



**BERKELEY LAB**  
LAWRENCE BERKELEY NATIONAL LABORATORY



# DZAC December 2012

## Opening Remarks



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# DZAC News

# Items of Interest

- Review of Purpose and Expectations
  - Bring safety suggestions, complaints or concerns from your workgroup directly to Senior Management
  - Communicate status or resolution of concerns back to your workgroup
  - Present the DZAC training subjects to your workgroup – **Spend at least 10 minutes!!!**
  - Sign-in sheets are returned to Lisa, Janice, Gene
  - Your responsibility to arrange replacement

# Items of Interest

Safety Spot Awards Issued in November:

- Dave Cota – Stopping work
- Watch your use of appliances – toaster oven left on in B76





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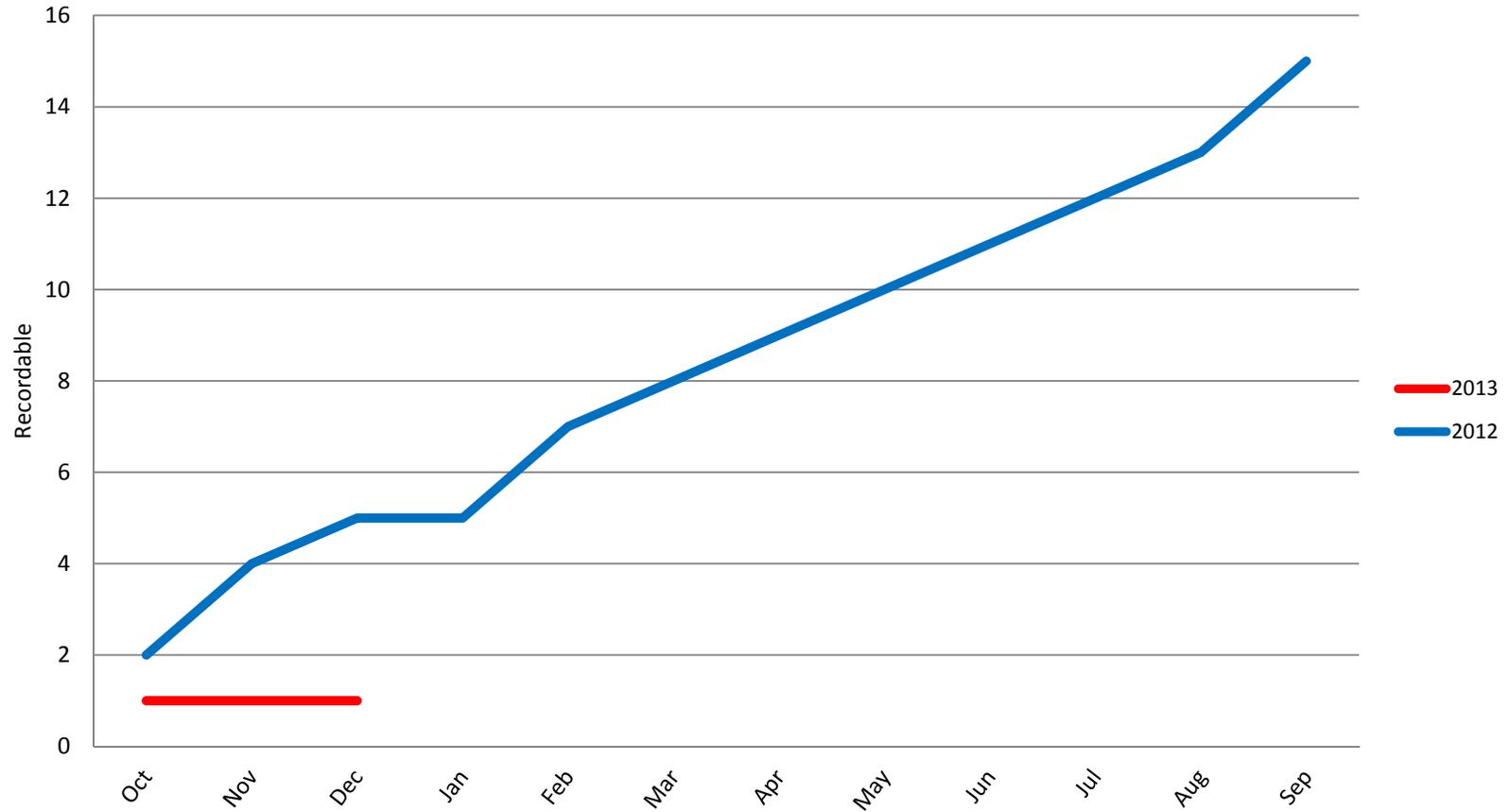


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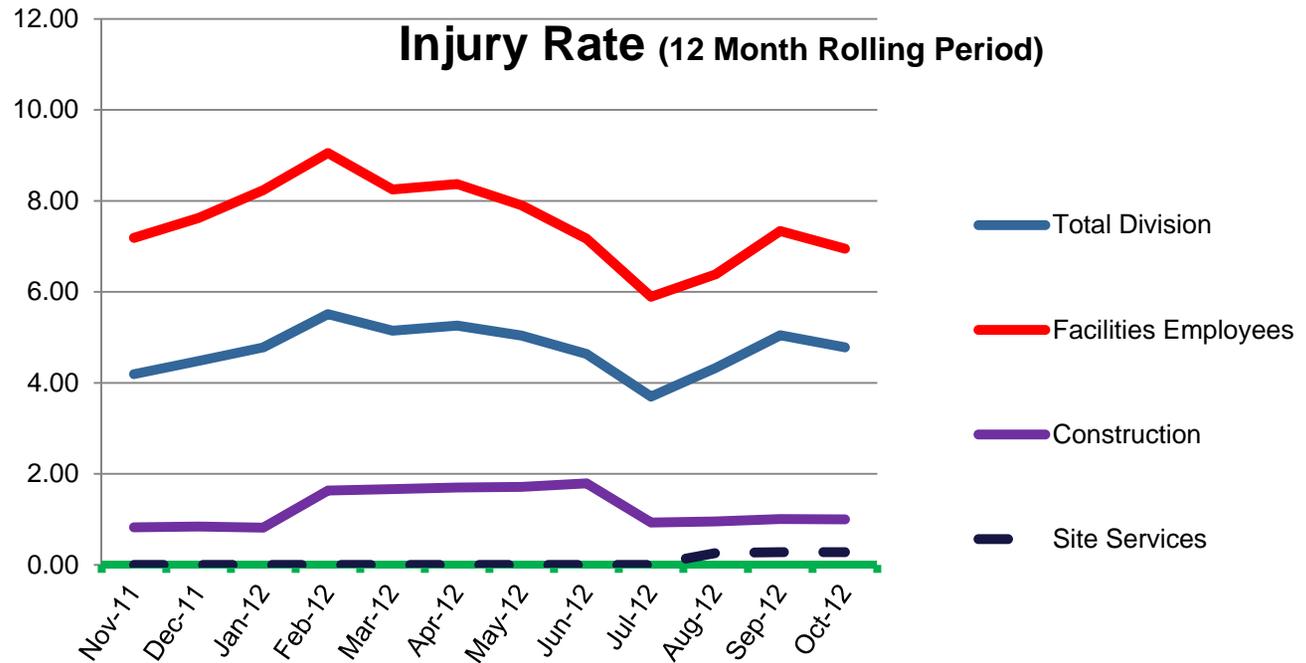
**Expectation:  
Zero Injuries**

# Expectation: Zero Injuries

Facilities Injuries FY 2012/2013



# Expectation: Zero Injuries



Injury Rates	
Facilities Workers	6.95
Construction Workers	1.00
Contract Workers	0.28
<b>Total Division</b>	<b>4.78</b>

# Recognizing Ourselves in Case Studies

- **Injury and Incident Investigation**
- **We all make mistakes**
- **Case studies help us recognize where the human and organizational factors appear in our workplace**



# Assumptions Aren't Always Right

A work team using a high pressure water jet was asked to cut steel and pipe

- The work was added to the scope after the team arrived at the work platform
- The work packet only made a general reference to removing equipment
- Toolbox talk instructed the team to cut all material in the area
- Some pieces of the steel and pipe were marked with red and white tape



# Assumptions Aren't Always Right

- As the team began cutting the steel and pipes they found they had cut through a live drain line
- In the absence of any other indication, the team assumed the red and white tape marked the pipelines and steel which needed to be cut
- The red and white tape marked trip hazards on the work site



# What Human Factors Were Involved?

- **The team were asked to do work which was not in the original scope-  
There was no management of change**
- **Supervision did not communicate the scope and hazards properly**
- **The operations team assumed people would understand that red and white tape marked trip hazards**
- **The team thought the red and white tape marked the items to be cut**

# What Can We Learn from this Incident?

- **When we make decisions we interpret the information available to us**
- **A clear work packet is a good start and an effective tool-box talk helps to get everybody clear on what needs to be done**
- **Talk about the job at the work site-walk ,point, and mark the are to be worked on**
- **Late changes and additions often lead to incidents - That's why management of change process are important**



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# Safety Issues Discussion

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- Issues last month
  - GEM windows moist in mornings – Squeegees ordered
  - Trash in front of dumpsters – due to cars parked in front – No parking to be established
  - All others referred to FA traffic engineer – awaiting response

# Safety Issues Discussion

- New Issues