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Our recent transition to Office 2007 has highlighted some good observations for safety in general. Overnight, our reliable and known environment changed. This required us to stop and review the new layout. We had to look for things that we had previously put on "auto pilot". It's all too easy to get so used to doing our job a certain way that we no longer pay attention to what we are doing. Going to a new software version forced us to re-evaluate what we were doing previously. The positive side of this process was that it provided an opportunity for us to learn about changes we might not have been aware of previously and thus gave us an opportunity to improve the way we do our job.

Please note that TD Policy 1100, "Operational Occupancy of Newly Constructed or Refurbished Work Areas", has been revised (and improved with the inclusion of a simple form template) with Rev. 3 as of January 21, 2010. There is a link to the Policy Manual on the front page of the Technical Division website for your convenience. As always, please be aware that the Master/latest copies of our policies are located on the Technical Division website. Please refer to the website, rather than printed copies of policies, which may be out of date.

INCIDENT BACKGROUND	HOW IT MIGHT HAVE BEEN PREVENTED
An employee was cutting up tree limbs downed by an ice storm, and as he was nearing the end of the job, his protective eyewear fogged up. The employee removed the eyewear and proceeded to finish the job. A piece of ice became airborne and came into contact with the individual's unprotected eye. Initially the individual felt no pain or discomfort. During the drive home after his shift, the employee felt some irritation in the eye and proceeded to an urgent care facility for treatment. The employee was prescribed antibiotic eye drops, which makes this case reportable.	The injury could have been prevented by the employee wiping the fog off of his protective eyewear and replacing them over his eyes, and/or carrying an extra pair of safety goggles. A long term solution is to use an anti-fogging spray on the eyewear, or to purchase anti-fogging eyewear.
An individual working in the D0 detector hall on electronic components removed their hard hat to work in a tight location. An individual working above kicked a screwdriver through an open space between two platforms. The screwdriver struck the individual at the lower level in the head, causing a small laceration that required first aid only treatment. Hard hats are required in the area of the incident when overhead work is in progress.	This injury would have been prevented if the individual had not removed their hard hat. Though working in a tight location, there was no need to remove the hard hat.
An employee was brazing, and to cool down the metal he had placed a wet towel on the floor into which he placed the metal. To reach this towel and metal pieces he had to bend down in a crouched position. After repeatedly doing this, the employee's knee began to hurt and he noticed swelling of the knee.	This injury could have been prevented by establishing a better ergonomic working pattern. The wet towel used to cool the parts could have been placed on a cart or table, thus eliminating the need to continually squat down to floor level to place and retrieve the parts.

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.