Notice of Joint Safety Committee Meeting - 2020

To: All parties in interest

Date: 09/11/2020

Via: E-Mail Transmission

E-Mail: jweaver@westernlineneca.org

This is a reminder that our next **Quarterly Meeting** of the **California [Red Safety Book] Joint Safety Committee** is scheduled for **Tuesday, September 15, 2020** at **10:30 AM** pacific time.

FYI, the meeting tomorrow is being held via the GotoMeeting platform and **you will have to log into a computer to participate in this meeting**. Please download the GoToMeeing app and plan on having a computer/iPad available at 10:30 AM in the morning to participate in this virtual meeting.

If you need a calendar link for this meeting, please email Mr. Weaver for that link.

You can now download the Revised California Safety Manual **"Red Safety Book"** from the Chapter's new website: WesternLineNeca.org

The **Meeting Minutes** from our last Safety Committee Meeting held on June 18, 2020 are available for download from the Chapter's new website: WesternLineNeca.org

-Wednesday, December 2, 2020 at TBD

Thanks,
Jules W. Weaver
Chapter Manager

MEETING MINUTES
IBEW 47-1245 / WLCC-NECA JOINT SAFETY COMMITTEE
June 18, 2020
Via: GoToMeeting Platform

Present:

Mgmt:

James Stapp
AJ Zartman
Lon Peterson
Raul Guardado
Zach Zuelner
Jeremy Atchison
Kelly Whittemore
Trevor Kirkland
Ward Andrews
Jacob Milhoan
Clayton Loback
Ian B. Neff
Hal Lindsey
Jeremy Hessler
Ben Nelson
George Bradshaw
Lawrence "Kaz" Kazmierski
Danny Ashmore
Ed Antillon
Christine Tedder
Matt Tedder
Ron Cochran
Andy Smoot
Chris Hess
Jerad Simmons
Jacob Milhoan
Jules Weaver

IBEW:

Ralph Armstrong
Ralph Kenyon
Rod Peterson
Arnold Trevino
Charlie Randall

Cal-NEV JATC:

Armando Mendez
Don Jamison

Meeting called to order by Chairman Armstrong at 9:00am.

Chairman Armstrong welcomed the group to our first virtual meeting and had everyone introduce themselves.

Previous Minutes:
M/S/C *to approve the* ***Meeting Minutes*** of the Joint Safety Committee Meeting held on ***March 11, 2020***.

Review of Accidents & Incidents:

The updated **Accident** & **Incident Reports** is attached hereto as **Exhibit A.**

Local 1245 - Northern California: as reported by Mr. Armstrong & Mr. Kenyan:
They discussed a couple of incidents that are covered in the attached **Exhibit A** and have no other outside line contractor accidents or incidents to report beyond what the Contractor's will report on today.

Local 47 - Southern California: as reported by Arnold Trevino and Rod Peterson:
They discussed some major incidents on the West of Devers Transmission Line Project where they have had a rash of incidents including an arm collapse, wire dropped and other incidents luckily, we have had no major injuries. Beyond these incidents they didn't have any outside line contractor accidents or incidents to report beyond what the Contractor's will report on today and those incidents are set forth below in the Accident & Incident Report attached hereto as **Exhibit A**.

Contractor's Reports:
The Contractors present reported on the accidents and incidents in the attached **Exhibit A** and some additional incidents or near misses. The following Contractors noted they had no accidents or incidents to report on today:

Ferreira Power West, LLC
Michels Pacific Energy, Inc.
Pinnacle Power Services, Inc.
Source Power Services, Inc.
Underground Electric Construction Co., LLC

A discussion was held regarding a very recent Contractor Helicopter Incident in PG&E's area that is not included in **Exhibit A** that unfortunately resulted in multiple fatalities. As of now PG&E has suspended short haul operations. A general discussion followed regarding helicopter work in general in our Industry.

JATC Reports: Director Jamison noted he had nothing to report beyond what has already been reported on today and those incidents are set forth below in the Accident & Incident Report attached hereto as **Exhibit A**.

Observations: Overall there are way too many incidents and a general discussion followed.

Exhibits attached hereto:

Exhibit B – SCE Safety Stand Down – Contractors
Exhibit C – Various Wired for Safety Bulletins from SCE
Exhibit D – WLCC Safety Alert Foreman Training
Exhibit E – 3M Inspection Notice

Old Business:

1. Chairman Armstrong noted that unfortunately there were some printing errors with the hardbound copy of our first Red Safety Book [Red Book] and it is being edited as we speak. Hopefully theses corrections can be made prior to our next meeting.
   It was noted the "*pdf*" copies that are available for download on the Chapter's website and other places has been corrected.

   Note: See **Exhibit F** on July 1, 2020 the IBEW /NECA Safety Committee passed a **M/S/C** *to approve the edits to the revised Red Book correcting the printing errors discussed above.*

   For the record, the **Red Book Subcommittee** is composed of the following 8 individuals from Labor and Management:

Labor	**Management**
Ralph Armstrong	Ward Andrews
Richard Lane	Hal Lindsey
Rod Peterson	Chris Larson
Arnold Trevino	Hank Rivera

   It was noted for the record that the **8 - IBEW /NECA Safety Committee** members per the California Outside Line Construction Agreement are as follows:

Labor Representatives	**Management Representatives**
Ralph Armstrong	Jim Stapp
Ralph Kenyon	AJ Zartman
Rod Peterson	Ward Andrews
Arnold Trevino	Jules Weaver

New Business:

1. Mr. Armstrong led a discussion regarding the impact of Covid-19 pandemic on our Industry and a general discussion followed.

Next Meeting Date and Location:

Thursday, June 18, 2020 at 10:30am via GoToMeeting platform.

Meeting adjourned at 10:20am

IBEW 47 - 1245 / WLCC - NECA
3rd Qrt 2020 Accident/Incident Reports

Date Of Incident	Occupation	Type of Incident	Body Part / Root Cause	Description
Contractor Significant Accidents				
1/3/2020	Outside Crew	Injury	Finger Laceration	**January 3, 2020 -** A line crew was in the process of loading an empty reel onto a trailer using a crane with mandrel and spreader bar. An apprentice lineman was guiding the mandrel out of the reel, which was still attached to the crane. Due to the weight of the mandrel, it swung away as it was clearing the reel and then swung back. The groundman's reaction was to try and physically stop the mandrel from swinging back, putting his hand between the mandrel and the reel. Although the groundman was wearing proper PPE gloves, the force and impact caused a laceration to his left hand index and middle fingers. Instantly, the groundman felt pain. He removed his glove and noticed that he had ripped open the skin on his finger. The groundman was then transported to the nearest urgent care for treatment.
1/22/2020	Tree Trimming Crew	Fatality	Fatality	**Fatality - Janaury 22, 2020,** Update on Significant Safety Event Distributed on 1/24/2020. We reported previously that a worker suffered a serious injury in a traffic accident last week. It is with great sadness that we share the news of his passing over the weekend. Our colleague was part of a crew conducting hazard tree removal in Crestline to support Southern California Edison's wildfire mitigation efforts. Tragically, according to reports, he was struck by a third-party vehicle while removing traffic cones.We extend our deepest sympathies to our colleague's family and friends. Please share this update with your team and reinforce your team's focus on safety so we can all work together to ultimately eliminate worker fatalities and serious injuries.
2/11/2020	Outside Crew	Injury	Brusing & Abrasians	**Injury - February 11, 2020**, A crew was assigned to disassemble two critical spare B bank transformers at a substation. Two workers were specifically assigned this task. The tailboard discussion included using the forklift to be positioned under the lightning arrester stand crossarm to support the stand while a transformer helper removed the bolts for removal of the stand. Using this procedure, the two workers successfully removed the lightning arrestor support stands on one transformer. However, there was a change in plans when the transformer helper noticed the arrester support stand had lifting eyes. They made the decision to use a sling with the forklift to remove the stands. There was no re-tailboard conducted when they changed plans nor did they notify the foreman that they were going to use a different procedure. Once the forklift was positioned near the lightning arrester crossarm, there was no communication between the two workers when one decided to operate the forklift. The driver of the forklift planned on extending the forklift boom when he inadvertently used the wrong control lever and tilted the forks down, causing injury to the transformer helper's back. The transformer helper was transported to a hospital for evaluation and was found to have an abrasion and bruising to his back. The foreman re-tailboarded with the rest of his crew members emphasizing the need to communicate whenever there is a change in plans from the original tailboard. He also reinforced the need for proper 3-way communication when operating forklifts or cranes. All crews were called to make sure they are using the correct tool for the task, especially when lifting heavy equipment off transformers.
2/15/2020	Traffic Control Crew	Injury	Multiple Bruising Sprains & Strains	**Injury - February 15, 2020**, A traffic control crew had a right lane closure utilizing signs, cones and an arrow board. While another crew was pulling wire up across the street, the flagger was standing in the street with a stop/slow paddle to stop oncoming traffic as a vehicle approached. His partner on the other end of the job yelled "Look out" and the flagger was struck by the oncoming vehicle.The electrical crew foreman heard a loud crash, which sounded like a vehicle hitting another vehicle, but when he turned to look, he saw the flagger flying off the windshield and landing in the center median. 911 was called and the appropriate notifications were made. The flagger did get up and walk around; however, workers advised him to stay still until the ambulance arrived.The flagger was transported to a hospital and was released the next day. He is currently undergoing pain management and considering a second opinion.

Date Of Incident	Occupation	Type of Incident	Body Part / Root Cause	Description
2/20/2020	Outside Crew	Significant Injury	Multiple Fractures	**Injury - February 20, 2020**, Overhead distribution crews were tasked with replacing three poles and re-conductoring seven spans of wire. The crews arrived on site, tailboarded and began preparing for a late evening outage. Once the outages were taken and lines proven de-energized, the crews began to work on their assigned tasks. One crew, which was tasked with re-framing the crossarms, set up their bucket truck and prepared material for the task. The crew was unable to access the commercial property and decided to work the pole from the street. In order to eliminate potential backfeed, the foreman accessed the roof of an adjacent building to open the cutouts. The foreman successfully walked across the roof (corrugated steel) and opened the cutouts via an extendo stick. While returning from the task, the foreman stepped on a corrugated fiberglass sunlight section of the roof and fell through. He fell approx. 25 ft. to the concrete floor below. He sustained several injuries, including multiple fractures, and is currently recovering in the hospital.
3/9/2020	Outside Crew	Injury	Eye Injury - Flash Event	**Injury - March 9, 2020,** A substation operator was switching a planned, approved procedure to in-service a 12 kV circuit breaker (CB). As part of the procedure, the 12 kV line was being rolled from the inner 12 kV bus. After closing the 12kV Bus Parallel CB making a parallel between the No.1 Bank 115/12kV and No. 2 Bank 115/12kV, the Operator closed the 12kV Inner operating bus disconnects intending to make a box loop and then proceeded to open the 12kV Outer bus disconnects intending to break a box loop. A large arc and associated fire were produced when the operator opened the first 12 kV outer bus disconnect. During the flash event, the 12 kV bus parallel CB opened, and the 12 kV capacitor leads burned open, extinguishing the arc. During the initial rack inspection following the event, the 12 kV inner bus B-C section disconnects were found open. The operator initially declined medical evaluation, but later reconsidered as he began to feel irritation in his eyes. The operator was checked by a physician at a local medical clinic and later released. Currently, he is resting at home. Switching was completed by different operators to isolate the damaged equipment and return the station to normal.
3/12/2020	Outside Crew	Significant Injury	Fractured Left Leg Tibia	**Injury - March 12, 2020,** A crew was tasked to replace a pole and left the yard at approximately 0630 to try to complete the work before a change in weather conditions. The crew set up and transferred the pole without any incident. The crew stopped work when the rain started, given the ongoing rain forecasted for the day. Cleaning up the work area required loading the pole puller with line truck and heading back to the yard. While loading the pole puller, the worker entered the trailer using step location to make room for the pole puller to tie down for transport. The heavy boom operator was swinging the pole puller into location with help of a spotter on the ground when the worker exited from a rear location. The worker stepped on a side fender when his boot was caught on the lip of the trailer, causing him to fall to the ground and injure his left leg at the shin area. The crew stopped work to attend to the worker and advised him to seek medical attention. The foreman transported the injured worker to a nearby hospital for treatment. After medical assessment, the worker was found to have fractured his left leg tibia. His leg was splinted, dressed and given a soft boot. The worker was released home and is resting and recovering.
3/24/2020	Outside Crew	Significant Injury	Flash Incident Resulting in Burn	**Injury - March 24, 2020,** A crew was tasked with installing a new OMNI switch on an energized 16 kV line. The crew tailboarded and no test orders were in place. The crew successfully hung the switch on the pole, in the closed position, with all six jumpers coiled and affixed to the switch arm. Utilizing the tub truck, the two lineman successfully tapped up the field and center phase on the line side of the switch using the rubber glove method. In the process of tapping up the street side phase, a flash occurred, locking out the circuit. The two lineman were able to boom themselves to the ground and exit the bucket truck on their own. The foreman immediately dialed 911 while the other crew members applied burn gel to the affected areas, which appeared to be minimal. Both lineman were transported via ambulance to a local hospital where they were treated and released within 2 hours. Both lineman were in 8 CAL PPE.
4/1/2020	Outside Crew	Injury	Index Finger Laceration	**Injury - April 1, 2020,** A crew was sent out on an emergency repair order to change out a set of doubles on a 12 kV transformer. After arriving at the jobsite, the crew tailboarded and began preparation of the new composite crossarm. While prepping the new arm, the worker's ring-cut the lightning arrestor ground attached to the bottom of the crossarm. While ring-cutting the wire, the employee simultaneously moved his left hand. During this process, he ran his left index finger across the blade of the knife, resulting in a laceration to his left index finger. The lineman was utilizing Cut-Resistant Maxie Cut Gloves.

Date Of Incident	Occupation	Type of Incident	Body Part / Root Cause	Description
4/3/2020	Outside Crew	Significant Injury	Vehichle Rollover	**Injury - April 3, 2020,** An apprentice was driving in mountainous terrain with a digger derrick while towing composite poles on an extended pole trailer when he experienced brake failure. When the worker noticed his inability to brake, he attempted to slow his vehicle by driving onto a side grade, but he could not decelerate enough as he approached a sharp curve. He collided through a guard rail and rolled his vehicle down a canyon approximately 100 feet from the road. Two other members of the same crew were traveling behind and witnessed the incident. They immediately called their general foreman and instructed him to call 911. They pulled over and ran down the hill to assist. The coworkers kicked out the front windshield and pulled the driver out. Soon after, an ambulance arrived on scene and transported the worker to a hospital. X-rays were performed, and the worker was released the same day.
4/14/2020	Outside Crew	Significant Injury	Hand Punctured - Hydraulic Fluid	**Injury - April 14, 2020,** A crew was working on a pole replacement as part of a covered conductor project. An employee was transferring telecommunication conductors and was utilizing a reciprocating saw (Sawzall) to cut through a bolt. Unfortunately, the hydraulic tool circuit was in the "On" position when his downward force caused the saw to pierce the pressurized hydraulic hose. The apprentice grabbed the line to minimize spray. Unknown at that moment, the force of the pressurized fluid penetrated his right palm near his middle finger. The Apprentice Lineman shut off the hydraulic tool circuit and boomed down. After ten minutes, the apprentice complained of a lingering pain in his hand. He took his glove off and noticed a small puncture wound and progressive swelling. He was transferred by ambulance to the nearest hospital. He underwent surgery to clean his hand of fluid and was kept overnight for a follow-up surgery to ensure all hydraulic fluid had been removed.
4/15/2020	Laydown Yard Crew	Multiple Crushing Injuries	Fatality	**Fatality - April 15, 2020,** Three workers were on-site at a laydown yard loading trailers for transport. Two workers were loading bundled steel on a flatbed trailer. One worker atop the trailer tripped and fell to the ground. A bundled section of steel then fell off the trailer, landing on him. Emergency services were called, and they provided medical attention. Tragically, the worker later succumbed to his injuries.
4/15/2020	Outside Crew	Injury	Tower Arm Collapse	**Injury - April 15, 2020,** Two workers, utilizing the HEC (Human External Cargo) method, were working on ladders in the process of clipping in the lower double bundle phases of a new 220 kV ACCC conductor on existing tower. Utilizing a hoist and sling, the linemen were in the process of raising the new conductor out of the traveler and installing an armor rod in preparation of setting into the shoe when the tower arm collapsed, pinning both linemen between the collapsed arm and the tower body. A lineman working nearby observed the incident and immediately directed the foreman to call 911 and sent his apprentice to meet the emergency responders. He was the first to start the tower rescue. One of the injured linemen was rescued via helicopter off the tower and flown to the main road, where emergency services were waiting. The lineman was transported to the hospital for evaluation. The second lineman was then taken off the tower via helicopter and flown to emergency services. He was evaluated and was determined to have no injuries.
4/17/2020	Tree Crew	Significant Injury	Fractured Vertebra	**Injury - April 17, 2020,** A crew foreman was performing compliance tree trimming of a palm tree that was approximately 45 - 50 feet tall. The palm tree was in a customer's backyard and not accessible via bucket truck. The palm tree had a lean/bend at approximately 30 feet off the ground. The foreman did not use an adjustable false crotch while descending the palm. Instead, he placed his climb line over the palm fronds to descend from the tree. While descending, he lost his footing and swung out away from the tree. The shift in weight allowed the climb line to roll off the fronds and the foreman fell approximately 10 – 15 feet to the ground and landed on his back. A safety trainer was on-site and called 911. Emergency Medical Services arrived and transported the foreman to the hospital, where he was found to have a fractured vertebra. The foreman was released from the hospital the next day and is currently recovering at home.
4/23/2020	Outside Crew	Significant Injury	Head Laceration	**Injury - April 23, 2020,** A 3-man crew was working on a streetlight system cutover. Lineman 1 was working from the bucket of a streetlight patrol truck to install new duplex conductor. Lineman 1's bucket could be accessed by a door. Lineman 2 was working one span to the east in a separate truck. The foreman was assisting the linemen from the ground. While working at approximately 25 feet in the air, Lineman 1 was attempting to install the new duplex when the bucket door came open and he fell and hit the side of the truck before he impacted the ground. The foreman immediately called 911, pressed the emergency button on the radio, and accessed the AED/first aid kit. Meanwhile, Lineman 2 met the foreman at the back of the truck where the injured employee was sitting up and able to communicate with the crew. The known injury at the time was a laceration to head. The employee was transported by ambulance to the hospital.

Date Of Incident	Occupation	Type of Incident	Body Part / Root Cause	Description
5/14/2020	Tree Crew	Significant Injury	Multiple Serious Injuries	**Injury - May 14, 2020,** A crew was performing tree removal and the foreman was ascending the tree to be removed. At about 60 feet up, he leaned back and his work positioning lanyard was not connected. He fell from the tree, landing on his back/neck. The crew alerted emergency services and the foreman was air lifted to the nearest medical center. The foreman sustained multiple serious injuries and underwent multiple surgeries. He is currently in critical/stable condition. Preliminary findings indicate that the climber was using a "2-in-1" lanyard and he may have inadvertently disconnected the wrong side of the lanyard.
5/22/2020	Outside Crew	Injury	Finger Laceration & Crushing	**Injury - May 22, 2020,** One week into a new project, a worker was hammering conduit stakes with a sledgehammer. The worker "choked up" on the handle of the sledgehammer, swung and missed the stake. The sledgehammer smashed his right index finger between the hammer and the stake. The General Foreman secured the worksite, provided first aid and then transported the injured worker to the hospital emergency room for treatment where he received 7 stitches. The worker was released and has returned to work.
7/7/2020	Outside Crew	Vehicle Rollover	Minor Injuries	**Injury - July 7, 2020,** A Contractor Groundman was driving a Digger Derrick line truck while pulling a utility pole trailer, and as he travelled downhill, he felt a loss in the brake pressure. He steered the vehicle to the shoulder of the roadway to slow the truck down. During this maneuver, the front and rear passenger wheels contacted the edge of the roadway causing the driver to overcorrect and overturn the vehicle onto the passenger side. The truck came to a stop with the trailer intact. The driver suffered minor injuries, was transported to the hospital and released to full duty the same day.
7/29/2020	Outside Inspector Crew	Significant Injury	Wrist & Fingers	**Injury - July 29, 2020,** A lineman conducting a relay patrol of a 115 kV line rolled a Polaris-off-road-vehicle. As the Polaris was going sideways, the front right tire hit a boulder on the opposite side of the Right of Way (ROW). The slope of the ROW and the momentum of the Polaris caused the Polaris to hit the boulder, resulting in the Polaris rolling over 360 degrees back onto the tires. The lineman identified that his left hand had hit the ground injuring his wrist and multiple fingers. The lineman immediately reported the incident and injury to his supervisor. The Patrolman arrived and drove the lineman to the nearest medical facility.
8/7/2020	Outside Crew	Significant Injury	Vertebral Fracture	**Injury - August 7, 2020,** A crew was tasked to install a 25 kVA transformer, fuse holders, fuse holder arm, and secondary triplex at the rear of a residential property, next to a chain link fence line with a gate. The property had a significant number of trees and the pole was surrounded by a dense canopy of leaves and branches. The crew arrived onsite, assessed, and held a tailboard, then proceeded to set up the equipment. The lineman and an apprentice were tasked to ascend the structure to install protective cover, place rigging, and install a new cutout (fuse) arm and transformer. They utilized a capstan, transformer gin, swivel block and bull rope to install the transformer. The foreman was in charge of operating the capstan, and the cable splicer and another apprentice were assigned to be ground support. The trees and the dense canopy made it challenging for the crew to have a clear line of sight to the pole top and aerial work being performed. Much of the work was performed utilizing verbal communication. The crew successfully installed new cutout arm and transformer with no issues. Once their work was completed, the rigging was removed and the lineman handed down the bull line to the apprentice with the block still attached. As the apprentice took control of the bull line with the block attached, the block rotated toward the gate, the gate released, and the block detached from the bull line. The Apprentice yelled "Headache" to advise ground crew of falling object. As the cable splicer turned to distance himself from the structure, the swivel block struck him on the right lower back and the impact caused him to collapse to his knees. The cable splicer was approximately 6.5 feet away from the structure at the time of impact. The foreman tended to the crewman as he sat and rested for a few minutes, then later was transported to the nearest hospital. The incident resulted in a fractured vertebra.

Date Of Incident	Occupation	Type of Incident	Body Part / Root Cause	Description
8/20/2020	Outside Crew	Significant Injury	Fractured Toe	**Injury - August 20, 2020,** A transmission crew was tasked with removing underground equipment in a wooden crate from a Conex box and to load it up on a trailer in preparation for transport the next day. A groundman and 6th step apprentice planned to use a forklift to remove and load the crate on the trailer but determined that the wooden crate was stored too far into the Conex box for the forks to get under and lift the crate safely. The apprentice and groundman decided to rig a rope sling around the wooden crate and attach it to the forklift to pull the crate out so the forks could effectively get under and lift the load. The apprentice operated the forklift and, using hand signals to communicate, they positioned the forklift in as far as it could go within the Conex box to rig the rope to the forklift. The forks were approximately 4 to 6 inches off the floor of the Conex box. Once the forklift was in position, the apprentice turned off the forklift to better communicate with the groundman and verify they were ready for the next steps. While the groundman was rigging the rope to the frame of the forklift, the forks came down on the left foot of the groundman. The groundman started yelling to the apprentice that the forks were on his foot and to raise them. The apprentice turned on the forklift and raised the forks off the groundman's foot. Once the forks were off the groundman's foot, the groundman fell to the ground and was assisted by the apprentice operating the forklift and another lineman. The forklift was moved out of the way to provide enough room for the crew to check on the employee and to provide assistance. The foreman and GS were notified immediately. The groundman was transported to the local hospital. X-rays were taken of the groundman's foot, which identified that the groundman had a broken left big toe. After the incident and while the groundman was being transported to the hospital, the crew, under the direction of the foreman, set the forklift back up in the position it was in when the incident happened. It was identified that even when the forklift is turned off, the forks can be lowered if the handle is pressed.
8/22/2020	Outside Crew	Injury	Fall from Elevation	**Injury - August 22, 2020,** A 5-man crew and regional single-conductor crew were tasked with installing primary cable to a primary metering cabinet. After the tailboard was conducted and equipment was set up, a worker was assigned with bringing 350 cable off the reel to land at the primary metering cabinet. The worker began to use a 4-step ladder to put cover over the chain-link fence in order to feed cable over it. A metro inspector stopped the worker and requested that a taller ladder be utilized. The worker then returned to the task with the extension ladder and rested it against the chain-link fence. When the worker began to climb the ladder, the bottom slid out from under him, causing him to fall from the elevated position on top of the ladder, sustaining laceration to his elbow. The crew foreman called an "All Stop" and attended to the worker using the first aid kit, ensuring to follow all blood-borne pathogen protocols. The crew foreman then transported the worker to the ER. On the way to the ER, the worker complained of pain in his chest and had difficulty breathing. Once at the ER, the worker received four stitches in his elbow and was diagnosed with a bruised sternum. He was released from the ER later that day and was taken home where he is currently resting.

Date Of Incident	Occupation	Type of Incident	Body Part / Root Cause	Description
Contractor Circuit Interruption Incidents				
1/16/2020	Outside Crew	CCCI	Operator Error	**CCCI - January 16, 2020,** A nighttime line crew was tasked with replacing a padmount transformer. Following their switching procedure, the crew de-energized a section of a 12kV circuit for a planned outage. The crew checked hot reads on the elbows and proceeded with their program. When checking to see whether the elbow de-energized, the worker observed minimal deflection and pulled the elbow using the hot stick method. At this time, an electrical flash occurred locking out the circuit. No workers were injured, and the crew called an all-stop.
1/23/2020	Outside Crew	CCCI	Wire Control	**CCCI - January 23, 2020,** A line crew was tasked to replace a 95-foot pole outside of a substation. The pole had six (6) circuits on it: (3) 16 Kv and (2) 4 Kv with 3 primary risers. All circuits except for the Slack 4 Kv were de-energized and grounded. While in the process of shaping the jumper on the grounded Troy 4 Kv circuit, the lineman lost control of the C Phase tap and it inadvertently made contact with the energized Slack 4 Kv above (4-5 feet) the lineman, causing a large flash to occur. The lineman came to the ground and the crew stopped all work. Fortunately, all crew members were uninjured. Impact Inside the Substation. There was no damage to the pole, but there was damage to the conductor and the personal grounds inside the substation. During the inspection following the fault condition, there was found to be some pitting on the line conductor and signs of heating inside of the clam shell of the personal grounds applied to C phase. The personal grounds were taken out of service and will be destroyed.
2/4/2020	Outside Crew	CCCI	Wire Control	**CCCI - February 4, 2020,** Two transmission crews were tasked with changing out two H-Frame structures on a 55 kV line. Crew A was working on the structure that had a 16 kV crossing at a 90 degree angle under it, covered with rubber hose and blankets. This structure was located at the upper portion of a hillside. Crew B was tasked with changing out the structure that was lower on the hill and the first structure outside of a substation. While crew A was transferring the final phase of #2 copper conductor into its position on the new structure, the conductor broke. When the conductor fell, it contacted the 16 kV circuit, causing it to lock out. An All Stop was initiated immediately and the appropriate notifications were made.
4/30/2020	Outside Crew	CCCI	Wire Control	**CCCI - April 30, 2020,** A wire removal crew prepped the north and south static wires for the static wire removal over a canyon along a 220 kV line. A portion of this crew (one lineman and one apprentice) secured the north and south static wires to the snub poles. The crew also installed a sock & shackle on the static wire, but when they installed the sock to the north static wire, they did not properly complete the installation of this sock because the punch-lock bands were not installed. The next day, 4/29/20, the same wire removal crew properly removed the south static wire. On 4/30/20, the same lineman and apprentice removed the rigging securing the north static to the snub poles and began to prep for removal. The previously installed sock was secured to the 7/8'' rope puller, and the rigging and safeties were removed from the snub pole. At this time the static wire secured to the 7/8'' rope puller had approximately 3200 lbs. of tension. The lineman and apprentice realized that they had not properly installed the sock (the punch-lock bands still had not been installed). Before they were able to re-install the safeties, so they could then install the punch-lock bands and properly complete the sock installation, the north static wire slipped out of the sock and fell. When the wire fell, it contacted the crane guards that were in place. After initial contact with the guard structures, the static wire then bellied down in-between the guards and contacted the crossing 33 kV and 4 kV lines, causing a circuit interruption and four small fires which were immediately extinguished. Proper fire prevention equipment, tooling, and water resources were onsite and the crews in the immediate vicinity promptly responded to extinguish the small fires. The fire department was contacted, but the fires were extinguished prior to their arrival onsite. Fortunately, no one was injured in this incident.
6/8/2020	Outside Crew	CCCI	Circuit Map Error	**CCCI - June 8, 2020,** On June 8th a five-person crew was given the task of de-energizing all cables for a vault replacement. The structure contained three primary circuits and associated secondary cables. The crew tested the primary cable as energized prior to starting the switching program. The crew completed de-energizing and identifying grounding locations on two circuits. Once completing grounding on two circuits, the crew returned to prove that the cable at the work location was de-energized. Utilizing the Live Line Tester, the lineman and hot apprentice tested with no deflection on test points in the structure. When the crew started breaking torque on the second set of 600A components, the crew heard arcing in the component and exited the vault. The structure was cleared and the line relayed shortly after. Upon further review of the vault, it was discovered that part of a third circuit was actually routed through the vault (which did not match the circuit map). Fortunately no one was injured.

Date Of Incident	Occupation	Type of Incident	Body Part / Root Cause	Description
7/1/2020	Outside Crew	CCCI	Work Procedure Error	**CCCI - July 1, 2020,** An Electric Transmission Line Contract crew was tasked with replacing a pole on the Smartville-Nicolaus #1 60kv circuit. The crew set up at the work location, tested the circuit and found the circuit was still energized. They verified the tester by: 1) testing the adjacent 60kv and 2) testing the underbuilt distribution circuit. The tester indicated that both the circuits were energized. The crew notified the onsite inspector who contacted the Grid Control Center (GCC) operator that the circuit was testing as energized. The operator confirmed that the section of the circuit within the clearance limits was de-energized and that they were possibly testing induction from an energized 115kv crossing and adjacent 60kv. The crew then grounded the line locking our the circuit. This started a small fire at the ground source. There wer no injuries associated with this incident.
8/24/2020	Civil Crew	CCCI	Operator Error	**CCCI - August 24, 2020,** At a substation, the scope of work was to upgrade the existing substation automation. In order to provide an additional path for secondary cables, an additional cable tray was engineered to penetrate two walls in the basement and be supported under the existing cable tray. To prevent the sawcut of rebar or conduits within the wall, x-ray services were requested through Engineering. On August 4, 2020, an x-ray technician conducted a scan of the existing concrete walls and floor where saw cutting and core drilling were required. When the scanning was completed, vertical and horizontal rebars were marked out and no other conductive material was noted. On the morning of August 24, 2020, a tailboard was conducted with the civil contractor, site rep, and checker to review their scope and layout. The worker then prepared the area and proceeded to cut through the existing basement wall from top to bottom with a concrete chainsaw. At approximately 8:30 am, while saw cutting about 5 to 6 inches deep, the saw hit a conduit housing the 16 kV Latchford line. On contact, a flash occurred. The worker was operating from the second rung of a fiberglass ladder and the flash knocked him off the ladder, landing with his feet on the ground. The line re-closed and about 10 to 15 seconds later a second flash occurred. The checker witnessed the first flash, which sent him into the room with the worker just before the second flash. After that, all work immediately stopped on-site. At this point the team left the work area to assess if anybody was injured and verify what happened. The worker was not injured or burned from this event. The team then made the appropriate communication to Maintenance, Operations, and Safety about the incident.

Date Of Incident	Occupation	Type of Incident	Body Part / Root Cause	Description
Contractor Other Incidents				
4/1/2020	Outside Crew	Vehichle Incident	Operator Error	**Vehicle Incident - April 1, 2020**, A 5-man crew was tasked with replacing a run of deteriorated CIC from a vault to a 3-phase transformer in support of a 12 kV CIC replacement project. The crew arrived on-site at approximately 07:00 a.m. to prepare for the scheduled outage taking place at 08:30 a.m. They tailboarded on-site, discussing the specific tasks for each person along with notable items including clearance information and the proper testing and grounding procedures, as well as back-feed prevention. Once remote spiked, the deteriorated CIC was successfully removed with the aid of a Grasshopper (tractor), and the new cable was pulled in without incident. By approximately 14:15 p.m, most of the cable had been made up and crew members not making up cable were cleaning the site. The foreman tasked the apprentice with prepping the Grasshopper to be loaded onto the trailer. All cable had already been offloaded from the Grasshopper, so the apprentice just needed to drive it to the trailer. He put his seatbelt on, started the tractor, and lifted the outriggers in preparation to move forward. At this point, he realized that he could not see the clearance between the bottom of the witches hat and the inclined slope in front of him, so he began lifting the boom to see if that would improve his visibility. As soon as he released the controls for the boom-up, the boom jerked to a stop, causing the Grasshopper to shake and begin to tip on the uneven terrain. Despite the apprentice having the instinct to immediately boom down, it was already too late and the Grasshopper rolled on its side. The apprentice was able to unbuckle himself without assistance and radioed to the foreman while walking over to him, explaining what had just happened. The foreman immediately asked if he was okay and needed any medical assistance, to which the apprentice said no. The foreman then called an all-stop and got the crew together to evaluate steps moving forward.
4/27/2020	Outside Crew	Close Call	Back Feed	**Close Call - April 27, 2020,** Contractors in the Palm Springs district were tasked with replacing equipment on the Carriage 12kV. Two troublemen switched out a section of the Carriage 12kV beyond pos. 4, PME 4054. Prior to grounding, as the contractors performed their high voltage testing, they detected a pulsating voltage on the line. The crew called an All S.T.O.P. and called the troublemen back. The troublemen tested the line and found the same results. The troublemen recalled what they had learned in the troubleman refresher class regarding generation and interconnection. The troublemen found a house that was backfeeding into a transformer about three miles from where the crew was located. There was a customer battery backup that had not opened when the power was shut off, causing it to backfeed into the Carriage12kV. Once the troublemen cleared the problem the voltage went away, and they were able to continue the job as planned. The crews working in the field did their work in accordance with all policies and rules and used the S.T.O.P. method to prevent what could have been a very serious incident.
8/21/2020	Outside Crew	Rope Failure	Equipment Failure	**Rope Failure - August 21, 2020,** A crew installed 0.44 Unitrex rope utilizing a helicopter in preparation to haul back the 3/8's straw line and subsequently install the static and fiber lines. While the crew was performing a haul back, they experienced a failure of the rope between the rope pulling equipment and the nearest structure roughly 700 feet away from the rope pulling equipment, resulting in the rope dropping. It was noted that the failure occurred around the payed-out length of 7,000 feet from the top of the drum. The rope fell into the guard structures protecting the two distribution lines and road at the bottom of the canyon. No injuries occurred.

Date Of Incident	Occupation	Type of Incident	Body Part / Root Cause	Description
Customer Accidents/Incidents				
6/18/2020	Emergency MGMT Team	Burn	Hand Burned on Hot Muffler	**Burn - June 18, 2020,** An employee was demonstrating how to utilize a fire pump to his coworkers. As he learned forward, he unwittingly place his right hand (not wearing gloves) on the hot muffler of the fire pump injuring his hand. A serious Injury Prevention Team (SIPT) member onsite provided first aid and transported the employee to the hospital for treatment where he was later released to return home.
7/29/2020	Substation Operator	Potential Flash	Operator Error	**Potential Flash - July 29, 2020,** A substation operator was dispatched to return the 1B Bank 66 kV CB after MM&D and inadvertently closed the 1B Bank 66 kV Bank Ground disconnects while intending to open the 1B Bank 66 kV Transfer Bus disconnects. No injuries were sustained to the operator. Small pitting was identified to the disconnects. Load was interrupted until a second substation operator arrived to complete the switching to return the 1B Bank to normal.
7/30/2020	SC&M Maintence Crew	Potential Exposure to Fire or Explosion	Equipment Failure	**Potential Exposure to Fire or Explosion - July 30, 2020,** While a SC&M Maintenance Crew was working at a substation, a 12 kV Circuit Breaker (CB) bushing failed, dropping a section of the 12 kV Operating bus and associated substation load. Proper Clearances, Personal Grounds and all PPE were in place. The crew had a dedicated electrical checker for the work being performed in the air to replace the line disconnects on the 12 kV CB. The electrical checker performing his duties, noticed smoke coming from the top portion of the adjacent 12 kV CB. The electrical checker immediately notified the crew. As the crew was exiting the switch rack, one of the 12 kV CB bushings failed catastrophically. The subsequent bushing failure and flash damaged the 12 kV CB and adjacent positions and associated equipment.
9/3/2020	Outside Crew	Flash	Equipment Failure	**Flash - September 3, 2020,** A crew was executing a project to replace a deteriorated residential transformer with the aid of district troubleman. A troubleman was assigned to operate a PME-type switch, making and breaking a parallel with an adjacent circuit. After reviewing and verifying all bullets within the Switching Technique, the troubleman communicated with the switching center and received the switching order to close position 1 of the PME. Position 1 was closed using proper rigging without incident. The switching center reviewed the circuit reads and then gave the troubleman the switching order to open position 2 of the same switch, breaking parallel. The troubleman let the equipment soak before returning to the switch to verify successful operation. As he approached, the switch failed internally, causing the doors to blow open, striking the troubleman on the shoulder. The troubleman immediately separated himself from the equipment and performed a self-check. Once he confirmed he was not injured, he contacted the switching center to relay the sequence of events and confirm that the circuit had locked-out. An All-Stop was called and the troubleman gathered to discuss and assess what had happened. Once everyone was re-tailboarded, they proceeded to isolate the faulted switch and restored power to the remaining customers.
9/4/2020	Outside Crew	Flash	Burns to hands, neck & face	**Flash - September 4, 2020,** A crew was tasked with replacing a hot elbow on a looped/switched three-phase transformer out of a substation. The crew was comprised of an upgrade foreman, a lineman, and a 5th-step apprentice. The job was set up to utilize the loop switch to de-energize the B side of the transformer so the crew could safely replace all three of the existing load break elbows. The crew successfully completed the elbow change-out and, upon re-energizing, used a 15' hot stick. The transformer failed, causing the circuit to lock out. The upgrade foreman called the switching center and the field supervisor. The lineman and the apprentice suffered burns to the hands, neck, and face. 911 was called, and they were immediately transported to the local hospital before being transferred to Grossman Burn Center. Both are in a stable condition and in good spirits.

Safety Stand Down – Contractors

August 2020

Energy for What's Ahead℠

SOUTHERN CALIFORNIA EDISON®

Exhibit B

Instructions for Leaders: Meeting Prep

Your Role

- Schedule a team meeting to discuss information in this presentation within **1 week** (2 weeks if you held a stand down the week of 7/31)
  - Address ideas and concerns related to wellbeing, production pressures and other changes that may affect your team, such as COVID-19. Ask workers to reflect on each of the incidents and how the outcomes could affect their lives
  - Ask your team to share their insights on how they plan to recommit to owning their safety and the safety of their peers, and changes that can be made that improve the safety of their work
- If facilitating onsite – follow all COVID-19 physical distancing requirements (see slide 3)
- If facilitating via Skype/MS Teams – ensure employees have access to the material so they can follow along (on screen or in email)
- Help your people feel comfortable by creating a caring tone – share personal stories and insights

Tips to keep your team safe

- Discuss distractions (such as COVID-19) and the importance of focusing on What's Important Now (WIN)
- Ask how they're choosing to be safe for themselves, coworkers and family
- Remind them to make the safe choice. Every time. – use the STOP method, don't rush, use proper equipment
- Talk about identifying what's in their control – instead of what they can't control
- Monitor them to prevent injury – shift resources, take a break, stop work if necessary
- Before critical tasks always use "Pause and Peer Check" process

THIS SLIDE SHOULD NOT BE SHOWN DURING EVENT

Instructions for Leaders: COVID-19 Reminders

If attending this stand down onsite, comply with all COVID-19 requirements:

- Practice physical distancing by standing/sitting at least 6 feet apart
- Wear a mask and gloves, as necessary
- If handling hard copy material, be sure to wash or sanitize your hands thoroughly

DO NOT COME TO WORK IF YOU HAVE ANY SIGNS OF ILLNESS

Distractions and stresses can take a toll, use these safety and health resources:

- Edison's External Contractor Site (access may need to be granted)
- CDC COVID-19 mental health support

THIS SLIDE SHOULD NOT BE SHOWN DURING EVENT

Instructions for Leaders: This Is What You Need To Do

Your primary role as a leader is to **ensure the welfare of your team**.

- **Gauge your team's wellbeing and mindset** – before your team leaves the yard, check-in and talk to your people – if they're not in the right frame of mind, find a new plan
- **Create a positive environment** where everyone has a voice and is empowered to speak up
- **Be an active leader** – have ongoing conversations with your team, and perform observations and crew visits so you know what your teams are doing and **how** they're doing
- **Adjust priorities –** be thoughtful when it comes to work assignments to ensure the physical and mental safety of your teams
- **Reach out** – engage your management and peers when issues are not addressed

Safety should not be compromised – EVER.

THIS SLIDE SHOULD NOT BE SHOWN DURING EVENT

Ten families' lives have been changed forever.

Whether their loved one was fatally or seriously injured, their families will never be the same.

Why We're Meeting

This is a serious **call to action** – not just a 'check-the-box' activity

We must do something different.

Between May and July, **10** of our colleagues were significantly injured – **1** of which was fatal.

The work performed during these events is not new or different.

Put yourself in their shoes. How would the outcomes impact you?

How would they affect the people you love and activities you enjoy?

How can we keep each other safe?

What can we change or do differently?

Why We're Meeting

During these unprecedented times, it's especially important to bring an increased awareness to everything you do. It's easy to get distracted during the best of times, that's why it's even more critical to focus on what's important now.

We must be extra caring and careful.

We must stop a job if it is unsafe.

We must speak up when something is going wrong or going right.

We must think about the outcome and who it affects.

We must make a choice to have a positive impact.

We must do something different.

Recent Incidents | May 14 – July 29

On **May 14** a foreman was ascending a tree. He leaned back and fell 60 feet because his lanyard was not connected. He sustained a back injury.

On **June 1** a lineman was struck by a wire grip that fell from an elevated work platform. The lineman sustained neck and shoulder injuries.

On **July 1** a lineman sustained multiple injuries after a pole swung around and he was caught in the bight between the trailer tongue and pole.

On **July 6** a lineman sustained multiple injuries when he climbed out of his bucket onto the rack to remove and replace a crossarm. He then fell 30 feet to the ground.

On **July 6** an E-Crew foreman sustained a concussion and lost consciousness when the double bucket, 3-axle truck he was driving tipped over on a downhill curve.

On **July 6** an apprentice lineman was struck by a crossarm after it hit the top of one pole, causing it to swing erratically and hit the apprentice in the back resulting in a compression fracture.

On **July 22** an apprentice lineman was operating capstan and after hitting the dump button for the power take off (PTO), the rope recoiled back towards the capstan, lacerating his left thumb.

On **July 22** a lineman made contact with energized conductor, resulting in a fatality.

On **July 28** a lineman fell 37 feet from a bucket, resulting in multiple severe injuries, including brain swelling, a broken pelvis and liver damage.

On **July 29** a lineman was injured when he had a rollover in a Polaris while conducting a relay patrol.

Critical Reminders

We are facing extraordinary distractions during COVID-19 that can contribute to a loss of focus putting us at higher risk for injury.

Take this time to reframe your mindset. Commit to owning your safety in all that you do.

Things you can do **right now.**

- Talk about it. Discuss what you can do differently or better
- Find a way to keep your head in the game – focus on what's important now (WIN)
- Reframe your thoughts when you're anxious to finish a project or meet a goal
- Take a break if you're distracted, tired or thinking about personal issues
- Identify what can go wrong on a job BEFORE you start
- Speak up if you see an unsafe practice or an unsafe team member
- Remind yourself about why you want to stay safe and what would happen if you got hurt

Critical Reminders

In addition to your tailboard, perform a self or peer check to prevent a serious injury, using the **Pause and Peer Check Process**

The Pause and Peer Check Process includes validating:

- You and your peer are clipped in and ready to begin your task
- The required arc flash calorie count is worn for your task
- You have the right level of cover, plus 1
- You are testing and grounding correctly
- Aerial lifts are free of debris or clutter – you should be standing on the bottom of the lift, not debris or clutter
- Aerial lift operating controls are easily accessible and not blocked by material or equipment

This list is not exhaustive.

Discuss with your team ways the Pause and Peer Check Process can be applied to other tasks.

Critical Reminders

Working on high-voltage is never routine.

SCE contractors are expected to follow their own rules and consider SCE's practices, as these steps help eliminate serious injuries and fatalities.

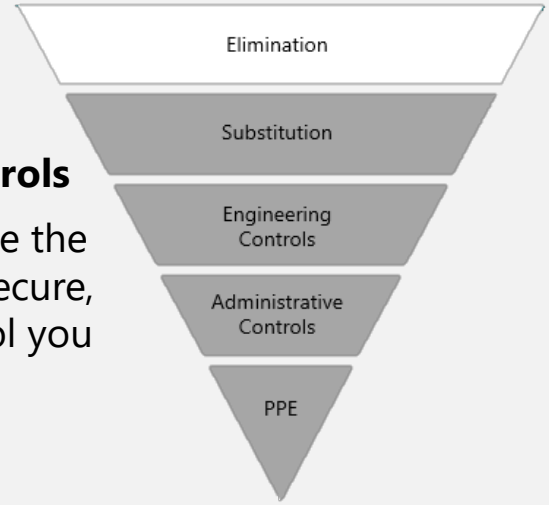
STOP before starting any critical task
Assess the scope of work and STOP the job if there's any observable hazard.

Ask for Help
If you're not familiar with a tool, equipment, or task – **ask someone** – for help, for a spotter, for someone more familiar to the lead the way.

- ✓ Ensure 3-way communication on any critical tasks
- ✓ Utilize peer checks regularly to reduce risk
- ✓ Know your powerflow
- ✓ Always use proper rigging practices
- ✓ Have an emergency preparedness plan prior to starting the job
- ✓ Keep your body and equipment out of the line of fire
- ✓ Ensure drivers are qualified and understand potential hazards for the equipment they're handling
- ✓ Know the required arc flash calorie count for your task
- ✓ Have a quality tailboard to identify hazards and eliminate risk

Use the hierarchy of controls

Your PPE should be the **first** control you secure, but the **last** control you rely on



WIRED FOR SAFETY

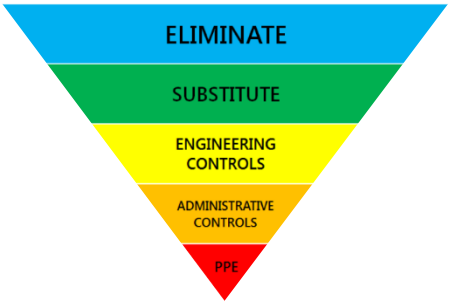
September 7, 2020

Primary Hazard Focus: Situational Awareness

Something to learn for all lines of work. Safety topics, trends, known hazards and best practices for use in tailboards to help keep yourselves safe.

Situational Awareness: that's a fancy term for being aware enough of your surroundings to identify potential threats and dangerous situations.

Hierarchy of Controls



What's the connection?

By being aware of what's going on around us and using the Hierarchy of Controls to get ahead of or properly address real-time threats and hazards, we create a cycle that can result in the safest work environment within our control

Situational Awareness

HISTORY TELLS US...

You are more situationally aware than you might think.

Walking to your car at night. Driving through an unfamiliar part of town. Walking with your family through a crowded venue (remember those days?). Getting cash out of an ATM...these are personal situations in an average day when we are often more aware of our surroundings, scanning for potential threats and dangerous situations. So, what keeps us from transferring that same level of attention to our work life?

Now, before we get too far into this, few things are as frustrating as being lumped in with the masses whose behavior is lacking. So, to those of you who intentionally keep your head on a swivel out there, we applaud you. You are the ones who notice things out of the corner of your eye. You are the ones more interested in scanning the jobsite for hazards throughout the day rather than being head-down on your mobile device. You are the ones who review and keep emergency procedures top of mind at each jobsite. You are the ones who do all this in an effort to create or keep a safe work environment for yourself and those you work with – even when no one else is doing it.

Yes, it might take some doing to be focused enough on your own task but still be mindful of what's going on around you but, again, it's really just a matter of engaging the mindset you use elsewhere. There are some quick wins to help you get used to the idea, like checking in on each other when you're working in high heat, knowing what the Emergency Action Plan is for your specific job that day (and not just relying on what it was for the "last job.") And, there's always asking those "what if" or "what happens when" questions before: moving equipment, managing the controlled load with that tag line, working near a drop zone or working in proximity to energized equipment or circuits.

Personal safety isn't just following policies and procedures...it starts with an awareness of your environment and - within that context - how you apply those policies and procedures while being aware enough to adjust if you need to.

Because, it's a given that even though we may not be able to foresee every eventuality, no one wants to be sucker punched by something they could have seen coming.

WIRED FOR SAFETY

September 7, 2020

Primary Hazard Focus: Situational Awareness

No matter the type of work you do, there is always something to learn from shared events.

INCIDENT: Kernville, CA August 2020 | Real Incidents for Your Real Life

A Hot Line Construction (HLC) traffic control subcontractor was tasked to provide flaggers and a lane closure for three HLC crews re-conductoring a 12kV line. The traffic crewmen were actively engaged in the flagging operation, with a flagger to control the flow of traffic.

One of the HLC crews was in the process of setting a new structure, with an SCE troubleman observing the work - a typical joint-work effort. While observing the HLC crew, out of the corner of his eye the troubleman spotted the flagger on his back in the roadway. The troubleman was right next to the HLC foreman and both rushed to the flagger's aid. Upon initial evaluation, the flagger was cold to the touch, no pulse and sustained a laceration to the back of the head from his collapse. The HLC foreman told a crewman to call 911 and the SCE Troubleman utilized his SCE radio to dispatch emergency medical services to their location.

An HLC apprentice - who happened to be a former Army medic - took control of the scene and performed a medical evaluation while the troubleman retrieved an AED from his vehicle. The apprentice started CPR on the flagger. Once the AED arrived, the foreman placed it on the flagger and after evaluation, the first shock was administered. No response. CPR was administered for approximately 1 minute 45 seconds, followed by a second shock. The flagger gurgled for a second but still, no pulse. CPR was administered again, followed by a third shock.

The flagger gurgled, started to breathe on his own and had a shallow pulse. Once the flagger was revived, a crewman applied gauze and pressure to the head wound. The flagger was combative with seizure-like episodes. Tulare County Fire, Station 5, arrived on-scene and relieved the crew. The flagger was transported to the hospital by ambulance and suffered two additional heart attacks while in transit. He was revived after each episode and admitted to the hospital. As of the time of this publication, the flagger is recovering.

Note: Not images of the actual flagger involved in this incident.

Safety Reminders | Learning From What They Did Right

- ✓ The troubleman was aware enough of his surroundings to notice the dangerous situation. That's situational awareness at its best.
- ✓ The crew, troubleman and apprentice reacted immediately, worked together and used clear communication during the incident
- ✓ There were individuals on the job properly trained in CPR and AED operations
- ✓ The trained individuals clearly paid attention during their training so that when the opportunity arose, they could put their training into action
- ✓ The crew and troubleman knew and followed jobsite emergency protocols and had an accessible AED on-site

How Much Do You Know?

1. If a bystander had an AED and placed it on the patient, whether or not it ultimately delivered a shock, survival increased to 23%, and if an AED was placed and a shock given, the survival rate was _____ . For patients who received bystander CPR followed by defibrillation by the EMS services, survival was 15%.
2. The Occupational Health and Safety Administration (OSHA) identifies a workplace emergency primarily as "an _____ situation that threatens your employees, customers or the public."
3. Using electronic devices can seriously impair your ability to be aware of what is going on around you. Look up occasionally to ____-_____ your surroundings and make note of any changes.
4. Most people automatically _____ new situations or environments, but don't always focus on the most _____ information
5. _____ safety begins with an individual's _____ to their environment – no one can defend against danger they couldn't see coming.

Answers: 1. 36% **2.** unforeseen **3.** re-scan **4.** scan, useful **5.** Personal, awareness

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When was the last time you reviewed the guidelines for calling on emergency services for help? There may be more recommended times than you think.

Comments or questions? Contact: ContractorSafety@sce.com

EXCERPT: SCE Accident Prevention Manual, Rule P-14

Here's what SCE's Accident Prevention Manual (APM) says about what to do when an accident occurs.

P-14. What To Do When An Accident Occurs
The following procedures covering the reporting and preliminary evaluation of all accidents shall be strictly observed:

a. Injury to Employees

1. If possible, at least one employee should stay with the injured person, rendering first aid they are qualified to perform until Emergency Medical Services arrives. If only one employee is available, they must summon emergency medical services as quickly as possible even if that means leaving the victim momentarily.
2. In the event of an emergency requiring EMS, supervisors or responding employees must call for medical assistance using available communication devices (phone, mobile phone, radio, etc.). The caller should dial 911 or follow any site-specific instructions regarding when and how to call the 911 emergency operator. The caller should be prepared to give the following information:

   (a). Name, nature of emergency.
   (b). Address, nearest cross street, and city.
   (c). Phone number you are calling from.
   (d). The caller should stay on the line until information is confirmed.

   Employees should follow any site-specific instructions regarding when and how to call the 911 emergency operators.
3. Supervisors, or responding employees, shall report the emergency per site specific or field emergency procedures. For SCE Office buildings this point of contact would be the Edison Security Operations Center. For field operations they should follow relevant OU field procedures.
4. Supervisors, or responding employees, shall report injuries that require EMS to the Watch Office: PAX 44286 or (626) 812-4286. The Watch Office will notify Corporate Safety, Claims/Law, Workers' Compensation and appropriate Business Unit Management.
5. Employees shall report all industrial injuries and illnesses to the work location supervisor as soon as possible.

What's the situation?

- Does everyone know where emergency supplies are located?
- How can I be focused on my work but maintain peripheral vision?
- Did we identify an escape route?
- Does everyone know emergency procedures to follow in various emergency scenarios? (fire, flash, fall, confined space, earthquake?
- There are lots of moving parts to this job – should we assign responsibilities to keep an eye on certain areas?
- What work is going on above me? Next to me? Behind me?
- Did I communicate this immediate task requires all my attention so they know I am hyper-focused?
- If we're playing music, can we still hear each other? What's the policy on using ear buds?
- When was the last time I scanned my work area or the overall jobsite for changes or other issues?
- Before I do this, did I ask "what if?" so I can plan ahead? Maybe play out potential scenarios before a critical task?
- Are there any specific conditions that might change we should keep an eye on?

WIRED FOR SAFETY

August 24, 2020

Primary Hazard Focus: Drop Zone

Something to learn for all lines of work. Safety topics, trends, known hazards and best practices for use in tailboards to help keep yourselves safe.

WHAT WE'VE NOTICED

255 In the U.S. in 2016, there were 255 fatalities caused by a falling object.[1]

Drop Zone[2]: An area below work that is being performed, where there is the **potential for suspended loads, tools, equipment, waste, or other items to fall** and create a hazard.

[1]U.S. Bureau of Labor Statistics [2]SCE Accident Prevention Manual

Our Edison Field Safety Advisors had good reports about most of the crews out there when it comes to drop zones. Well done. Still, recently we've had several significant injuries related to drop zones, so we are focusing an entire publication on this topic. We wouldn't be doing our job, if we didn't.

In the last four months, the following at-risk behaviors related to drop zones were identified and mitigated by Edison Field Safety observers. You may think, "Only 27? That's a pretty small number considering how many crews we have working every day." But, that was 27 lives…27 families…27 of your peers that could have been injured or worse and affected forever. Suddenly that number 27 doesn't seem so small.

No. of Observations	AT-RISK BEHAVIORS
27	• Crew has not designated or enforced a drop zone • Tools and material not secured while working aloft

HISTORY TELLS US…

Being in the zone while working is good, just don't be in the drop zone.

According to Neverletgo.com, "There are two primary types of incidents: direct impact and deflection.

Gravity as a force does all it can to make dropped items fall vertically. But, life isn't always straightforward. Dropped objects often have their vertical path obstructed, causing the tool to be deflected.

This turns the dropped object into a projectile.

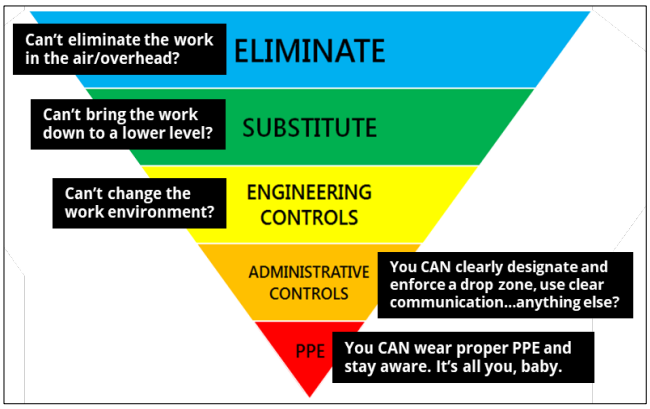
And, people often don't realize the impact forces that are generated when an object is dropped. Even with some form of protection, the result of being struck by an item of relatively low weight can be significant.

Here's example**:**

A 4 lb hammer
↓
Dropped 16 feet
↓
Will have an impact force of over 1 ton
That's like an elephant!"

So, what does all this mean for you? It means that drop zones are more important than some crews may think, because in your lines of work, items heavier than a 4 lb hammer get dropped. You risk dropping sheaves, tools, branches, chainsaws, logs, crossarms, heavy equipment and the list goes on.

Like many work practices, in addition to wearing proper PPE,



effective use of drop zones to keep crew members from being injured involves a few key things:

1. **Clear designation**: use cones or caution barrier tape to clearly designate the drop zone *(with a radius proportional to the elevated work being performed)*
2. **Follow-through in communication**: clear, 3-way communication between workers on the ground and workers in the elevated position – prior to drop zone entry and when ground workers are clear
3. **Continued awareness:** ground workers stay aware when they are near to or within the drop zone *(after receiving confirmation to enter)* and workers in the elevated position call out when something drops

And, it may seem like a hassle to shift the drop zone as the work moves, but it'll be worth it every time. Promise.

SOUTHERN CALIFORNIA EDISON®
Energy for What's Ahead®

How does your crew communicate when it comes to drop zones? Verbal commands and responses? Visual Communication? Yes, please.

Comments or questions? Contact: ContractorSafety@sce.com

INCIDENT: 2018 – 2020 | Selected Real Incidents and Close Calls for Your Real Life

Year	INCIDENT
2020	• Employee was struck on the head by a falling/cut branch during tree removal operations. • An unsecured battery-operated socket wrench fell from an elevated position striking an employee on his left hand. • While transporting Dead-ending board with a helicopter, a wire grip came loose and fell 15 feet striking an employee on neck and right shoulder. • While employees were performing work functions aloft, a grip fell and struck an employee who was working in the drop zone on the top of the head. Force from the impact striking the employee caused an approximant 1-inch laceration above ear. The struck employee was wearing all PPE, including Class E hardhat. • As an apprentice working in a bucket took control of the bull line with the block attached, the block rotated toward the gate, the gate released, and the block detached from the bull line. The Apprentice yelled "Headache" to advise ground crew of falling object. As the cable splicer turned to distance himself from the structure, the swivel block struck him on the right lower back and the impact caused him to collapse to his knees. The cable splicer was approximately 6.5 feet away from the structure at the time of impact.
2019	• Employee 1 working out of bucket was removing pole steps at the communication level. Employee 2 entered the drop zone without communicating to Employee 1. A sawzall that was in a bag on the outside of the bucket got snagged on the communication line causing the sawzall to fall and hit Employee 2 on upper back. • While dead-ending a set of cables, a threaded bolt sheared and dropped the conductors to the ground. The crew had covered the drop zone during the tailboard and identified the area. There were no personnel in the drop zone and no injuries occurred. • Upon lowering hot cutters down on hand line, cutters became entangled within a tree and communication lines falling from hand line. Upon hitting the ground the cutters grazed the front of an employee's shin. • As the helicopter was beginning to get tension on the long line, the belly hook inadvertently released the line causing the grapple hook to fall 6 feet onto an employee's thigh, who was in a squatting position on the ground. • While working de-energized property line secondaries, wire slipped through a 3-spool rack falling to the ground striking employee on hard hat. • Crew was hoisting an insulator using a truck mounted butterfly wheel. The insulator was being raised to the employee working in the bucket approximately 30'-40' from the ground. As the insulator was being raised, the knot used to secure the rigging line came apart causing the insulator to fall to the ground. The crew immediately yelled "in the hole" as the insulator fell. No employees were working in the identified drop zone. • While removing an underground transformer the long line from the helicopter was released. An employee under the helicopter was struck by the rope and ring. • While in the process of re-conductoring, de-energized wire made contact with yellow bag hanging on arm. Wrench fell out of bag striking employee on hard hat. The employee received laceration to forehead and required 6 stiches.
2018	• In the process of setting a pole that was framed with a one-inch riser, a crew used an old back brace to protect the riser from the choker sling. As the pole landed in the hole and the load was released, the back brace fell and struck employee in the back of his head. • Employee on pole was hit in cheek by drill that fell out of the Bucket truck. • During a pole replacement, an employee was struck in hard hat by a roller. • While working in a manlift on 220kV disconnects, an impact driver fell from the elevated position and struck employee below on his hardhat.

Critical Observable Actions (COAs): Excerpts from complete COA lists

This week's Critical Observable Actions* (COAs) focus on drop zones. And, since there are COAs related to drop zones for Underground Civil, Compliance Tree Trimming, Overhead Distribution, Substation and Transmission Bulk Power, we've listed them here. You'll notice some commonalities. Check them out. Commit them to memory. Put them into practice.

Compliance Tree Trimming

Climbing and Palm Trees
- Clearly marked and enforced drop zone
- Ensure tools used aloft are secure
- Clear three-way communication with all crew members

Aerial Lift
- Clearly marked and enforced drop zone
- Ensure tools used aloft are secure
- Clear communication with all members

Chainsaws
- When a chain saw is carried aloft it is secured against falling

Overhead Distribution

Dropped Objects
- Crew has established a clearly defined drop zone.
- Tools are tethered.
- Tools hung from the bucket are secured properly.
- Crews are using handlines

Suspended Loads - Rigging Failure
- Rigging is tagged and in good condition.
- Rigging sufficient for the weight of the load.
- The load is rigged correctly.
- The crew is using tag lines to control the load if applicable.
- Rigging is protected against sharp edges.
- The load is not flown over crew members, pedestrians, etc.

Helicopter Operations – Dropped Loads
- Load is rigged correctly.
- Rigging is inspected and in good condition.
- Pole is secured by ground crew.
- Crew is using SONO tubes when setting poles
- Crew waits until pole is at waist level before guiding.

Underground Civil

Suspended Loads - Rigging Failure
- Rigging has been inspected, is tagged, and is in good working condition.
- The load lifted is within the working load limit of the rigging and equipment.
- The load is rigged appropriately and by a qualified rigger.
- The load is moved in a controlled manner, using tag lines when necessary.
- Crew and pedestrians remain out from under the load and its path of travel.

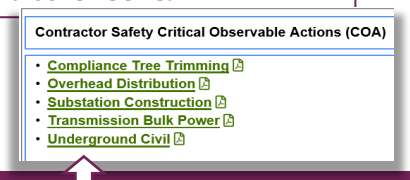
What does SCE's Accident Prevention Manual (APM) say about drop zones? Rule 148...check it out. See anything you can use?

SCE APM - Rule 148. Drop Zone

Prior to a worker entering into the drop zone area, the person(s) on the ground will communicate to those worker(s) in an elevated position that they are entering the area. Confirmation will be communicated prior to entering the drop zone.

Drop Zone is an area below work that is being performed, where there is the potential for suspended loads, tools, equipment, waste, or other items to fall and create a hazard.

Featured on this page are drop zone/falling object COAs for these work types. Bookmark this site for complete lists of these and other COAs!



*Critical Observable Action: An effective, visible action to mitigate a primary hazard.

Critical Observable Actions (COAs), continued

Substation

Ladders
- Work zone is secure
- Workers remain clear of the drop zone
- Worker on ladder secures tools and materials from falling, using tool lanyards when applicable
- Employees use a handline to raise and lower materials. If worker must carry tools or materials, it is done in such a way as to not compromise safe movement on the ladder

Aerial Lift
- Employees are kept away from the drop zone
- Employees aloft secure tools and materials from falling, using tool lanyards if applicable

Enclosed Space
- Material lines are used when required

Concrete Construction
- Work zone is secure
- Workers remain outside of the drop zone

Scaffolding
- Work platform is free of clutter, mud, oil or any tripping hazard

Wiring Installation - Secondary Cable
- Work zone is secure
- Workers remain clear of the drop zone
- Crews are communicating well

Transmission Bulk Power

Aerial Devices
- Crew has established a clearly defined drop zone
- Tools are tethered
- Tools hung from the bucket are secured properly
- Crews are using handlines

Helicopter Operations – External Cargo
- Approved long line is inspected and in good condition
- Loads are rigged appropriately
- Pre-approved flight plan is in place
- Load is not approached or handled until chest height or lower
- Minimal personnel are underneath load

Helicopter Operations – Human External Cargo
- Tools are tethered

Spacer Cart Operations
- Tools and equipment are secured

On average, nearly 140 people are struck by a falling object every day in the US[3]

Use that big brain of yours to think about what you are going to do before you do it.

- Based on the overhead work, how wide should the drop zone be?
- The overhead work has moved. Did we move the drop zone with it?
- Before I go up, are the tools in my belt properly secured? What about from the bucket?
- Is there clear line of sight between workers in the air and workers on the ground? If not, what's the plan?
- Is there anything the handline, tools or material can get hung up on? Did we establish a wide enough drop zone?
- How are we going to mark the drop zone? Cones? Caution tape?

- Is there any part of the work that can be done on the ground?
- How will we communicate to be sure ground support receives confirmation to enter the drop zone? And to confirm that the ground support is clear?
- Which one of us is responsible to enforce the drop zone? That means keeping crew members, work site visitors and the public out of there.
- Did we talk about the drop zone in the tailboard? If not, let's talk about it now.

*Critical Observable Action: An effective, visible action to mitigate a primary hazard.

[3]OSHA

WIRED FOR SAFETY

August 10, 2020

Primary Hazard Focus: Fall Hazards & Prevention

Something to learn for all lines of work. Safety topics, trends, known hazards and best practices for use in tailboards to help keep yourselves safe.

WHAT WE'VE NOTICED

Are you doing the right thing the wrong way?

649 Observations where the crew was using 100% fall protection

111 Observations where ladders were in good condition and used properly

No. of Observations	AT-RISK BEHAVIORS
15	Fall protection not worn properly
10	Fall protection not in good condition
8	Climber not using two points of attachment when in working position
6	Fall protection not properly anchored
7	Ladders not in good condition or used improperly

HISTORY TELLS US…

The "one time" you *don't* do something may be the most important time you should have done it. You've got your routine, your process, your program or technique, your checklist, your personal thought process – whatever it is that prompts you to take the step(s) necessary to provide the best or safest outcome. Then…the one time you don't lock your vehicle, something gets stolen. The one time you don't ignore a link from an unknown source, you get hacked. The one time you don't double check that tie-in, that knot, those ladder feet, that anchor point, that next spot you'll step to…you get the idea. So what's behind that "one time" of not doing it?

Could be a number of reasons, some unintentional and some not. But regardless of the intent or lack thereof, the impact happens all the same. The distinction of intent vs. impact is an important one to make, especially when it comes to tools and PPE. **Using the proper** tool or PPE shows your intent to keep yourself from injury, follow the rule or policy. **Properly using** that tool or PPE shows you are actually making an impact on working safely, for yourself and those around you. That's where awareness and prevention come in to play. As they relate to falls, you're going to use the ladder – awesome. But, did you check its condition from one day to the next or are you assuming those feet still won't slip because they didn't yesterday?

You're using your fall protection – what a rock star. But are you using it correctly? Is it anchored properly? Did you conduct an assessment of the structure you are

going to climb? You've identified your best three points of contact to scale that equipment or get in and out of that vehicle – right on. But do you actually use those points for leverage or think "you've got it" and will be fine? Or back out if your path doesn't work as anticipated? You set up the barricade around the trench – good looking out. But is it set up properly…sturdy and visible to crew and passersby? You're tied off or anchored in for the job – but do you double check that status before you continue your climb or lean out? Your harness is tied in but is it being worn and adjusted properly?

Many of you are nodding yes, because many of you do these things. But the one time you don't, well, you never know. And only you can commit to yourself to make good on your intent so that the resulting impact is what you're after. So, ask yourself, what do you need to do to make that happen? And since very few things are just about ourselves, use the Pause and Peer Check Process to look out for your crew members' fall protection as well.

Is everyone clear on what 100% fall protection really means?

WIRED FOR SAFETY

August 10, 2020

Primary Hazard Focus: Fall Hazards & Prevention

No matter the type of work you do, there is always something to learn from shared events.

INCIDENT: 2018 – 2020 | Selected Real Incidents and Close Calls for Your Real Life

Year	INCIDENT
2020 5 incidents *(1 fatality)*	• Two employees were tasked to double dead end a wire at a pole. Employee 1 climbed the pole and employee 2 used a bucket truck. Employee 2 fell 37' out of the bucket to the ground. He did have his harness with lanyard on. It was also determined employee 2 was standing on various tools and material in the bucket. • Two employees were in separate buckets working a 2-pole structure with a 17-4 rack platform. While replacing 2 sets of double-arms which supported the bus work for the bank, one employee climbed out of the bucket and onto the rack to remove the arm inside of the structure. The employee did not secure himself to the structure, fell to the ground and suffered serious injuries. • While performing tree removal operations, an employee ascending the tree to be removed reached a point on the tree (approximately 60'), and he leaned back. The work positioning lanyard was not connected, and the employee fell out of the tree and landed on his back. The crew alerted EMS and the employee was air lifted to a medical facility. • An employee was observed falling from trailer flat bed. The employee landed on the ground, on his back, then a steel section of material (previously loaded during operations) immediately fell on the employee, which resulted in a fatality. • An employee ascended a palm tree with the use of a choking configuration on their climbing system. The employee trimmed the palm tree away from the overhead conductors and once the trimming was complete, the employee switched from the choking configuration and placed their climb line over the palm fronds to descend from the tree. As the employee was descending the tree, the employee lost footing, which caused the employee to swing out from the palm tree and the climb line to roll off the palm fronds. The employee fell about 10-15 feet to the ground and landed on his lower and mid-back.
2019 4 incidents	• Employee was standing on wire trailer fender adjusting the brake on the wire reel. The surface had dust and road grime on it, which created a semi-slippery surface. The employee's foot slipped off and caused him to fall approximately 2 feet 6 inches off the trailer and land awkwardly on the ground. Employee sprained their knee. Foreman checked area and took employee to the hospital. • Employee stepped onto a lateral branch during tree trimming operations; the tree was wet due to rainfall from the previous day. The employee was tied into the tree and when he stepped onto the branch, the employee slipped and injured his crotch area. • While setting up wire stringing equipment, an employee was carrying guy-wire material/hardware on uneven ground surface across a culvert/ditch embankment, and he stumbled and lost his balance. The employee fell onto their left side, which resulted in a fractured left collar bone. The job was stopped, and the employee was transported to a medical facility. • While an employee was positioning to kneel on a kneeling mat behind a control panel, the steel floor plate he was standing on became dislodged from its location and caused the employee to fall partially into the basement beneath the floor plate, striking their left ribcage on panel-mounted equipment and floor.
2018 4 incidents *(1 fatality)*	• While an employee was aligning a flange on top of a bank, a pry bar came loose, which caused the employee to lose balance and fall approximately twenty feet to the ground. Employee sustained serious injuries. • While replacing a pole, an employee was removing the last point of attachment and the pole broke approximately one foot below ground level. The employee was attached to the pole with an approved fall restraint device near the communication level and rode the pole to the ground. • While performing tree removal operations, an employee fell from the tree, which resulted in a fatality. • An employee was in the process of loading equipment in a bucket truck. The employee was on the top step that is on the outside of the of the bucket (not part of the bucket) and had both hands on the bucket for support while preparing to descend. As the employee stepped down, he contacted the edge of the 2nd step and his ankle rolled, which caused the employee to lose his footing and fall approximately 9 ½ feet onto the street.

The Adjustable Friction Saver – a recently implemented fall protection device for our compliance tree trimmer partners. Special training required. Way to stand out and lead the charge.

Comments or questions? Contact: ContractorSafety@sce.com

Critical Observable Actions (COAs): Excerpts from complete COA lists

This week's Critical Observable Actions* (COAs) focus on falls. And since there are COAs for underground civil, compliance tree trimming and overhead distribution work types, we've listed them all. You'll notice some commonalities. See attachments for complete COA categories in each work type. Check them out. Commit them to memory. Put them into practice.

Compliance Tree Trimming

Aerial Lift
- Fall protection correctly worn
- Lanyard attached to bucket anchor
- Boom truck set up per manufacturer's recommendation with outrigger pads and wheel chocks

Ladders
- Maintain 3 points of contact
- Ladder won't fall and in good shape
- Engaged observer when worker over 12 feet in the air
- Non-slip safety feet on each ladder

Climbing and Palm Trees
- Pre-climb and trim assessment done
- Double tie-in when in working position
- Tie-in to main trunk/stem
- Correct gear and tools in good condition
- Fall protection correctly worn
- Tied into main trunk/stem with a false crotch

Chainsaws
- Secondary tie-in when using a chainsaw aloft

Underground Civil

Vehicles and Heavy Equipment
- The crew uses three points of contact when ascending or descending heavy equipment and vehicles
- Crews working aloft have personal fall protection equipment and are anchored to a rated anchor point

Excavation
- Excavation is barricaded or covered to protect pedestrians and crew members
- Crew has evaluated and confirmed any task-specific requirements for fall protection
- Trench plates are placed correctly to protect vehicle traffic and pedestrians

Enclosed Space
- The enclosed space is barricaded and/or monitored by an attendant

Overhead Distribution

Vehicles and Heavy Equipment
- Crew maintains three points of contact when ascending and descending
- Walking surfaces are free of tripping hazards and oil

Overhead Distribution
- The crew has confirmed the structure is safe to climb *(visually and physically)*
- Pole is adequately supported if required before climbing
- The crew is using 100% fall protection
- Personal fall protection and equipment is in good condition and worn correctly
- Fall protection attached to appropriate anchorage point

Ladders
- Ladder is in good condition
- Ladder has non-skid pads
- Ladder is secure from falling and on firm level ground
- Ladder extends three feet above upper landing
- Crew is using fall protection, if required
- Ladder is set up with a 4:1 ratio
- Crew is using appropriate ladder as intended for work being performed
- Crew maintains three pints of contact, facing the ladder and working without overreaching

Are any of these COAs worth your time and attention?
Hint: the answer is "yes."

Featured on this page are fall protection COAs for these work types. Attached are complete COA lists. Bookmark this site for these and other complete lists of COAs!

Contractor Safety Critical Observable Actions (COA)
- Compliance Tree Trimming
- Overhead Distribution
- Substation Construction
- Transmission Bulk Power
- Underground Civil

When you're working from a bucket, is the bucket floor free of tools and equipment? If not, let's clean it up.

Comments or questions? Contact: ContractorSafety@sce.com

WIRED FOR SAFETY

June 1, 2020

Primary Hazard Focus: Last Line of Defense

Something to learn for all lines of work. Safety topics, trends, known hazards and best practices for use in tailboards to help keep yourselves safe.

COVID-19 UPDATES

- Executive stay at home order remains in effect with modifications for counties that qualify to move into Stage 2 and begin re-opening.
- Physical distancing continues to be required
- The CDC continues to recommend facial coverings in public. SCE requires facial coverings in-keeping with the CDC both in public and appropriate for your work type.
- Always check the CDC website for the most current information.

CDC English Resources CDC Spanish Resources

WHAT WE'VE NOTICED

Although there is no recorded observation data on the topic of last line of defense work practices – those final checks, processes and procedures that are performed just before a critical task to keep you safe – we know that most of the time they are used…and sometimes, they're not.

You've seen it happen. Maybe you said something. Maybe you didn't. Maybe it was you who missed the step without consequence (thankfully) or maybe you made the conscious choice to disregard it. Either way, it happens. What percentage of the time would you say you've observed others' behaviors on this topic? Or in your own work? Can you improve your own stats?

?% **What's your percentage?**

HISTORY TELLS US…

Sometimes the best defense is a good offense.

A lot of "pre-work" can be involved before a job gets underway…planning, switching, ordering material, scheduling, notifications, pre-job walks, coordination, outages, you name it. So much effort goes into the offensive plan. Often enough, however, and for a variety of reasons, "pre-work" gaps, work scope changes or unforeseen circumstances can show up on game day and the crew has to deal with them and still get the job done. So, a crew has got to be at the top of its defensive game because challenges like changing gears, pivoting direction or a good amount of downtime can often take your head out of the game. And in your line of work, the last thing you want is for your focus to be somewhere else.

Of course, proper PPE is recognized as the last line of defense for good reason. But, aren't there some other unsung heroes in that last line of defense category? Let's spend a minute on the importance and benefit of required safe work practices. That word "required" can be off-putting because it's an expectation others have of you but consider that when it comes to safety, that expectation can be incredibly valuable. It isn't just for kicks that certain work practices are required, like testing before grounding normally energized conductors, gas detection before entering vaults, tool and equipment inspections before use, using 3-way communication or checking structure stability before climbing trees, poles or towers. Those all fall in line with how you, on the defensive line, keep yourself from giving lurking threats field advantage over you and your crew.

Throw in use of special teams like pause and peer check, stop work authority, hierarchy of controls, detailed tailboards

and awareness of and addressing the effects of fatigue, complacency, rushing and frustration when you're out there, and you've got yourself quite a game.

How many times after a negative experience in different areas of our lives have we thought, "I should have or could have said or done something different. I could have possibly prevented it/diffused the situation/or made it safer if… " Now that's not a guilt-inducing statement by any means. Instead, it's to help us recognize that those last few seconds just before something happens or that double check, verbal confirmation, review of powerflow, tool/equipment/structure inspection or final testing before performing work on the line or position could very well be included as last lines of defense, particularly before a critical task.

So, it might help all of us if we remember to put in the work and focus on the front end of what we're doing instead of Monday-morning-quarterbacking what we've done.

What is your routine before a critical task to help you stay focused?

Comments or questions? Contact: ContractorSafety@sce.com

WIRED FOR SAFETY

June 1, 2020

Primary Hazard Focus: Last Line of Defense

No matter the type of work you do, there is always something to learn from shared events.

INCIDENT: 2018 – 2020 Close Calls | Selected Real Incidents for Your Real Life

Year	INCIDENT
2020	• Contractor A was preparing to fly the sock line for wire stringing between structures of a span that would cross over (2) existing circuits. A clearance for both circuits was issued to the general foreman. At the same time, Contractor B (a different contractor) started to perform work on one of the circuits for which Contractor A held a clearance. During testing procedures, Contractor B found the circuit to be energized and informed Contractor A, who was preparing to string wire over the circuit. Both contractors stopped work and re-tailboarded. • A crew was scheduled to replace a deteriorated H-frame structure. The foreman on the job called the senior patrolman to verify clearance on the line and the patrolman was under the impression the crew was working in an area on which they'd already held a clearance. The crew went up in a bucket to test the line before grounding and discovered the line was energized. The crew stopped work. It was discovered the deteriorated H-frame was in an energized section of line.
2018	• During a daily Pre-Trip inspection a troubleman found a bucket was not performing as normal. Upon deeper review, the troubleman discovered a sheer pin missing and a bolt backed out that supports the bucket on end of boom.

Sure, they were just doing their jobs, what was required of them.
But what if they hadn't?

How Much Do You Know?

1. The five levels of Hierarchy of Controls are Eliminate, _____, Engineering Controls, Administrative Controls and PPE.

2. An example of Engineering Controls is, "Can we change or make a change to the _____ _____?

3. The most commonly known last line of defense is use of proper _____.

4. Another way to think of Administrative Controls is, "What _____, _____ or _____ can we use to lessen the hazard threat?"

5. A level of formality that can help prevent unsafe acts but often goes unused is ____-_____ _____.

Answers: 1. Substitute **2**. work environment **3**. PPE **4**. policies, training, procedures **5**. 3-way communication

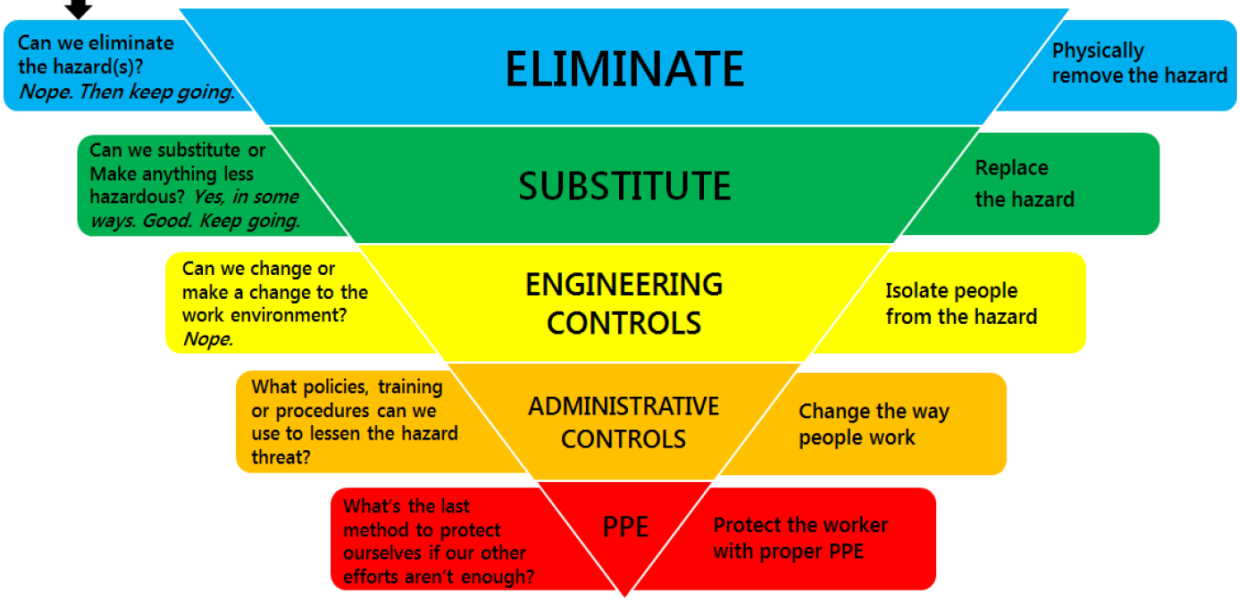
Here's Another Look…

Question: What are the most effective ways to mitigate hazards?
Answer: Use the Hierarchy of Controls

You use the Hierarchy of Controls all day, every day. You just didn't know it until now.

We rank our hazards by severity. Now rank the way you control them, by level of effectiveness. It gives you a systematic approach to controlling hazards. So go ahead, be controlling…in a good way.

Start here.



August 3, 2020

WLCC
Western Line Constructors Chapter, Inc.
An Outside Line Chapter of NECA

Foreman Upgrade Training for California Contractors

Ladies and Gentlemen, as you know we held a Special Called Red Book Committee Meeting call/webinar on July 29, 2020 to discuss the recent rash of tragic and serious accidents that have occurred in both Southern & Northern California. The overall response to the call was very positive with good participation and the discussions were very productive with the call lasting over 90 minutes. One of the suggestions that that came out of this call was the Foreman's role on the crew and the importance of having the Foreman continually receive upgrade training on their responsibilities as the Foreman on a line crew.

In that light we are encouraging everyone to participate in our Foreman Class that has been developed and updated over the years by IBEW Local's 47/1245, Cal-Nevada JATC and Western Line Constructors Chapter - NECA.

The Foreman Class is administered by our Cal-Nevada JATC Program and can be scheduled at its facilities located in Riverside (South) and Sacramento (North).

If you are interested in putting your Foreman through this course, you will need to contact our Cal-Nevada JATC Director Don Jamison to schedule a class. Mr. Jamison contact is: djamison@calnevjatc.org.

Prior to contacting Cal-Nevada JATC here is some information needed regarding the Foreman Class:

- The class will be done in person as we feel it would not be effective to try and do this via an on-line platform.
- The JATC will need several individuals signed up to do a class and because of Covid-19 they will have to work with each Contractor on scheduling the class based on other classes being held at our facilities and where the training will be taking place South vs. North, etc.
- How many individuals in your group need this training?
- What are the preferred date(s) you have for this class? The JATC will do its best to accommodate your requested dates.
- Do you have any company specific protocols, forms, tools, etc. that need addressed?
- Are there any other specific expectations you want from this class?
- Will this be a group of new Foremen, seasoned Foremen or a mix? We recommend a mix if possible.

As you can see Cal-Nevada JATC is giving us a great opportunity and we encourage all of you to take advantage of this important upgrade training.

THE SEAL THAT SYMBOLIZES ELECTRICAL SATISFACTION
NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION
QUALIFIED ELECTRICAL CONTRACTORS
NECA

Exhibit D

3M | Fall Protection

28 August 2020

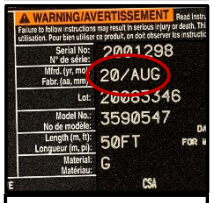
INSPECTION NOTICE

IMMEDIATE ACTION REQUIRED

3M™ PROTECTA® Rebel Self-Retracting Lifelines (ANSI Versions)

3M™ Fall Protection has identified a potential manufacturing issue with a limited number of 3M™ Protecta® Rebel Self-Retracting Lifelines (with galvanized or stainless-steel lifelines) produced between October 14, 2019 and February 25, 2020. There have been no reports of injuries or accidents associated with this issue. This manufacturing issue could result in the SRL not engaging properly but can be easily detected through the pre-use inspection as specified in the Protecta® Rebel Instruction for Use (IFU) document.

Rebel SRL



Rebel Label

Impacted Part Numbers can be found at www.ProtectaRebelInspect.com.

End Users: Please follow the steps listed below.

Step 1: Locate the label on the Rebel SRL to identify the manufactured dated (see picture to the right). If the SRL has a manufacture date of 19/10 (October 2019) through to the end of 20/02 (February 2020), continue to step 2. (Please note that regardless of the manufacture date, all SRLs should be inspected prior to every use and by a competent person annually as per the IFU).

Step 2: Pull the lifeline quickly to ensure that the SRL locks up. As per the IFU *"Ensure the device locks up when the lifeline is jerked sharply. Lockup should be positive with no slipping."* It the SRL locks up properly and passes all other aspects of the pre-use inspection as defined in the IFU, the SRL is acceptable for use. (For a full listing of inspection criteria please refer to the IFU for your respective regions which can be found at www.ProtectaRebelInspect.com). If you find that your SRL does not lock up, take the Protecta® Rebel SRL out of service immediately. Please contact our Customer Service department at 1-833-638-2697 or email us at 3musfpserviceaction@mmm.com and we will arrange to have the SRL inspected and repaired/replaced as per our standard warranty.

Distributors: Upon receipt of this Notice, please contact our Customer Service department at 1-833-638-2697 or email us at 3musfpserviceaction@mmm.com for a listing of the affected Protecta® Rebel SRLs sold to you. If you have any of the affected parts in stock, you should return them to 3M Fall Protection for repair and/or replacement as per our standard warranty. Please forward this Notice to any of your customers who have purchased affected products from you and provide any assistance requested by your customers to complete the process.

3M Fall Protection will post this Notice at www.ProtectaRebelInspect.com. 3M remains committed in providing quality products and services to our customers. We apologize for any inconvenience that this situation may cause you. We appreciate your continued support of 3M Fall Protection products and services.

3M Fall Protection
1-833-638-2697

Exhibit E

July 1, 2020

WLCC

An Outside Line Chapter of NECA

Western Line Constructors Chapter, Inc.

CHAPTER SAFETY ALERT

Approved Revised California Red Safety Manual - July 1, 2020

Ladies & Gentlemen, pursuant to an approved Motion this morning by the Safety Committee the Red Safety Manual was updated to correct printing errors form the original copy. Please note the effective date was changed to **July 1, 2020**, this will help distinguish this corrected copy vs. the previous printed copy that was dated March 11, 2020.

Please replace your previous posted PDF copies with revised Red Book that is posted on the Chapter's Website on the Home page under the Safety & Training section that is available for download now.

Thanks and have a safe and great 4th of July Holiday!

Jules

Exhibit F