



Recent Incidents

Frito-Lay, Inc. (Constance Woodfin)

Eastern Municipal Water District (Douglas Hefley)

Walter Gonzalez – GE Cardinal Cogen Stanford



Frito-Lay Incident



■ *Type of Incident*

- Finger Tip Amputation Resulting In A Lost Time

■ *Description Of Incident*

- A Packaging Machine Operator Trainee, while working on a Polaris Bagmaker, stuck his hand into the jaw area while trying to unjam packaging film



Frito-Lay Incident



■ *Action Taken*

- Team Member Medically Treated
- OSHA Notified
- Safety Stand-Downs Held Across Site
- Equipment Evaluated To Ensure Properly Working
- Conducted Formal Investigation
- OSHA Investigated
- Guarding Enhanced
- Team Member Held Accountable

■ *Root Cause*

- Disregard For LTT Procedures



Frito-Lay Incident



- ***Team Member Status***
 - Team Member Back To Work On Full Duty

- ***OSHA Status***
 - Visits Are Complete
 - Outcome Pending



Eastern Municipal Water District Incident



■ *Type of Incidents*

- Improperly Guarded Drive Shaft Resulting in Employee Injury
- Shoulder, Neck, and Facial Laceration Resulting in Lost Time

■ *Description Of Incidents*

- Employee making adjustments to vertical water pump seal caught clothes in improperly guarded drive shaft
- Employee utilizing gas powered portable cut off saw to cut 12 inch PVC water pipe is struck by saw blade when saw bound and kicked back



Eastern Municipal Water District Incident



■ *Action Taken*

- Employees Medically Treated
- OSHA Notification Made (cut off saw incident)
- Immediate Notification to All Employees
- Management Direction to Suspend 'Like' Activities
- Inspection of 'Like' Equipment
- Conducted Formal Investigation
- OSHA Investigation in Process
- Counter Measures to Ensure Proper Guarding of Drive Shafts
- Investigate Alternative Equipment for Performing Tasks Involving Field Cutting of Pipe
- Crisis Management Intervention
- Work to Ensure System to Notify Other Agencies and VPP Sites



Eastern Municipal Water District Incident



- **Root Cause of Drive Shaft Injury**
 - Improperly Guarded Drive Shafts on Engine Driven Equipment
 - Utilize Pre-Use Analysis to better identify hazards during design phase
 - Just because the manufacturer says it is okay doesn't mean it is – Manufacturer stated that equipment meets all OSHA requirements





Eastern Municipal Water District Incident



- ***Root Cause of Cut Off Saw Incident***
 - Insufficient Horizontal Supporting of Pipe





Cardinal Cogen Contractor Incident



- ***Type of Incident***
 - Cal/OSHA Stop Work Order for contractor on-site

- ***Description Of Incident***
 - Contractor doing weld repairs on a boiler for 3 months, the last day of the repair work a Cal/OSHA compliance inspector calls Cardinal Cogen Mgr. and arrived on site shortly thereafter to investigate the complaint.



Cardinal Cogen Contractor Incident



■ *Action Taken*

- Allow the inspector to conduct the investigation
- Notified Cal/OSHA VPP Team for assistance/advice
- Notified Corporate EHS
- Conference with contractor to develop action plan
- Follow up with contractor for supporting docs. Requested by Cal/OSHA
- No fines issued all alleged violations dropped
- Safety meeting with Cardinal Cogen/Contractor
- Strengthen our work permit requirements
- Strengthen our contractor pre-approval requirements

■ *Root Cause*

- Anonymous call to Cal/OSHA claiming that the welding contractor was welding on "lead pipe"



Incidents



- *Thoughts Regarding Your Site*
 - Consider The Total Impact
 - The Injured Team Member
 - Team Member's Involved In Assisting
 - Your Other Team Members
 - Your Managers
 - Team Member's Family/Friends
 - Catastrophic Incident Management



Incidents



■ *Thoughts Regarding OSHA's Involvement*

- Develop Partnership With OSHA
- Invite OSHA To Your Location *Before* Something Happens – (Ceremonies, Etc.)
- Communication Is Key
- When OSHA Is On Site To Investigate – Ensure Key Managers/Leaders Are Involved
 - Leadership, Maintenance Managers, Engineers
- When In Doubt About A Reportable – Call
- Keep In Loop