Dominion Virginia Power
Near Miss Library

A Briefing for
National Electrical Workers
Near Miss System

Jake J. Mazulewicz, Human
Performance Specialist, DVP

February 2013
Washington, DC
DVP Near Miss Library
Dominion’s anonymous, voluntary, non-punitive system for sharing and reading Near Miss stories to save lives and prevent errors.

There are currently 54 published Near Miss Events

Recent Near Miss Event

01/29/2013 - The Smoking Jumper

We had a job to replace three arresters on a underground dip pole tap to the mainline with disconnects. We pulled up on the job and held a pre-job discussing the task at hand and the hazards involved. The serviceman and the service helper were making up the new arresters while the trainee took the old arresters offline. As the trainee was starting to take the last arresters offline the serviceman... read more
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<table>
<thead>
<tr>
<th>Event Date</th>
<th>Title of event</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/29/2013</td>
<td>The Smoking Jumper</td>
<td>We had a job to replace three arresters on an underground. Another service helper were making up the new arresters while the trainee was starting to take the last arresters offline. The trainee noticed the pad was dead. The trainee made a phone call to make immediate repairs. Excellent key to alternate service fed and maintain all critical hospital facilities to customers.</td>
</tr>
<tr>
<td>Report ID Number</td>
<td>02</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td>Title of event</td>
<td>The Smoking Jumper</td>
<td></td>
</tr>
<tr>
<td>Agreement</td>
<td>Yes, I agree with the statement above, and the event I'm about to enter is NOT a reportable event.</td>
<td></td>
</tr>
<tr>
<td>Event Date</td>
<td>1/29/2013</td>
<td></td>
</tr>
<tr>
<td>Event Description</td>
<td>We had a job to replace three ammeters on a ground dip pole tee to the mainline with disconnects. We pulled up on the pole and held a prejob discussing the task at hand and the hazards involved. The service man and the service repair man were making up the new ammeters while the trainee took the old ammeters offline. As the trainee was starting to take the last ammeter offline the service man asked if the jumper looked like it was starting to burn off the disconnect. The trainee then noticed that the pad was partially held on by one bolt and the pin from the diesel shoe was also melted. The trainee realized there was little holding the disconnect in the air and the crew made a phone call to make immediate repairs. Excellent key account customer communications allowed hospital to alternate service feed and maintain all critical hospital facilities. SOC switching prevented outage to over 1,000 customers.</td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td>We switched out the line to make repairs. We ended up changing out all three disconnects. Similar near misses can be prevented to always be aware of your surroundings at a ground level as well as at aerial level. Human Performance tool of tactical work zone &amp; red alert level resulted in a successful non event.</td>
<td></td>
</tr>
<tr>
<td>Coder commentary</td>
<td>When this disconnect was installed it was likely not installed correctly. The issue started where the connector was bolted to the disconnect. It could have been a couple of things that happened perhaps installers did not use connector paste, or did not get the bolts tight enough.</td>
<td></td>
</tr>
<tr>
<td>Worst Case Loss</td>
<td>Death</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Planned, scheduled, or routine</td>
<td></td>
</tr>
<tr>
<td>Stage of job</td>
<td>On site during the work task</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>Completed formal training</td>
<td></td>
</tr>
<tr>
<td>Experience</td>
<td>3-10 years</td>
<td></td>
</tr>
<tr>
<td>Business unit</td>
<td>Distribution Operations and Construction</td>
<td></td>
</tr>
<tr>
<td>Hours into shift</td>
<td>1-2</td>
<td></td>
</tr>
<tr>
<td>Sleep</td>
<td>About 7+ hours per day</td>
<td></td>
</tr>
<tr>
<td>Overtime</td>
<td>5-6</td>
<td></td>
</tr>
<tr>
<td>Contact Info</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Causal Code - 1</td>
<td>Cld - Human Actions - Error - Latent</td>
<td></td>
</tr>
<tr>
<td>CC summary - 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Causal Code - 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CC summary - 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Causal Code - 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CC summary - 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Near Miss</td>
<td>Field</td>
<td></td>
</tr>
<tr>
<td>Searchable keywords</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered on a Thursday morning conference call</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Date covered on conference call</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of person who covered it on conference call</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Photos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Published Coded Result</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Attachments</td>
<td>Photo for 1982.jpg</td>
<td></td>
</tr>
<tr>
<td>Created at</td>
<td>2/1/2012 4:27 PM by Jane J Haslowi (Virginia Power - 1)</td>
<td></td>
</tr>
<tr>
<td>Last modified at</td>
<td>2/17/2013 3:19 PM by Jane J Haslowi (Virginia Power - 1)</td>
<td></td>
</tr>
</tbody>
</table>
1) Headers

- Event Description:
  - We had a job to replace three arrester assemblies on an underground dip pole test to the mainline with disconnects. We pulled up on the job and held a pre-job discussion covering the tasks at hand and the hazards involved. The serviceman and the service repair crew were making up the new arrester assembly while the trainee took the old arrester offline. As the trainee was starting to take the arrester offline, the serviceman asked if the jumper looked like it was starting to burn off the disconnect. The trainee then noticed that the cap was partially held on by one bolt and the pin from the dead-end shoe was also melted. The trainee then fitted it in place, the disconnect in the air, and the crew made a phone call to make immediate repairs. Excellent key account customer communications allowed hospital to alternate service feed and maintain all critical hospital facilities. ROC switching prevented outage to over 1,000 customers.

- Prevention:
  - We switched out the line to make repairs. We ended up changing out all three disconnects. Similar near misses can be prevented by always being aware of your surroundings at a ground level as well as at an aerial level. Human Performance tool of tactical work zones and red alert level resulted in a successful non-event.

- Coder commentary:
  - When this disconnect was installed, it was likely not installed correctly. The issue started where the connector was bolted to the disconnect. It could have been a couple of things. Two that happened, the feeder did not use connector paste, or did not get the bolts tight enough.
  - During pre-job briefings, be sure to inspect pole and devices as thoroughly as practical before going out.

- Worst Case Loss:
  - Death

- Fatality:
  - Planned, scheduled, or routine

- Stage of work:
  - On site during the work task

- Training:
  - Completed formal training

- Experience:
  - 3-10 years

- Business unit:
  - Distribution Operations and Construction

- Hours into shift:
  - 1-2

- Sleep:
  - About 7+ hours per day

- Overtime:
  - 5-6

- Contact Info:

- Causal Code - 1:
  - Cld - Human Actions - Error - Ignorant

- CC summary - 1:

- Causal Code - 2:

- CC summary - 2:

- Causal Code - 3:

- CC summary - 3:

- Type of Near Miss:
  - Bad

- Searchable keywords:

- Covered on a Thursday morning conference call:
  - No

- Date covered on conference call:

- Name of person who covered it on conference call:

- Photos:

- Published Coded Result:
  - Yes

- Attachments:
  - Photo 1.jpg

Created at 2/1/2013 4:27 PM by Jimi J. Hazeldene (VirginiaPower - 1)
last modified at 2/27/2013 3:16 PM by Jimi J. Hazeldene (VirginiaPower - 1)
1) Headers

2) Story
<table>
<thead>
<tr>
<th>1) Headers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2) Story</td>
</tr>
<tr>
<td>3) Categories</td>
</tr>
</tbody>
</table>

<table>
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<tr>
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<tr>
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<tr>
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<tr>
<td>Causal Code - 3</td>
<td></td>
</tr>
<tr>
<td>CC summary - 3</td>
<td></td>
</tr>
</tbody>
</table>

- Type of Near Miss: Fail
- Searchable keywords
- Covered on a Thursday morning conference call: No
- Date covered on conference call
- Name of person who covered it on conference call
- Photos
- Published Coded Result: Yes
- Attachments: Photo for 19082.jpg

Created at 1/12/2013 4:27 PM by Jane J Hauser (VirginiaPower - 1)
Last modified at 1/27/2013 3:16 PM by Jane J Hauser (VirginiaPower - 1)
1) Headers

2) Story

3) Categories

4) Causal Codes (added by coders)
1) Headers

2) Story

3) Categories

4) Causal Codes (added by coders)

5) Sender Info
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1)</td>
<td>Headers</td>
</tr>
<tr>
<td>2)</td>
<td>Story</td>
</tr>
<tr>
<td>3)</td>
<td>Categories</td>
</tr>
<tr>
<td>4)</td>
<td>Causal Codes (added by coders)</td>
</tr>
<tr>
<td>5)</td>
<td>Sender Info</td>
</tr>
<tr>
<td>6)</td>
<td>Coder Info</td>
</tr>
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Event Description: We had a job to replace three arresters on an underground dip pole to the mainline with disconnects. We pulled up on the job and held a prepods discussing the tasks at hand and the hazards involved. The service man and the service repair were making up the new arresters while the trainee took the old arresters offline. As the trainee was starting to take the last arrester offline the service man asked if the jumper looked like it was starting to burn off the disconnect. The trainee then noticed that the jump was partially held on by one bolt and the pin from the dead end was also melted. The trainee realized there was little holding the disconnect in the air and the crew made a phone call to make immediate repairs. Excellent key account customer communications allowed hospital to alternate service feed and maintain all critical hospital facilities. ROC switching prevented outage to over 1,000 customers.

Prevention: We switched out the line to make repairs, we ended up changing out all three disconnects. Similar near misses can be prevented to always be aware of your surroundings at a ground level as well as aerial level. Human Performance tool of tactical work zone & red alert level resulted in a successful non event.

Coder commentary: When this disconnect was installed it was likely not installed correctly. The issue started where the connector was bolted to the disconnect. It could have been a couple of things that happened: perhaps installer did not use connector paste, or did not get the bolts tight enough.

Worst-Case Loss: Death

Priority: Planned, scheduled, or routine

Stage of Job: On site during the work task

Training: Completed formal training

Experience: 3-10 years

Business Unit: Distribution Operations and Construction

Hours into shift: 1-2

Sleep: About 7-8 hours per day

Overtime: 5-6

Contact Info:

Causal Code: 1

CC summary: 1

Causal Code: 2

CC summary: 2

Causal Code: 3

CC summary: 3

Type of Near Miss: Field

Searchable keywords:

Covered on a Thursday morning conference call: No

Date covered on conference call:

Name of person who covered it on conference call:

Photos: Yes

Published Coded Result:

Attachments: Photo for 1962.jpg

Created at 2/1/2013 4:27 PM by Jane J. (Audited) (VirginiaPower - 1)

Last modified at 2/1/2013 5:16 PM by Jane J. (Audited) (VirginiaPower - 1)
<table>
<thead>
<tr>
<th>Report ID Number</th>
<th>82</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of event</td>
<td>The Smoking Jumper</td>
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<tr>
<td>Agreement</td>
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<td>Event Date</td>
<td>1/29/2013</td>
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</table>
## 1) Headers

### Column Headers:
- Worst Case Loss
- Priority
- Stage of Job
- Tasking
- Experience
- Business unit
- Hours into shift
- Sleep
- Overtime
- Contact Info
- Causal Code
- CC Summary
- Type of Near Miss
- Keywords
- Covered on a Thursday morning conference call
- Date covered on conference call
- Name of person who covered it on conference call
- Photos
- Published/Released
- Attachments

### Sample Data:
- Worst Case Loss: Death
- Priority: Planned, scheduled, or routine
- Stage of Job: On site during the work task
- Tasking: Completed formal training
- Experience: 3-10 years
- Business unit: Distribution Operations and Construction
- Hours into shift: 1-2
- Sleep: About 7-8 hours per day
- Overtime: 5-6
- Contact Info
- Causal Code: Human Actions
- CC Summary
- Type of Near Miss: Fall
- Keywords
- Covered on a Thursday morning conference call: No
- Date covered on conference call
- Name of person who covered it on conference call
- Photos
- Published/Released: Yes
- Attachments

## 2) Story
We had a job to replace three arresters on a underground dip pole tap to the mainline with disconnects. We pulled up on the job and held a pre-job discussing the task at hand and the hazards involved. The serviceman and the service helper were making up the new arresters while the trainee took the old arresters offline. As the trainee was starting to take the last arresters offline the serviceman asked if the jumper looked like it was starting to burn off the disconnect. The trainee then noticed that the pad was partially held on by one bolt and the pin from the deadend shoe was also melted. The trainee realized there very little holding the disconnect in the air and the crew made a phone call to make immediate repairs. Excellent key account customer communications allowed hospital to alternate service fed and maintain all critical hospital facilities. ROC switching prevented outage to over 1,000 customers.
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2) Story

3) Categories
<table>
<thead>
<tr>
<th>Worst-Case Loss</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority</td>
<td>Planned, scheduled, or routine</td>
</tr>
<tr>
<td>Stage of job</td>
<td>On site during the work itself</td>
</tr>
<tr>
<td>Training</td>
<td>Completed formal training</td>
</tr>
<tr>
<td>Experience</td>
<td>3-10 years</td>
</tr>
<tr>
<td>Business unit</td>
<td>Distribution Operations and Construction</td>
</tr>
<tr>
<td>Hours into shift</td>
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<td>Sleep</td>
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<tr>
<td>Overtime</td>
<td>5-8</td>
</tr>
</tbody>
</table>
1) Headers

2) Story

3) Categories

4) Causal Codes (added by coders)
<table>
<thead>
<tr>
<th>Causal Code - 1</th>
<th>C1c - Human Actions - Error - confusion-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC summary - 1</td>
<td>Requestor linked work location to nearby tx in NMS. Comments included with request described a different work location (very near linked local). ROC failed to recognize differences. ROC produced &amp; approved incorrect switch plan.</td>
</tr>
<tr>
<td>Causal Code - 2</td>
<td>G2 – Comm./Coord. - between sites LTA - verbal only comm. is default - (e.g. crew and SOC/ROC, etc.)</td>
</tr>
<tr>
<td>CC summary - 2</td>
<td>Requestor linked work location to nearby tx in NMS. Comments included with request described a different work location (very near linked local). ROC failed to recognize differences.</td>
</tr>
<tr>
<td>Causal Code - 3</td>
<td></td>
</tr>
<tr>
<td>CC summary - 3</td>
<td></td>
</tr>
</tbody>
</table>
A1 - Design - not exhaustive
A2 - Design - error in design
A3 - Design - incorrect version
B3 - Equip.Tool.Mtl. - Design or operation confusing
B4 - Equip.Tool.Mtl. - malfunction - root cause unclear
C1a - Human Actions - Error - habit-based
C1b - Human Actions - Error - judgment-based
C1c - Human Actions - Error - confusion-based
C1d - Human Actions - Error - latent
C2a - Human Actions - Deviation - unusual
C2b - Human Actions - Deviation - routine
C3 - Human Actions - Non-Dominion controllable (e.g., 3rd party drive
D1 - Precursors - Personal (cold, flu, stress, etc)
I9 - Technique – Personal protective Equipment (PPE)
I9a - Technique – PPE - Used, but LTA
I9b - Technique – PPE - Essential piece of PPE not used
I9c - Technique – PPE - Maintenance or testing of PPE by end user LTA
NA
1) Headers

2) Story

3) Categories

4) Causal Codes (added by coders)

5) Sender Info
<table>
<thead>
<tr>
<th>Optional contact info (first name and phone number) - You do not have to complete this info, but it can be very helpful if we don’t understand something in your story and need your help to clarify it. (Over 90% of firefighters using the firefighter near miss database do share their contact info).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alfred Taylor - Monican Office Construction - 804-555-1212</td>
</tr>
</tbody>
</table>
FAQ - Frequently Asked Questions

Q. : After the Near Miss story that I send in gets reviewed and published, who will be able to read it? (1)

Q. : Can I be disciplined for the information I enter in the Near Miss Library? (1)

Q. : Can I connect to the Near Miss Library from a computer in a vehicle? (1)

Q. : Can I send in photos with my Near Miss story? (1)

Q. : Do I have to give my name when I send in a Near Miss? (1)

Q. : Does the Union support this Near Miss Library? (1)
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- Q. : Do I have to give my name when I send in a Near Miss? (1)
- Q. : Does the Union support this Near Miss Library? (1)
“Near Miss” Reporting

As we strive to send each and every co-worker home at the end of the day in the same shape they arrived, we can do more by adding a key safety component. That component is sharing near misses when they occur. A near miss is defined as an unplanned event that did not cause injury, damage, or ill health, but had the potential to do so. No one wants to have to tell a loved one that you have been injured, especially if it could have been avoided. Sharing near miss information is critical to preventing injuries and possibly saving lives. What we learn from a near miss is really a second chance that we do not often get in this business.

Safety discussions are nothing new to DVP or IBEW, Local Union 50. Company and Union leaders are in agreement that near miss reporting is very important to improving workplace safety. To avoid the fear of discipline resulting from the reporting of a near miss, Company and Union leaders intend for this letter to serve as formal notice to both employees and supervision that reporting a near miss incident WILL NOT result in discipline or other negative consequences. We want to encourage individuals to be proactive by promptly reporting near misses. This does not replace the requirement to report an accident. Injuries or property damage must be reported to a titled supervisor as soon as possible.

Company and Union leaders stand together on this important aspect of our safety effort. We have been successful in decreasing injuries over the years; however, we can always do more to prevent injuries. You will hear more about near miss reporting this summer.

If you have any questions, please talk to your management team, your local union representative, or call us.

Rodney Blevins
Vice President
Distribution Operations

Scott Hathaway
Vice President
Electric Transmission

Brad Stevens
President, Business Manager
IBEW, Local Union 50
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