

# Office of Marine and Aviation Operations SAFETY NEWS

*From the Safety and Environmental Compliance Division*

NINTH EDITION

JULY 2012

This month's policy spotlight focuses on slip, trip, and fall accidents which remain one of the most common causes of injuries in OMAO. There are also important reminders in the news and notes section about recent procedures documents as well as an informative article from Aircraft Operations Center in the best practices section on product quality deficiency reporting.

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## POLICY SPOTLIGHT

Title 29 of the Code of Federal Regulations, Part 1910, Subpart D, promulgates the OSHA standard for "walking and working surfaces." In addition to general "housekeeping" requirements, the standard provides comprehensive definitions and specifications for those responsible for the design, installation, and use of stairs, railings, ladders, and scaffolding. Although the standard goes to great lengths to create a safer working environment free of known slip, trip, and fall hazards, it does not address or replace the need for employees to remain aware of their surroundings at all times. It is all too common to read accident investigation reports that state the employee "was in a hurry, lost their balance, miss-stepped, or failed to look where they were walking." For those interested in learning more, the complete OSHA standard on walking and working surfaces is available at <http://www.gpo.gov/fdsys/pkg/CFR-2011-title29-vol5/pdf/CFR-2011-title29-vol5-part1910-subpartD.pdf>.

## ACCIDENT STATISTICS

The total number of OMAO near miss; minor/first aid; medical treatment; lost time/light duty; and other incidents reported during July 2012 is listed in the table below. Accident rates over the past 15 months are shown on the bar graph that follows.

**Near Miss - 1**

Near miss - 1

**Minor/First Aid - 2**

Slip, trip, fall - 1      Laceration - 1

**Medical Treatment - 6**

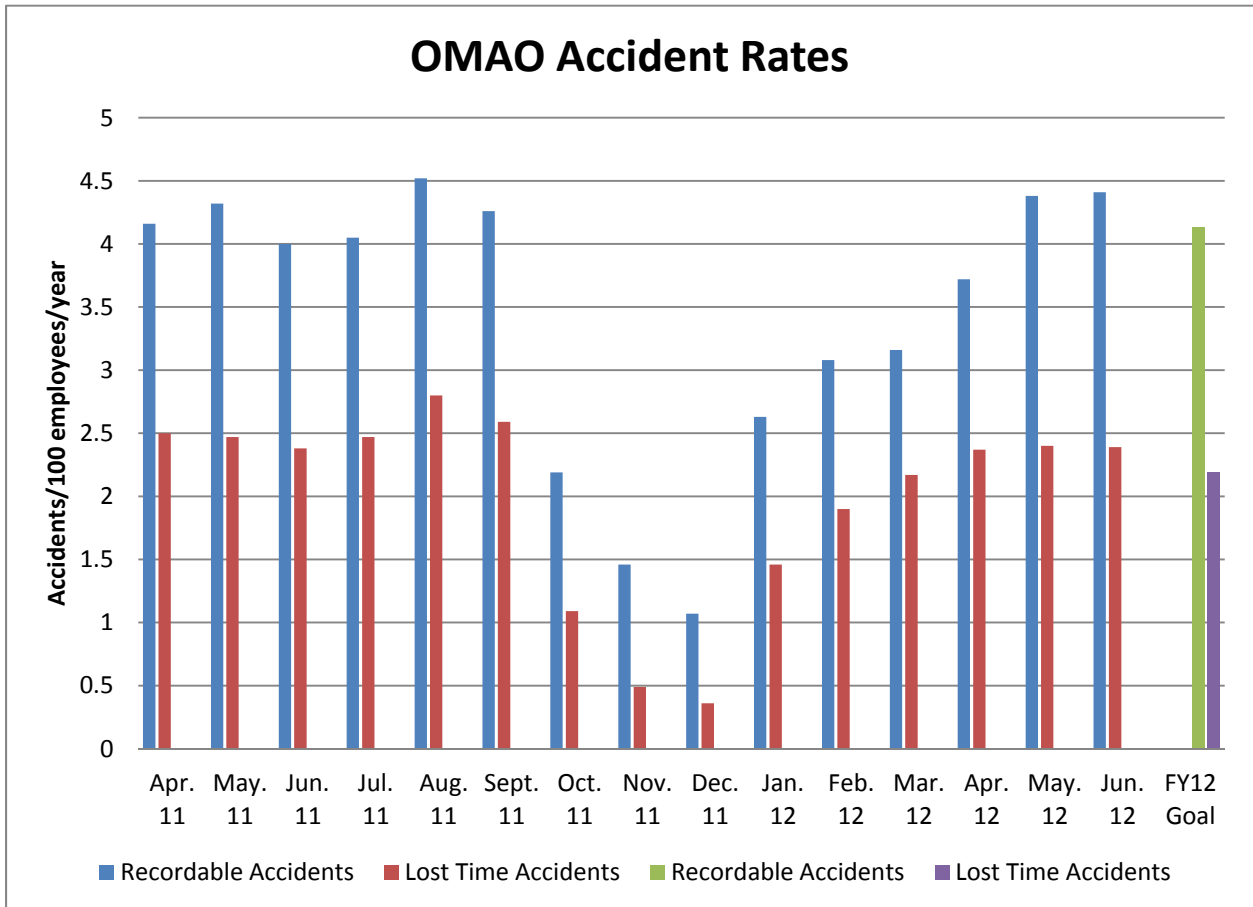
Slip, trip, fall - 3      Laceration - 1      Caught on - 1      Contact - 1

**Lost Time/Restricted Duty - 2**

Exposure - 1      Exertion - 1

**Other - 1**

Environmental - 1



**OMAO Annual Accident Rates\***

FY11 Total      FY12 YTD      FY12 Goal

Recordable Accident Rate	4.26	4.41	4.13
Lost Time Accident Rate	2.59	2.39	2.19

\*Accident rates are calculated based on the total number of recordable and lost time accidents that occur in the workplace compared to the total number of hours worked by all employees at that workplace. The accident rate represents the number of accidents that have occurred per 100 employees for the year.

## RECENT INCIDENTS: CAUSES AND LESSONS LEARNED

This section provides a description of recent incidents that have occurred in OMAO. In many cases, more thorough follow-up investigations have been conducted and more comprehensive lessons learned have been disseminated to targeted audiences within OMAO. The information below is intended to remind us of the importance of staying safe.

<p><b>Description:</b> While handling fenders over the side during small boat recovery operations aboard a NOAA ship, a fender was caught under the gunwale of the small boat and pulled forcefully downward as a swell passed. The finger of a crewmember assisting in the small boat recovery operation was caught underneath the fender line and pinched against the gunwale of the boat, causing an injury.</p> <p><b>Causal Factors:</b> Primary cause was improper placement of hands while handling fenders.</p> <p><b>Lessons Learned:</b> In this case, following the incident, the crew was briefed regarding the importance of attention to lines and associated equipment especially when conducting small boat deployment and recovery operations.</p>	<p><b>Description:</b> A crewmember aboard a NOAA ship at night tripped on an elevated portion of the weather deck, fell, and sustained injuries requiring first aid. The ship reported there had been a number of slips and trips in the area; most of the incidents involved personnel not familiar with the ship. In this case, the crewmember was well acquainted with the area but did not step high enough to clear the raised portion of the deck.</p> <p><b>Causal Factors:</b> Primary cause of the incident was inattention to immediate surroundings. Contributing factors may have been inadequate lighting in the area, or poorly painted markings on the deck warning and reminding those transiting the area of the raised portion of the deck.</p> <p><b>Lessons Learned:</b> Evaluate and re-evaluate on a regular basis the adequacy of lighting, contrast painting, and other markings, especially in areas with known hazards. Ensure adequate lighting and warnings are noticeable, maintained, and in place.</p>
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**Description:** Near miss incident. While preparing for over-the-side operations aboard a NOAA ship at night, the ship's A-frame lights were energized using the main disconnect switch and then the operator's switch. After several minutes of being energized, a coiled-up unused portion of wire that had been previously connected to the lights sparked and "popped" posing a potential shock and fire hazard. The A-frame lights had been used on several occasions since new lights were installed without incident.

**Causal Factors:** Primary cause was improper termination and removal of an unused circuit. It was discovered that only one side of the unused wire had been disconnected; not both. A contributing factor was failure to properly close-out a lock-out/tag-out tag that had been in place when work was being done on the circuit, and failure to notice the improperly terminated wire during regular inspections.

**Lessons Learned:** In this case a safety stand-down was conducted with engineering department personnel to review Lock-out/Tag-out procedures, emphasizing accountability when clearing tags, and requirements for proper termination of unused circuits.

**Description:** A crewmember aboard a NOAA ship felt what was described as a "twisting" pain in the neck and shoulder area while tightening fittings with a wrench on a piece of equipment in the engine room. Intensity of the pain did not subside and medical examination and treatment was required.

**Causal Factors:** Exertion was cited as the primary cause of the injury. A contributing factor may have been aggravation of a previous injury in the same area brought on by repetitive motion associated with use of the wrench. It was felt that the crewmember may have returned to work before fully recovering from a previous injury.

**Lessons Learned:** In this case, it was felt a discussion with Health Services may have been beneficial regarding factors to consider when declaring an employee fit for duty after being designated temporarily not fit for duty. Other lessons learned include review of proper positioning of the body to reduce over-exertion, and ensuring the right tool is being used for a given job.

OMAO Safety and Environmental Compliance Division regularly posts Accident Investigation and Lessons Learned on the following web site:

[http://www.oma.noaa.gov/accident\\_investigations\\_lessons\\_learned/index.html](http://www.oma.noaa.gov/accident_investigations_lessons_learned/index.html)

## BEST PRACTICES

Poor contractor performance, product quality, or workmanship is a potential source of risk that can lead to unsafe conditions in the workplace. When discovered, action is necessary to correct known deficiencies and to prevent future occurrence. Below is an article about the process used at the NOAA Aircraft Operations Center to formally communicate product quality deficiencies related to contractor performance that has yielded good results.

### Product Quality Deficiency Reporting

By: Kurt E. Larson

Product Quality Deficiency Reporting (PQDR,) was originally implemented by the Defense Logistics Agency as an avenue for the reporting of product quality deficiency data and to

establish a system for feedback of product quality deficiencies. This provided a consistent method to track initial reporting, cause correction, and status accounting of individual product quality deficiencies as well as to identify problems, trends, and recurring deficiencies.

The PQDR reporting procedure is currently utilized by the DLA, Army, Navy, Air Force, Marine Corps, and General Services Administration (GSA). Other entities, such as the National Security Agency, Defense Mapping Agency, Defense Communications Agency and U.S. Coast Guard that are DoD users of component-provided supplies or contract administration services, are encouraged to use the PQDR process for reporting of any product quality deficiencies.

For several years Aircraft Operations Center (AOC) has predominately used the PQDR process as a vehicle to identify and report defective material, design specifications, manufacturing, quality and workmanship received from contractors and vendors as a maintenance centric policy. It is currently under review to become a command policy.

Of the many methods available in identifying deficiencies in products and services, AOC has elected to use three PQDR categories:

**Category I PQDR:** A defect or nonconforming condition affecting the safety of flight and/or safe operation of an aircraft. This includes, but is not limited to, deficiencies in design, form, fit or function, specifications, material, manufacturing, quality and workmanship.

**Category II PQDR:** A defect or nonconforming condition which does not affect the safety of flight and/or safe operation of an aircraft. This includes, but is not limited to, deficiencies in design, form, fit or function, specifications, material, manufacturing, quality and workmanship.

**Informational Only Report:** A deficiency report sent to a vendor as a “copy furnished” or “informational only copy.” A written response is not required however; local action may be required by the recipient such as in-house corrective action.

Some possible outcomes resulting from the issuance of a single or multiple PQDR's.

- Contractor or vendor corrective action and improvement of products and services;
- Documentation of a systemic nature by a contractor in areas like: material, design, specifications; manufacturing, quality and workmanship;
- Used as evidence against a contractor to include: contract cancelation, stop work order, cure letter, disbarment, letter of reprimand or recoupment of funds.

Further information and questions can be answered by contacting: Kurt E. Larson at (813) 828-3310 X3027 or [kurt.larson@noaa.gov](mailto:kurt.larson@noaa.gov).

References:

Defense Logistics Agency Regulation (DLAR) 4155.24 Product Deficiency Report Program, July 20, 1993

AOC Policy 221-4 Product Quality Deficiency Reporting Procedure (the numeric portion soon changing to 209-x).

The best ideas for improving safety come from the field. Do you have an idea to help prevent injuries? Please send it to the SECD Chief ([omao.secd@noaa.gov](mailto:omao.secd@noaa.gov)) and we will plan to share it throughout OMAO.

## NEWS AND NOTES

**Marine Operations Procedures Documents** – Commands are reminded of the requirement to comply with procedures outlined in the following documents: 1701-05, Lockout/Tagout; and 1701-15, MOC Fall Protection Program. It has been reported that not all ships are using the procedures, or otherwise have not fully or properly implemented the procedure documents. Electronic copies of the documents were distributed to the fleet when they were issued. Copies of the documents can also be found in the Document Management System on the inside OMAO website, <http://10.49.29.4/WebDesktop/Binders.aspx>.

**NOAA Dive Program On-line Courses** – Dive program safety-inspection training is available via the Commerce Learning Center (CLC). Diving Unit Safety Assessment Training includes courses on: Administration; Inspection Training; SCUBA Equipment and Storage; Compressors and Systems; and Support Equipment. A complete list of dive safety courses and instructions on how to access the training is available on the NOAA Dive Center (<http://www.ndc.noaa.gov/>) and CLC websites (<https://doc.learn.com/login.asp>).

**Aviation Safety Training** – AOC recently held aviation safety training at MacDill Air Force Base in Tampa, Florida. In addition to classroom work, the training included exercises using a Portable Reduced Oxygen Training Enclosure (PROTE) which creates an actual loss of oxygen environment that pilots may experience at high altitude. There were also exercises in the use of Helicopter Emergency Egress Device (HEED) for underwater escape breathing, and in-pool swimming and water survival training. The training was a huge success. 34 people were trained in total, 24 of which were PROTE trained and 21 HEED trained. AOC saved \$21,800 by having PROTE shipped on site.

**Ship of the Quarter Safety Award** – Please remember to submit reports of proactive safety activities to [Safeship.moc@noaa.gov](mailto:Safeship.moc@noaa.gov). For more information about the award, please refer to safety procedures document 1701-23, Proactive Safety Improvement Award – Ship of the Quarter. The document is available via the OMAO Document Management System on the inside OMAO website, <http://10.49.29.4/WebDesktop/Binders.aspx>.

## TERM OF THE MONTH

**Lost time/restricted duty accidents**– To meet OSHA requirements for safety reporting, an accident is considered lost time only in those cases where the injured employee is unable to report to work for their next scheduled shift. For example, let's assume an employee, whose working hours are 8:00 a.m. - 4:30 p.m. Monday through Friday, is injured on the job Friday morning at 8:30 a.m. The employee goes to the emergency room for medical attention, and is away from work for the remainder of the day Friday. If after two days recovering at home, the employee is able to report to work at 8:00 a.m. Monday morning, then the accident **is not recorded as a lost time accident**. If the employee misses work on Monday due to the injuries sustained at work on Friday, then the accident **is a lost time accident** and needs to be recorded as such. Similarly, an accident is considered restricted duty if the injured employee is unable to perform assigned duties, is re-assigned light duties, and someone else is needed in

their place for their next scheduled shift.

## COMMON INTERESTS

The Atlantic hurricane season begins on June 1 and ends on November 30 each year.

A hurricane is a tropical storm with winds that have reached a constant speed of 74 miles per hour or more. The eye of a storm is usually 20-30 miles wide. The storm overall may extend over 400 miles. The dangers of a storm include torrential rains, high winds and storm surges. A hurricane can last for two weeks or more over open water and can run a path across the entire length of the Eastern Seaboard.

The deadliest hurricane in U.S. history was at Galveston Island, Texas, in 1900, estimated to be a Category 4 storm. This storm claimed more than 6,000 deaths and is noted as the worst natural disaster in our country's history. The storm surge was 16 feet. Nationwide, hurricanes annually account for an average of 17 deaths while flooding deaths average 147 per year.

The costliest hurricane recorded was Hurricane Andrew, in August 1992. It was also the third strongest storm to hit the United States. It hit both the States of Florida and Louisiana. Damages were estimated to be over \$25 billion.

NOAA is a great source of information for hurricane preparedness. Please visit <http://www.nhc.noaa.gov/prepare/ready.php> for more information.

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*Safety . . . our mission depends on it*