Dear Colleagues,

With almost half of the fiscal year gone, 5 JLab employees and subcontractors have experienced injuries that were serious enough to warrant medical treatment beyond first aid. In one of those cases, an employee was injured seriously enough that he was unable to work. With the upcoming 6 Month Down, we need to make sure we are doing all that we can to prevent injuries.

From these injuries, the injuries in 2010, and Work Observation data one can conclude that:

1. We are understating and underestimating the hazards of what we consider “Skill of Craft” (SOC). Remember that SOC designation does not require a formal – written task hazard analysis (THA).
2. Employees were in a hurry to complete the work.
3. Work is performed under non-optimal working conditions, with workers not always properly oriented and non-optimal tools used.

 We need to ensure that SOC work includes effective pre-job planning and line supervisor involvement. This includes:

* recognition and communication regarding hazards for each aspect of the work activity, including work environment and equipment,
* Efforts to correct identified hazards such as non-optimal workspace conditions; and
* Seeking the best plan and tools for completing the work safely.

Over the next week, all supervisors should meet with their work groups. Attached is a tool-box package provided for you to share with your work groups. It includes description of the 5 serious injuries we have had thus far this year, the causal factors and the actions supervisors/employees need to take to prevent injuries. We should all emphasize that there is no work that we do that is so important as to need short-cuts and work-arounds that increase the probability of injury.

In addition to this tool box talk, all supervisors should conduct a walkthrough of the work group’s routine work spaces to identify any work environment hazards that need mitigating or tools/equipment that need to be replaced. We would like you to report that you have completed this activity by April 7, 2011, with supervisors providing feedback to the AD/DM on needed improvements.

Sincerely,**FY11 Recordable Injuries**

With almost half of the fiscal year gone, 5 JLab employees and subcontractors have experienced injuries that were serious enough to warrant medical treatment beyond first aid. In one of those cases, an employee was injured seriously enough that he was unable to work.

Below is a description of the events and the causal factors. You will notice some commonalities:

**Case #1:** A subcontractor employee’s wrench slipped while turning wrench, causing the right index finger knuckle to be cut on a metal box – 4 sutures

**Causal Factors:**

1. Worker was in a hurry and did not take the time to fully remove the panel cover before starting work.
2. Assumed to be Skill of Craft Work: Work area was not properly assessed to determine that work gloves were needed when the panel cover was not fully removed. This created the laceration hazard.

**Case #2:** A subcontractor employee slipped while climbing down a ladder on a box truck, spraining knee – prescription

 **Causal Factors:**

1. Worker was hurrying to complete the job.
2. Work area was not properly assessed to determine that the rungs of the ladder were wet and there was mud on the boots that reduce traction.

**Case #3:** A subcontractor employee closed a door on his finger – prescription

 **Causal Factors:**

1. Employee not paying attention as he closed the door.

**Case #4:** An employee tripped on a copper cable, dislocating shoulder – lost time

 **Causal Factors:**

1. Protective measures (cardboard taped over cable) were less than adequate.
2. Follow-up after previous failure of tape less than adequate.
3. Grounding system design of created a trip hazard.

**Case #5:** A temporary employee was grinding the cap off a pipe, the grinder jammed and jerked out of his hand cutting his leg – 10 sutures

**Causal Factors: Incident is still under investigation, however initial investigation has yielded:**

1. Over reliance on worker’s experience resulted in less than adequate planning and pre-job briefing.

**What is Common to these Events?**

1. Most of the activities were determined to be “Skill of Craft”. The pre-job planning and pre-job briefing were minimal, ignoring work environment hazards.
2. Employees were in a hurry to complete the work.
3. Work is performed under non-optimal working conditions, with workers not always properly oriented and non-optimal tools used.

**What Can You Do?**

1. Plan your job, no matter how brief -
2. If the task is Skill of Craft, have you considered what’s different with this task that may increase the risk? Are you working at heights, working with unfamiliar equipment, working in cramped quarters, working outdoors? Perhaps a more formal work plan is appropriate to assure all hazards are recognized and mitigated.
3. Do you have the best plan? Just because it’s how you’ve always done something, there may be a better way to do it.
4. Ask yourself – what’s the worst that could happen and have I taken precautions to prevent it?
5. Do you have the best tools?
6. Inspect – Don’t Just Accept. Look around before you start work – Look Up, Down, Around, In Front, Behind
7. What are the work environment hazards?
8. Does everyone know about them?
9. How can you or your supervisor fix them?
10. If they can’t be easily fixed, how will you protect yourself?

**As a Group – Walk through your work areas:**

1. Are there any hazards in your workplace that need to be mitigated?
2. Are there tools you need to perform your work more safely?