



Safety Gram

Protecting Resources Through Better Risk Management

Safety Division's Monthly *Safety Gram* is provided to senior leaders to maintain awareness of mishap trends that directly affect the operational readiness of the Corps. This information should also be disseminated at every level of your command to assist high-risk Marines and Sailors in understanding the impact of the decisions they make every day both on and off-duty.

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January 2014: Mishap Summary

The Mishaps below occurred throughout the USMC from January 1 - 31, 2014, causing serious injury or death to Marines, and/or damage to equipment.

1 January 2014. After a New Year's celebration with friends, a Marine was dropped off at the incorrect address by a sober ride. SNM attempted to gain entry to the mistaken address, was unable to do so, and died of hypothermia (exposure) due to outdoor temperatures of -20 degrees Fahrenheit.

5 January 2014. When driving along a lake, two Marines crossed the road's center line, left the road, and landed in a canal. The vehicle was found submerged by park services approximately 24 hours later, and the cause of death was deemed immersion syndrome. Toxicology reports are pending.

13 January 2014. While treading water during an initial swim screening, SNM lost consciousness. A pool deck instructor noticed the Marine struggling and had two other instructors assist him to the side. The Marine lost consciousness upon reaching the pool-side, and was lifted out without vital signs. Safety corpsman and

EMS administered CPR, but were unable to revive him in an incident of accidental drowning.

31 January 2014. A Marine was cutting wood in the early afternoon with a table saw when the wood jammed in the blade, causing kickback. The table "jumped" and the blade cut his right index finger. The incident resulted in partial bone loss to the Marine's right index finger above the first knuckle.



Knowledge Management Officer Recognized for Community of Practice Safety Website

In an effort to improve the knowledge management implementation within the offices of the Deputy Commandant for Combat Development and Integration, Mr. Reese Olger has been key in the development of some extremely valuable safety tools. Consequently, the USMC Knowledge Management Officer received recognition through the DON IM/IT Excellence Award.

Based in Quantico, Mr. Olger has improved the efficiency and effectiveness of his organization through knowledge management best practices. As a product of his contributions, he has accomplished a great deal in the implementation of the Safety Community of Practice (COP) and the MCCDC Internal Controls (MIC) program virtual work spaces.

The COP has developed into an expansive SharePoint environment which helps sustain the safety and occupational health programs throughout the Marine Corps, and allows for substantial reach for communication dissemination. Additionally, the MIC serves as a SharePoint database for the collection and sharing of information in regard to the command's internal controls program.

By utilizing the capabilities and tools existing in the SharePoint environment, Mr. Olger was able to develop exceptional tools that are valuable to users, without incurring any additional cost to the command or the Marine Corps. The electronic management of this information reduces the time and funds previously attributed to hard-copy maintenance of content. From the COP alone, the command estimates a cost-reduction of \$390,000 in manpower efforts previously dedicated. With over 80 members of the COP, and a continuously growing community, Mr. Olger is providing increasing access to Safety Brief templates and other documents to improve the efficiency of USMC safety personnel.

The Marine Corps safety community now has a valuable tool in the form of the COP. Available at <https://ris.usmc.mil/sites/usmcsafety>, the Community of Practice is a tool that can and should be utilized by Marine personnel with a variety of relevant safety billets. One again, congratulations to Mr. Olger on such a valuable product!



OSHA's Top 10 Most Frequently Cited Violations in FY2013

This content was previously published in the National Safety Council's February 2014 issue of OSHA: Up to Date.

For the third consecutive year, OSHA's Fall Protection Standard tops the list of the agency's top 10 most frequently cited violations. Fall Protection was also the most frequently cited willful violation and the most frequently cited serious violation. The following data, provided by OSHA, represents violations issued by federal OSHA in FY 2013, which ran from 1 October 2012, to 30 September 2013.

1. Fall Protection - General Requirements (1926.501) - 8,739

 4,733

Residential Construction (b)(13)

 1,696

Unprotected sides and edges (b)(1)

 912

Roofing work on low-slope roofs (b)(11)

 656

Steep roofs (b)(11)

 328

Holes (b)(4)

2. Hazard Communication (1910.1200) - 6,556

 2,469

Maintaining a written hazard communication program (e)(1)

 1,561

Providing employees with information and training (h)(1)

 701

Chemical container labeling (f)(5)

 611

Maintaining Safety Data Sheets (g)(8)

 496

Obtaining for developing Safety Data Sheets (g)(1)

3. Scaffolding (1926.451) - 5,724

 1,589

Protection from falls to a lower level (g)(1)

 788

Planking or decking requirements (b)(1)

 781

Point of access for scaffold platforms (e)(1)

 632

Foundation requirements (c)(2)

 376

Guardrail requirements (g)(4)

4. Respiratory Protection (1910.134) - 4,153

 705

Medical evaluation general requirements (e)(1)

 650

Establishing and implementing written respirator protection program (c)(1)

 510

Covering situations when respirator use is not required (c)(2)

 342

Respirator selection general requirements (d)(1)

 332

Ensuring respirators are fit tested (f)(2)

5. Electrical - Wiring Methods (1910.305) - 3,709

 1,004

Use of flexible cords and cables (g)(1)

 821

Conductors entering boxes, cabinets, or fittings (b)(1)

 703

Identification, splices, and terminations (g)(2)

 577

Covers and canopies (b)(2)

 194

Temporary wiring (a)(2)

6. Powered Industrial Trucks (1910.178) - 3,544

 905

Safe Operation (l)(1)

 575

Refresher training and evaluation (l)(4)

 377

Avoidance of duplicative training (l)(6)

 336

Taking truck out of service when repairs are necessary (p)(1)

 304

Maintenance of industrial trucks (1)(7)



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7. Ladders (1926.1053) - 3,524

1,866

Requirements for portable ladders used for accessing upper landing surfaces (b)(1)

482

Ladder use only for its designed purpose (b)(4)

268

Not using the top or top step of step-ladder as a step (b)(13)

215

Marking portable ladders with structural defects with tape noting them as defective (b)(16)

107

Employees shall not carry objects or loads that could cause them to lose balance and fall (b)(22)

8. Lockout/Tagout (1910.147) - 3,505

996

Energy control procedure (c)(4) - 996

653

Periodic inspection (c)(6) - 653

651

Energy control program (c)(1) - 651

580

Training and communication (c)(7) - 580

169

Lockout or tagout device application (d)(4) - 169

9. Electrical _General Requirements (1910.303) - 2,932

814

Installation and use of equipment (b)(2) - 814

670

Space around electric equipment (g)(1) - 670

347

Guarding of live parts (g)(2) - 347

327

Services, feeders, and branch circuits (f)(2) - 327

280

Examination of equipment (b)(1) - 280

10. Machine Guarding (1910.212) - 2,852

1,815

Types of guarding (a)(1) - 1,815

662

Point of operation guarding (a)(3) - 662

214

Anchoring fixed machinery (b) - 214

79

Exposure of blades (a)(5) - 79

73

General requirements (a)(2) - 73

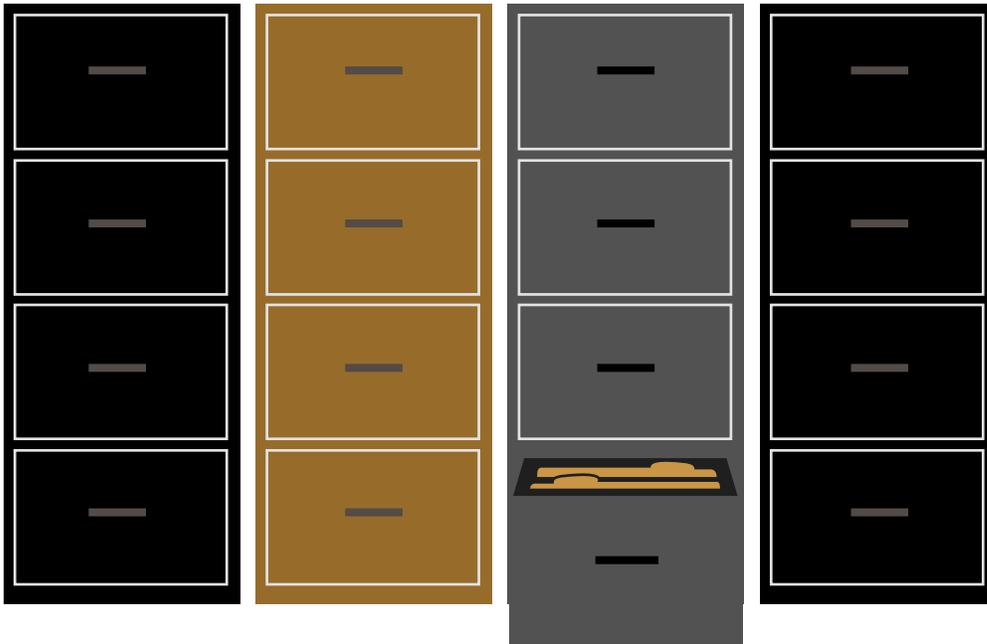
Top 10 Serious Violations Federal OSHA Issued in FY13

1. Fall Protection (1926.501) – 7,492
2. Scaffolding (1926.451) – 5,213
3. Hazard Communication (1910.1200) – 3,761
4. Ladders (1926.1053) – 3,162
5. Electrical – Wiring Methods (1910.305) – 2,923
6. Lockout/Tagout (1910.147) – 2,832
7. Machine Guarding (1910.212) – 2,588
8. Powered Industrial Trucks (1910.178) – 2,539
9. Respiratory Protection (1910.134) – 2,365
10. Electrical – General Req. (1910.303) – 2,204

Top 10 Willful Violations Federal OSHA Issued in FY13

1. Fall Protection (1926.501) **73**
2. Excavations (1926.652) **34**
3. Lead (1926.62) **25**
4. Machine Guarding (1910.212) **23**
5. Lockout/Tagout (1910.147) **20**
6. Scaffolding (1926.451) **19**
7. Guarding Floor and Wall Openings/Holes (1910.23) **18**
8. Respiratory Protection (1910.134) **17**
9. Process Safety Management (1910.119) **14**
10. Powered Industrial Trucks (1910.178) **10**





MISHAP Investigations, Reporting, & Record- Keeping

The Naval Safety Center recently featured the following content pertaining to Mishap Investigations and Reporting processes through their February 2014 Occupational Health and Industrial Safety Programs newsletter. In keeping with the principle that fundamentals make for the strong foundation of any structure, CMC(SD) encourages safety personnel to be mindful this valuable information in the event of mishap

There has been a mishap, now what? If the mishap involved a fatality or the loss of a high dollar item, there is a very strong chance that someone outside of your command will handle the investigation. Thankfully, “Class A” mishaps are few and far between. Most of the time, a Safety Professional will deal with the little annoying mishaps. You know the ones: Slip, Trips, and Falls – twisted ankles from basketball games; the big curb that people keep tripping on, or your average read from the “Friday Funnies.” Most of these barely meet the “Class C” requirements. Most are the “other” mishaps that may not meet criteria for reporting. Should the Class C and “other” type mishaps be reported and investigated?

All Class C and “other” mishaps must be investigated but to what depth should the investigation occur? The Safety Professional and the Supervisor will answer that question. There are times when the small mishaps are a precursor to a larger mishap. If there is a trend developing, a more thorough investigation may be necessary. OPNAVINST 5102.1D/MCO P5102.1B (5102) (Navy & Marine Corps Mishap and Safety Investiga-

tion, Reporting and Recordkeeping Manual) describes which mishaps should be reported and investigated. (Note: the “5102” is currently in re-write).

Chapter 4 of the 5102 covers “Hazard Reports.” What is a hazard? According to the 5102, “a hazard is an unsafe act or condition.” If there is something in the workplace, recreation center, or somewhere else that can cause an injury, it is a hazard. That includes – but is not limited to – trip hazards from mislaid or damaged carpet, missing tile, or ungrounded or improperly wired workbenches. If the item or thing can injure someone or cause material damage, it is a hazard and should be reported!

In addition to the mishap reporting instruction, OPNAVINST 5100.23G, Change 1 has a complete chapter on “Mishap Investigation, Reporting, and Record Keeping.” All Safety Professionals should be familiar with both instructions. In accordance with the 23G, “personnel who conduct Class A, B, C and other mishap investigations shall complete formal training ... Safety professionals responsible for investigating region or activity

level mishaps or Class A and B mishaps shall attend the Naval Occupational Safety and Health and Environmental Training Center course, Mishap Investigation and Prevention (Ashore), course A-493-0078, or an equivalent course ... Safety professionals with formal mishap investigation training may provide formal classroom training to others in the region or activity (e.g., supervisors) who may perform Class C and other mishap investigations.” Most individuals are receiving this training, however, many Class C and other mishaps are not being investigated, or the investigation is not being properly conducted.

The Naval Safety Center receives most mishap reports, but the quality of mishap data being reported is sporadic. The 5102 does not describe what should be in a narrative. So, what should be in the narrative? Narratives must contain the “what, when, where, why and how” information. The narrative should NEVER contain the individual’s name, other PII, or the name of the command. What the narrative should contain is what happened and why. What are the casual factors or the root causes? A large number



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of narratives contain the word “training.” Is training really the root cause of the mishap? Training may be a possible root cause, but why was the proper training not conducted? This question is usually not answered.

If the root causes of the mishap are identified, there is a chance that the future mishap can be prevented. That is the reason for the investigation, to prevent or try to prevent the mishap from recurring.

Information on WESS can be located at <https://wess.safetycenter.navy.mil/wess/index.html>.

Mishap Investigations and Narratives

A young Junior Officer (JO) submitted a WESS report. During the narrative review, (Yes, Naval Safety Center does read them!) we read “service member are no longer authorized to injure themselves,” this ill-advised attempt at humor was not taken very lightly. It would have been humorous to be the fly on the wall when the Naval Safety Center representative (O-5) who happened to be in the area stopped by to ask the young JO what was the reason for such a response.

As we review submitted mishap reports, we note that many narratives do not contain enough information to identify causal factors and underlying systemic issues.

The following are examples of mishap narratives. These narratives were made up. If there is any comparable information it is strictly a coincidence.

Here is an example of a well written narrative:

The incident occurred on 29 February around 1400. The 43 year old individual was in the process of doing annual clean-up of the work area. Upon the conclusion of the cleanup the individual was removing items to be discarded. The individual decided to take out the trash first and picked up a 33 gallon full trash can with one hand using the handle. While carrying the can outside he felt a pain in his wrist. He disregarded the pain. Although he knew the trash can was too heavy, he wanted to prove to the younger workers he was not a wimp. The dumpster was located across the parking lot so he decided to drag the trash can the remaining few feet. While dragging the can he stepped into a pot hole twisting his ankle. The pain was not bad so he decided to “walk it off.” Once the ankle felt better he finished dragging the trash can to the dumpster. Knowing that the can was heavy he used his legs to lift the can. He did not look into the dumpster first.

A cat was inside the dumpster. The noise startled the cat, which jumped from the dumpster scratching the individuals face. He only felt a little blood and wiped it off with the back of his hand. While lifting the trash can he felt a small pain in his back. The pain is routine to him because he feels it all the time while taking trash out at home. Upon returning to the building, the other employees asked him what took him so long. He said he was taking his time because he did not want to get hurt. The next item requiring removal was the recycle bin. Knowing that paper is heavy he went to get a dolly. He carried the dolly up two flights of stairs instead of using the elevator. Again he felt a pain in his back. Realizing that the building had an elevator he used it to bring the recyclable paper to the proper bin. He remembered the cat from the dumpster and opened the top of the recycle bin first. Nothing came out. He decided that he only had to lift the bin four feet off the ground to dump it and it would be faster than small handfulls. While lifting the bin he again felt the pain in his back but continued to lift. He did not see the metal latch was broken and cut his hand on it.

Upon returning to the office his supervisor noticed the wrapping on his hand and asked him what happened. The supervisor instructed the individual to get the hand looked at. The individual went to the dispensary where the wound was cleaned and dressed. The following morning, the individual was late for work because his back hurt, his wrist was swollen, and his ankle was purple. Upon arriving for work he told his supervisor that there was a possibility that he had hurt himself while removing items from the office. He was again directed to get a medical opinion. The injured back was more than just a minor pain, as the individual had pinched a nerve. His wrist was broken, and the ankle had a severe bruise. The individual

was given 10 days off for the ankle and back followed by 21 days limited duty for the wrist with a follow up. While at the dispensary, the doctor noticed the scratch on the individuals face. Although not infected, it did require cleaning. The root cause of this mishap was lack of a risk assessment.

The individual involved in this mishap did not use any risk assessment techniques. If ORM was used, he would have asked for help with the trash can, and recycle bin. Since the dumpster is used to discard food items rodents and cats in and around the dumpster would be a normal occurrence.

Recommendations: There is no reason to tackle any lifting job alone if there is help available. Use ORM on all situations and determine what can and could happen.

Note: A number of narratives do not contain address systemic issues but usually contain a recommendation to provide additional training or conduct a Safety Stand-Down to correct the problem. Although Safety Stand-downs and other training can correct some issues or make a command aware of an issue, it does not always correct a root cause. Narratives should address systemic issues which if corrected might solve the problem.

This is an example of a poorly written narrative:

Employee injured knee

Note: We receive this type of narrative routinely; the report is usually returned to the sender for additional information. If the report is returned for additional information that does not mean the Naval Safety Center does not want it. We want the mishap report returned with the additional information.

