn at the bottom of a steep hill on a rocky, uneven dirt road, the tractor rolled to the left and threw him to the ground toward the rear of the machine. When the tractor rolled onto its side, the lower part of the forks landed on his skull.

There were no witnesses, but another operator saw the tractor on its side and yelled to a manager who was nearby. They found the operator face down, gasping for air, so the manager called 9-1-1. First responders arrived minutes later and pronounced the worker dead at the scene.

#### Manager told him to slow down 15 minutes before incident

Investigators said that excessive speed could have been a contributing factor as the manager had warned the operator to slow down about 15 minutes before the rollover occurred. They also found

that the employer didn't ensure use of ROPS or seat belts and failed to provide operator safety training and evaluations.

One may assume that if the employer didn't require ROPS or seat belt use, then the manager probably didn't worry about it either. Obviously, there was some sort of rule regarding excessive speed since the manager told the operator to slow down, but there was no motivation for pointing out any of the other safety issues.

#### The definition is the key

In short, there was supervision, but it wasn't adequate as far as the FACE Program investigators were concerned. They cautioned that "ample supervision" was needed and that supervisors or managers should "always enforce" safety policy requirements.

Ample, according to Merriam-Webster, means:

- generous or more than adequate in size, scope, or capacity, and
- generously sufficient to satisfy a requirement or need.

In the context of the FACE recommendation, ample supervision means employers should:

- have enough supervisors employed across the company to spot safety infractions, which meets the "size, scope and capacity" part of the definition, and

- train supervisors to look for and correct safety issues and enforce company safety policies, which makes up the "generously sufficient to satisfy a requirement" meaning.

Whether or not the single manager in this case was enough to adequately supervise the employees in his area is unknown. However, the supervision provided by the employer certainly wasn't ample because the manager wasn't empowered to address safety issues due to the lack of formal rules to enforce.

## HAZARDS

# 4 ways to ensure subcontractors' mobile equipment is safely maintained on your worksite



by Merriell Moyer

## Fatality caused by subcontractor's poorly maintained dump truck



**A**s a safety professional, you do everything you can to make sure your employees can work safely around mobile equipment on a jobsite. But what about the vehicles of subcontractors or vendors who visit the site?

Whether the workplace is a construction site or a loading dock, your employees will probably have to work around equipment operated by workers employed by a company other than your own.

When those situations occur, you may ask yourself, "Will these subcontractor employees work safely around my people?" and "Is their equipment properly maintained and safe to work around?"

Typically, the first question can be answered by asking to see worker

training records or, to a less certain degree, by checking to see if the company has safety violations via the OSHA establishment search tool.

However, the question regarding equipment safety is often either overlooked or seen as more of a hassle to prove since it requires looking at the maintenance records for every piece of equipment in use onsite.

Also, this task could get particularly unwieldy in situations where there's a general contractor and a host of subcontractors, or a loading dock that's visited by a multitude of third-party trucking companies.

The question then becomes, "Is ensuring an outside company's equipment safety worth the effort?"

In short, yes it is. Here's an example that demonstrates why.

## Worker killed by runaway truck with defective parking brake

A 45-year-old construction worker died on a residential worksite when he was struck by a rollaway dump truck, according to a Washington State Fatality Assessment & Control Evaluation (FACE) Program report.

The driver, who was a subcontractor employee using a leased vehicle, didn't really do anything wrong. Instead, it was because the truck had a defective parking brake, which the company who leased the vehicle knew about.

On Aug. 13, 2022, the worker and the project manager arrived on site to finish the punch list items for a newly constructed home.

One of these items involved pressure washing the home's long driveway of mud and dirt left behind by the construction activity. While the worker began performing this task, the project manager went to finish painting the side of the garage.

As the worker was pressure washing the driveway, a subcontractor worker from a landscaping business arrived and parked a commercial medium-duty dump truck at the top of the driveway. The truck was loaded with pallets of small pavers, stepping stones and crushed rock. The driveway had a very slight and hardly visible slope.

The driver told the worker he was going to go inside to ask the homeowner where to put the

materials. In doing so, the driver left the truck unattended.

Six minutes later, the dump truck rolled down the driveway and struck the worker. No one saw the incident occur, but the driver, homeowner and project manager heard the truck roll away and crash. When they investigated, they found the worker face down in the driveway.

First responders pronounced him dead at the scene.

### Subcontractor truck was leased from another contractor

Investigators found that the dump truck:

- was parked in first gear with the emergency brake set
- had an emergency brake that didn't work, and
- was owned by another landscaping business that leased the truck out to the other company.

They also learned that the truck's owner:

- didn't have the required annual Department of Transportation commercial motor vehicle inspection completed on the truck, and
- knew that the emergency brake didn't work.

The FACE report points out that under Washington State safety requirements, employers must:

- make sure vehicles on construction sites have parking brakes that are maintained in

operable condition, engaged properly and inspected for safety before each shift

- not allow operation of commercial motor vehicles that are in such a condition they are likely to cause an accident or breakdown of the vehicle, and
- comply with annual commercial motor vehicle inspection requirements.

### 4 practices to help prevent this kind of incident

This is all well and good if you, as the employer or safety professional, have control over all of the vehicles and equipment at the worksite.

What happens, as in this case, when you're dealing with multiple employers? That's when you need to see the paperwork, according to the FACE report.

FACE investigators recommended that employers in this type of situation should:

- request that subcontractors show their current maintenance and safety inspection records for any commercial vehicles they own or lease that will be used at the worksite
- not allow unsafe vehicles to drive onsite
- advise worksite owners to ask other contractors they hire directly to show safety inspection records for any commercial vehicles before they drive onsite, and
- emphasize the need to prevent hazardous vehicle roll-away incidents onsite.

Depending on the size of the worksite, the amount of subcontractors involved and the amount of vehicles used onsite, looking over all those vehicle inspection records may seem painful.

However, keep in mind that a lot of this equipment will likely be used regularly at the worksite, which means checking those records wouldn't be a daily task. It would end up working much like keeping up with subcontractor employee training records. You'll initially have a lot of paperwork to review, but after that first big batch, you'll only have to worry about it for the occasional new addition or replacement. For situations involving work being done over a longer period of time, then annual or other periodic checks would have to be made as well.

Obviously, not all worksites are the same, and this could be a bigger headache in some situations than in others. However, it's all worth it if it'll help your employees go home safe and sound at the end of the day.

[Read this story online](#) 



# Demolition worker crushed by concrete wall: Did employer overlook hazards?

"First let me say, I'm sorry for your loss," said Sean Kendricks, the company lawyer. "I know Joey was like family to you."

"He was, and thank you," said Frank Smith, owner of Smith Construction. "The funeral was ... a tough day, let's just leave it there."

"I'm glad we could talk now," said Sean. "You know we'll be receiving a report from OSHA soon."

"Yep," said Frank. "To be totally honest, I don't know what went wrong. I've racked my brain. But you're probably right, an employee dies on a demolition job, OSHA's going to fine us for something."

"Tell me what happened," said Sean.

"This was a pretty standard job for us," said Frank. "Taking down four concrete walls at a park. Nothing out of the ordinary. I did a site check the week before. Conditions looked good. No spalling at the base of the walls -"

"Spalling?" Sean asked.

"Deterioration of the concrete," said Frank. "If we cut at the base of the wall, there were no signs

it might crumble on someone. The ground around all the walls, practically level.

"Basically the conditions were about as good as you get," said Frank. "Sometimes you've gotta brace the wall before you start breaking it apart."

## Process worked like charm on first wall – then disaster struck

"Joey and my foreman took down the first wall, no problem," Frank continued. "They got to work on the second wall. Joey scored a line along the width of the wall.

"As he finished the cut, the wall started to break apart," said Frank. He paused for a few seconds. "On top of his body.

"There was nothing the EMTs could do for him," said Frank. "Nothing."

Sean gave Frank a few seconds to compose himself. "I'm sorry," said Frank.

"No apology necessary," said Sean. "Let's go back to what you said about your site check."

"Right, right," said Frank. "I did an engineering survey. I've done thousands over the years."

"Thousands, literally?" asked Sean.

"Literally thousands," Frank nodded. "And this is the first time anything like this ever happened."

"Let's be clear on what you're saying because you'll eventually have to do a deposition," said Sean. "You're saying you've never made a mistake doing a demolition estimate?"

"The mistakes you make in this line of work are being careful if you don't know," said Frank. "I've braced walls and structures when I'm not 100% sure of the condition. Better to be safe than sorry.

"Or maybe a mistake like underestimating how long a job's going to take," said Frank. "Nothing out of the ordinary for a contractor, you know?"

"What I'm saying is, based on my experience, I didn't see any reason why scoring and breaking those walls apart wouldn't get the job done smooth and safe," Frank concluded.

"I believe you," Sean sighed. "This is a terrible accident, but fact of the matter is, accidents do happen.

"I'll be in touch once I hear back from OSHA," said Sean.

## Real Life Safety

### Demolition worker crushed by concrete wall: Did employer overlook hazards? (continued)

#### OSHA says owner didn't assess the job properly

The safety agency zeroed in on the demolition company owner's prowess (and integrity). It cited the company with a serious violation, namely failing to conduct an adequate engineering survey of the demolition operations prior to commencing work.

While the penalty amounted to \$13,653, if left uncontested, it could lead to a much higher jury verdict or settlement in a wrongful death suit brought by the deceased

worker's family. Juries are more likely to award money in workplace accident cases where OSHA citations were issued.

The company contested the citation in a timely fashion. Before the case could be heard before an administrative law judge (ALJ), the OSHA inspector handling the case resigned. The agency couldn't locate any written files or laptop documents of his, so a second agency employee had to gather info and conduct interviews for a second time.

OSHA decided to pursue the penalty anyway. An engineer

testified for the agency and argued the company's owner should've conducted a more thorough pre-job survey, and continued inspecting the walls to be knocked down on the site.

**Result:** The ALJ ruled in favor of the company after finding the owner "credible" in both his testimony and work experience. The citation was vacated.

(Based on [Secretary of Labor v. Wildcat Demolition](#). This case has been dramatized for effect.)

## Training Tips



### Veterans can be the linchpin to improving safety buy-in

Have veteran workers on your staff make a list of the top 10 things they wished someone had told them about safety when they started the job.

Then share the list with any rookie on your staff or discuss the list at your next safety training session.

It's great conversation fodder and helps boost learning.

Bonus benefit? This exercise can help the veterans on your staff take a harder look at how safely they work now.





## SAFETY MANAGEMENT

# Worker's fatal fall due to supervisor's failure to stay at the worksite

 by Merriell Moyer

**O**n April 10, 2019, the employee of a subcontractor fell to his death from the roof of a 12-story building in Brooklyn, New York. Why did this tragedy happen? In part, because there was no supervisor onsite.

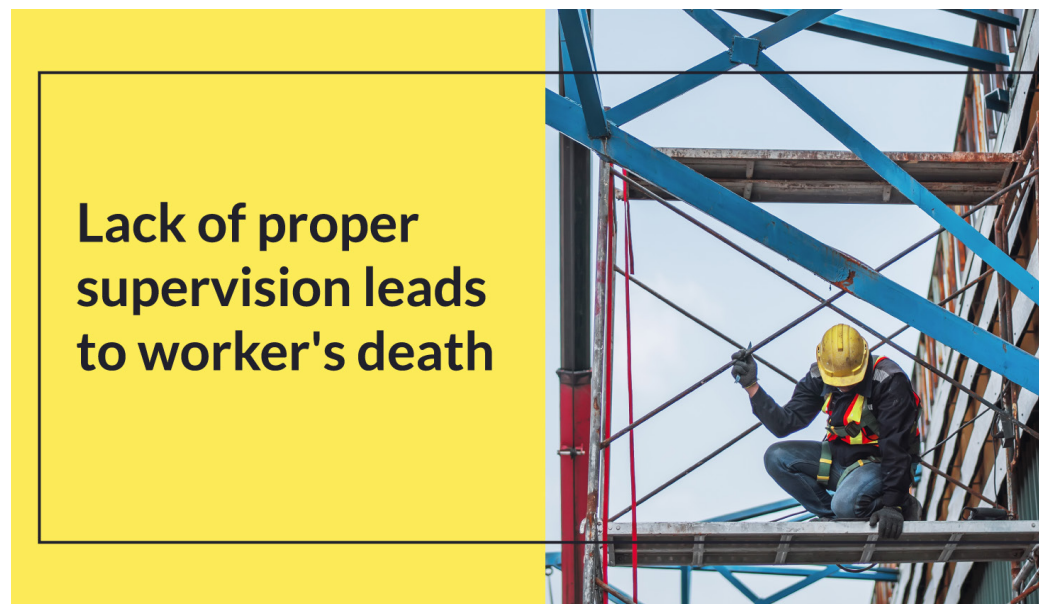
While the failure to use fall PPE certainly contributed to the fatal incident, OSHA found that the general contractor's lack of supervision over the worksite was also a major factor.

Even though the deceased worker was expressly told to stay off the roof, he and a co-worker who did have fall protection were left alone with no supervision to complete a project on a tight deadline.

### Overlap between contractor, subcontractor, administrative service

General contractor Skyline Restoration was hired to perform masonry and roofing repair on and around the rooftop water tower of a 12-story building in Brooklyn, New York. One of the water tower's four brick-veneer supporting columns was the focus of the repair work. The rooftop was about 130 feet above ground level.

Skyline subcontracted the job to Jaen Restoration, a company that was run by one person – the spouse of Skyline's vice president – and that had no supervisors. This wasn't the first time Skyline subcontracted a job



to Jaen, and the general contractor was aware of this fact.

Despite Skyline's policy that subcontractors had to supervise their own employees, the company offered to have its supervisors oversee the work Jaen's employees were undertaking on the rooftop water tower. Likewise, the standard contract Skyline used for with Jaen and all subcontractors implied that the subcontractor would oversee its employees' safety and would adhere to Skyline's safety rules.

Skyline expected Jaen to finish the job in two days.

Administrative services at Skyline were provided by a company called Andromeda Advantage, which was affiliated with Skyline and shared office space with the general contractor. Andromeda also provided Skyline and other companies with worker training

through its Andromeda Academy. Jaen's employees were trained by Andromeda.

A project manager and two supervisors were assigned to oversee the rooftop water tower project. Jaen assigned two of its employees to the job, but there was never any communication between the Skyline project manager and Jaen's owner.

### Fall protection devices were supposed to be installed

The week before Jaen was to start work on the project, one of the supervisors went to the worksite to perform an inspection and see what would be needed for the job.

He found that all of the areas specified for repair were on and



## Worker's fatal fall due to supervisor's failure to stay at the worksite

around the northwest column of the building's rooftop water tower. The rooftop was flat and had unprotected edges.

A penthouse balcony was the immediate next lower level from the rooftop and was about 10 feet lower than the roof surface. The only way to reach the rooftop was via a fixed ladder extending up from this balcony. The edges of the penthouse balcony were protected by a parapet wall that was topped by a railing that provided sufficient protection from falling, so no fall protection was needed for work done from the balcony area.

The way the water tower was positioned on the rooftop meant that the masonry work specified in the contract would have to be done from a position on the rooftop surface.

To get to the water tower, the Jaen employees would have to climb the fixed ladder from the balcony, step onto the rooftop and then walk about 15 to 20 feet to reach the column. Using the fixed ladder would put the workers within 2 or 3 feet of the roof's unprotected edge.

The Skyline supervisor determined that fall protection would be needed for the Jaen employees. In multiple telephone conversations with the other Skyline supervisor, the two men agreed that anchors for a fall arrest system would be installed on the roof along with a guardrail system. The supervisor who didn't perform the inspection was responsible for installing these systems by April 8, 2019, the day before Jaen would be starting work.

### Supervisor gave instructions then left the worksite

On April 9, 2019, the Skyline supervisor who performed the inspection picked up the two Jaen

employees along with the materials they needed and drove them to the worksite. Once the Jaen employees unloaded the materials onto the sidewalk, the Skyline supervisor left and didn't return until the end of the day. The Jaen employees moved the materials from the street level to the balcony and did some demolition work on the rooftop.

When the supervisor returned to the worksite to pick up the Jaen employees, he found that his fellow supervisor had failed to install the anchors or the guardrail system that they agreed were needed. However, one of the Jaen employees had a fall harness and the supervisor told him to be careful and to remember to tie off for the next day's work. He also told the worker who didn't have fall PPE to work from the balcony level and to stay off of the rooftop.

The supervisor didn't take any action to have anchors or a guardrail system installed before work resumed. He failed to report the lack of fall protection to anyone at Skyline or Jaen.

The next day, the two Jaen employees returned to the worksite. Sometime after they began working, the employee who was told to stay on the balcony fell to his death.

### Judge: General contractor should've anticipated unsafe behavior

OSHA cited both Skyline and Jaen for failing to provide fall protection on the worksite. Under the multi-employer worksite doctrine, Jaen was deemed the exposing employer and Skyline the controlling employer.

In court, Skyline argued that it wasn't the controlling employer because it subcontracted the entire job to Jaen but an administrative law judge with the Occupational Safety and Health Review Commission disagreed. The judge ruled that Skyline was

the controlling employer because it provided materials and assigned supervisors to oversee the work being done.

The judge said that Skyline should have anticipated that the employee without fall protection would go onto the rooftop because:

- there was little work to do from the balcony
- he and his co-worker were expected to finish the job in two days, and
- there were no supervisors onsite to prevent him from doing so.

Based on this and other findings, the judge upheld a \$25,194 OSHA fine.

### Bottom line: Proper supervision is required

Would the use of fall PPE have prevented this fatality? It certainly could have. Would the deceased employee have used the fall PPE if there was no supervisor present to ensure its use? The answer to that question is unknown.

However, if a supervisor had been present at the worksite to ensure safety rules were enforced, then the worker would likely still be alive. The supervisor would have, hopefully, prevented him from going onto the rooftop without fall protection.

There were a lot of things that were handled poorly leading up to this tragic incident, and the last two lines of defense that could have protected the deceased worker – a supervisor to enforce safety rules and proper PPE – were both completely absent.

If an employer wants a safe worksite, then proper supervision is required by personnel who know and follow the company's safety rules and who feel empowered to enforce them.

[Read this story online](#) 



# Freight company fined \$379K for exposing workers to suspended cars, motorcycles

OSHA fined a New Jersey freight handling company \$379,000 for exposing dozens of employees at its Port of Savannah, Georgia warehouse facility to potentially deadly hazards.

Employees were allowed to work with automobiles and motorcycles that were suspended overhead by forklift operators at the facility.

Inspectors found that the company willfully exposed workers to the risk of being struck or crushed by falling vehicles elevated by the forklifts during loading and unloading.

The company also failed to provide eye protection for workers using nail guns and changing liquid propane tanks.

**Fine:** \$379,709

**Company:** W8 Shipping LLC, Linden, NJ

**Business:** Warehousing and storage

### Reasons for fine:

*One willful violation for failing to:*

- prevent employees from standing under elevated loads

*22 serious violations, including failure to:*

- provide employment free from recognized fall, struck-by, crushed-by, and ejection hazards that were likely to cause death or serious physical harm
- keep walking-working surfaces in a clean, orderly and sanitary condition
- ensure exits were clearly visible and marked
- provide a continuing, effective hearing conservation program for employees
- ensure that no more than two liquid propane gas containers were used on an industrial truck for fuel purposes
- ensure employees used eye or face protection when appropriate
- ensure employees wore protective foot wear when appropriate
- provide suitable facilities for quick drenching or flushing of the eyes and body in areas where corrosive materials were present
- ensure forklift operators had successfully completed an adequate training program consisting of a combination of formal instruction, practical training and evaluation
- develop a written hazard communication program

## Who Got Fined & Why

### Freight company fined \$379K for exposing workers to suspended cars, motorcycles (continued)

*One other-than serious violation for failing to:*

- prevent space around electric equipment rated at 600 volts or more from being used as storage space



### Workers installing solar panels on snow-covered roof without fall PPE: \$170K OSHA fine

A safety complaint about solar panel installers working on a snow-covered two-story roof without fall PPE led to a \$170,000 OSHA fine.

The company was found in violation for failing to provide fall PPE to its workers.

An onsite company manager told an OSHA inspector that he didn't enforce the safety program for a one-day job.

The company, which has locations in 11 states nationwide, has been cited 12 times since 2018 for endangering its workers.

**Fine:** \$170,992

**Company:** Ion Solar LLC, Denver, Colorado

**Business:** Solar provider

**Reasons for fine:**

*One willful violation for failing to:*

- protect employees working 6 feet or more above lower levels with guardrail, safety net, or personal fall arrest systems

*One serious violation for failing to:*

- ensure employees wore protective helmets when working in areas where there was a danger of head injury

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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.

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