Oregon OSHA

Construction Advisory Committee

Tuesday June 3, 2014

Meeting Minutes

Attendees:

Barry Moreland	Gary Beck	Mark Tobiasson
Bret Taylor	Ian Chase	Melissa Diede
Bruce Roller	Jeff Wilson	Pat Brunson
Bryan Davis	Kathleen Fenton	Roger Dale-Moore
Chris Ottoson	Kevin Jensen	Russell Nicolai
Cindy Regier	Kevin Wheatcroft	Tony Howard
Clark Vermillion	Marilyn Schuster	

The meeting was called to order by Mark Tobiasson, chair.
Self introductions were made.

Minutes of the April meeting were reviewed by the group.

Lessons Learned:

There was a discussion on being aware of wobble light dangers. When the housing inside the wobble lights break, the bulb can melt the plastic and could potentially start a fire. Per the discussion this is a common problem. So far, no one has come up with a feasible alternative. The manufacturer is aware of the problem.

An incident was discussed that involved a gentleman, not wearing safety glasses, tying something up with bungee cords, his hand slipped off the bungee, and the wire hook hit the gentleman in the eye, tearing his cornea.

Incident was discussed involving a worker that was not properly tied off due to the challenges of the particular situation. The need for 100% tie off was reinforced.

An incident was discussed that involved an employee who was taking a short cut to get some tools. He put the tools into a dock elevator. The employee stuck his hand in an opening at the top of the roll up bar. His hand got stuck while it was still going. He was pinned for about 5 minutes. There is a pressure bar that doesn't allow the roll up bar to move but the pressure bar didn't work where the hand was placed.

Rules:

Electric Power Generation, Transmission, and Distribution rules are in the process of being reviewed by stakeholders in the industry. Meeting dates, time and location was announced. Anyone interested in attending was encouraged to do so. Information including meeting minutes are available on the Oregon OSHA web site. At this time the stakeholder group had reviewed the changes in the Federal rule that had the biggest impact and were in the process of reviewing the Oregon initiated rules in sub division V. Several rules had been found to be addressed in the new Federal standard, or for other reasons no longer needed. These were being eliminated.

Confined space – before June 15th, it will be finalized.

Compressed gas – emergency responders didn't want to determine if they were full or not, have not adopted yet

Continuing Business:

A question was raised what is going on with the man hole inspection. It was brought up OSHA should do a follow up in Construction Depoe. We need to talk to Ellis.

We discussed a recent event regarding a waterline where a portion of the pipe needed to be replaced. The valves were shut off but one of the pipes was not secured and the valve burst opened. Jeff asked Mark who was to blame. Mark stated it was shared blame between the contractor and the city water department.

Monthly Overnight Hospitalizations and Fatalities Report

Accidents

1. MFO May
   Employee was bitten by a spider. He did not tell the employer or get medical attention until serious tissue damage had occurred. The employee was admitted to the hospital for treatment.

2. Portland May
   An employee was climbing a fixed ladder to access a roof area through a hatch. His right hand went for the rung and did not get a full grip. The employee fell backwards hitting a light fixture on the way to the ground. The fall to the ground was approximately15 feet. The employee landed feet first resulting in shattered ankles, Broken pelvis, and a back fracture. The employee had a soft case lunch bag strapped to his back which happened to end up under his head protecting him for any head injuries. The employee was wearing gripper gloves. The rung diameter on the ladder was 1inch.

3. MFO May
   An inspection was conducted when a compliance officer came upon trenching work in progress. Approximately five minutes prior to the officer coming to the site the employees were in the trench when it partially collapsed burying one employee to the waist and the competent person to the knees. 14 foot deep trench. The owner jumped into

the trench to assist in the rescue of the other three already in the trench. Hydraulic shoring with fin form had been in place prior, but got in the way of the workers being able to manipulate the pipe being moved. In the photographs taken by the SCO employees can be seen holding back the walls of the trench to prevent further cave in. Close up's of the walls show signs of the walls breaking away.

Fatalities

1. Portland I-84 May 9th
   A truck and trailer gradually drifted to the left and struck the guardrail on the south side of traffic lanes. The truck and trailer continued westbound into the center median before coming to an uncontrolled rest after colliding with a tree.

2. Sandy May 13th
   Employees were using a pressure washer on a residence. The pressure washer was mounted in the back of a box truck. The employee was using a bucket in the back of the truck for a restroom and possibly closed the door. The pressure washer was a gas powered unit.

3. Philomath May 14th
   The employee was acting odd after coming back from a break. He told the host employer he could not see. The employee became belligerent and incoherent. An ambulance and the police were called to the site. The employee was handcuffed and taken to the hospital. He passed away the next morning. A Sherriff found a pipe with a product thought to be synthetic marijuana called Spice in the deceased's vehicle. The employee was also thought to have consumed several energy drinks prior.

4. Roseburg May 15th
   The employee showed signs of possible heat stroke. The employer transported the employee to the hospital where he was pronounced DOA.

5. Portland May 27th
   The employee was found deceased in the women's restroom. Security was called and attempted CPR. Apparent heart attack.

6. Sherwood May 29th
   Apparent heart attack. The employee was working on a residential sub division. He moved his vehicle and was walking to the back when he sat on the back step. He appeared to be in distress and called for help. He collapsed and co-workers performed CPR until medics arrived. He was pronounced deceased on the site.

Round table:

Bryan Davis brought up that he was at a conference where there were 60 inspectors in a room. A question was asked at the conference of how many of those inspectors witnessed or was involved with an excavation collapse. Out of the 60, 7 people raised their hands.

Next Meeting: July 1, 2014 at 9:00am, AGC Office, Wilsonville