

**Safety Review Committee**  
**June 16, 2006**  
**10:00 AM – 12:00 PM**

**Minutes**

<b>Committee Member</b>	<b>Representing</b>	<b>Present</b>
Ager, Joel W.	Materials Sciences Division	<b>X</b>
Banda, Michael J.	Computing Sciences Directorate	
Blodgett, Paul M.	Environment, Health and Safety Division	<b>X</b>
Cork, Carl	Physical Biosciences Division	<b>X</b>
Fletcher, Kenneth A.	Facilities Department	<b>X</b>
Franaszek, Stephen	Genomics Division	<b>X</b>
Garbis, Carla	Directorate/OCFO/Human Resources	<b>X</b>
Kadel, Richard W.	Physics Division	
Kennedy, Burton Mack	Earth Sciences Division	
Leitner, Daniela	Nuclear Science Division	<b>X</b>
Lucas, Donald	Environmental Energy Technologies Division	<b>X</b>
Lukens Jr., Wayne W.	Chemical Sciences Division	<b>X</b>
Martin, Michael C.	Advanced Light Source Division	
Seidl, Peter A.	Accelerator & Fusion Research Division	<b>X</b>
Taylor, Scott E.	Life Sciences Division	<b>X</b>
Thomas, Patricia M.	Safety Review Committee Secretary	<b>X</b>
Wong, Weyland	Engineering Division	

**Others Present:** John Chernowski, Richard DeBusk, Michelle Flynn, Howard Hatayama, Carol Ingram, John Seabury

**Chairman's Comments – Don Lucas**

**Laser Safety:** Don asked whether we would need to change the Partnership Agreement with UC to implement the Laser Safety Subcommittee's recommendations for laser safety on campus. John Seabury would like to implement the recommendations within the existing Partnership Agreement, if possible. John needs to review Bob Schoenlein's report. The training requirements for LBNL and campus are different – they are consistent, but not equivalent. People doing DOE-funded work should have LBNL training. LBNL has a requirement for the LSO to observe alignment, but campus does not. Bob Schoenlein and the LBNL EH&S Laser Safety Officer (LSO) will discuss with the campus EH&S office and LSO. Howard Hatayama has a meeting with campus today. He will suggest a meeting to try to resolve the differences. The goal is to reduce the probability of accidents on campus.

**MESH Status:** MESH reviews are being scheduled.

**Matrixed Employees:** Kem Robinson suggested that a default MOU should apply to matrixed personnel, unless the home and matrix divisions establish an MOU.

### **Peer Review Validation – Howard Hatayama**

Howard briefed the Division Directors at their meeting yesterday. Dr. Chu wants to accelerate development of the Line Management definition. Bo Bodvarson, Kem Robinson, and Don Lucas will help. The safety role for post-docs needs to be defined. There may be an interim definition, pending Human Resources review. We are looking at different models that work – ALS, Physics, Earth Sciences, EETD, etc. We need to ensure graduate students and post-docs are aware of their responsibilities and know how to implement the responsibilities. The training course for managers and supervisors in research divisions (EHS0026) will have to be revised. Accountability for non-employees is a challenge. Proposed changes affecting represented employees will be discussed with counsel. The corrective action plan needs to be communicated at different levels. Division Directors want to provide input early in the process. The post-docs and students roles do not relieve the PI of responsibility. To prepare for the validation, communicate Line Management responsibility down the chain. The validation team may want to talk to the SRC. The Corrective Action Plan is posted on the EH&S website. Students are where the work gets done and changes happen. They need to recognize when new hazard controls are needed. There must be a dialogue with the Project Leader. Some supervisors may be managing too many people. The AHD defines responsibilities to some extent, but not all work is under an AHD. We are looking at how these issues are handled at other labs. LLNL has an Integration Work Sheet that defines a “responsible individual”, who may be a post-doc. It calls out the training needed. Other labs have more formal reviews for work, including low hazard/routine work. Interpretation of hazard review and work authorization processes varies. LBNL has more graduate students and post-docs than other labs.

### **Incident Investigation Process – Richard DeBusk**

Weaknesses in the existing investigation process were documented in the Peer Review. Some EH&S people are skilled in cause analysis, but most supervisors are not highly trained in this skill. Supervisors complete the Supervisor Accident Analysis Reports (SAARs). We want to improve the investigator training and provide support to the supervisors. Some employees are reluctant to report accidents because of a perceived difficulty in going to Health Services, or a fear of making LBNL look bad in comparison to other labs. They don't want to have to tell their story too many times. Two days is insufficient to complete a SAAR.

Under the proposed system, the supervisor, safety coordinator, and a trained investigator will form a team. They will organize a joint interview so the employee will not have to repeat the story of the accident. Four days would be allowed for the preliminary review, six days to submit the OSHA Log report, and seven days to develop the corrective actions.

SRC members had questions about the proposed process:

- Are we requiring too much investigation for small first aid incidents? Should investigations only be required for recordable injuries? There will be no formal root cause analysis for first aids. A division can choose to do root cause analysis for near-misses. First Aids may be useful as lessons learned.
- What are the roles of Supervisors, Safety Coordinators, and EH&S Liaisons? What will happen if the Safety Coordinator or Supervisor is out of town? If the Supervisor is gone, it should go to the next highest level of management. The Safety Coordinator is not always part of Line Management. Safety coordinators should ensure the SAAR process works. Should EH&S Liaisons take the lead? There has been no formal accident investigation training for Safety Coordinators and Liaisons. The goal is to train 90% of Safety Coordinators and Liaisons in Root Cause Analysis by August 30 (to ensure meeting a September 30 commitment to DOE). They will be trained in how to fill out the SAAR form and in TapRoot concepts.
- How does the accident investigation process fit into DOE and OSHA reporting requirements? ORPS have a separate procedure. DOE wants to see formal root cause analyses. OSHA can check accident logs for compliance but they are not routinely submitted.
- Who will provide and fund the investigators? There will be a core team of 5-7 people. We expect EH&S to be the center of expertise. People in Engineering, AFRD, EH&S, and AFRD have been trained. There is no institutional funding for work for other divisions, except for EH&S personnel. The investigators need to do enough investigations to maintain their proficiency. There are usually about 2-3 recordable accidents per month that would require investigation.
- Who leads the investigation? There would be a division, EH&S team, but accident investigation is still a Line Management responsibility. The procedure will specify the supervisor's role in the team and responsibilities of team members.
- Some divisions have different accident investigation procedures in their ISM plans. What should they do? The ISM plans would have to be updated to incorporate the new process.
- How would corrective actions be tracked? They should be entered into CATS within 1 day of completion of the investigation.

The Committee asked to see more details and a draft procedure. Safety Coordinators and EH&S Liaisons should be asked for input.

The meeting was adjourned at 12:00 PM

Respectfully submitted,

Patricia M. Thomas, SRC Secretary