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SAFETY COMPLIANCE LETTER

Incorporating *Safety Management*

Reportable Workplace Injuries and Illnesses Unchanged from 2017 to 2018

First Time in Six Years BLS Sees No Decline

There were 2.8 million nonfatal workplace injuries and illnesses reported by private industry employers in 2018, unchanged from 2017, the U.S. Bureau of Labor Statistics (BLS) has reported today. These data are estimates from the Survey of Occupational Injuries and Illnesses (SOII). The incidence rate for total recordable cases (TRC) in private industry also remained unchanged from a year ago. This is the first year since 2012 that the TRC rate did not decline. The incidence rates for days away from work (DAFW) cases and for days of job transfer and restriction only (DJTR) cases did not change from 2017. Within private industry, there were 900,380 injuries or illnesses that caused a worker to miss at least one day of work in 2018, essentially unchanged from 2017.

About the SOII

The SOII is a federal/state program in which employer's reports are collected annually from approximately 200,000 private industry and public sector (state and local government) establishments and processed by state agencies in cooperation with the Bureau of Labor Statistics. Summary information on the number of injuries and illnesses is transcribed by these employers directly from their recordkeeping logs to the survey questionnaire. The questionnaire also asks for the number of employee hours worked (needed in the calculation of incidence rates) as well as its annual average employment (needed to verify the unit's employment-size class).

The SOII excludes all work-related fatalities as well as nonfatal work injuries and illnesses to the self-employed; to workers on farms with 10 or fewer employees; to private household workers; to volunteers; and to federal government workers.

Injuries and illnesses logged by employers conform to definitions and recordkeeping guidelines set by OSHA. Under OSHA guidelines, nonfatal cases are recordable if they are occupational injuries or illnesses that involve lost worktime, medical treatment other than first aid, restriction of work or motion, loss of consciousness, or transfer to another job. Employers record injuries separate from illnesses and also identify for each whether a case involved any days away from work

INSIDE

Wolters Kluwer

OSHA Highlights

■ **OSHA Enforcement and Compliance Increased in 2019.** According to OSHA's fiscal year (FY) 2019 final statistics show a significant increase in the number of inspections and a record amount of compliance assistance to employers. Federal OSHA conducted 33,401 inspections—more inspections than the previous three years (which were substantially lower than previous years)—addressing violations related to trenching, falls, chemical exposure, silica, and other hazards.

In FY19, OSHA provided a record 1,392,611 workers with training on safety and health requirements through the Agency's various education programs, including the OSHA Training Institute Education Centers, Outreach Training Program, and Susan Harwood Training Grant Program. OSHA's compliance assistance programs are designed to help small businesses address safety and health hazards in their workplaces. In FY19, OSHA's On-Site Consultation Program identified 137,885 workplace hazards affecting 3.2 million workers. ■

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or days of restricted work activity, or both, beyond the day of injury or onset of illness.

Occupational injuries, such as sprains, cuts, and fractures, account for the vast majority of all cases that employers log and report to the BLS survey. Occupational illnesses are new cases recognized, diagnosed, and reported during the calendar year. Overwhelmingly, reported illnesses are more often acute cases that are easier to directly relate to workplace activity (*e.g.*, contact dermatitis or carpal tunnel syndrome), as opposed to long-term latent illnesses, such as cancers. The latter illnesses that generally would not be known until well after survey data for a particular year have been collected are believed to be underrecorded and, thus, understated in the BLS survey.

Survey estimates are based on a scientifically selected sample of establishments, some of which represent only themselves but most of which also represent other employers of like industry and workforce size that were not chosen to report data in a given survey year.

Reportable Cases

OSHA considers an injury or illness to be work-related if an event or exposure in the work environment either caused or contributed to the resulting condition or significantly aggravated a pre-existing condition. Recordable cases include work-related injuries and illnesses that result in:

- Death
- Loss of consciousness
- Days away from work
- Restricted work activity or job transfer
- Medical treatment (beyond first aid)
- Significant work related injuries or illnesses that are diagnosed by a physician or other licensed health care professional. These include any work related case involving cancer, chronic irreversible disease, a fractured or cracked bone, or a punctured eardrum.

Additional criteria that can result in a recordable case include:

- Any needlestick injury or cut from a sharp object that is contaminated with another person's blood or other potentially infectious material
- Any case requiring an employee to be medically removed under the requirements of an OSHA health standard
- 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
- Noise-induced hearing loss

Other OSHA definitions include:

- Cases involving days away from work are cases requiring at least one day away from work with or without days of job transfer or restriction.
- Job transfer or restriction cases occur when, as a result of a work-related injury or illness, an employer or health care professional keeps, or recommends keeping an employee from doing the routine functions of his or her job or from working the full workday that the employee would have been scheduled to work before the injury or illness occurred.
- Other recordable cases are recordable cases that do not involve death, days away from work or days of restricted work activity or job transfer.
- Incidence rate is the number of injuries and/or illnesses per 100 full-time workers and were calculated as: (N/EH) × 200,000 where:
    - N = number of injuries and/or illnesses
    - EH = total hours worked by all employees during the calendar year
    - 200,000 = base for 100 full-time equivalent workers (working 40 hours per week, 50 weeks per year).
- Occupational injury is any wound or damage to the body resulting from an event in the work environment.

Defining Occupational Illnesses

Skin diseases or disorders are illnesses involving the worker's skin that are caused by work exposure to chemicals, plants, or other substances. Examples include contact dermatitis, eczema, or rash caused by primary irritants and sensitizers or poisonous plants; oil acne; friction blisters, chrome ulcers; and inflammation of the skin.

Respiratory conditions are illnesses associated with breathing hazardous biological agents, chemicals, dust, gases, vapors, or fumes at work. Examples include silicosis, asbestosis, pneumonitis, pharyngitis, rhinitis, or acute congestion; farmer's lung, beryllium disease,

tuberculosis, occupational asthma, reactive airways dysfunction syndrome (RADS), chronic obstructive pulmonary disease (COPD), hypersensitivity pneumonitis, toxic inhalation injury, such as metal fume fever, chronic obstructive bronchitis, and other pneumoconioses.

Poisoning includes disorders evidenced by abnormal concentrations of toxic substances in blood, other tissues, other bodily fluids, or the breath that are caused by the ingestion or absorption of toxic substances into the body. Examples include poisoning by lead, mercury, cadmium, arsenic, or other metals; poisoning by carbon monoxide, hydrogen sulfide, or other gases; poisoning by benzene, benzol, carbon tetrachloride, or other organic solvents; poisoning by insecticide sprays such as parathion or lead arsenate; and poisoning by other chemicals such as formaldehyde.

Noise-induced hearing loss for recordkeeping purposes is a change in hearing threshold relative to the baseline audiogram of an average of 10 decibels (dB) or more in either ear at 2000, 3000, and 4000 hertz and the employee's total hearing level is 25 dB or more above the audiometric zero (also averaged at 2000, 3000, and 4000 hertz) in the same ear(s).

All other occupational illnesses include heatstroke, sunstroke, heat exhaustion, heat stress, and other effects of environmental heat; freezing, frostbite, and other effects of exposure to low temperatures; decompression sickness; effects of ionizing radiation (isotopes, x-rays, radium); effects of nonionizing radiation (welding flash, ultraviolet rays, lasers); anthrax; bloodborne pathogenic diseases such as AIDS, HIV, hepatitis B, or hepatitis C; brucellosis; malignant or benign tumors; histoplasmosis; and coccidioidomycosis.

2018 Data Highlights: Retail Trade

Retail trade was the only private industry sector where the TRC rate increased in 2018, rising from 3.3 cases to 3.5 cases per 100 full-time equivalent (FTE) workers. (*See* Table 1.) This was the first increase

24-Hour Safety

Resolve to Get Enough Sleep in 2020

The research has confirmed what our bodies have always known: Sleep is crucial for maintaining life and health and for working safely. Sleeping seven to eight hours a night is linked with a wide range of good health and safety outcomes.

The risks of long work hours and too little sleep are many, from physical and mental decline, long-term health effects, and strained personal and work relationships.

Most people do not feel refreshed and at their best with just six hours of sleep. Yet, research shows that more and more people are sleeping only six hours a night. With the demands of work and family and too few hours in the day, it is usually sleep hours that get cut. Resolve this year to make sleep a priority; that likely means giving up something that takes the place of sleep. Is it television watching, computer time, volunteering, household chores, or overtime hours? Is there a way you can streamline or simplify your schedule to allow that extra hour or two of sleep? Only you—and your family—can decide.

Make Every Hour of Sleep Count

These tips have helped people fall asleep—and stay asleep—and wake refreshed:

- Stick to a sleep schedule. Go to bed and wake up at the same time each day. Sleeping later on weekends won't fully make up for a lack of sleep during the week and will make it harder to wake up early on Monday morning.
- Exercise earlier in the day. Try to exercise at least 30 minutes on most days but not later than two to three hours before your bedtime.
- Avoid caffeine and nicotine. The caffeine in coffee, colas, certain teas, and chocolate can take as long as eight hours to wear off fully. Therefore, a cup of coffee in the late afternoon can make it hard for you to fall asleep at night. Nicotine is also a stimulant, often causing smokers to sleep only very lightly.
- Avoid heavy foods and alcohol before sleep. Heavy, greasy foods are anti-sleep because of stomach upsets. If you must eat, a light snack won't disturb your sleep. Alcohol might make you feel sleepy, but it will wake you up too quickly after falling asleep. Don't drink alcohol in the hour or two before sleep.
- Avoid medicines that delay or disrupt your sleep. If you have trouble sleeping, talk to your doctor or pharmacist to see whether any drugs you're taking might be contributing to your insomnia and ask whether they can be taken at other times during the day or early in the evening.
- Have the right sunlight exposure. Daylight is key to regulating daily sleep patterns. Try to get outside in natural sunlight for at least 30 minutes each day. If possible, wake up with the sun or use very bright lights in the morning. Sleep experts recommend that, if you have problems falling asleep, you should get an hour of exposure to morning sunlight and turn down the lights before bedtime.
- Don't take naps after 3 p.m. Naps can help make up for lost sleep, but late afternoon naps can make it harder to fall asleep at night.
- Relax before bed. Don't overschedule your day so that no time is left for unwinding. A relaxing activity, such as reading or listening to music, should be part of your bedtime ritual. A hot bath before bed may also help. The drop in body temperature after getting out of the bath may help you feel sleepy, and the bath can help you relax and slow down so you're more ready to sleep.
- Keep a regular sleep routine. Always sleep in the bedroom.

Continued on page 10 ➤

in the TRC rate in retail trade since the series began in 2003. Retail trade accounted for 14 percent of all injuries and illnesses in private industry in 2018.

Both the number and rate of nonfatal cases in the private retail trade sector increased in 2018. The number increased 4 percent to 409,900 cases, and the incidence rate increased from 3.3 cases to 3.5 cases per 100 FTE workers. Within the retail trade sector, general merchandise stores reported 96,000 injury or illness cases; food and beverage stores reported 92,600 cases; motor vehicle and parts dealers reported 61,500 cases; and building material and garden supply stores reported 53,800 cases.

Of the 126,850 DAFW cases in retail trade in 2018, those resulting from falls, slips, or trips increased to 34,190 cases, an increase of 11 percent from 2017. Cases resulting from contact with objects and equipment increased 10 percent in 2018 to 38,940 cases. These events had a higher rate for workers in the retail trade sector than for workers in private industry in 2018.

Injuries and illnesses in retail trade most often resulted from sprains, strains, and tears, which accounted for 45,340, or 36 percent, of the DAFW cases in 2018. The DAFW incidence rate for sprains, strains, and tears was 38.4 cases per 10,000 FTE workers, essentially the same as in 2017. (*See* Table 2.) Seventeen percent, or 21,320, of DAFW cases reported in retail trade were the result of injuries to the back.

Within retail trade, 15 occupations had at least 1,000 DAFW cases in 2018. Injuries and illnesses to retail salespersons accounted for 20 percent of the DAFW cases in retail trade, increasing from 23,240 in 2017 to 25,600 in 2018. First-line supervisors of retail sales workers accounted for another 13 percent (15,940) of DAFW cases in retail trade in 2018, an increase of 25 percent from 2017.

Table 1. Incidence Rates of Nonfatal Occupational Injuries and Illnesses by Selected Industry and Case Types, Private Industry, 2017–2018

Industry	Total Recordable Cases		DAFW Cases	
	2017	2018	2017	2018
Agriculture, forestry, fishing, and hunting	5.0	5.3	1.7	1.7
Mining, quarrying, and oil and gas extraction	1.5	1.4	0.7	0.6
Construction	3.1	3.0	1.2	1.2
Manufacturing	3.5	3.4	0.9	0.9
Wholesale trade	2.8	2.9	1.0	1.0
Retail trade	3.3	3.5	1.0	1.1
Transportation and warehousing	4.6	4.5	2.0	2.1
Utilities	2.0	1.9	0.7	0.7
Information	1.3	1.3	0.6	0.6
Finance and insurance	0.5	0.5	0.1	0.1
Real estate and rental and leasing	2.4	2.3	1.0	0.8
Professional, scientific, and technical services	0.8	0.8	0.2	0.2
Management of companies and enterprises	0.9	0.8	0.2	0.2
Administrative and support and waste management and remediation services	2.2	2.3	0.9	0.9
Educational services	1.9	1.9	0.5	0.6
Health care and social assistance	4.1	3.9	1.1	1.1
Arts, entertainment, and recreation	4.2	4.1	1.2	1.1
Accommodation and food services	3.2	3.1	0.9	0.9
Other services (except public administration)	2.1	2.2	0.7	0.8
Total for private industry	2.8	2.8	0.9	0.9

Source: Bureau of Labor Statistics, Survey of Occupational Injuries and Illnesses, November 2019

2018 Data Highlights: ER and Hospital Visits

Results from the 2018 SOII contain the first national estimates for emergency room (ER) and hospital visits for nonfatal occupational injuries and illnesses requiring DAFW. Estimates include case and demographic data elements such as industry, event, and occupation. A total of 333,830 DAFW cases resulted in a visit to a medical facility such as an emergency room or in-patient hospital.

Medical treatment facilities, based on definitions from OSHA, include facilities designated as an ER or an inpatient hospital facility. Urgent care facilities, health units (within an establishment), infirmaries, and clinics are not considered an ER.

The SOII categorizes medical treatment facility visits in the following way:

1. Any medical treatment facility visit (ER visit and/or inpatient hospitalization);
2. ER visits only (excluding inpatient hospitalizations); and

Continued on page 6 ➤

Up to Standard

Respiratory Protection Review

When OSHA showed up at Ohio Gratings, Inc., in Canton, Ohio, in response to a formal complaint in December 2018, the employer immediately went on the "naughty" list. According to the complaint, workers at the aluminum, stainless steel, and carbon manufacturing facility were exposed to poor ventilation and chemicals they weren't trained to safely handle. OSHA found those problems and more, noting that the company was operating a dip tank containing flammable liquid without using proper drainage, overflow piping, adequate ventilation, or fire protection. The employer also failed to ensure employees used personal protective equipment, exposed workers to flammable liquids and struck-by hazards, and had inadequate machine guarding and recordkeeping deficiencies.

Ultimately, OSHA cited Ohio Gratings for 17 serious and five other-than-serious safety and health violations, carrying penalties of $183,748. Among the citations? A citation for failing to provide workers who voluntarily wore respirators with the information found in Appendix D of the respiratory protection standard. Surely, implementing an effective respiratory protection program would have been a better choice for this employer. Would it also be the better choice for your company?

In order to create and implement an effective respiratory protection program, you must first identify the respiratory hazards your workers face. Respiratory hazards that can injure or kill your workers typically fall into three categories.

Oxygen-Deficient Atmospheres

Oxygen is the essential ingredient in air that enables humans to function; both our bodies and our brains depend upon it. When some other chemical—any other chemical, even one that is nontoxic—displaces the oxygen in the air, workers are in immediate life-threatening danger. Air is considered oxygen-deficient if it contains less than 19.5 percent oxygen. Whenever workers are working with chemicals that have the potential to displace oxygen—a hazard that is especially likely to arise in enclosed or confined spaces—you will need to take action to ensure that they receive breathing air with adequate oxygen content. Your intervention may be as simple as providing mechanical ventilation to ensure that contaminants are removed and fresh air is restored to the space, or it may involve fitting workers with respirators that will supply fresh air directly to their breathing zone.

Toxic and Hazardous Chemicals

Some chemicals are toxic when inhaled, and the hazard typically increases as the concentration of the chemical increases in the worker's breathing zone. You can identify chemicals that are respiratory hazards by:

- Reading labels and safety data sheets (SDSs);
- Checking your facility's hazardous chemical list against OSHA's substance-specific standards and its list of chemicals for which permissible exposure limits (PELs) have been established; and
- Checking your facility's hazardous chemical list against other sources of hazardous chemical information, such as those published by the National Institute for Occupational Safety and Health (NIOSH) and by the American Conference of Government Industrial Hygienists.

It is important to recognize that hazardous chemicals come in different forms. Some are gaseous, like the simple asphyxiant nitrogen; others are fumes, mists, or vapors, like welding fumes; and others are particulates, like coal dust.

Other Respiratory Hazards

Other respiratory hazards that may require you to create a respiratory protection program include biological hazards—airborne infectious diseases like tuberculosis—and radioactive particles. Some radioactive particles that are not dangerous outside the body can be extremely hazardous if inhaled. If your workers are exposed to these hazards, you will likely need a respiratory protection program.

Controlling Respiratory Hazards

The respiratory protection standard (29 CFR 1910.134) explicitly requires employers to first control respiratory hazards through prevention. Before you create a respiratory protection program, OSHA requires you to try engineering controls. Paragraph (a)(1) of the respiratory protection standard requires employers to first "prevent atmospheric contamination" through the use of engineering controls. These may include enclosing the operation, providing either general or local exhaust ventilation, or substituting a less toxic material.

If engineering controls will not control worker exposures within OSHA's PELs, or if you need to protect workers while engineering controls are being put in place, you will need to provide workers with respirators.

Creating a Respiratory Protection Program

If you must put workers in respirators, even temporarily (while engineering controls are being implemented, for example, or for the duration of a single project), you must institute a fully compliant respiratory protection program. This program must include the following elements:

It must be in writing. This is one area where OSHA requires a written program that addresses every required element. Required elements include:

- Specific workplace factors that necessitate the program
- Respirator selection
- Medical evaluation of workers who will wear respirators
- Fit testing
- The type of respirator use that will be required (routine or emergency use)
- Procedures for the proper care and maintenance of respirators
- Procedures for ensuring air quality for supplied-air respirators
- Training for workers, in respiratory hazards and in respirator use and care
- Program evaluation and updating
- Voluntary respirator use, if applicable
- Employer payment for equipment, training, and medical evaluations

It must be specific to the identified hazards. You can't address an oxygen-deficient atmosphere with an air-purifying respirator. You also cannot address an atmosphere that is immediately dangerous to life and health (IDLH) with an air-purifying respirator. Both of these situations require supplied-air respirators. If your respiratory protection program is designed as an "escape" program—you are providing respirators that workers can use to escape a hazardous release—you may need atmosphere-supplying respirators rather than air-purifying respirators, as well.

If you are addressing a situation where respiratory hazards can safely be filtered out of a worker's breathing air—for example, if your workers require protection from asbestos fibers—you'll still need to put some effort into respirator selection. Different hazards require different types of filtration; a particulate filter will not be effective against organic vapors, and an organic vapor cartridge will not protect workers against acid mists or radioactive particles. For guidance in selecting an appropriate respirator, check out NIOSH's Respirator Selection Logic at *www.cdc.gov/niosh/docs/2005-100/default.html*.

It must be competently administered. OSHA requires employers to designate a program administrator, who is responsible for implementing and maintaining the respiratory protection program. The administrator must have training and experience appropriate to the complexity of the respiratory protection program. For example, if workers will be entering confined spaces that contain IDLH atmospheres wearing airline respirators, the administrator must have the training and experience to run a program that involves each of those things. If employees will be wearing dust masks to control their exposure to nuisance dusts, the administrator, however, does not need such a high level of training and experience. ■

➤ *Reportable Workplace Injuries*

Continued from page 4

3. All inpatient hospitalizations (with or without ER visits)

Of the 900,380 DAFW cases in private industry, 333,830 (37 percent) required a visit to a medical facility. Of these, 294,750 required a trip to the ER and did not require hospitalization, and 39,080 cases required inpatient hospitalization, either with or without an ER visit.

The median number of days away from work for all private industry cases in 2018 was eight days. The median number of days away from work for ER visits only was seven days, and the median for inpatient hospitalization was 41 days.

This SOII is the first in a series of two releases from BLS covering occupational safety and health statistics for the 2017 calendar year. Detailed tables are available at www.bls.gov/web/osh.supp.toc.htm. ■

Table 2. Incidence Rates of Nonfatal Occupational Injuries and Illnesses Involving Days Away From Work by Selected Nature of Injury or Illness and Event or Exposure, Private Industry, and Private Retail Trade Sector, 2017–2018

Characteristic	Private Industry		Retail Trade	
	2017	2018	2017	2018
Nature of injury or illness				
Sprains, strains, tears	31.5	30.7	40.5	38.4
Soreness, pain	14.5	15.9	13.3	16.1
Bruises, contusions	8.0	7.9	11.8	14.1
Cuts, lacerations, punctures	7.4	9.2	9.8	12.0
Fractures	8.5	7.9	7.8	8.4
Event or exposure				
Overexertion and bodily reaction	30.0	28.2	36.9	36.3
Contact with objects and equipment	23.2	23.5	29.8	33.0
Falls, slips, trips	23.1	23.9	26.0	29.0
Transportation incidents	4.9	5.0	3.3	3.3
Violence and other injuries by persons or animal	4.0	4.4	1.8	2.1
Total				
Incidence rate	89.4	89.7	101.4	107.6

Source: Bureau of Labor Statistics, Survey of Occupational Injuries and Illnesses, November 2019

Safety Management Clinic

There's Been an Accident at Your Workplace: What Are OSHA's Next Steps?

You've had a reportable incident, and a worker has been injured, become ill from a reportable disease, or—in the worst case—has died. Do you know what happens at the OSHA area office after your report is received?

After OSHA receives an employer report and has obtained the necessary information, the report is triaged. The area director or his or her designee must determine whether to conduct an inspection or a Rapid Response Investigation (RRI).

In order to make this decision, employer reports are separated into one of three categories:

- Category 1 are reports that require an OSHA inspection.
- Category 2 are reports that may result in either an inspection or an RRI.
- Category 3 are reports that result in an RRI.

In practice, there are some instances in which the area director may determine that, based on all available information, there is no factual basis for concluding that a violation or hazard exists. In such instances, the area director has the discretion to decide that neither an inspection nor an RRI should be conducted.

Let's review the criteria and explanation for each of the three categories.

Category 1

When an employer report is identified as Category 1, OSHA will conduct an inspection. Any one of the following conditions requires that OSHA categorize a report as Category 1:

- All fatalities and reports of two or more inpatient hospitalizations;
- Any injury involving a worker under 18;
- A history of the same or similar hazards or incidents within the past 12 months;
- Repeat offenders (history of egregious, willful, failure-to-abate, or repeated citations);
- Employers in the Severe Violators Enforcement Program (SVEP);
- Report of a hazard covered by a local, regional, or national emphasis program; or
- Any imminent danger.

If the employer is an exempt industry under the Appropriations Act of 1998, the area director will follow the exemptions and limitations under the act. Exempt employers have a Days Away, Restricted, or Transferred (DART) occupational injury and illness rate below the national private sector rate for their industry, as classified in the North American Industry Classification System (NAICS) codes.

Category 2

An employer report is identified as Category 2 if it does not involve any of the conditions described in Category 1. For Category 2 reports, the area director has the discretion to determine whether an inspection or an RRI will be conducted. This determination is based on the area director's knowledge of the circumstances of the event and consideration of the following factors:

- Have the work conditions that resulted in the employer report of injury or illness been corrected? If so, what were the corrective measures taken and how quickly were they implemented?
- Can complete abatement of the reported workplace condition be implemented before an inspection is conducted?
- Are other employees still exposed to the hazard that resulted in the reported injury, illness or fatality? If so, how many employees?
- Was the work related incident the result of a safety program failure such as PRCS, LOTO, PSM, etc.?
- Does the employer have work rules or procedures that address the hazard/incident? If so, were the work rules/procedures followed? If not, why not?
- How are the work rules/procedures communicated to employees and how are the work rules/procedures enforced?
- Did the work-related incident involve a serious hazard such as explosive materials, combustible dust, or falls?
- Did the report of injury or illness involve temporary workers or other vulnerable employees?
- Has another government agency (federal, state, or local) made a referral regarding the reported incident or hazard?
- Does the employer have a prior OSHA inspection history?
- Has there been any whistleblower complaint or investigation involving the employer?
- Is the employer a Cooperative Program participant? Examples of such programs include Voluntary Protection Programs, OSHA strategic partnerships and alliances, and the Safety & Health Achievement Recognition Program. Area offices will follow existing procedures for reporting fatalities involving employers in these programs.
- Did the work-related incident involve such health hazards as chemical or heat stress exposures?

Continued on page 10 ➤

On the Docket

Lockout/Tagout

Did the Employer Willfully Fail to Develop Machine-Specific Procedures?

A poultry processing facility in Birdsboro, Pennsylvania, had been cited by OSHA for failing to have written, machine-specific lockout/tagout procedures. As part of its settlement agreement with OSHA, the employer hired an outside consultant to help bring the factory into compliance. Among other things, the consultant was tasked with developing a written lockout/tagout plan for use by the employer.

Two years after the initial inspection, a worker put his hand into the mixer machine and was injured, triggering a new OSHA inspection. The new inspection revealed that the mixer machine and three other machines used in the facility—the chamber machine, the gizzard machine, and the frank-o-matic—did not have detailed, written lockout/tagout procedures. The lockout/tagout plan written by the consultant for the employer provided background on the control of hazardous energy, including the text of the lockout/tagout standard, and had a detailed written procedure for single energy source/single plug machines. It, however, did not address how to control the energy sources for those four machines. In its correspondence with the employer, the consultant noted that the facility would need to develop machine-specific procedures for those machines, but this had not been done. The employer was cited for a willful violation of the lockout/tagout standard for failing to create detailed, machine-specific lockout/tagout procedures for each of those machines.

Issue

The employer contested the citation, arguing that its plan was sufficient for all four machines. OSHA disagreed, pointing out that all four machines had more than one energy source—electric and pneumatic—meaning that a generic lockout/tagout procedure such as the one prepared by the consultant was not adequate. The employer claimed that although those procedures were not in the lockout/tagout plan, they had been developed separately for the U.S. Department of Agriculture. The employer, however, provided no further evidence or documentation that such procedures existed.

Did the employer's failure to have an adequate lockout/tagout written plan merit a willful citation?

Decision

Yes. To satisfy the requirements for a willful citation, OSHA must show that it was committed voluntarily with either an intentional disregard of, or plain indifference to, the Occupational Safety and Health (OSH) Act's requirements. An employer's prior history of violations, its awareness of the requirements of the standards, and its knowledge of the existence of violative conditions can all be considered in determining whether an employer acted in this way. In this case, more than half a dozen emails had been sent by the consultant to remind the facility's management of the need to develop machine-specific lockout/tagout procedures. Despite these regular reminders, the employer never developed the necessary machine-specific procedures before the new inspection. The willful classification was upheld.

Management Memo

The administrative law judge (ALJ) in this case noted that motive does not matter in the determination of whether a violation was willful. The employer in this case was understaffed and had struggled to fill a full-time safety manager position. Safety management duties had been assigned to the human resources manager, who was already working a full-time job and who had no background or experience in health and safety. The need to write machine-specific lockout/tagout procedures simply never made it to the top of her list. But, as the ALJ noted, the motive for failing to comply with the OSH Act "need not be evil or malicious" for the violation to be characterized as willful—and that's exactly how this case turned out.

What's going on the back burner at your workplace that could draw a willful citation if OSHA turns up at your door?

Secretary of Labor v. Birdsboro Kosher Farms Corp., OSHRC Docket Nos. 16-1575 and 16-1731, September 23, 2019

Machine Safeguarding

The Bushing was Exposed, But Were the Workers?

At a corn mill in Burley, Idaho, 12 full-time employees were responsible for processing approximately 36,000 bushels of corn each day. The corn was delivered to the facility by truck or by rail and stored in seven large bins. The whole grain corn was transferred from the bins to the grinding building, to be processed or "milled" into cattle feed. From there, the milled corn was transferred to overhead tanks, where local dairy farmers and cattlemen would fill their trucks, drive across a scale, and pay based on the weight of the milled corn.

During a programmed inspection of the facility, an OSHA compliance safety and health officer (CSHO) came to a platform near the grinding building where she observed a gear box with a shaft

bushing that was not guarded. The bushing was an exposed disc with protruding bolt heads that rotated at approximately 49 revolutions per minute. The rotating bushing was located roughly 8 inches above the ground and partially blocked by an enclosed piece of machinery. According to the facility's superintendent, the bushing was part of the gear box that drives a drag chain. The drag chain delivered whole grain corn to the leg that, ultimately, took the whole grains to the grinder.

The drag chain was operated remotely from a room on the opposite side of grain holding bins 2 and 3, called the MCC room. According to the CSHO's interviews, as well as the superintendent's testimony, the only time an employee accessed the platform where the bushing was located was to perform maintenance on the drag and leg inside the boot pit once every three months, or occasionally to pump out rainwater. Otherwise, employees walked in the areas surrounding the platform that housed the gear box. There was no indication that any employee walked over, or even near, the platform as part of their everyday duties.

In order to perform the required maintenance, an employee would lift up a hatch located roughly 5 feet away from the bushing, and climb down the ladder to enter into the boot pit to grease various pieces of the machinery located below. According to the superintendent, this procedure required locking out both the drag and the leg, which was done from the MCC room and the grinder building, respectively.

The employer was cited for a serious violation of the machine guarding standard found at 29 CFR 1910.212(a)(1) which requires employers to provide one or more methods of machine guarding to protect the operator and other employees in the machine area from the hazard created by rotating parts.

Issue

The employer contested the citation, arguing that there was no employee exposure to the hazard.

Were workers exposed to a hazard from the unguarded bushing?

Decision

No. Workers were not exposed to a hazard, the judge said, merely because the shaft bushing rotated and was not fully enclosed. OSHA needed to do more than show that it was physically possible for an employee to come into contact with the unguarded machinery in question. Rather, OSHA had to show that workers were exposed to a hazard as a result of the manner in which the machine functioned and the way it was operated. The only exposure scenarios proposed by OSHA involved accidental contact as the result of a slip and fall. The employer argued that both of OSHA's proposed scenarios presented only a remote possibility of exposure. Based on the location of the bushing and the infrequency of work performed in its vicinity, the judge agreed. The citation was vacated.

Management Memo

Whenever OSHA issues a citation, the agency also bears the burden of proving employee exposure to the violative conditions. The Occupational Safety and Health Review Commission's (OSHRC) longstanding "reasonably predictable" test for hazard exposure requires OSHA to "show that it is reasonably predictable either by operational necessity or otherwise (including inadvertence), that employees have been, are, or will be in the zone of danger." It has further defined the zone of danger as the "area surrounding the violative condition that presents the danger to employees." In this case, OSHA could not demonstrate that any reasonably predictable action by workers would expose them to the hazard. So, even though the bushing was exposed, the citation was vacated.

When you're prioritizing hazard abatement, it is wise to take exposure into account, and deal first and most urgently with the hazards that workers are in frequent close proximity to.

Secretary of Labor v. Gavilon Grain, LLC and its successors, OSHRC Docket No. 18-0702, October 21, 2019

Electrical Safety

Who's at Fault When Workers Don't Wear Their PPE?

An electrical contractor in Holbrook, Massachusetts, was hired by a local police station to install 60 replacement batteries for its universal power supply system (UPSS). The UPSS provides continuous electricity to critical equipment in the event of a power outage. The police station's UPSS contained two sets of 30 batteries each in two UPS module cabinets connected in a series. Each battery carried approximately 12 volts of electricity, such that each series of 30 batteries carried approximately 360 volts when all connected. The UPSS was located in the basement of the police station directly below the lobby.

A journeyman electrician was initially assigned to replace the batteries. After arriving at the police station, he began by putting the system in "bypass" to divert the electricity feeding the batteries. He then realized he could not complete the work by himself because each battery weighed 103 pounds and he needed someone to help lift them. He left the police station, returning two weeks later with an unlicensed apprentice electrician. The two electricians decided that they would remove the batteries together due to their weight, and then the apprentice electrician would reconnect the new batteries in the basement while the journeyman would package the old batteries and load them onto a pallet upstairs. The two electricians did not don their electrical protective clothing to perform this work, although the journeyman electrician admitted later that he did know he should have been wearing personal protective equipment (PPE).

After the apprentice electrician had connected about 20 to 24 of the new batteries, an arc flash occurred that burned the apprentice electrician's hand. The journeyman electrician was getting off an elevator in the basement when he heard a "pop" and first became aware of the accident. The apprentice was taken by ambulance to a hospital for treatment. An investigation by the employer concluded that the incident occurred as the result of a tool with uninsulated parts that either bridged the air gap or made contact across the terminals, causing the tool to superheat and burn the worker's hand.

A subsequent OSHA investigation of the incident resulted in several citations against the employer for violations of the electrical safety standards, including 29 CFR 1910.335(a)(1)(i), which requires employees working in areas with potential electrical hazards to use electrical PPE.

Issue

The employer contested the citation, arguing that it had provided extensive training to its electricians, and could not have known that they would not wear their PPE while performing a hazardous electrical task.

Did the employer have either actual or constructive knowledge of the violation?

Decision

Yes. The employer tried to argue that its journeyman electrician was not, in fact, "supervising" the apprentice, because if he was a "supervisor," then his knowledge of the violation could be imputed to the employer. The judge rejected this defense, noting that an employee who "has been delegated authority over other employees, even if only temporarily, is considered to be a supervisor for the purposes of imputing knowledge to an employer." Although the employer denied at trial that the journeyman was supervising the apprentice, the employer's own email documents used language that indicated that the work was being performed "under the supervision of a licensed electrician" as required by the state of Massachusetts. Thus, the journeyman's knowledge of the violation was imputed to the employer.

Even failing that, however, the judge found that the employer had constructive knowledge of the violation. If the journeyman was not qualified to supervise the work, then the employer was guilty of failing to exercise reasonable diligence because it had dispatched an unlicensed apprentice electrician to perform the UPSS work without onsite supervision. The citation was upheld.

Management Memo

This employer also alleged that the employees in this case committed unpreventable employee misconduct. Their defense failed because they were not able to show that they had a clear work rule requiring the use of PPE. As an essential element of the misconduct defense, the employer needs to establish that it has work rules designed to prevent the unsafe condition or violation of an OSHA standard. A work rule is defined as "an employer directive that requires or proscribes certain conduct, and that is communicated to employees in such a manner that its mandatory nature is made explicit and its scope clearly understood." In the absence of a clear and clearly communicated work rule, the employee misconduct defense will always fail.

Is there an important safety work rule your workers are constantly disregarding? Make sure that they know about it and that you enforce it, or you could be the one who gets burned.

Secretary of Labor v. Infra-Red Building and Power Service Inc., OSHRC Docket No. 17-1511, October 7, 2019 ■

➤ ***24-Hour Safety***
Continued from page 3

Make the bedroom as dark as possible. Follow your regular bedtime routine every time you go to sleep. Don't use the bed for anything except what it is intended for. For example, don't read, eat, watch TV, write bills, or argue with your spouse in bed. Make sure you have a comfortable bed that won't disturb your sleep.

- Don't lie in bed awake. If you find yourself still awake after staying in bed for more than 20 minutes or if you are starting to feel anxious or worried, get up and do some relaxing activity until you feel sleepy.

If you consistently find it difficult to fall or stay asleep and/or feel tired or not well rested during the day despite spending enough time in bed at night, you may have a sleep disorder. Your family doctor or a sleep specialist should be able to help you. ■

➤ ***Safety Management Clinic***
Continued from page 7

This list is not intended to be exhaustive. The area director may consider additional criteria particular to the reported hazard or incident. Based on an evaluation of the information obtained in response to the above questions, the area director will decide whether an onsite inspection or an RRI is appropriate.

Category 3

When the area director (or his or her designee) determines that, based on the criteria discussed above, an employer report does not warrant an inspection, an RRI will

be conducted. What happens during an RRI inspection is discussed in detail below.

Procedures for a Category 1 and 2 Inspection

After the area director (or his or her designee) determines that an employer report falls within Category 1, an onsite inspection will be conducted in accordance with the procedures contained in the Field Operations Manual (FOM). Similarly, if the determination is made that an employer report falls within Category 2, and an inspection by OSHA is warranted, the inspection will also be conducted in accordance with procedures contained in the FOM.

If the area director (or his or her designee) determines that an employer report is Category 2 but an onsite OSHA inspection is not warranted, an RRI will be conducted.

OSHA inspections will begin, resources permitting, within five working days (except for fatalities and catastrophes) of receipt of the employer report. RRIs will begin, resources permitting, within one day after receipt of the employer report.

Procedures for a Category 2 and 3 RRI

When an employer report falls within Category 3 or within Category 2 and the determination is made not to conduct an onsite inspection, an RRI will be conducted. The RRI is intended to identify any hazards, provide abatement assistance, and confirm abatement. Here's what to expect if you are chosen for an RRI.

The area office should begin the RRI within one day after receipt of the employer's report. The RRI begins with an initiating telephone call that covers the following information:

- **Incident details.** The compliance officer (CO) or other area office designee will review the incident with the employer and collect any additional information missing from the initial report (such as details of the incident; the machinery or equipment involved; what systems are in place to prevent this type of incident; what work rules are in place; and whether the rules were followed—and if not, why not?
- **Internal investigation.** The CO will discuss in detail the need for the employer to immediately conduct its own internal investigation to determine the reasons for the occurrence of the work-related incident, to identify the hazards related to the incident, and to implement corrective measures.
- **Employer actions.** The CO will explain the actions the employer must complete as part of the RRI process: that is, internal investigation, abatement verification, posting requirements, and sending a copy to employee representative.
- **Antidiscrimination.** The CO will review whistleblower and antidiscrimination protections protections.
- **Consultation and compliance assistance.** The area office will provide consultation and compliance assistance regarding safety and health issues, best practices, and abatement. Some of the resources provided to employers includes information on the hierarchy of controls, OSHA Web page for information (guidance, eTools, etc.), and other assistance (for example, sample programs and contact information for local consultants). In addition, a link to a guidance document developed by the OSHA/National Safety Council National Alliance will be provided to employers.

During the initiating call, OSHA will also discuss and then send the following documents:

- A letter detailing the steps the employer should take to investigate and correct the incident. Employers must post the letter from OSHA in a conspicuous place where all affected employees will have notice or near the location where the incident occurred. The employer must also provide the letter to the authorized employee representative, employee union representative, or safety and health committee in the facility.
- Investigative guidance in the form of *Appendix D-1: Non-Mandatory Investigative Tool for Employers*. This investigation tool is provided to assist employers in finding the cause of incidents and to prevent similar incidents in the future. It contains criteria that may be used to evaluate the capabilities of current safety practices. OSHA encourages employers to use this or a similar document as a means for abatement verification and to submit their corrective actions in the appropriate section. Note, however, that this is a nonmandatory tool.
- A Certification of Posting, which must be completed and returned to OSHA.

The Employer's Response to an RRI

Key components of an RRI are the employer's actions regarding its internal investigation of the incident, abatement verification, and posting:

- **Conduct an internal investigation.** Within five working days after the initiating RRI call described above, the employer should inform the area director in writing of the results of its internal investigation by letter, email, or fax. The written document should confirm that actions have been taken to correct the conditions that resulted in the employer report. If the employer cannot complete its internal investigation and/or completely correct the condition within those five working days, it should notify OSHA in writing, before expiration of the five days, of the reasons why the investigation and/or corrective action cannot be completed.
- **Complete and send the Abatement Verification.** Within five working days after the initiating RRI call, the employer should send, by mail, fax or e-mail, to the area director an Abatement Verification

Continued on page 15 ➤

State Roundup

California

■ **Court of Appeal Upholds Cal/OSHA Citations.** A court of appeal has upheld Cal/OSHA citations issued to Home Depot for violating safety standards after a warehouse employee suffered a serious foot injury in 2014. Cal/OSHA's investigation found the warehouse workers were not provided protective footwear such as steel-toed shoes in an area where industrial vehicles were operating. The Fourth District court ruling also affirms an earlier lower Superior Court decision that the citations were correctly applied following an accident investigation at Home Depot's warehouse in Mira Loma.

"This is the first California Court of Appeal decision on the issue of protective footwear in warehouses and it sends a strong message on the need to protect workers," said Cal/OSHA Chief Doug Parker. "Cal/OSHA has investigated a number of serious foot injuries related to forklifts and rider pallet jacks in the warehousing industry. In many cases, injuries could have been avoided with protective footwear."

In April 2015, Cal/OSHA cited Home Depot after investigating an accident in which a worker's foot was seriously injured from a collision between two pallet jacks at a warehouse in Mira Loma. The investigation found that at the warehouse, which functions as a distribution center for retail stores, employees exposed to foot injuries wore sneakers and were not required to wear protective footwear. Investigators also identified violations with the safe operation of industrial trucks.

Home Depot appealed the citations and the Occupational Safety and Health Appeals Board (OSHAB) affirmed both, finding that employees were exposed to foot injures when manually lifting loads and when working in close proximity to industrial trucks. The board ruled that Home Depot's lifting safety policy and prohibition of open-toed or open-heeled shoes were not adequate to protect workers from the realistic hazard of serious foot injuries. After the board's decision, Home Depot filed a writ of mandate with the local superior court asking for relief of the footwear citation, but the court denied the writ. The employer subsequently took the case to the Court of Appeal, which ruled to uphold OSHAB's decision and Cal/OSHA's citations.

Foot injuries from being struck or run over by industrial trucks are the single leading cause of foot amputations and other serious foot injuries among workers in California. In the last five years, Cal/OSHA has opened over 70 investigations with home center employers engaged in retailing home repair and improvement materials.

■ **Unhealthy Air Quality from Wildfire Smoke Puts Workers at Risk.** Cal/OSHA is advising employers that steps must be taken to protect workers from harmful exposure if the air quality is unhealthy due to wildfire smoke. California's protection from wildfire smoke standard applies to workplaces where the Air Quality Index (AQI) for fine particles in the air is 151 or greater and where workers may be exposed to wildfire smoke.

When wildfire smoke affects a worksite, employers must monitor the AQI for particulate matter in the air, known as PM2.5. If the AQI for PM2.5 is 151 or greater, employers must take the following steps to protect employees:

- Inform employees of the AQI for PM2.5 and the protective measures available to them.
- Train all employees on the information contained in Title 8 § 5141.1 Appendix B.
- Implement modifications to the workplace, if feasible, to reduce exposure. Examples include providing enclosed structures or vehicles for employees to work in, where the air is filtered.
- Implement practicable changes to work procedures or schedules. Examples include changing the location where employees work or reducing the amount of time they work outdoors or exposed to unfiltered outdoor air.
- Provide proper respiratory protection equipment, such as disposable respirators, for voluntary use.

Smoke from wildfires contains chemicals, gases, and fine particles that can harm health. The greatest hazard comes from breathing fine particles in the air, which can reduce lung function, worsen asthma and other existing heart and lung conditions, and cause coughing, wheezing and difficulty breathing.

Missouri

■ **Contractor Cited for Exposing Workers to Trenching Hazards.** OSHA has cited Blue Nile Contractors Inc., based in Birmingham, for failing to protect employees from trench collapse and electrical hazards. The company faces $210,037 in penalties.

OSHA inspectors observed workers exposed to trenching and excavation hazards while installing water lines at a Kansas City jobsite in May 2019. OSHA cited the company for four repeat and five serious safety violations of trenching and electrical hazards, and placed the company in the Agency's Severe Violator Enforcement Program.

"Trench collapses can be quick and cause serious or fatal injuries, but they are preventable," said OSHA Kansas City Area Director Karena Lorek. "Employers must ensure that there is a safe way to enter and exit a trench, cave-in protection is used, all materials are placed away from the trench's edge,

standing water and other hazards are addressed, and no one enters a trench before it has been properly inspected."

OSHA recently updated the National Emphasis Program on preventing trenching and excavation collapses, and developed a series of compliance assistance resources to help keep workers safe from these hazards. The agency's trenching and excavation Web page provides additional information on trenching hazards and solutions.

New Jersey

■ **Construction Company and Its President Charged with Contempt.** OSHA has recovered payment of $442,000 in penalties and interest from Washington Township-based construction company Altor Inc. and its president, Vasilios Saites, after years-long efforts by the department to collect unpaid penalties for the company's safety violations.

On July 25, the U.S. Court of Appeals for the Third Circuit in Philadelphia, Pennsylvania, issued a decision finding Altor Inc. and Saites in contempt for failing to pay $412,000 in OSHA penalties. After the contempt finding, and subsequent briefing and negotiations by the parties, Altor Inc. and Saites agreed to pay the full penalty, plus $30,000 in accrued post-judgment interest. On November 26, the department filed a Satisfaction of Judgment with the Court of Appeals confirming their payment of the judgment.

The recovery of the unpaid penalty plus interest resolves lengthy litigation between Altor Inc., Saites and the Department's Office of the Solicitor. This litigation included multiple hearings before the Occupational Safety and Health Review Commission (OSHRC) and the Court of Appeals to affirm Altor's violations of OSHA's safety requirements, and subsequently hold the employer and its president in civil contempt for failure to pay the affirmed penalty. OSHA initially cited the company after an October 1998 investigation identified numerous safety violations at a construction site in Edgewater, including multiple willful violations of OSHA's fall protection standards. The settlement remedies the company's longstanding refusal to pay the associated penalties.

"This settlement brings to a close the long overdue fines that Altor Inc. was responsible to pay," said OSHA Regional Administrator Richard Mendelson, in New York. "These penalties were assessed because Altor Inc. allowed their employees to be exposed to dangerous falls and other hazards. By planning ahead, training employees, and providing the right equipment, employers can protect their workers, prevent falls and other hazards in the workplace, and avoid OSHA fines."

New York

■ **Stiff Penalty Assessed for Multiple Hazards.** OSHA has cited Frazer & Jones Company Inc. for 33 workplace health and safety violations at the manufacturer's Solvay iron foundry. The company faces $460,316 in penalties.

OSHA inspectors cited the company for multiple hazards, including exposing employees to crystalline silica, iron oxide, combustible dust, falls, and struck-by and caught-between hazards; unsafe work floors and walking surfaces; inadequate respiratory protection; deficient safeguards for entering confined spaces; inaccessible and unavailable fire extinguishers; and an impeded exit route. The company also lacked an effective program for removing pests and did not prevent the build-up of bird feces on equipment.

"These hazards expose workers to injuries and long-term health effects," said OSHA Syracuse Area Director Jeffrey Prebish. "Employers must recognize the safety and health risks inherent to their work operations and environment, and take necessary precautions to protect employees who perform those operations."

New Hampshire

■ **Compensation Ordered for Worker Who Refused to Drive Without Safety Measure.** OSHA has determined that UPS Ground Freight Inc. violated the Surface Transportation Assistance Act (STAA) when managers retaliated against a driver at the Londonderry facility. The driver had refused to operate a commercial motor vehicle that did not have either a permanent electronic logging device (ELD) or a mounting device for a portable ELD. OSHA ordered UPS Freight to pay the driver $15,273 in compensatory damages, $30,000 in punitive damages, and approximately $2,700 in back wages plus interest.

OSHA investigators determined that the driver refused in good faith to drive a truck without either a permanent ELD or a mounting device for a portable ELD because he believed doing so would violate the Federal Motor Carrier Safety Regulations (FMCSR). ELDs automatically record an operator's driving time and facilitate the accurate recording of a driver's hours of service. FMCSR required the driver to use an ELD, and the company to provide a vehicle with either a permanent ELD or a portable ELD mounted in a fixed position during his assigned route.

Investigators also determined that the driver's supervisor was not trained on FMCSR's requirements for ELDs, and that company managers attempted to coerce the complainant into violating the regulation. When he refused, the company terminated him for "gross insubordination." The investigation revealed that the company later modified the driver's termination to a suspension and engaged in post-reinstatement harassment.

OSHA also ordered the company to take additional corrective actions to resolve violations of the whistleblower provisions of STAA, including:

- Clear the driver's personnel file of any reference to the issues involved in the investigation;

- Post a notice informing all employees of their whistleblower protections under STAA;
- Refrain from firing or discriminating against any employee who engages in STAA-protected activity; and
- Not use a driver's refusal to drive because of a good faith concern that doing so would violate a FMCSR as a contributing factor in any termination decision.

OSHA enforces the whistleblower provisions of STAA and more than 20 whistleblower statutes.

Ohio

■ **Contractor Sentenced After Worker's Fatal Fall.** An Ohio county court has sentenced Jim Coon, a roofing contractor based in Akron, to prison after he pleaded guilty to involuntary manslaughter in the death of a 39-year-old employee who fell from a three-story roof while working without required fall protection in November 2017. The court's action follows an OSHA investigation that found the contractor failed to install fall protection systems.

On September 6, Summit County Judge Alison McCarty sentenced Coon, owner of Jim Coon Construction, to three years in prison for ignoring safety hazards, and failing to provide workers' compensation coverage as required. In addition to his incarceration, the court ordered Coon to pay $303,152 in restitution to the Bureau of Workers' Compensation after he pleaded guilty to workers' compensation fraud.

Pennsylvania

■ **Worker Loses Life in Unguarded Meat Grinder.** OSHA has fined Economy Storage Locker Co. Inc. $49,062 following the death of an employee who fell or was pulled into a commercial meat grinder in Pennsdale. On April 22, Jill Greninger, a four-year employee at the company, was seen last standing on stairs near the grinder. A coworker discovered her body after turning off the machine because it was making an odd noise. Because nobody saw what happened, neither OSHA nor the coroner could determine how or why she fell.

The company was cited for operating the mixer/grinder with the lid open, exposing the operator to the rotating mixer paddles. OSHA also found that the lid had a 10-by-24-inch opening that exposed employees to hazards. OSHA also found other violations related to machine safeguarding, use of personal protective equipment (PPE), electrical hazards, hazard communication, and forklifts.

Washington

■ **Three Employers Cited after Fatal Seattle Crane Collapse.** The Department of Labor & Industries (L&I) has cited and fined three companies more than $100,000 for safety violations in connection with the fatal collapse of a tower crane that was being dismantled in Seattle on April 27. L&I's nearly six-month investigation determined that the crane collapse was caused by the companies not following the manufacturer's procedures for dismantling the structure, including prematurely removing nearly all of the pins and sleeves that helped hold the crane together. With the pins removed, the tower was significantly weakened, making it susceptible to the 45-plus miles per hour wind gust that toppled it. When the pins are in place, tower cranes can withstand much stronger gusts.

Four people were killed when the crane fell, including two workers who were at the top of the crane, and two people in cars below.

L&I investigators spent hundreds of hours interviewing workers and company representatives, examining the wreckage and working to understand what went wrong. The agency has taken steps to increase crane safety and prevent similar incidents from happening in the future, including issuing a hazard alert stressing proper procedures for assembling and dismantling tower cranes. Some states and countries have used L&I's alert as a model to draft their own crane hazard alerts.

The tower crane is owned by Morrow Equipment LLC and was leased by GLY Construction for the construction project. Northwest Tower Crane Services provided the crew dismantling the crane. Morrow Equipment, LLC was cited for one willful serious violation for not following the crane manufacturer's procedures, which directly contributed to the collapse. In a willful violation, an employer either knowingly ignored a legal requirement or was indifferent to employee safety. Morrow approved the removal of the pins. As the crane equipment supplier, they had the highest amount of expertise at the jobsite. The manufacturer's procedures say not to remove pins other than the ones for each individual section being dismantled. Morrow was fined $70,000.

GLY Construction was cited for three serious violations, including not having a qualified supervisor and other personnel onsite at all times during the disassembly operations; not ensuring the manufacturer's procedures were followed, and not accounting for weather conditions. GLY was fined $25,200.

Northwest Tower Crane Services was cited for three serious violations, including not following the manufacturer's procedures, not ensuring workers understood their assigned duties, and inadequate training of workers. They face $12,000 in fines.

■ **Amputations and Crushing Injuries Lead to Massive Fine.** A Battle Ground dairy bottling and distribution operation has been fined nearly $2 million for multiple willful violations after a worker's hand was crushed in the bottling plant. L&I has fined Green Willow Trucking, also known as Andersen Plastics and Andersen Dairy,

$1,848,000 for 22 willful violations, 16 of which were also determined to be egregious. It's the second-largest safety and health fine L&I has ever issued.

This inspection was initiated after a worker at the company's bottling facility had her hand crushed in a plastic bottle-molding machine while she was trying to clear a jam. Employees at the company have reported serious injuries and amputations over several years. In 2014, 2015, and 2018, L&I cited the company for willful and serious violations related to lockout/tagout and machine guarding hazards.

Twenty-two of the violations for this 2019 inspection are considered serious in nature and willful. The situation is so serious that 16 of the violations are also defined as egregious. L&I cited the company for one egregious willful violation for each employee exposed to the amputation/crushing hazards.

Most of the violations were a result of the employer requiring or allowing workers to put their limbs or bodies inside machines while they are still operating. Despite 10 serious incidents in the past six years including amputations, crushing injuries, and broken bones, the company has failed to adopt known and required safe practices, which is why L&I deemed these violations egregious. ■

➤ ***Safety Management Clinic***
Continued from page 11

signed by a company official, which describes the completed corrective action. If OSHA has agreed to additional time beyond the five days for the employer to complete abatement, the employer should send the abatement verification within one day of the new completion date. The abatement verification should include a detailed description of the corrective action taken. In addition to the abatement verification, the employer should provide supporting documentation to verify the implementation of the corrective action—for example, a copy of new or revised operating procedures, policies, and work rules; copies of monitoring results; photographs or videos; and training records.

- **Post the RRI Letter.** The employer must post a copy of the RRI letter from OSHA in a conspicuous place where all affected employees will have notice or near the location where the incident occurred.
- **Return the Certificate of Posting.** The employer must return a copy of the signed Certificate of Posting to the area office.
- **Notify employees of the RRI.** The employer must provide a copy of the RRI letter from OSHA and its written abatement verification to the authorized employee representative, employee union representative, or safety and health committee in the facility.

At the discretion of the area director, the employer may be given additional time to provide the results of the internal investigation and/or to complete abatement as long as the employer provides information on interim abatement of the condition. Based on the information and circumstances, the area director may agree on a time frame for completion of the investigation and implementation of complete abatement. If an agreement cannot be reached regarding additional time, OSHA will conduct an onsite inspection.

Failure to Provide Adequate Responses

If OSHA has not received a response from an employer within the five working days specified above, the area director will decide whether to conduct an onsite inspection or to make further attempts to contact the employer.

If OSHA determines that an employer has not provided adequate responses to the RRI, or if OSHA determines that an employer's responses are not consistent with other information, the area director may decide to conduct an onsite inspection.

Closing an RRI

When an area office concludes that an employer has satisfactorily completed all actions described above, the area office will summarize its findings and the employer's response enter that information into the OSHA Information System (OIS). The area director will then send an email or letter to the employer informing it that based on the information provided the matter is closed.

Monitoring and Other Inspections

OSHA may conduct monitoring inspections of closed RRIs based on a randomized selection of closed investigations. The monitoring inspection is to ensure accuracy in the reporting and will be limited to an inspection of the previously reported condition. OSHA recognizes that a critical part of the RRI procedure is an employer's willingness to conduct their own internal investigation to determine the reasons for the occurrence of a work related incident, to identify related hazards, and to implement corrective measures. Therefore, if OSHA conducts a monitoring inspection or an inspection for any other reason of a worksite previously subject to an RRI, OSHA will not use the employer's internal investigation to cite a condition or conditions discovered by the employer during its internal investigation, as long as employees are not exposed to a serious hazard and the employer is taking diligent steps to correct the condition. ■

Wolters Kluwer

Wolters Kluwer
Safety Compliance Letter
Distribution Center
7201 McKinney Circle
Frederick, MD 21704

Safety Manager's Resource Desk

■ **New Report Discusses Role of Worker Participation in Preventing Accidents.** The U.S. Chemical Safety and Hazard (CSB) Investigation Board has found that worker participation is an essential element to improve process safety and prevent chemical incidents. Existing federal regulations require worker participation in matters of process safety, and industry standards similarly call for worker participation. Yet, CSB incident investigations have identified missed opportunities for workers to effectively participate in process safety activities at facilities where they work, typically in proximity to the most serious hazards. A lack of effective worker participation can lead to an increase in the risk of injury to workers and, in the event of a serious safety incident, can adversely affect the company and members of the public who live near these industrial facilities.

Safety Digest: The Importance of Worker Participation summarizes four CSB investigations where ineffective worker participation contributed to a major chemical incident or otherwise provided insights into opportunities for improved practices. It highlights key lessons and offers guidance to help ensure effective worker participation.

The four incidents covered in the digest led to a total of 13 employee deaths, many injuries, and, in one case, 15,000 residents living near the facility seeking medical evaluation. The incidents took place at an explosives manufacturing site, a chemical production facility, and two oil refineries. They occurred in Nevada, Washington, California, and Louisiana. Each of these CSB investigations found that worker participation programs were inadequate, despite the existence of federal regulations and industry standards.

The nine-page report is available online at *www.csb.gov/assets/1/6/worker_safety_digest.pdf*.

■ **Role of WC Prices in Outcomes of Injured Workers Examined in Recent Study.** The Workers Compensation Research Institute (WCRI) has released a new study addressing a long-standing policy debate about the role of workers' compensation (WC) prices in outcomes of injured workers, specifically what happens to outcomes of injured workers when prices increase or decrease.

One of the concerns that is often expressed is that when workers' compensation prices are set too low, workers would experience problems getting timely access to medical care. This, in turn, would lead to poor recovery and problems with achieving timely return to work. Prior evidence about the relationship between WC prices and outcomes was limited until this study.

The study, *Workers' Compensation Medical Prices and Outcomes of Injured Workers,* is the first to combine surveys of injured workers with claim data to examine the relationship between WC prices for medical services and the outcomes that workers experience after a work-related injury. The study reveals that the answer to questions about what happens to outcomes when prices increase or decrease is nuanced and depends on whether the WC prices are higher or lower than those paid by group health insurers.

According to the study, little relationship between prices and many of the policy relevant outcomes (such as recovery of health and functioning and speed of return to work) suggests that factors other than medical prices are important in shaping differences in outcomes observed across states. Although worker outcomes differ across states, the study suggests that these differences are not due to the differences in medical prices for workers' compensation services. Future studies may need to focus on other system features that may explain large differences in outcomes across states.

The analysis for this study included states with a range of different price experiences. For more information about this study or to purchase a copy, visit WCRI's Web site at *www.wcrinet.org/reports/workers-compensation-medical-prices-and-outcomes-of-injured-workers*. ■

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