

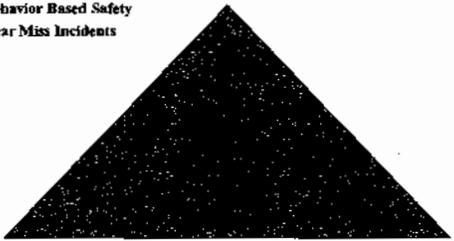
5.20.04
8am

Near Miss Investigations and Reporting

Monsanto
Soda Springs, ID
2004

Proactive base of the Safety Triangle

- ✓ Pre-Job Risk Analysis
- ✓ Behavior Based Safety
- ✓ Near Miss Incidents



Culture and relationship to reporting

- ✓ Culture 1 - Near miss incident is known only to the involved employee(s).
- ✓ Culture 2 - Near miss incident known only to the crew and their first line supervision.



Culture & it's relationship to Reporting

- v Culture 3 - Near miss captured and communicated to all employees.
 - v Anonymous
 - v Management commitment - Protection
 - v Workers see process work to their advantage
 - v ESH personnel aware, and therefore able to help provide corrective actions, prevent significant incidents
 - v Highest level of near miss education
 - v Resources - \$\$\$ (weekly review)

"Lessons Learned"

Near Miss incident investigation and reporting

- v Capturing Incidents - (near miss, potential, or concerns)
- v Responsibility - all employees to report all incidents
- v Objective - to find the facts (cause) and proactively prevent incidents.

Definitions: ESH Incidents

- v **Safety:** Recordable injury, or has significant potential to cause such an injury.
- v **Health:** Occupational illness, or has significant potential to cause such an illness.
- v **Environmental:** Release, or has significant potential to cause such a release.

Frontline Supervisor Responsibilities

- v **Initiate incident investigation and preserve evidence. - Photos**
- v **Form in-field investigation team as needed.**
- v **Take immediate corrective actions.**
- v **Determine root cause(s) if possible.**
- v **Make immediate recommendations.**
- v **Responsibility - Complete and route the Corrective Action Form (CAF) by the end of the shift to the CAF Manager.**

The Corrective Action Form (CAF)

- v **Description of the Incident**
 - v Anonymous if needed
- v **Root Cause (if known)**
- v **Immediate Action Items**
- v **Recommendations / Assignee(s)**
- v **Estimated date of completion**
- v **Efficiency with the CAF (speed)**

Near Miss Incident Investigation Responsibilities

- v **Front line Supervisor**
 - v Take the correct immediate action items
 - v Submit Training Request
 - v Submit job notification (request)
- v **CAF Manager**
 - v Collect CAF
 - v Review / Approve & Sign CAF
 - v Enter CAF to spread sheet for Site-wide review
 - v Provide copy of CAF to either the Safety, Health or Environmental owner for review

Summary

- ✓ Incident identified and communicated
- ✓ CAF obtained
- ✓ Investigative Team gathered
- ✓ CAF completed
- ✓ Immediate Corrective Actions taken
- ✓ CAF placed in CAF manager mailbox
- ✓ CAF Manager reviews/copies/enters/tracks
- ✓ ESH owners help determine incident potential beyond CAF.

Questions? & Contact information

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CAF CORRECTION ACTION FORM

Instructions:

- a. Fill out this form, attach additional sheets if necessary. *Note: If a formal incident investigation is likely, include information about the incident (including eyewitness accounts) in sections 1 & 2.*
- b. Forward the completed form to the ACR (if the ACR is unavailable, forward to the Safety Department).

Department _____	Date _____	Time of Incident _____
Your Name _____		
Duration: From _____ To _____		
1. Describe the incident / concern:		
2. Describe the cause of the incident / concern (if known):		
3. Describe any immediate corrective actions which were taken:		
4.1 Recommendation		
Assigned To: _____ Estimated Date of Completion: _____		
4.2 Recommendation		
Assigned To: _____ Estimated Date of Completion: _____		
4.3 Recommendation		
Assigned To: _____ Estimated Date of Completion: _____		
This section is to be filled out by ACR		CAF# _____ Area Compliance Rep Signature: _____
Compliance Issue?	<input type="checkbox"/> Yes: Study ID: _____ CAR# _____ <input type="checkbox"/> No	Out of Process Control? <input type="checkbox"/> Yes <input type="checkbox"/> No

Minor Near Miss Investigations - Corrective Action Forms 2003

									12/29/03 189:7
AREA	CAF#	DEPT	DATE	TIME	LOCATION	SHORT DESCRIPTION	CAUSE(S)	RECOMMENDATIONS	IMMEDIATE ACTION TAKEN / CLOSURE STATEMENT
North 001	NS001	HEG	1/4/2003	Not Reported	Fuel Station	The gas nozzle does not shut off automatically when tank is full. Contractor employees noted this problem and shut nozzle off without overfilling tank.	Nozzle malfunctioned	Repair/replace nozzle.	Nozzle has been tagged identifying problem. Order #50446288 has been created to make repairs.
North 002	NS002	Burden Prep	1/5/2003	7:00 AM	Sizing Screens	Employee noticed a 5/8" steel plate ready to fall onto the area he was working from the top of the west sizing screen.	The plate is used to isolate the screens. It was set in a position after the last use that allowed it to vibrate to the edge.	Install bracket to hold plate.	Notification 60291724 submitted to install hanger.
North 003	NS003	Burden Prep	1/6/2003	2:00 PM	Scaleroom	Employee was walking past #10 scale when a 3/4"X3"X4' piece of iron fell from above missing the employee by a couple of feet.	Several items were left on top of the scale. The vibration of the scale caused the item to fall.	Use incident to stress importance of housekeeping.	Incident has been discussed at several meetings throughout the plant. A safety display using this incident has been set up near the locker rooms.
North 004	NS004	HEG	1/5/2003	6:30 PM	HEG Shop	An operator felt a particle get in his right eye while he was in the process of greasing a loader. The eye was immediately flushed by an EMT and appeared to be OK. Employee continued to experience pain and went to the eye doctor on 1/8/03, where it was diagnosed as a scratched eye.	PPE failed to provide adequate protection.	Conduct Incident Investigation.	Incident investigation completed on 1/10/03.
North 005	NS005	Burden Prep	1/9/2003	1:30 PM	289 Pan	While walking down the stairs on the east side of the 289 pan, one of the stairs broke away on one side. Employee was walking slowly, inspecting wheels and holding onto the handrails, which prevented a fall. Stair was approximately 25' above grade.	Vibration in area likely caused weld to crack and break. Damaged was noted before complete failure. All stairs are inspected annually.	Use incident to stress importance of using handrails and checking work area on a daily basis for potential problems and having those concerns corrected.	Stairway immediately inspected for additional concerns and barricaded until repaired. A safety display using this incident has been set up near the locker rooms.

North 006	NS006	Burden Prep	1/9/2003	N/A	Dust Bin Area	There is some old compressed gas cylinders that are no longer used for the O2 analyzer that need to be removed and the brackets and tubing removed. Bottles and tubing are mainly an obstacle in the area.	Failure to remove after use was no longer necessary.	Remove.	Notification 60292982 submitted to have bottles removed and tubing dismantled.
Rock Springs	RS001	Rock Springs	1/13/2003	12:05 A.M.	Coal Silo	While rodding feeder, slipped and fell striking elbow bruising elbow requiring Rx medication at emergency room.	Piece of coal laying on landing creating a slipping hazard.	Keep area free from spillage for potential slipping hazards & notify effected employees of	Area spillage immediately cleaned up and caution notification posted on employee bulletin board. CAF
South 007	SS001	HR	1/2/2003	7:00 A.M.	Admin. Building	While delivering cleaned clothes to the plant. The vendor backs the delivery truck up next to the admin. Clothing room. While performing this task the operator of the American Linen delivery truck backed into the opened door of the building damaging the door.	Usually the driver can back straight into the unloading area by the door. Due to excessive snow the driver had to back around a pole and couldnt see how close he was to the door.	The insurance company is replacing the door that was damaged. The were in the plant on January 27th, evaluating the damage and determining what would be needed to insuring what was needed to repair the damage.	Contacted the HEG group to clear the snow so the driver can back up straight. Contacted purchasing to begin the process of getting a new door. Had pictures taken of the door. For use if the insurance provider asks.
South 008	SS002	AU Boiler	1/6/2003	10:00 PM	A/U Boiler Bldng.	The plant breathing air system CO monitor alarmed and indicated 10 PPM.	Unable to determine what occurred.	Equipment was checked by I.H. and nothing could be found wrong with the system. It was recalibrated and put back into operation. (back in operation 1/6/03)	Checked the system with a handheld monitor through a relief valve but could not detect any CO. The system was then shut off and isolated and tappers instructed to and informed to use the battery operated respirator with there 3M hoods. The next morning the system was started and rechecked and nother abnormal appeared.
South 009	SS003	Maint.	1/16/2003	11:30 AM	Not mentioned on CAF	Foreign body in Eye	Ceiling tile were being lifted out and material dropped into eye.	The eye was treated and the paricle was removed from the individuals eye. Worker was coached on the need to wear goggles when performing this job in the future. (immediately)	The eye was treated and the paricle was removed from the individuals eye. Worker was coached on the need to wear goggles when performing this job in the future. (immediately)

South 010	SS004	HR	1/15/2003	N/A	Admin. Building	It was pointed out to me that we have some pretty sizable snow/ice slides on the west canopies of the new admin. Building. The canopies appear to be working as some of these blocks of snow /ice would weigh tons and would kill someone or crush a vehicle. For some reason the ice buildup has bent and is tearing off the rain gutter	Suspect that the heat tape may not be working.	Notification No. 60295781 submitted to have the damaged rain gutter repaired. Lynn Gerber is working the long term issue of installing ice dams on the canopies that will prevent snow buildup from sliding off the roofs damaging the rain gutter. Also had shift electrician check to be sure heat cab(Completed	Submitted a CAF to alert safety of the concern and ensure there is no danger to pedestrians and vehicles.
South 011	SS005	Furnace	1/17/2003	10:30 AM	Storeroom	While picking up parts at the store room. The truck was parked on the west side of the building. When the workers came back out of storeroom the truck had rolled down the hill, stopping when it ran into a snow berm.	The shifter on the truck has a lot of play in it. Workers thought it was in park and it really wasn't.	Tagged truck out of service and submitted and safety ticket to have the truck fixed. Notified ACR of the concern. (Immediately)	Tagged truck out of service and submitted and safety ticket to have the truck fixed. Notified ACR of the concern. (Immediately)
South 012	SS006	Mark III	1/14/2003	7:30 AM	No. 9 Furnace	The handle of a ball valve was struck and turned the hot water on. The water had been lying idle in a steam traced line becoming super heated. When the handle was opened the water blew onto a persons side generating 2nd degree burns.	A quarter turn valve was inadvertently bumped open.	A formal investigation will be conducted on 1/28/03.	The handle in question was removed and replaced with a gate valve. The individual was treated at the plant dispensary and then taken to a physician for further evaluation. (immediately)
South 013	SS007	Training	1/22/2003	N/A	North East corner of No. 7 furnace	The new location where the natural gas exits the ground to tie into the existing line, is not protected on the east side.	It was identified that the new natural gas lines needs to have barricades/pylon installed on the east side prior to be connected to the source and made live.	Contacted the project lead of the project and was informed by him that prior to the project being turned over it would have pylons installed on the EAST side. (before being tied in live)	Contacted the project lead of the project and was informed by him that prior to the project being turned over it would have pylons installed on the EAST side. (before being tied in live)

South 014	SS008	Electrical Dept.	1/24/2003	N/A	Scaleroom	When performing calibration of the scales operators are required to work in a very precarious position with multiple ergonomic and safety issues.	Cramped working space and weights that are barely adequate for the job are placing technicians in awkward and risky positions.	When MOC is approved a SAF notificatio will be submitted to have the weights built and a cart to move them in built.(CAR No. 81 of Study ID. 1580 created to remediate this concern)	Submitted a MOC and notification to build a set of weights and install a singly calibration pad eye on the bottom of each weigh bin feeder. Turned in a CAF to document corrective actions. (immediately)
South 015	SS009	Furnace	1/13/2003	10:30 PM	No. 9 Furnace	While drilling plugged taps on No. 9 furnace, pulled drill up and caught finger between drill and bolt on the 5' center riser rodding port.	Possible that the bolts holding the 5' center riser ports were longer than needed.	EMT treater and dressed the wound, completed a first aide card and a CAF. Replaced the bolts on the 5' port with shorter ones. Immediately	EMT treater and dressed the wound, completed a first aide card and a CAF. Replaced the bolts on the 5' port with shorter ones. Immediately
South 016	SS010	Planning	1/30/2003	8:00 AM	Shutdown Planning.	While sitting at a computer desk in shutdown planning, I scratched my left knee on a screw that was protruding through from the other side.	Scre protruding through desk from a shelf that had been attached onto the side.	Removed and replaced the bolts on the 5' port with shorter ones. Immediately	EMT treater and dressed the wound, completed a first aide card and a CAF. Attempted to file the protruding end off from the screw but a file would not do the job. Need to replace the scew with a shorter one. (immediately)
South 017	SS011	Mark III	1/30/2003	7:10 AM	Mark III	Particle in right eye.	Drilling on furnace roof. Probably blown into eye from the air of the pneumatic drill.	All contractors drilling on the furnace roof were placed in dust goggles while drilling on the furnace roof. (initiated on 1/24/03)	EMT treater and dressed the wound, completed a first aide card and a CAF. (immediately)
South 18	SS012	Core Reliability	1/31/2003	7:00 AM	No. 9 East boring bar pump	When locking out the East boring bar pump it is very confusing at to which disconnect is for the East pump and which is for the West pump.	Labeling is confusing.	ACR discussed this issue with electrical crew supervisor, planner and Project lead of the new MCC. Supervisor indicated that they would include East/Weat in the discription of the new labels when they are made. (2/1/03)	Reliability mechanic submitted a CAF raising the issue and suggested that when the new motor control panel is installed the tags indicate the pump No. as well as East or West pump. (immediately)
South 19	SE001 SS013	Furnace	1/31/2003	10:00 AM	No. 9 treater wash out sump	No. 9 treater washout sump overflowed into phos alley. Releasing 1500 gallons of phosy water onto phos ave.	The sump pump for the treater wash would not pump	The area was cleaned up and the pump was replaced and job of washing the treater began again. (immediately) The pump hosing and parts will all be changed to stainless prior to re-installing the pump that	Barricaded the area and applied nodule fines then entered the information into the 24 hour spill database. ACR contacted Environmental department(not a releaseable quality) immediately