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Fermilab is launching a new safety program called Take Five. This campaign is intended to avoid injury and reduce the environmental impact of our actions. It is Fermilab's goal to have zero injuries and we can only accomplish that if we all work together with a primary focus on safety. To support the employees in implementing this program, a Take Five website has been created at: http://www.fnal.gov/pub/takefive/. I encourage you to visit this site and review the many materials that have been posted.

We recently completed the annual Division Head safety talks. If you were unable to attend the Division Head Safety Talks due to travel or other conflicts, contact Rich Ruthe or Les Peters to view the recorded version.

INCIDENT BACKGROUND	HOW IT MIGHT HAVE BEEN PREVENTED
While attempting to remove a water hose on a magnet, an employee was struck by the hose when he disconnected it. Two valves needed to be closed to isolate the hose from system pressure before disconnecting the hose from the magnet. The employee suffered lacerations on the nose and lower back. The employee overlooked closing the second valve. When the employee disconnected one end of the hose, the still pressurized hose whipped around, striking them on the nose and torso.	The employee should have done a hazard analysis of the task. This incident points to the necessity to know the system you are working on performing a "what if" analysis. This was an ideal situation where <i>taking five minutes</i> at the beginning of a job to evaluate what needs to be done would have reminded the employee of the multiple steps needed to be safe.
While opening boxes using a pair of scissors, a technician suffered a puncture wound to the wrist when the scissors slipped from under packaging tape. The technician was holding scissors in their right hand and using them to cut through packaging tape on a cardboard box. Their left hand was on top of the box to hold it in place. As the technician was cutting towards their left hand, the scissors slipped and the tip of the scissors struck their left wrist.	This employee should have been wearing proper personal protective equipment (PPE). In addition, the employee should have <i>taken five seconds</i> to evaluate the wisdom of the position of their hands in holding the box while cutting the tape. Finally, using correct equipment (in this case a box cutter rather than scissors) would have minimized the risk.
While exiting a trailer with aluminum steps, an employee stepped onto a dented step and twisted their ankle. One of the steps had a v-shaped bend in it, which caused the employee to turn their ankle as they stepped on the side of the V-shape.	Several employees were aware of the dented step, but had not reported it to the Building Manager who was unaware of the condition of the step. Employees need to be proactive in notifying either their supervisor, the building manager, or safety personnel of potential dangers. In addition, staying aware of our surroundings will reduce our chances of injury.
An employee was using a cart to transport a power supply that weighed approximately 30 pounds. As the employee exited the room through a standard doorway, the employee's finger was pinched between the cart and door handle, resulting in a laceration and contusion.	The employee's hands were poorly positioned on the cart handle for moving the cart through a narrow doorway. <i>Taking five seconds</i> to become familiar with the area and evaluate the task would have highlighted the lack of space in the doorway relative to the cart.

Most safety experts believe that all accidents can be prevented. As you can see by the prevention column, a little extra care and attention on the part of the individuals might have avoided these accidents from occurring.