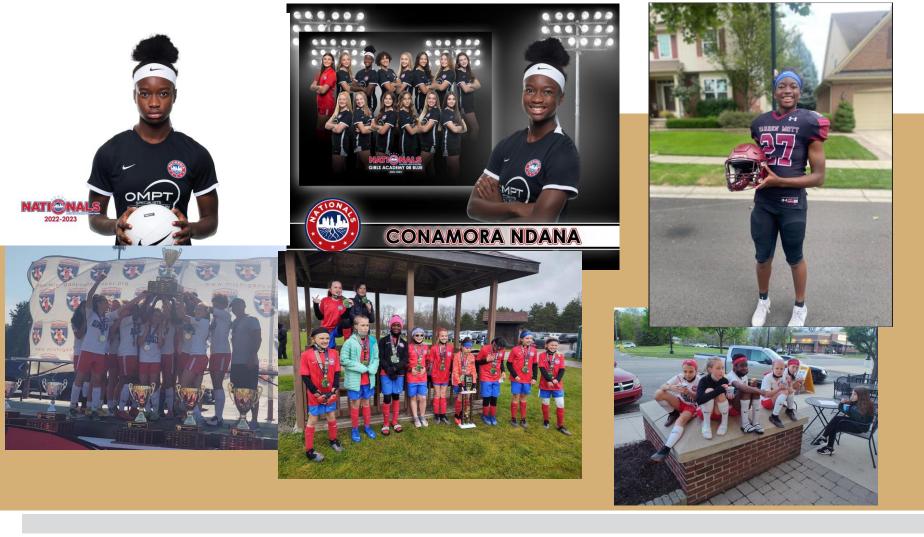
#### 7 Hidden Barriers and Solutions to Near-Miss Reporting

By JEAN NDANA CSP;CIH,CHMM,PMP;SSBB; CQE ndanaflavor@gmail.com cell#:586-243-9429







#### **Problem Plant**

9 Ways to Change From Severe Violator to Safety Model

> By Jean Ndana veral OSHA citations origicomplaints led MIOSHA to

> far. The persistent OSH-rergonomics, machine guard-'kout/tagout) not only were

> tivity, quality and employee esulted in turnover of OSH thor was the plant's third ss than a year. rs on the job, the author de-

> sted initiatives to turn things any began making progress ty excellence. The company nto all phases of manufactureffects on efficiency, quality, ale, as well as the bottom line. eginning implementation.

> performance went from the

idustry into the first quartile.

ncidence rate dropped dra-

f the then industry average.

ears, the company reduced

. Workers' compensation

1.5 million to \$300,000, an

reviously strained relation-

had a better understanding

soints, and workers began

tead of mutely waiting for

10 Proven Best Practices

By Jean Ndana

the tragic story of a 23-year-old temporary employee who did not return home from his first day at a the best practices presented in this article. Michigan factory. He was removing imperfections on spherical surfaces with a pedestal grinder when the abrasive wheel exploded. The father-to-be was fatally struck on the head by flying fragments. His death prompted a Michigan OSHA inspection, and the company was cited for trained in the safe use of equipment should operveral safety violations and received fines ate it. Companies spend many resources preparing

worker's first day shouldn't be his 10 Best Practices for Using Grinders Safely last day on earth. 1 said these chilling in Pr2014, OSHA (2015) cited 1,014 set between the property of the pr In FY2014, OSHA (2015) cited 1,014 serious vis lations related to grinders. Many of these hazards became a cooperative one are preventable if employers and workers follow respect and trust. Manage-

> Best Practice 1: Display a List of Persons Trained & Authorized to Operate, Mount & Dress Grinding Wheels at or Near the Grinder In most workplaces, only employees properly workers to safely use grinders, but as time passes it

**Creating Proa Objectives Bas** Leading Indic

F YOU THINK A SAFETY GOAL such as "reduce the OSHA recordable rate 5% by the end of the calendar year" is effective, think again. Setting such safety goals can have powerful side effects that can undermine an organization's efforts to build a solid, vibrant safety culture. The author's former employer learned this the hard way.

The old advice to "define your goals" is applicable to both one's personal life and to the occupational world. This axiom usually gets head nods from those who hear it. Many books and articles have been written throughout the years that support this advice. Goals are necessary for anyone who is trying to be successful in life or any business function striving for high performance, regardless of the industry or size of com-

•reducing the OS calendar year, •reducing the lost

 reducing workers These answers an on the outcomes ba tors. Many times, th levels of the organiz OSH professionals, First, such goals are (Janicak 2010 n 14 From a young age

**Best Practices** 

#### Increasing Safety Committee Effectiveness Through a Team-of-Teams Approach

By Jean Ndana knowledge, information, skills and An OSH professional has many tools to choose from when it tools necessary to create a safe and healthy workplace. The previously dys functional safety committee meeting quickly changed to an environment ing plant-wide interest in preventing

place, keeping safety top of mind for workers and management, motivating employees and superv to become actively involved in the company's injury and illness ing transformed into a safe, collabora-

Upon joining his fo a 700-person, round-specializing in manuf tor vehicle steering a omponents, the auth plant's safety con

health policies and procedures, as well as identified risks and risk reduction activities in a meaningful, productive manner. The safety committee meet

a meeting committee to a solutionssolutions team (SST). Change the Structure

#### The next challenge was to update the

safety committee's structure. Compa-nies should avoid a one-size-fits-all structural approach. Each organization has its own individual needs, strengths and weaknesses. A safety committee'

#### AT-A-GLANC A Proven Technique Mismatches & Cro

THE OSHA HAZARD COMMUNICATION STANDARD, 29 CFR 1910.1200, was the second most cited standard in general indus-try for fiscal years 2018 and 2019, with 4,170 violations in 2019 alone. Section 1910.1200(f)(6), relative to workplace labeling, was among the top five sections cited, with a total number of 352 cases (Druley, 2019). Each case cited will likely carry either a recommended or a mandatory penalty. Beyond the financial losses, these violations imply countless

potential for human suffering (e.g., injuries, illnesses, emotion al distress) and organizational loss. Chemical exposure may cause or contribute to many serious health effects (e.g., heart ailments, central nervous system, kidney and lung damage, sterility, cancer, burns, rashes). Some chemicals may also pose safety hazards and have the potential to cause fires, explosions and other serious incidents.

Considering these potential negative impacts, every work-place, no matter the size, should prioritize the development of a system designed to, at least, promote the systematic labeling of containers, regardless of where the company uses, stores, labels or disposes of chemicals. The author's former employer devel-oped such a system and reaped benefits well beyond avoiding OSHA fines and promoting worker safety and health.

worker turnover, high workers' compensation costs and a strained relationship with Michigan OSHA. Hourly workers presented persistent criticism of virtually every aspect of the presented persistent criticism of virtu plant, safety and health in particular.

The plant investigated the contributing factors to systemic chal-lenges to identify what was going wrong. Table 1 summarizes the key concerns captured from the investigation. The investigation revealed that the high incidence rate stemmed from mismatche revessed that the nigh incidence rate stemmed from mismatches and cross contaminations of hydraulic oils. A mismatch occurs when a hydraulic oil is transferred to the wrong machine. A cross contamination occurs when incompatible oils are mixed either in a portable container or in a machine's tank. The mismatches and cross contaminations resulted in worker injuries and hospitalizations and affected machine operation and productivity.

An at-a-glance labeling system was employed to address the indings. The plant found the system to be easily executable, actionable and in a practical form that can be implemented quickly by other organizations facing similar issues. This arti-cle details the investigation findings, the at-a-glance labeling system, the nine-step process to implement the system, and





#### **VANTAGE POINT**

#### **NEAR-MISS REPORTING**

**Eight Hidden Barriers & Solutions** 

By Jean Ndana



An effective near-miss management system is a simple but powerful mechanism to drive incidents and injuries down, engagement up and culture forward. This article calls for a paradigm shift that ties near-miss reporting to other common safety programs organizations have in place to prevent workplace injury and illness.

Wouldn't it be great to have some sort of system in place to stop work-place injuries, fatalities and equipment damage incidents before they occurred? If your organization has developed and rolled out an effective and efficient near-miss management system (NMMS), it has taken an important step toward achieving that goal.

In the safety world, such an implementation is beneficial for incident prevention and safety improvement in general. Near-miss reporting and analysis and the implementation of adequate corrective measures based on investigation results can prevent the recurrence of near misses and incidents. The National Safety Council (NSC) agrees, stating that "History has shown repeatedly that most loss-producing events (incidents), both serious and

#### Case Study

Upon joining a 350-person roundthe-clock plant specializing in manufacturing motor vehicle steering and suspension components, the author found that the plant indeed had implemented a near-miss program. However, the program was not well structured, had no real goals in place, and had not generated meaningful workplace safety gains. It seemed that the program existed merely to check a box. What constituted a near miss was not clear in everyone's mind. Most frontline workers and even supervisors viewed some near misses as too minor and inconsequential to report as safety and health issues. There were also deeper problems.

When the NMMS had been rolled out, insufficient attention was paid to limiting beliefs or views workers held.

follow-up information about the situation or condition was communicated back to the reporting individual, further emphasizing the company's due diligence. The NMMS ceased to be the missing system and instead became a vital component of the safety and health management system that positively transformed the plant.

This transformation resulted not only in the metamorphosis of the physical work environment but also (and more importantly) in workers assuming substantial responsibility for their own workplace safety and health and a significant reduction in incidents and injuries. The facility's OSHA incidence rate dropped dramatically to 3.2, half of the then-industry average. In other words, in 2 years, the company reduced its injury rate by 75%.

In a unionized manufacturing plant,

## **Presentation Objectives**



Common barriers to near-miss reporting



7 Hidden barriers to near-miss reporting



7 Solutions to Hidden barriers to near-miss reporting

## **CASE STUDY**

#### SITUATION I FOUND: SOME HIGHLIGHTS

- The program had not generated any meaningful workplace safety gains.
- What constituted a near-miss not clear in everyone's mind.
- some near-misses were viewed as too minor and inconsequential to report
- Near- miss reporting forms not readily available and the completion was very timeconsuming
- Many frontline supervisors viewed near-miss reports as signs of poor supervision
- Near-miss program earned the moniker "the missing program."

#### **Situation AFTER: HIGHLIGHTS**

- The near-miss program ceased to be the "missing program" and became an employee engagement and involvement tool
- The revamped near-miss program became an employee engagement and involvement tool
- Confusion surrounding what constituted a near-miss was eliminated
- · Reporting process streamlined and made quick and efficient
- The revamped near-miss program was transformed into a vital component of the plant safety management system that drove incidents down, engagement up and culture forward

## IS IT POSSIBLE



#### **Common Barriers to Near miss Reporting**

Common barriers to Near-miss reporting

#### Question

What are some of the common barriers to near miss reporting?

#### Common barriers to near-miss reporting

- Form
- 2) Fear of Punishment & Retaliation
- 3) Lack of Recognition/Feedback
- 4) Peer Pressure
- 5) Concern About Record & Reputation
- 6) Desire to Avoid Work Interruption
- 7) Desire to Avoid Red Tape
- 8) Fault-Finding Mind-Set
- 9) Lack of sense of urgency
- 10) Difficult or ineffective reporting process
- 11) Etc.

#### Common barriers to near-miss reporting

#### **NOT SO COMMON BARRIERS**

- Lack of confidence that positive change will result from such reporting
- Psychological barriers to admitting an error
- Lack of a sense of urgency

#### **Hidden Barriers to Near miss Reporting**

Hidden barriers to Near-miss reporting

# Hidden Barrier #1 The OSHA definition of a "near-miss"

#### What is the OSHA definition of a "near-miss"?

OSHA defines a near miss as an incident in which no property was damaged and no personal injury was sustained, but where, given a slight shift in time or position, damage or injury easily could have occurred

Why the OSHA definition a hidden or subtle barrier to near-miss reporting?

The National safety Council defines a near miss as an unplanned event that did not result in injury, illness, or damage – but had the potential to do so. Only a fortunate break in the chain of events prevented an injury, fatality or damage

Why the OSHA definition a subtle barrier to near-miss reporting?

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#### ■ Not broad or Not all-inclusive



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■ Not customizable to the specific needs of an organization

### **Hidden Barrier #2**

The Term "near-miss"

#### **BARRIER#2: THE TERM NEAR-MISS**

- ☐ Does not have an intuitive meaning
- ☐ Hard to visualize it

#### **BARRIER#2: THE TERM NEAR-MISS**

- ☐ Just consider the inaccuracy or the contradictory nature of the term "near-miss."
- ☐ It was NOT a near miss!. Accurately, it was a "near injury" or a "near property damage."
- □ Terminology matters. When terminology is inaccurate, it becomes very difficult to earn widespread understanding and ownership of any subject

#### **BARRIER#2: THE TERM NEAR-MISS**

Sometimes synonyms that have an intuitive meaning such as "Near-Hit" or "near-collision", "narrow escape" etc, are used

DO YOU SEE ANY PROBLEM WITH THESE SYNONYMS?

### **Subtle barrier #3**

## Fear of being wrong or to be viewed as overly sensitive

- Sometimes workers don't want to report something that will turn out not to be considered as a near-miss according to the commonly used OSHA definition and, therefore, be ridiculed
- Often, in a predominately male workplace, the perception of being weak or overly sensitive is seen as a threat to one's masculinity.

#### **Hidden barrier #4**

## **Delayed Training on near-miss reporting**

#### Hidden barrier #4 Delayed Training on near-miss reporting

#### **QUESTION:**

IS NEAR MISS REPORTING PART OF YOUR NEW HIRE SAFETY ORIENTATION?

☐ Near-miss not part of the new hire safety

orientation

# Subtle barrier # 5 Near-miss reporting form

#### **Subtle barrier # 5:Near-miss reporting form**

- ☐ Thickness: Stiff paper should be used
- ☐ Size : Are the forms short and to the point?
- ☐ Location : Are they easily accessible to workers?
- □ Color : what is the color (if you are still using the traditional pen and paper)

use a color that stands out

# Subtle Barrier # 6 Too many safety programs that require workers' attention

BARRIER#6: Too many safety programs that require workers attention

- ☐ Hazards reporting
- □Suggestions box
- □Behavior Based safety (BBS) reporting
- □Injuries or illnesses reporting
- □Quality issues reporting
- □ Environmental issues reporting

#### **BARRIER#7**

### **Absence of a systematic Near-miss review**

# There should be a systematic Near miss review embedded in the day to day operations

## **Subtle barrier #8**

# Thinking that a near-miss program is one and done program

#### **Solutions to Barriers to Near miss Reporting**

#### **New Definition:**

A near-miss is any opportunity to make things safer, healthier or better

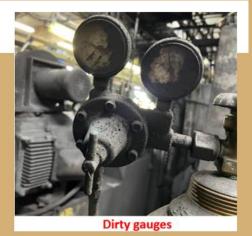
- a) It is no longer a "fixed," rote definition. It is customizable to the specific needs of an organization
- b) The focus shifts to outcomes- i.e., why near-misses are being reported in the first place.
- c) It simplifies the decision-making process
- d) It normalizes near miss reporting as a standard part of everyday working life, therefore ensures that safety is a priority for all employees
- e) Helps fight complacency by constantly evaluating processes and looking for improvements
- f) By using this definition, an organization can foster a culture of continuous improvement through near miss reporting











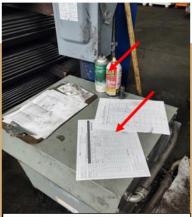




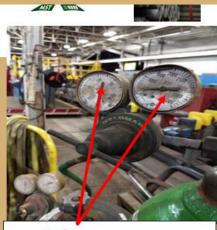
Flying wheel that is missing a bolt



Overfilled trash drum



Using a transformer as a paper shop desk. Also unsafe storage of spray cans



**Broken gauges** 



A guard that is damaged





Straps on the floor aisles



Unsafe storage: Rags on top of electrical box





Nasty water fountain



Not Legible Safety sign



Electrical Cabinet labeling on a piece of paper





Danger sign not properly hung





Illegible document / work instructions



Dirty control panel, with labels hard to



A beat up, damaged, duct taped chair is still being used



O D ring welded on the cap











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### Solution # 2 Change the term "near-miss."

#### Solution#2: Change the term near-miss

- ☐ "ORLI"
- ☐ "free learning"(FL)
- ☐ "Opportunity for safety improvement (OSI)"
- ☐ "Good Catch."
- ☐ "Opportunity for improvement"
- ☐ "ZIP"

### Solution # 3 Redesign your near miss reporting form

#### Solution#3: Redesign your near miss reporting form

New name: "Good Catch"

Color: "Bright yellow"

size: "8.5" X 5.5"

Thickness: "cardstock"

	GOOD CATCH form:	NA AVIII N
TO : BMT MANAGEMENT		
Benorting Employee:		Shift123_Date
NATURE OF OBSERVATION		
Safetx Bus. Efficiency	QualityEnvironnemental.	Time of observationsa_mp_
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Employee(s) involved (if appropri	ate)	
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# Solution # 4 Make near-miss Forms Easily Available and Accessible

#### Solution # 4:Make near-miss Forms Easily Available and Accessible

#### Near-miss forms and pens are easily accessible: Placed at each workstation









#### Solution # 4:Make near-miss Forms Easily Available and Accessible

#### Near-miss forms and pens are easily accessible: Placed at each workstation









## Solution # 5 Include near-miss training in new hire safety orientation





The sooner new hires are trained in near-miss reporting, the better

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### **Solution # 6 Make The Invisible Visible**

### Solution # 7 Consolidation of several safety programs

☐ Tie together Near-miss reporting, hazard identification and reporting, behavior-based safety, safety suggestions, quality defects and environmental releases programs

☐ This integration not only prevents workers for spreading thin but also save time, energy, and resources

### Solution # 8 Weekly Near Miss Reviews

#### Solution #8:Weekly Near Miss Reviews

- ☐ Ideally led by the Plant Manager
- ☐ Show and discuss accomplishments
- ☐ Debate new near-misses, establish priorities, assign owners, and set deadlines
- ☐ These reviews help management stay on top of issues and hold owners accountable.

#### Solution #9

#### **Institute a Near Miss Hall of Fame**



# **BEFORE**







**BEFORE** 





Handrail added and diamond plate stairs replaced with treaded stairs

**BEFORE** 

**AFTER** 



Dirty, missing labels Cleaned with new labels

**BEFORE AFTER** 



Dirty gauges



Cleaned gauges

**BEFORE** 



Dirty gauges



Cleaned gauges

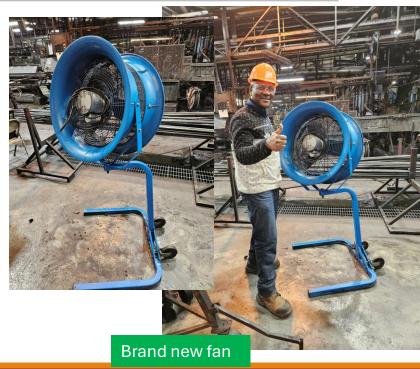
**AFTER** 

#### **BEFORE**

#### **CLEANING IN PROGRESS**

#### **AFTER**





**BEFORE** 



CLEANING IN PROGRESS





Lathe machine guard that is very dirty

#### Solution # 10

Build Trusting, Personal relationships & Strong workplace alliances with maintenance personnel



#### a) Shadow them &show interest

Shadowing them and show interest in learning about daily difficulties, constraints and hazards they face

b) Learn how to use a cutting torch, to weld or to grease a motor

Show them that you're really interested in learning

c) Make them feel appreciated

#### Solution # 11

A near miss program is NOT a one-time event but an ongoing process

- Constantly nurture, nourish and reinforce to keep it engaging, stimulating and maintain the needed plant wide interest
- Ask for feedback
- Make tool boxes about near-misses
- Reward and recognize

#### CASE STUDY RESULTS





















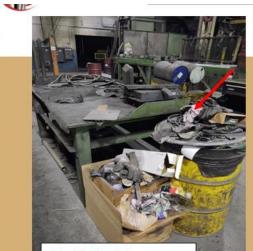
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Flying wheel that is missing a bolt



A guard that is damaged



Using a transformer as a paper shop desk. Also unsafe storage of spray cans



**Broken gauges** 

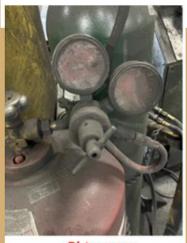




Straps on the floor aisles



Unsafe storage: Rags on top of electrical box



**Dirty gauges** 



Not legible Machine Specific LOTO



**Dirty gauges** 



Examples of "Good Catches"

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TO: MIST MANAGEMENT Observation Form	poli.
Reporting Employee Kevin Winston sun 1 2 /1 out 2	25-20
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spin a load with his hand. I gave him	
a nearby hands-free tool to complete the	
task safely.	

Behavior 32 chavior
TO: MOT MANAGEMENT Observation Form
Reporting Employee: GEDEF KENT SHIP: X1 _ 1 _ 3 Outs: 2:24  MATURE OF ORSERVATION
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Behaver Lisabury 10V pp 6
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about least a better moving loads the employee and I speed
about looking both ways and listening out for the
crane sinen to avoid potential injury.
-> Rehousel
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Examples of "Good Catches"

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and and Ciny 11
TO: MST MANAGEMENT
Reporting Employee: NICK LAZARUS Shift: XI _ 2 _ 3 Date: 2-10-20
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★Safety Bus. EfficiencyQualityEnvironmental
Work Station/Area Affected: ANYBODY WORKING AROUND AREA
Employee(s) involved (if appropriate):
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BAR OVER WALKWAY. I LOCATED THE CRANE
BOX AND MOVED IT SO IT WAS PARKED
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BAD LOOP AND SOME LINKS THAT WERE
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John.
et /
REPORT OF OBSERVATION
Did You Notify Supervisor?YesNo Date Supervisor Notified:
(Remember to notify supervisor whonever appropriate)
+ Hazard
Observation Form
TO: MST MANAGEMENT  Reporting Employee: AND COUNTY Shift: 1 1 2 3 Date: 5-20
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XSafety_Bus, Efficiency_Quality_Environmental Time of Observation: 10a.mp.m.
Work Station/Area Affected: East cold draw
Employee(s) involved (if appropriate):
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the crowe box and moved it
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Mr M' Ma





# **Samples of Good Catches**

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1156	1128	21-3		√ Entere √	Card Date	Work Are	Employee -	Notified -	(S,BE,	ditic	Issue  Vater pouring from S.V. corner roof of lab.	Resolution/Status	Observer Name1	ID 🔻	Dept.	Notes/Remarks/Steps	₩O # (if april	Comple*-	or Clos	Craf*	Ne T	м
1157		- 103	1022	W23/2019	1/23/2019	Area Between Ladies Bathhouse & Lab Building		Sue Thill	s	С	Water collecting between buildings. As temperature drops the area becomes dangerous. High traffic area as people go to bathhouse		Thill, Sue	19	Manufacturing	Joe Crane to re look at. "Talked to Joe Crane on 2/5, will get on those ones next, Gutters cleaned and resealed the holes on 4/22		4/23/2019	С	F	_	_
1159	1129	2)	1023	1/24/2019	1/24/2019	Hill Rack 21 & 22	Rob Thompson	Rob Thompson	s	С	Observed that rack was cracked and base was split.	I called Rahlo out and had him repair rack. Everything is okay.	Thompson, Robert	13	Manufacturing			1/24/2019	С	М	*	N/A
1160	1130	2/ 100	1024	W22/2019	1/22/2019	Stock House Table	Any/All	N/A	s	С	Need chain/strap horses for the Stock house area to keep straps off the floor.		Hollister, Russ	4	Manufacturing	Online Obs Material is ordered and here. Vill have Rahlo make up after tree farm racks	12724	2/25/2019	С	м		WA.
1161	1100	100		W25/2019	1/25/2019	#1Pickle	Operators/Assisti	N/A	S	В	Caps were left in material assumed being re-		Hollister, Russ	4	Manufacturing	Online Obs		1/25/2019	С	#N/A		
1162		10:	1026	1/25/2019	1/25/2019	#5 Pickle Racks	Supervisor/Opera tors	N/A	E	С	Relabel the racks @ #5 to create separation between #5 area and the rest of the area.		Hollister, Russ	4	Manufacturing	All racks at #5 were relabeled.		8/8/2019	С	Ops	_	+
1163 <sup>1135</sup>	1131	21 21 10:	1027	W26/2019	1/26/2019	970 Push Pointer	John Sherfield	N/A	s	В	Observed John using jib crane to pull out stuck chain on load on load table. Told John this was a safe way to do this instead of pulling it by hand and creating a pinch point.		Thompson, Robert	13	Manufacturing	Online Obs		1/26/2019	С	#N/A	_	N/A E
1165 1136	1133	2/ 10:	1028	W28/2019	1/28/2019	Stock Area Just Dutside Cold Draw Office	All Who Walk in Area	N/A	s	С	Snow is coming in from the ceiling between E- F row 15. Ceiling should be fixed to keep this from re-occurring. Temporary solution will be marking the area with caution device.		Hollister, Russ	4	Manufacturing	Online Obs " Have Joe Crane look at (2/5) " Get quote from Joe	12809	6/11/2019	С	Joe Crane	_	м
1167 1137		10:	1029	1/21/2019	1/21/2019	Pilger Tool Room	All Pilger Operators	Jeff Harding	S	С	Vater line to water softener is leaking	tightened hose clamps and the leaking stopped	Ladebauche, Christopher	495	Pilger			1/30/2019	С	F		_
1168	1134	2/	1030	1/24/2019	1/24/2019	125 Bench Bunk	Alan Jamison	Rob Thompson	s	В	Employee was observed having leg and hand in bunk while safety cable was still connected.	Both Ray Stidham and Rob Thompson talked to Alan about this and said it's totally unacceptable.	Thompson, Robert	13	Manufacturing	Counseled Employee		1/24/2019	С	#N/A		Ε
169 1139	1135	2/ 10:	1031	1/24/2019	1/24/2019	824 Crane & #3 Transfer Car	Aaron Chapman	Rob Thompson	s	В	Observed operator putting hands on load while turning to put on transfer car.	Talked to him and told him that this was not acceptable, use the hook that was given to him.	Thompson, Robert	13	Manufacturing	Counseled Employee		1/24/2019	С	#N/A	•	N/A
1170 1140	1136	2/	1032	1/26/2019	1/26/2019	Piercer Mill		Tony Stephens	s	В	Operator was behind mill getting billet out from under lid while the rolls were still going.	Explained to the operator the dangers of being behind the mill while it was on and told him he needs to turn off the mill before going behind it.	Stephans, Tony	10	Manufacturing	Counseled Employee		1/26/2019	С	#N/A	•	NPA
171		10:	1033	1/25/2019	1/25/2019	123 Bench	All operators	Rob Thompson	S,E	С	Overhead heater not working, not staying lit, constantly calling electricians to fix	Lyon Mechanical called and has come out to replace ignitor	Jamison, Alan	172	Cold Draw			1/30/2019	С	#N/A		
172	1137	2/	1024	W27/2019	1/27/2019	Voman's East Bathroom	Vomen	Eli Cash	Е	С	Fix hot water in the east bathrooms	fix water heater	Cash, Eli	14	Manufacturing	Facilities came out and de-thawed pipes, Electricians replaced the		1/30/2019	С	E/F		м
		10:	1035	W27/2019	1/27/2019	Line 1 Inspection Table	Inspectors	Eli Cash	Q,E	С	Add more lighting	put up a couple more LED lights.	Cash, Eli	14	Manufacturing		12783	1/30/2019	С	E		
1141	1138	2/ 10	4000	W27/2019	1/27/2019	Steel Yard Crane	Greg R. & HeeHav	Eli Cash	s	В	Scrap tub was sent outside with broken latch	tub was sent to machine shop to be repaired	Cash, Eli	14	Manufacturing			1/28/2019	С	#N/A		F
1143	1139	2/	1037	1/28/2019	1/28/2019	North EX boiler		N¥A	s	С	The #3 pickle dryer disconnect behind the North DX boiler is missing it's wire tray cover		Stidham, Ray	11	Manufacturing		12802	2/5/2019	С	E		Ε
		10-	1038	W28/2019	1/28/2019	125 Bench	Any/All	Ray Stidham	s	С	Flexible conduit broken at the east end of the orange safety cable, coming from the head block		Stidham, Ray	11	Manufacturing	Proper Conduit finally came in and repaired	12797	2/3/2019	С	Е		
		10-	1039	1/28/2019	1/28/2019	Column H53	Any/All	N/A	s	С	At column H53, no conduit between power box and switch		Stidham, Ray	11	Manufacturing	Proper Conduit finally came in and	12803	1/30/2019	С	Е		
		10-	1040	1/28/2019	1/28/2019	Hot Mill transfer car railing	Any/All	N/A	s	С	From the SW corner the railing is bent and loose at the floor.	need to be repaired and reattached to the floor	Stidham, Ray	11	Manufacturing	repaired Duplicate		3/16/2019	С	М		
		-			1						Broken flexible conduit on the 1st linkt west of								_			







**BEFORE** 





Handrail added and diamond plate stairs replaced with treaded stairs

**BEFORE** 

**AFTER** 



Dirty, missing labels

Cleaned with new labels

**BEFORE AFTER** 



Dirty gauges



Cleaned gauges

**BEFORE** 



Dirty gauges



**AFTER** 

Cleaned gauges



Safety signs not legible

#### **AFTER**



Legible safety signs

#### **BEFORE**



Untidy control panel

#### **AFTER**



**Tidy control panel** 

#### **BEFORE**



Steam Pipe that is leaking



Leak has been fixed



Hose is a tripping hazard



Hose reel installed

# BEFORE TO SECOND TO SECOND

Dirty controls with broken button



Cleaned with button replaced

KUDOS TO Tim Petrowski

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# A TO Z REVIEW Н В W X Q D R S Ε F N U G

# THANK YOU FOR YOUR ATTENTION

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**NEWSLETTER FOR MORE SAFETY TIPS &TRICKS** 



### **Tools 4 Safety Titans**

Proven, Effective and Cost Effective Tools, Techniques, Tactics, Routines for OHS Practitioners.

# Solution #9

# **Near-miss Weekly Reviews**

1- previous week's accomplishments are discussed

3. priorities are established, owners assigned and deadlines set.

Agenda:

2. Near-miss that were turned in are reviewed

# Solution # 10

# **Periodic Plantwide meetings**

#### Agenda:

galvanize

1- These meetings are about showing progress.

3. Venue for public recognition

2. Celebrating our achievements, maintaining our momentum and







Handrail added and diamond plate stairs replaced with treaded stairs

AFTER

BEFORE

**AFTER** 





Dirty, missing labels

Cleaned with new labels

BEFORE AFTER



Dirty gauges

Cleaned gauges

**BEFORE** 





Cleaned gauges

RE AFTER



#### **AFTER**



Legible safety signs

#### **BEFORE**



**Untidy control panel** 

#### **AFTER**



**Tidy control panel** 

#### **BEFORE**



Steam Pipe that is leaking

**AFTER** 



Leak has been fixed



Hose is a tripping hazard



Hose reel installed

#### **BEFORE**



Dirty controls with broken button



**AFTER** 

Cleaned with button replaced

KUDOS TO Tim Petrowski



















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Solution # 11
Daily Micro recognitions,
Daily Micro acknowledgement,
Daily Micro celebrations

# Solution # 12

# **Special Recognition**& Reward

# **Special Recognition Awards**



To employees who reported:

- Most "Good Catches" / Tiny gains
- 2) Most unsafe behaviors / act
- Best quality / impact " Good catches"
- Best (quality/impact) unsafe act or behavior
- 5) Maintenance team member who fixed the most "Good catches"

# **Conclusion**

# THANK YOU FOR YOUR ATTENTION

Q&A

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