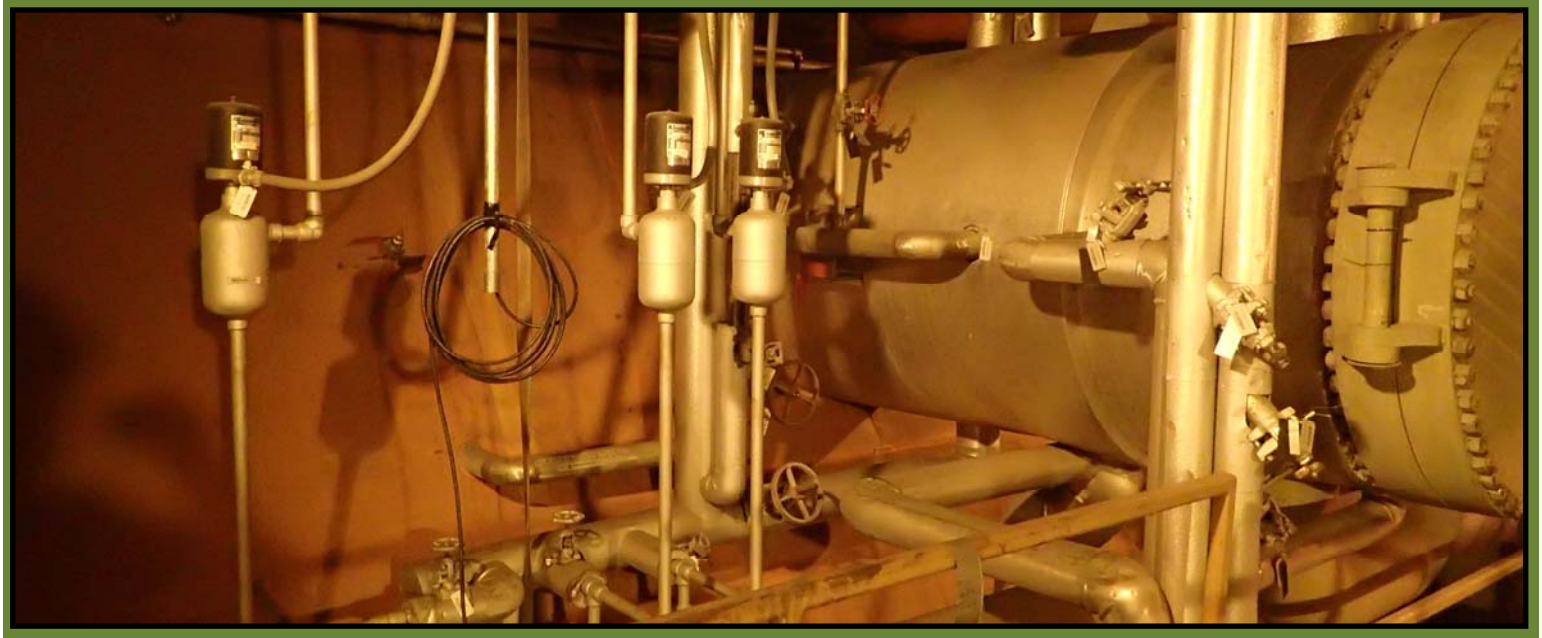
VOLTS Newsletter

VALUING OUR LIVES THROUGH SAFETY

July 2018 Morgan Christensen, Facilitator Volume 56



Terry's Treasure Chest

At the Safety in Action Conference, one of the classes offered was called Terry's Treasure Chest. The following story was told by a man named Terry who lost his brother John in an industrial maintenance mechanic accident.

John went to work that Thursday morning planning to go home after his shift that afternoon to enjoy a long weekend with his wife and two sons. The day was as regular as any other day at the plant. John was asked to perform a couple of small tasks which he completed alone with no problem. Then John's supervisor asked him to take a look at an electrical problem on a large water pump motor. Remember—John is a mechanic—not an electrician. However, he had a little electrical experience and a reputation as a guy who gets it done. John and his partner went up on the roof where the pump's electrical cabinet was located, or so they thought. They asked each other if this was the right electrical cabinet. They both had their doubts. The cabinet had no labeling at all. They looked around and traced wires from the pump to the cabinet feeling like this was the correct electrical termination spot for the pump. John shut off the breaker and put his own lock on the breaker. They then left to go to lunch across the street. When they came back, they checked the lock on the breaker once more. It was in place and the breaker was off. John proceeded to start disconnecting the high voltage motor that ran the pump. As soon as John made contact with the energized power lines, he was instantly electrocuted and died.

Terry, John's brother, received a phone call at work from his wife informing him that his brother had had an accident at work and that he needed to get over to the community hospital as quickly as possible. When Terry arrived at the hospital and saw his sister-in-law hysterically crying, he learned that his brother had been killed in an industrial accident.

Terry is 65 years old and has spent 40 years working in industrial safety with his company. He is also a safety consultant for other companies. Terry wanted some answers to what happened that day at work. He met with John's partner that day and others from John's work. Terry asked the partner many questions, but the one that stood out was the conversation John and his partner had over lunch. John and his partner were both unsure about the power being de-energized. Yet, John still made the choice to perform the work anyway.

From any reasonable person's standpoint, the company in this story did several things wrong. Asking a mechanic to perform electrical work is just the tip of the iceberg. John didn't even have an electrical meter. The company only received one citation from the OSHA investigation. It was for not having the electrical cabinet properly labeled so John could have known it was the wrong one. Terry was furious that the company didn't get into more trouble. He was even more upset that his brother made the choice to start work when he had doubts about his safety.

Habit-Attitude-Choices-Accident-Injury

Habit—Something we do without thinking. (It should feel awkward to perform unsafe acts, not be a habit.)

Attitude—What is your attitude toward safety?

Choice—If you make the right choice, you avoid the accident and injury all together.

Accident—Loose control of the worksite.

Injury—Someone does not go home the way they came into work.

Coaching

While: The *while* should be written so well that anyone could walk to that point in our facility if they read it.

Was at risk for: What did you see the person do to make you mark it at risk?

Because: You should ask the person, "Why are you doing it this way?"

The *because* needs to come from the person being observed. This is where the reason someone is choosing to perform an at-risk behavior is identified. This conversation is the most important part of the observation.

On the observation card, 5.7 Fall and 5.9 Seat Belt have a lot in common. If fall protection is worn and we fall, we go home alive. If seat belts are worn and we crash, our chances of survival are much higher. That automatically makes both of these items a serious injury or fatality (SIF). When performing a VOLTS observation, if someone needs a harness on and they don't have it, maybe you could ask them, "If you do fall from where you are, what is that outcome going to be?" Harnesses are constricting and ropes can get in the way, but their purpose is to keep us alive. A little burden while working is well worth going home alive and well.

During the last couple of months, the VOLTS Steering Committee has seen an increase in the observation data of at-risk behavior in the areas of fall protection and seat belts being marked SIF. It is good that we are getting to the point where we acknowledge the fact that they are SIFs. The next step is to mitigate those acts before they become SIFs. If we use the controls provided by the company, then they are no longer considered SIFs. Use fall protection and seat belts when they are needed.

Observation Card Deadline

Realizing that it is human nature to put things off until the last minute, we as a VOLTS Steering Committee would like to encourage you to turn your observation cards in throughout the month. Don't wait until the last week of the month or the first week of the following month. There is a report due to LADWP the first of each month. For the month of July 2018, this report was sent out on July 3. Observations for the previous month have been coming in past the tenth of the current month.

At the end of each month, data is compiled for the VOLTS Steering Committee meeting. If observations are not turned in by the end of the month, they do not make it into the bank of data for the VOLTS Steering Committee meeting.

The last thing is one of the most important items—the vacation hour. The goal is to have this figured out by the tenth of each month. As you can see, there are several reasons the observation cards need to be turned in before the next month begins. We appreciate each observation done! Thank you for all you do! Your cooperation in this effort would be appreciated.