



Case Study: Heavy Truck Manufacturer

Abstract

Heavy truck manufacturing as an industry has a history of high worker injury rates and related Workers' Compensation costs. One heavy truck manufacturer worked with O/E to implement SafetyIMPACT!, and significantly lower its injury rates and Workers' Compensation costs. While the heavy truck manufacturer saw remarkable improvements at all five of its locations, this document focuses on one plant that saw an 87% reduction in costs and saved nearly \$5 million in Workers' Compensation costs in the first year!

Background

Heavy truck manufacturing, as an industry, has traditionally struggled with high Workers' Compensation costs and worker injuries. One such heavy truck manufacturer came to O/E for help in reducing these costs through the implementation of SafetyIMPACT!

The plant was established in 1989 to build Class 8 vehicles and employed over 4500 workers across three shifts. The year 2007 promised to be a tough year for the heavy truck manufacturer. New emission standards that would raise the cost of a new truck by nearly \$1000 caused a buying spree as fleet owners and owner/operators raced to buy trucks built before the 2007 standard took effect. While these purchases meant record sales for the heavy truck industry, it also meant that orders for 2008 vehicles sank to dramatically lower levels.

But even without the economic factors, the heavy truck manufacturer's plant had been suffering. While in 2006 it had improved its injury rates, it still had Workers' Compensation claims totaling more than \$6.4 million. And, the union-represented plant was also facing the prospect of difficult contract negotiations, was behind in production, and would be forced to lay off 1528 of its 4500 workers.

Project Scope

O/E was hired by the heavy truck manufacturer's corporate offices to implement SafetyIMPACT! at its manufacturing locations. The one-year intervention put a SafetyIMPACT! coach on-site for a year. The coach was not on-site full time, however; rather, the coach came to the site as required to achieve specific goals and milestones. The coach's primary job was to instill six values that were held by the world's safest companies through the implementation of four benchmark practices.

Implementing the Project

The project began on May 15, 2006 and was rolled out in four distinct steps:

1. Planning
 2. Building the Foundation
 3. Implementation
- And ...
4. Measurement and Maintenance

Planning

The first step, Planning, consisted of preparing a project plan and ascertaining the company’s current state and assessing the gap between their current culture and the desired safety culture. But before these activities could begin, it was important to secure a clear and complete commitment from the executives who would be spearheading these culture changes. The coach conducted the Executive Commitment Meeting where he met with Senior Leadership and explained their roles and the importance of the successful execution of their duties. While the corporate executives agreed that SafetyIMPACT! was the best chance at successfully reversing a decade-long trend toward high worker injury levels, the Plant Leadership—while agreeing that something needed to be done—were far less confident that SafetyIMPACT! would deliver the promised results. Irrespective of these doubts, however, the Plant Leadership made a commitment to do its best to make the project successful.

One of the goals of the Planning stage is the completion of the Baseline Assessment. The Baseline Assessment records the location’s historical performance against standard safety metrics. But, perhaps more importantly, the coach asked for a personal commitment from Leadership.

The Incident Rate was very high for the location and seemed to be out of control. The plant manager believed that the increase in the Incident Rate from 2004 to 2005 was chiefly caused by an increase in new hires and that once work hardening was completed, the rate would return to its previous level.

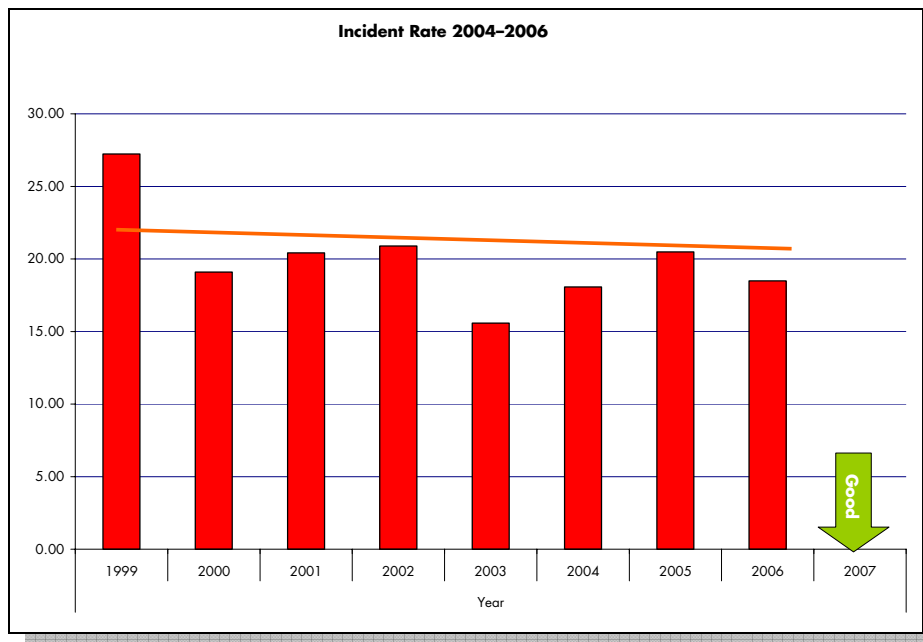


Figure 1: Plant Incident Rate

The severity of the injuries was also a concern. While the monthly totals showed no clear pattern, it was clear that there were far too many days lost because of injuries.

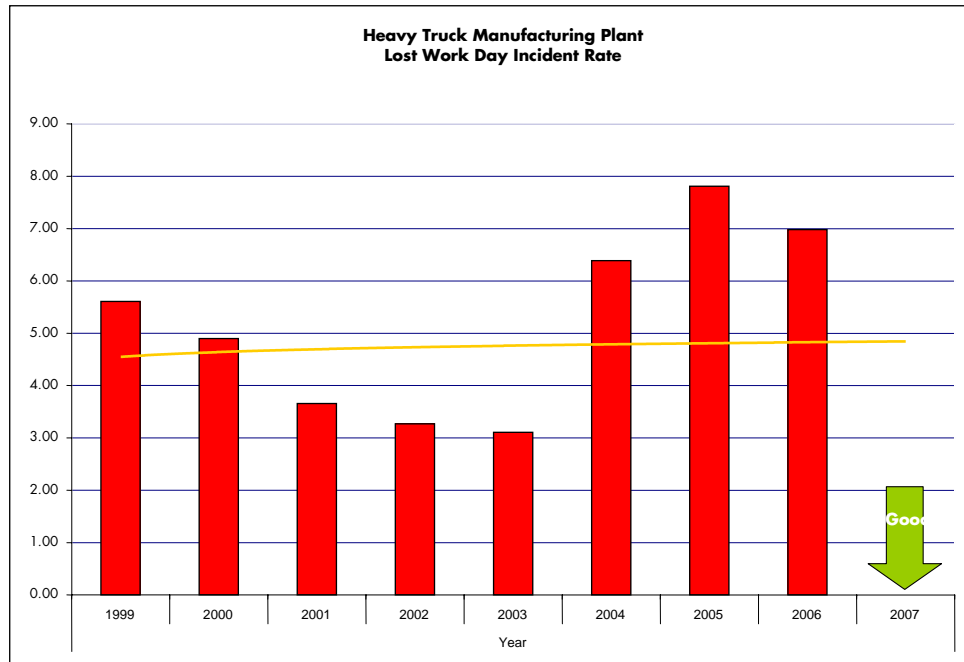


Figure 2: Plant Lost Work Day Incident Rate

In addition to the Incident Rate and Lost Work Days, the overall cost of Workers' Compensation claims and the average cost per injury was also a cause for concern because it had been rising for some time.

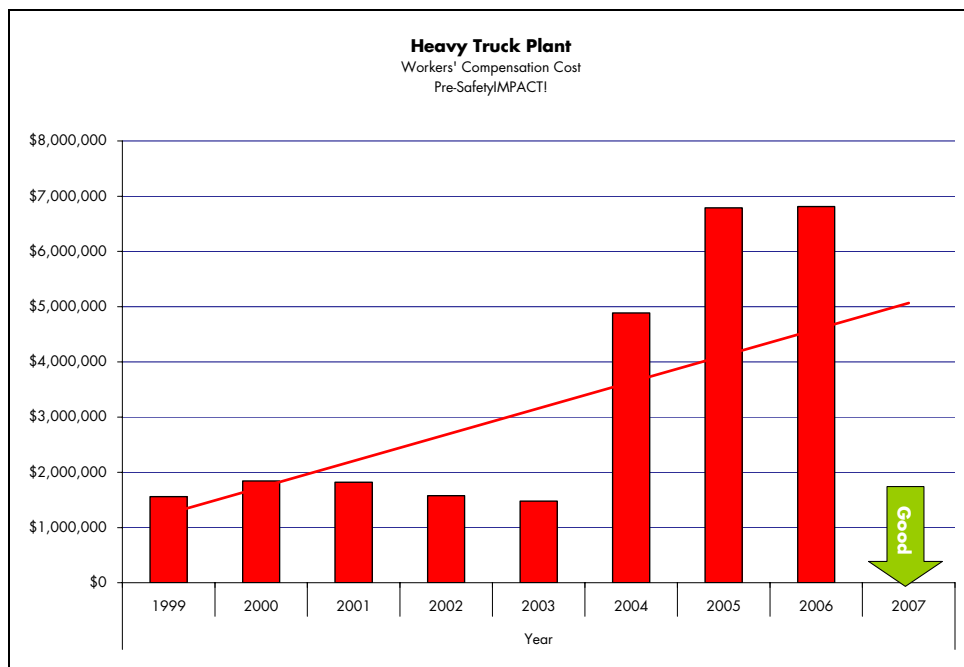


Figure 3: Total Workers' Compensation Costs

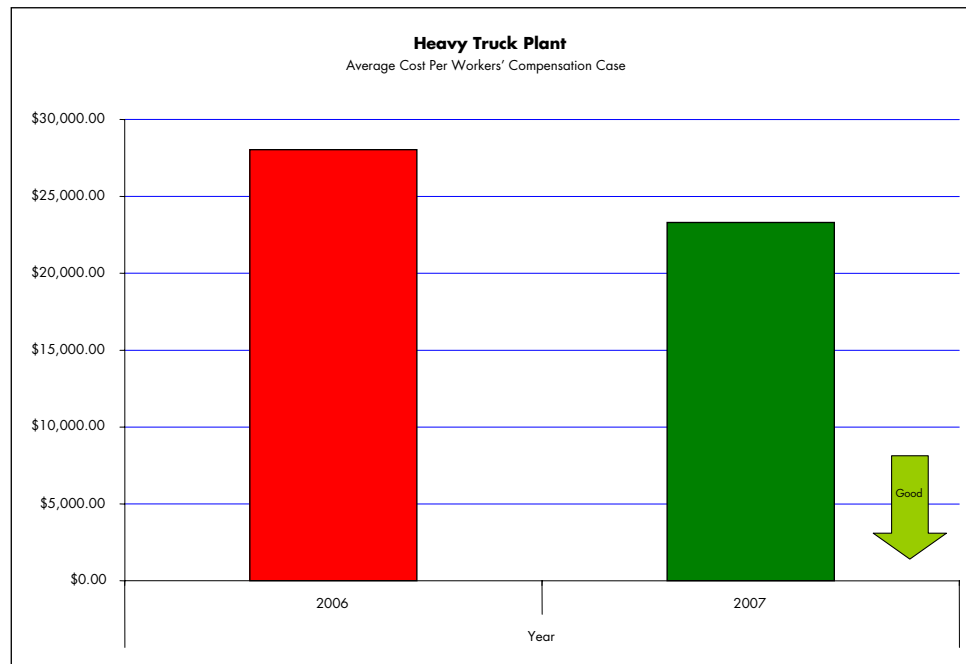


Figure 4: Average Cost Per Workers' Compensation Claim

The metrics were only part of the story, however, and the coach rapidly discovered that there was significant disagreement with the SafetyIMPACT! values:

1. *All injuries are preventable.* Many of the workers believed that it was impossible to manufacture heavy trucks without injuries. This belief was not shared by Senior Plant Leadership, however. The coach understood that this incongruence between the beliefs of Plant Leadership and those of first-line representatives and supervision could easily create significant obstacles in implementing SafetyIMPACT!
2. *Safety begins with compliance.* While there was a significant number of workplace hazards present at the plant, there was no evidence of any deliberate or willful violations of OSHA standards and requirements. This belief in the importance of complying with OSHA regulations would be an essential element in the success of SafetyIMPACT! at the heavy truck manufacturer.
3. *Prevention is more valuable than correction.* Few at the company would argue the veracity of this value, but when forced to choose between the firefighting so common in manufacturing and the preventive activities required of SafetyIMPACT!, most on the shop floor had become so engrossed in a culture of reaction that it would be very difficult to implement proactive measures without significant push back.
4. *Safety is everyone's job.* Many at the location saw safety as external from—and sometimes competitive with—production. While everyone at the company was willing to do his or her part to make the workplace safer, the location lacked an effective infrastructure for identifying hazards and prioritizing their correction.
5. *Safety is a strategic business element.* Safety was, in fact, viewed as a strategic business element, but the management of this element tended to be gauged against industry average. Since heavy truck manufacturing traditionally had high (relative to other manufacturers) Incident Rates and LWDI rates, few at the location viewed their rates as *too high* or, at very least, viewed these rates as being out of control.



6. *Safety is owned by Operations.* Operations believed that it already owned safety because the safety engineer reported to the Plant Manager (through the plant’s Human Resources organization). The Plant Operations Leadership had a different view of what this value meant than the benchmark companies believed.

In addition to the values, the SafetyIMPACT! coach assessed whether or not the company had an equivalent activity to the benchmark practices:

1. *Safety Inspections.* Members of the Safety Committee did walkthroughs and the safety engineer and union rep did annual audits. The corporate safety activity also did annual audits. In all cases, these activities were largely manual efforts and none of the data collected was tracked in a database.
2. *Hazard and Incident Investigations.* Hazards were rarely investigated, and unless an injury occurred, the root cause of hazards were rarely determined, contained, or corrected. Incident investigations were conducted by the safety engineer and his union counterpart.
3. *Safety Strategy Development.* There was no strategy related to improving worker safety. The plant Safety Committee was tactical and ineffective.
4. *Integration of Safety Into Continuous Improvement Efforts.* At the beginning of this project, the heavy truck manufacturer had a robust production system that they were integrating system-wide. In the Planning stage, the heavy truck manufacturer and O/E decided to integrate SafetyIMPACT! into their production system and associated Continuous Improvement methodologies.

While the Baseline Assessment went very well, the development of a project plan was more difficult. The initial timeline (see Figure 1) called for the completion of steps 1 and 2 by July 1, 2006, but it was soon obvious that this would not be possible.

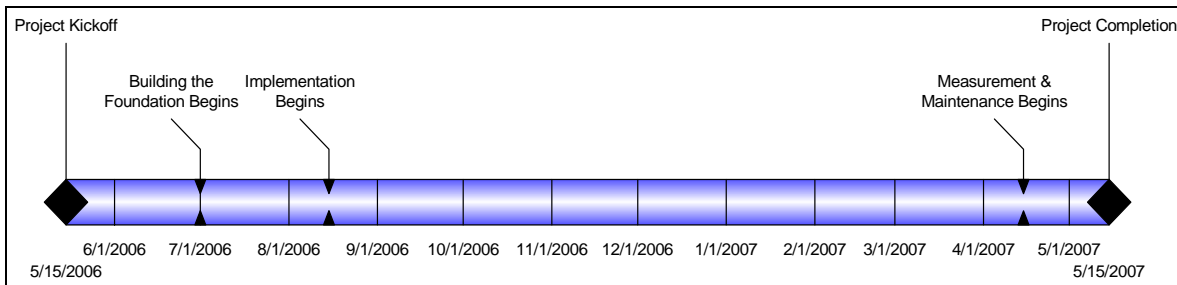


Figure 5: Initial Project Timeline

The Plant Leadership from both the company and labor sides was having difficulty visualizing what, operationally, SafetyIMPACT! would look like at their company and facility. While SafetyIMPACT! was successfully implemented in several industries, it had not yet been implemented in heavy truck manufacturing.

Additionally, many at the heavy truck manufacturer doubted that a process initially developed for the automotive industry was applicable to heavy truck manufacturing. These concerns were alleviated after O/E organized a benchmarking visit to one of its customers who had successfully implemented the process.

A small group of representatives from the heavy truck manufacturer’s plant (both salaried and hourly personnel) visited several automobile manufacturing plants that had successfully implemented the SafetyIMPACT! process. The group returned to the heavy truck manufacturer impressed with how effectively the process was working at the automobile manufacturer and with ideas on how the process would have to be tweaked to make it most appropriate to the business conditions endemic to heavy truck manufacturing.

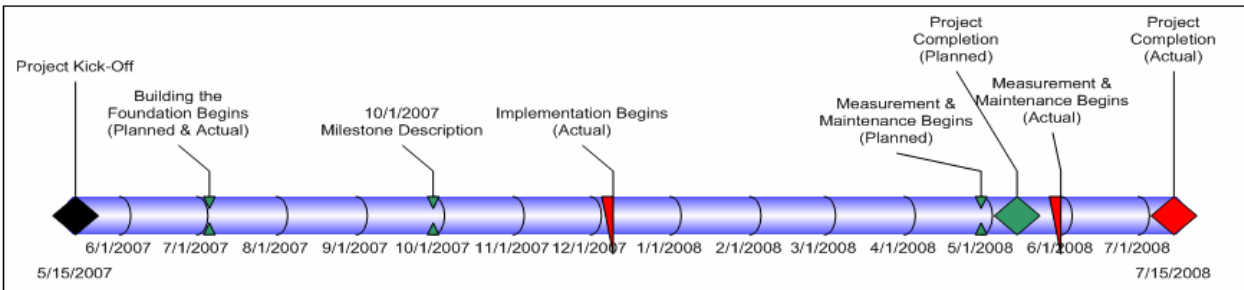


Figure 6: Revised Project Timeline

The benchmarking trip, while immensely beneficial, was not enough to propel the project forward according to the initial timeline. The implementation would be challenged by production issues, shutdowns because of part shortages, intermittent planned shutdowns, and contract negotiations.

Building the Foundation

The goal of the second step of the implementation, Building the Foundation, was to establish the infrastructure required to implement SafetyIMPACT! (establishing the membership of the Safety Strategy and Hazard Investigation Teams, selecting a pilot area, identifying the persons who would be conducting inspections, identifying the people responsible for correcting hazards, specifying inspection areas, and loading this information into the Hazard Tracking Database) and to communicate the changes the organization could expect and why these changes needed to be made.

The project co-champions—the Local Union President and the Plant Manager—communicated their commitment to creating a new safety culture and a safer workplace. The plant used a cascade approach to communications; although the Plant Manager and/or the Local Union President were present at all the meetings. The message was also delivered using the plant’s traditional communication vehicles—safety talks, the plant newsletter, and posters on the plant bulletin boards.

Implementation

Once a sufficient infrastructure had been built, the SafetyIMPACT! coach began the nine-month implementation of the four benchmark practices.

Safety Inspections

Each week, the supervisor of an area was required to inspect his or her area for hazards, contain the hazard, assess the risk level of the hazard, identify a person responsible for permanently correcting the hazard, and entering his or her findings in the Hazard Tracking Database.

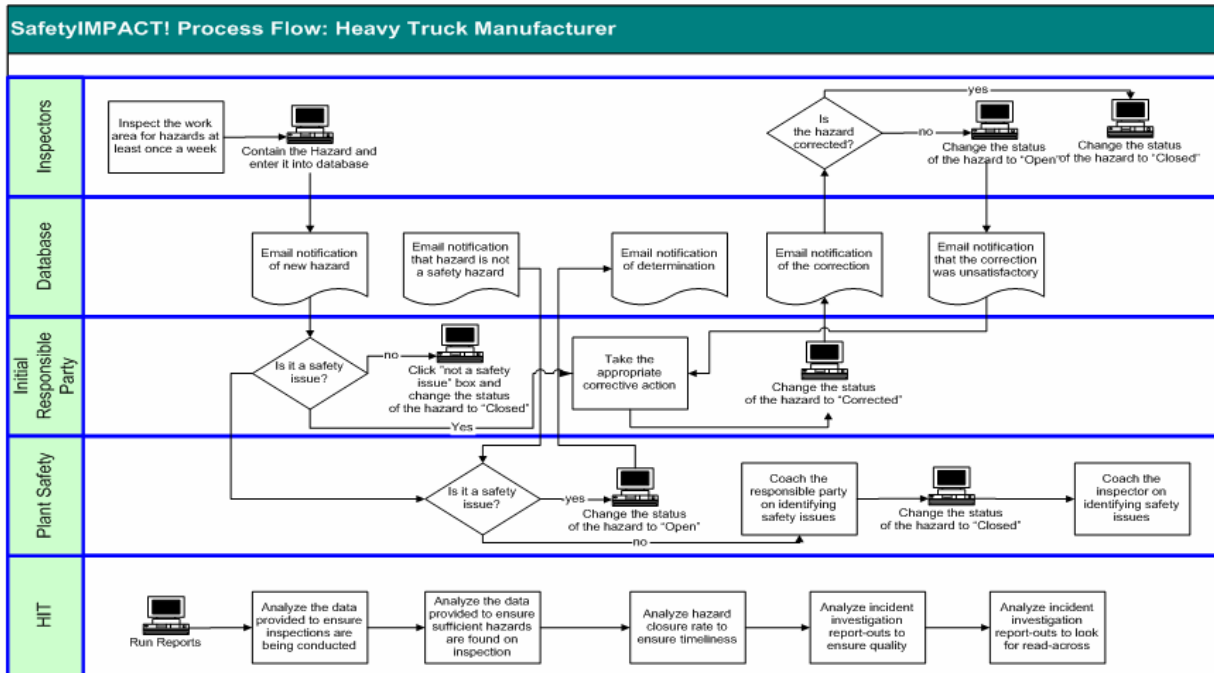


Figure 7: Heavy Manufacturer Safety Inspection Process Flow

Because of the size of the inspection area—the manufacturing area of the plant consisted of nine manufacturing areas that were further divided into 50 pools made up of several teams—and because a weekly inspection was required for all three shifts, the team locations were divided into three inspection zones. The supervisors and union stewards for each shift were responsible for inspecting one of the three areas. The responsibility would rotate across the shifts so that an inspector would inspect a different zone every week for three weeks.

A weakness of many organizations' inspection processes are the creation of a checklist mentality. As people review a work area while working with a checklist, they have a tendency to turn a blind eye toward hazards that aren't on the portion of the checklist on which they are focused. To combat this, O/E taught the inspectors to review the work area using a Failure Modes Effects Analysis (FMEA) approach. In this approach, rather than working from a checklist, the inspector creates a simple process map of the tasks performed in the area and then asks him or herself what could go wrong in the process that could result in an injury to someone.



To identify hazards you should physically walk through the area and analyze the workers' interaction with the following:

Manpower

- Are There Enough Workers To Do The Tasks Safely?
- Are The Workstations Clearly Defined And Do The Workers Stay Within Them?
- Are The Workers Forced To Bend, Twist, Sloop, Lift, Or Walk Excessively?
- Is The Job Designed To Address Ergonomic Concerns?
- Is There Sufficient Time For The Worker To Do The Job?
- Are The Workers Using The Appropriate Personal Protective Equipment?
- Is There Adequate Access To Emergency Response Equipment?
- Do The Workers Know The Fastest And Most Direct Evacuation Routes?
- Are Workers Exposed To Chemicals, Dross, Offal, Or Sharp Edges?

Machine

- Are Machines In Good Working Condition (Free Of Leaks, Rust, Sharp Edges, Etc.)?
- Are All Safety Devices Operational?
- Are The Machines Sufficiently Guarded To Protect Them From Contacting A Hazard?
- Are The Machines Configured Such That They Can Be Safely Operated And Maintained?
- Are The Emergency Stops Accessible And Operational?
- Are The Lockout Points Identified And Accessible?
- Have The Manufacturers' Safety Procedures Been Reviewed By The People Maintaining And Operating The Equipment?

Material

- How Do The Materials Flow Through The Area?
- Is There Sufficient Storage Space?
- Are The Materials In Their Correct Place?
- Do The Materials Create An Exposure Risk?
- Does The Placement Of Materials Impede Traffic In The Area?

Environment

- Does The Physical Layout Of The Work Area Allow Direct And Unhindered Access To Fire Access And Emergency Response Equipment?
- Does The Physical Layout Of The Work Area Allow Adequate Work-spaces?
- Does The Work In The Area Expose Workers/Visitors To An Exposure Associated With Chemicals, Temperature, Noise, Or Inhalants?
- Are There Obsolete Tools, Equipment, Or Materials Stored In The Area?

Method

- Are There Standard Work Instructions For Each Operation That Identify The Safest Way To Complete The Tasks?
- How Does Work Progress From One Work Station To The Next?
- What Changes Have Been Made To The Processes?

Changes in the Work Area

- Has The Physical Layout Of The Area Changed?
- Have There Been Changes In Personnel?
- Has The Process Changed?
- Have Materials Been Added Or Are Different Materials Being Used?
- Has The Rate Of Production Changed?

Figure 8: Safety Inspection Job Aid (front)

Unsafe Conditions and Behaviors Categories

<p>Walking/Working Surfaces and Workstations</p> <ul style="list-style-type: none"> Poor housekeeping Slip, trip, and fall risk Fluid leak Incorrect/absent work instructions Other 	<p>Environmental Risk</p> <ul style="list-style-type: none"> Inadequate visibility or lighting Low/high temperature Noise levels not within acceptable limits Improper exhaust or ventilation Other
<p>Evacuation Hazards/Emergency Response</p> <ul style="list-style-type: none"> Evacuation route inoperable or not posted Evacuation route obstructed / egress inoperable Inadequate access to fire extinguishers Inadequate access to, or non functioning, eyewash station Emergency phone numbers not posted or not up to date First aid kits/stations not easily accessible to each work area Fire Extinguishers Other 	<p>Exposure Risk</p> <ul style="list-style-type: none"> Improper energy control / power lockout Safety device bypassed Safety device / machine guarding not present or functional Cut, puncture, bump, or pinch risk Biohazard/pathogen exposure risk Working out of station, in lane, or in hallway Falling object risk Confined space location not identified or labeled Other
<p>Ergonomics</p> <ul style="list-style-type: none"> Improper lifting Ergonomic equipment not used Improper workstation layout Work area requires ergonomic evaluation Other 	<p>Electrical Safety</p> <ul style="list-style-type: none"> Electrical panels Unauthorized electrical device or extension cord Other
<p>Personal Protective Equipment (PPE)</p> <ul style="list-style-type: none"> Improper PPE or PPE not worn Inadequate fall protection Other 	<p>Tools/Equipment</p> <ul style="list-style-type: none"> Improperly maintained tools or equipment Improper tool or equipment use Tools stored improperly Other
<p>Powered Industrial Vehicle Safety and Material Handling</p> <ul style="list-style-type: none"> Improper vehicle operation Improper vehicle maintenance License/training not current Other 	<p>Material Storage/Labeling/Disposal</p> <ul style="list-style-type: none"> Improper material placement Improper material storage/disposal Inadequate storage equipment or space Improper material labeling
<p>Other (describe)</p>	<p>Near Miss (describe)</p>

Figure 9: Safety Inspection Job Aid (back)

Once the physical inspection was complete, the inspector entered the findings into the Hazard Tracking Database. This database was the linchpin of the process, acting both as a storehouse for hazard information, and a means of tracking and communicating accountability.

Because the inspector ranked the hazard according to its risk (high, medium, or low), the database was able to automatically assign a deadline to its corrective action and track the responsible party's progress toward completion.

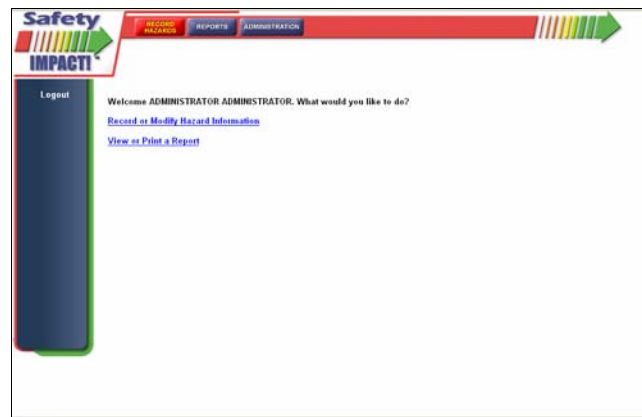


Figure 10: Hazard Tracking Database Welcome Screen



After the inspector assigned a person to be responsible for correcting a hazard, the database transmitted an email to the responsible person alerting them that they have been assigned a corrective action.

The Initial Responsible Party (IRP) took steps to correct the hazard, and changed the status to “in-progress” after he or she recorded what he or she had done (for example, issued a work order or ordered parts).

In cases where the IRP had completely corrected the hazard, he or she would record the corrective action taken and change the status to “corrected.” This change in status automatically triggered an email to the person who initiated the hazard in the database. This email informed the hazard owner of the change in status and prompted him or her to verify the corrective action and close the hazard.

This cradle-to-grave ownership of a hazard forced unprecedented Operations’ accountability for safety.

In addition to emails that were sent to all stakeholders, for the first time in the heavy truck manufacturer’s history, the actions taken to ensure a safer workplace were being electronically recorded, stored, and tracked.

In some cases, inspectors recorded issues that the IRP would determine were not safety issues. In those cases, the IRP would check the “not a safety issue” box. This action triggered emails to the plant safety engineer and the union safety representative asking them to review the issue and make a determination.

If the two determined that it was not a safety issue, they closed the hazard and provided the inspector additional coaching on how to better identify safety issues.

If, on the other hand, the two determined that it was indeed a safety issue, they provided the IRP with additional coaching as to why it posed a threat.

Figure 11: Hazard Tracking Database Hazard Input Screen

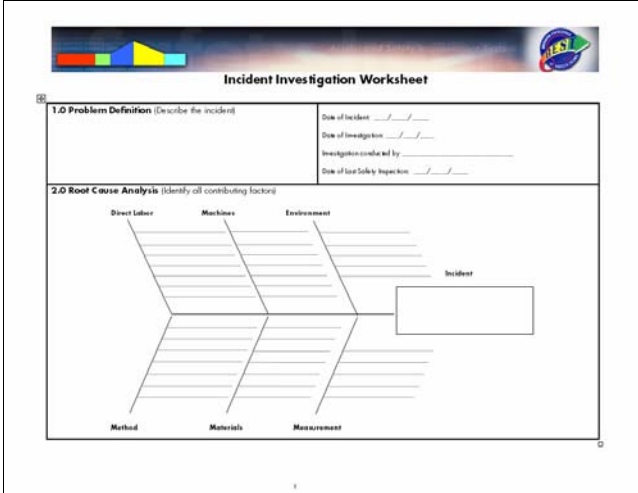
Figure 12: Hazard Tracking Database Hazard Category Screen

Figure 13: Completed Inspector Screen

Incident Investigation

Prior to this initiative, incident investigations were conducted by the safety engineer and union safety representative with input from the first-line supervisor. Far too frequently, incident investigations concluded that the root cause of an injury was carelessness on the part of the injured party or that the process was intrinsically unsafe. The approaches they used were not standard and relied more on anecdotal information gathering than scientific methods.

The plant did have a strong problem-solving methodology that it used in its production system however. O/E adapted the tool the heavy truck manufacturer used to solve quality problems for use in incident investigation.



Incident Investigation Worksheet

1.0 Problem Definition (Describe the incident)

Date of Incident: ____/____/____
 Date of Investigation: ____/____/____
 Investigation conducted by: _____
 Date of Last Safety Inspection: ____/____/____

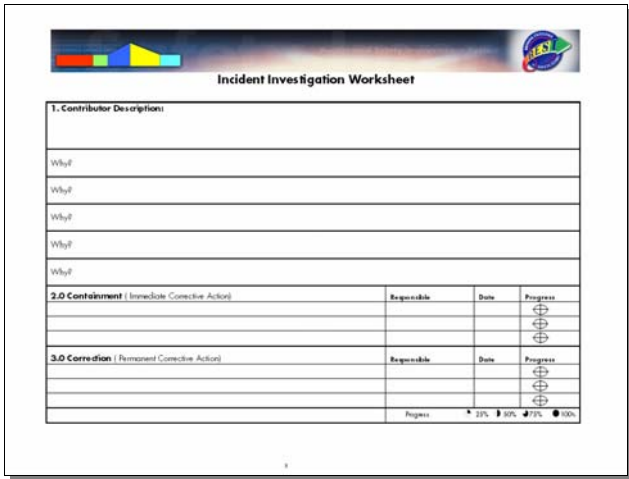
2.0 Root Cause Analysis (Identify all contributing factors)

Direct Labor Machines Environment

Method Materials Measurement

Incident

Figure 14: Incident Investigation Worksheet Page 1



Incident Investigation Worksheet

1. Contributor Descriptions:

Why? _____
 Why? _____
 Why? _____
 Why? _____
 Why? _____

2.0 Containment (Immediate Corrective Action)

Responsible	Date	Progress
		☐
		☐

3.0 Correction (Permanent Corrective Action)

Responsible	Date	Progress
		☐
		☐

Progress: 25% 50% 75% 100%

Figure 15: Hazard Investigation Worksheet Page 2

During the Implementation phase, supervisors were taught to identify multiple contributors to the injury, again using the same methodology the plant used in quality problem solving. Since the investigators were doing root cause analysis on multiple factors, the investigators quickly became skilled at this type of analysis, not only improving the quality of their incident investigations but also



their problem-solving skills overall. This approach also prevented the supervisor from ending the investigation after examining only the most obvious or easiest contributor.

Hazard Investigation Team (HIT)

The heavy truck manufacturer formed a team consisting of all center managers, their corresponding shop stewards, the plant safety engineer and the union safety representative. This tactical team met weekly to:

- Ensure the appropriate progress of the implementation.
- Evaluate and critique the quality of the findings of the safety inspections.
- Provide feedback on the appropriateness and quality of the supervisors' incident investigations.

While the HIT was eager to solve the safety issues, it faced significant hurdles. The volume of injuries at the plant (sometimes as high as 20 a week) made it nearly impossible to cover the full HIT agenda within the allotted hour. This presented the Operations manager (who co-chaired the meeting with the union local president) with a quandary: How could he cover the entire agenda without sacrificing the quality of the meeting? The co-chairs and the coach soon worked out a solution. While each supervisor that had an employee injured in his or her area would still be required to conduct a complete incident investigation and submit his or her findings to the HIT membership, only four would be called to present at the meeting. Since no one knew in advance of the meeting which four would be called to present, each had to be completely prepared with a full and complete report.

The HIT used reports from the database to judge whether or not appropriate progress had been made since the last meeting. These reports ranged from a detailed list of all the hazards found in a particular date range to a summary of the safety inspections. Each location/customer customized the agenda of the HIT meeting to focus on areas of particular significance within their corporate culture.

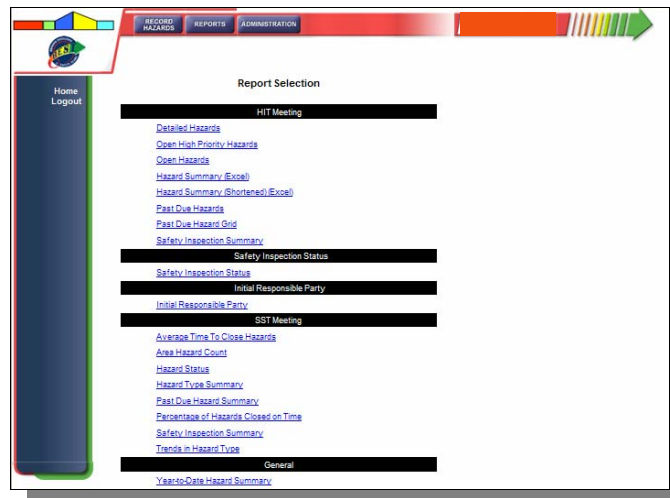


Figure 16: Hazard Tracking Database Report Menu Screen



Measurement and Maintenance

The last month of the engagement was spent measuring the affects the process change had on the organization. The coach and safety engineer prepared an assessment of the progress the plant had made since the project kick-off.

Roadblocks

While the plant's efforts were ultimately successful, progress was often impeded. A new EPA requirement created a surge in orders as customers bought 2007 trucks. This front-loaded surge in orders created a downturn in demand for later models. This meant a large reduction in the workforce was necessary mid-project, and the elimination of an entire shift ensued.

Additionally, the plant's labor agreement was to expire mid-project and negotiations occupied many key players' time and focus. To exacerbate the situation, a small number of union members conducted an unsanctioned walkout.

Despite cutbacks in production, a new model was introduced at the plant, and ramp-up of this new truck required major construction at the plant and threatened to siphon many key resources away from the implementation of SafetyIMPACT!

Throughout the project, parts shortages caused by a problem at a key supplier caused sporadic production problems that often furloughed plant personnel and created major distractions from the implementation of SafetyIMPACT!

Despite these arduous difficulties and roadblocks, the plant manager and union president refused to allow them to prevent the successful implementation of SafetyIMPACT! The efforts of the Plant Leadership and the hard work by all the teams associated with making SafetyIMPACT! a reality ensured that the plant would have a robust and capable safety system.

Results

The heavy truck manufacturer achieved remarkable financial, operational, and cultural results.

Financial and Safety Metric Results

At the beginning of the project, the plant manager asserted that the 11% rise in the Incident Rate (to 21.0) in 2005 was caused by the addition of a third production shift and the associated hiring. The plant manager contended that the spike in the Incident Rate would recede back to the 2004 level (of 19.0) once work hardening occurred. Prior to this increase, the Incident Rate had been relatively flat for the previous five years. The plant manager's prediction proved accurate. In 2006, the plant's Incident Rate fell 12% (a 1% net improvement over 2004). The implementation of SafetyIMPACT! at the plant had an even bigger effect; in 2007, the Incident Rate fell an additional 34% to a record low of 12.3.

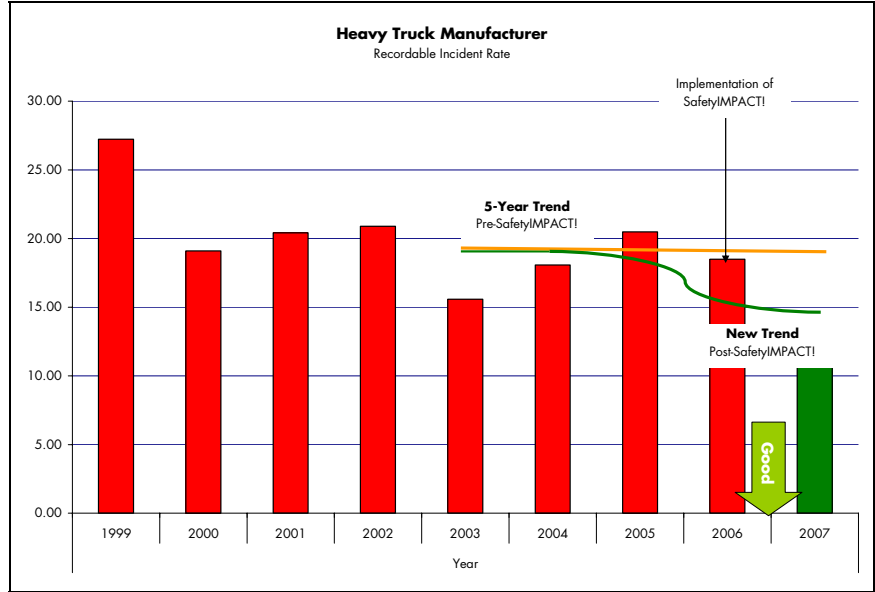


Figure 23: Incident Rate

The plant saw similar results in its Lost Work Day Incident Rate. In 2004, it was 7.1; it rose to 7.8 in 2005 just as the Incident Rate had. Again, as predicted, in 2006 the rate returned to its 2004 level (7.0). After the implementation of SafetyIMPACT!, the plant Lost Work Day Incident Rate fell 34%.

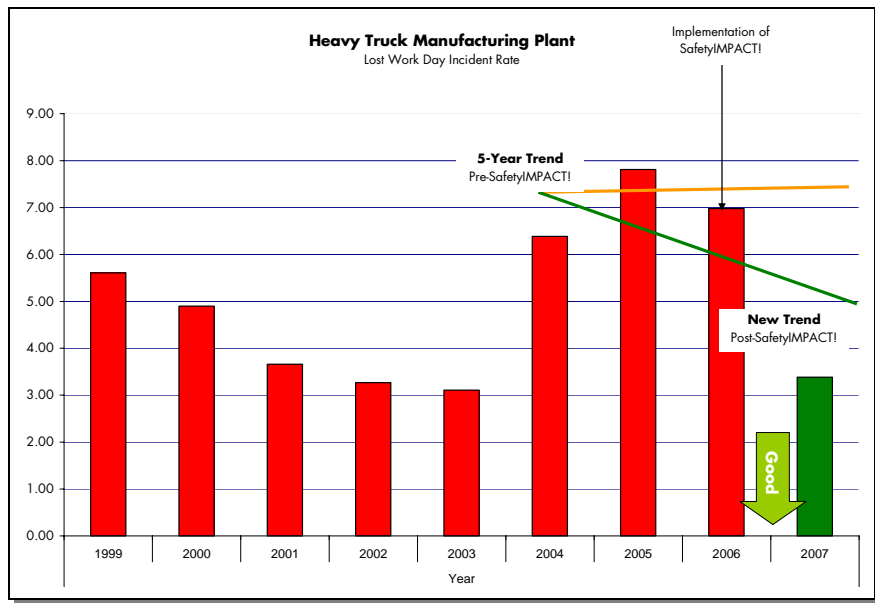


Figure 24: Lost Work Day Incident Rate

The implementation of SafetyIMPACT! at the heavy truck manufacturing plant drove down both the number of injuries and the severity of the injuries. The overall number of claims filed dropped 25% to 484.

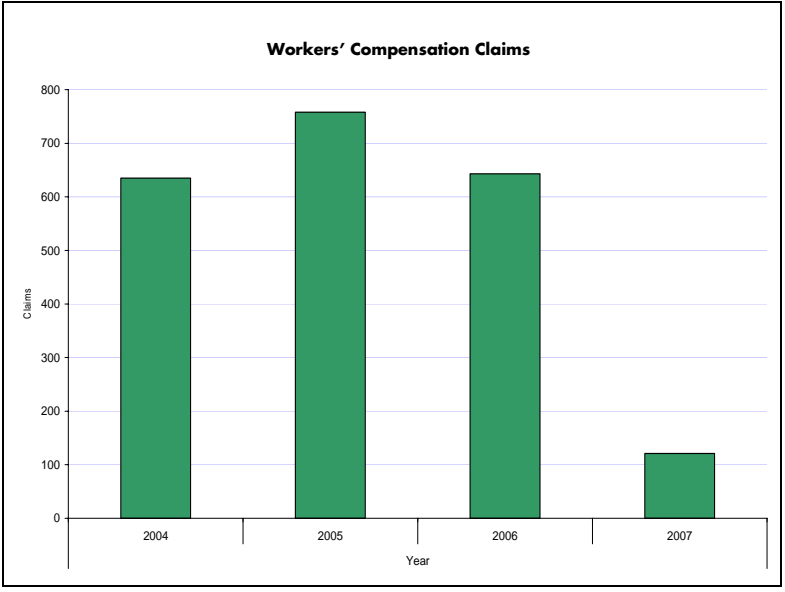


Figure 25: Number of Workers' Compensation Claims

The financial impact of these improvements was enormous—not only did the overall cost of injuries decrease, the average cost per injury dropped at a time when medical costs continued to skyrocket. Prior to this engagement, the heavy truck manufacturer saw the average cost of Workers' Compensation claims increase an average of 16%. This contrasts sharply with the 62% decrease the plant realized after its implementation of SafetyIMPACT!

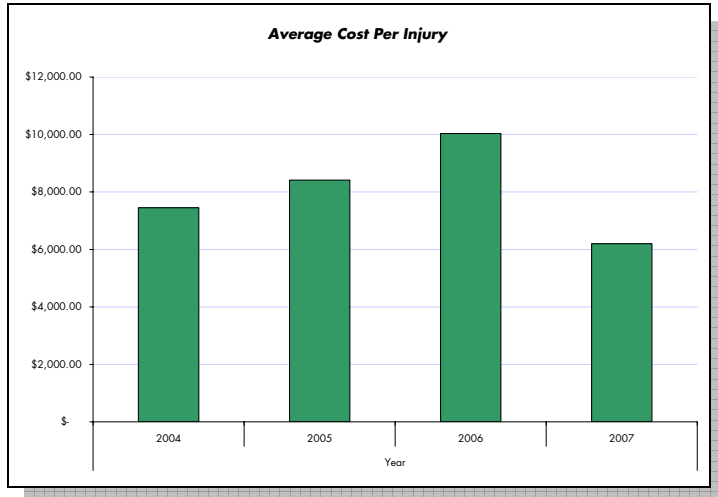


Figure 26: Average Cost Per Injury

The total costs of Workers' Compensation dropped to a record low for the plant for a total savings of \$5,132,388.

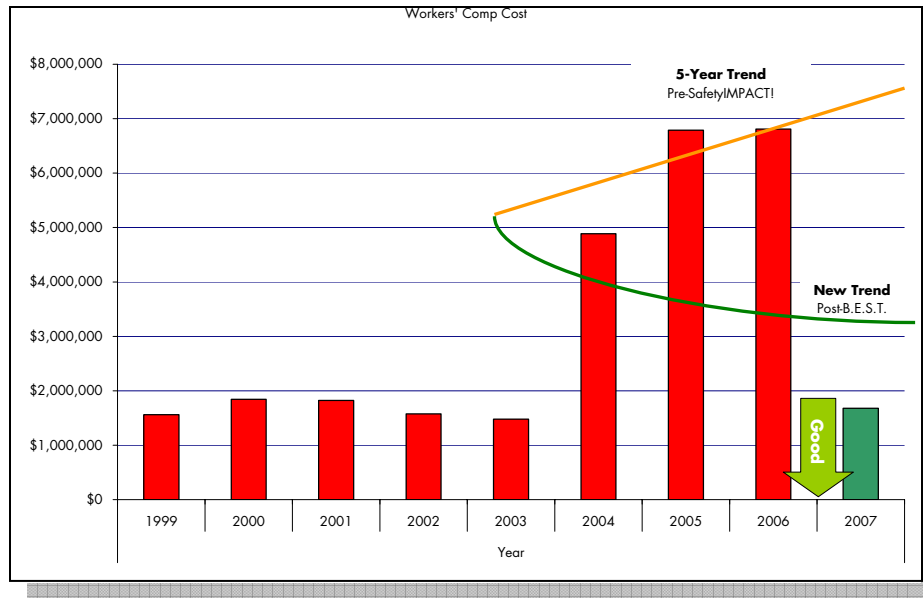


Figure 27: Workers' Compensation Costs

Operational Results

Prior to this engagement, safety inspections were conducted by the plant safety engineer and the union safety representative. Typically, these inspections were done twice a year and were augmented by a corporate audit conducted annually. Since the implementation of SafetyIMPACT!, the plant first-line supervisors and union stewards have conducted 170 safety inspections and identified 292 hazards of which 236 have been closed.

When this initiative began, the plant had a Safety Committee that met monthly. The committee was led by the plant manager and the union president and consisted of volunteers from the rank and file. Typically, this contractual meeting was a forum for people to raise safety issues and to complain about the lack of progress toward getting these issues fixed. After the implementation of the HIT and SST meetings, both sides recognized that the Safety Committee would no longer be necessary. Compared to the Safety Committee, the HIT and SST were wildly successful. Because the new process required shop stewards and supervisors to record hazards in the database where the progress toward correction was tracked and monitored, it was no longer acceptable to bring new, undocumented issues to the meeting. These teams were judged so superior to the Safety Committee that the union dropped its contractual demand for a Safety Committee and opted instead for contractual language ensuring its right to participate in the meetings.

The SafetyIMPACT! process was also seamlessly integrated into the company's production system, as a "human infrastructure" requirement. Not only has SafetyIMPACT! improved the safety of the plant, but it has facilitated the rollout of the company's production system.

Cultural Results

The plant culture has changed significantly. Prior to this engagement, there was a fiercely held belief that worker injuries were endemic to the manufacture of heavy trucks, and the cost associated with worker injuries was a cost of doing business in that industry. Now, most workers believe that injuries can be prevented, and that the company is sincerely interested in creating a safe workplace. When—during a recent surprise OSHA visit—an OSHA inspector questioned four



employees at random, all four mentioned SafetyIMPACT! as the reason that they believe the workplace was safer than it had been a year before.

While the plant had long valued firefighting and rewarded the people who would go to extremes to solve problems, the plant's implementation of SafetyIMPACT! helped them to see the value in preventing problems rather than reacting to them. SafetyIMPACT! showed the plant that strategic management of production issues was far superior than tactical reactionary efforts.

Perhaps the most profound cultural change was the transition of ownership of worker safety from Human Resources to Operations. Most of the day-to-day tasks associated with safety (inspections, correction of hazards, enforcement of safety policies, etc.) are now completed by Operations personnel instead of Safety personnel. The plant Safety personnel are now seen as a resource for improving the efficiency of operations instead of an impediment to production.

Summary

The heavy truck manufacturing industry has long been plagued with worker injuries, and for most in that industry, the cost associated with worker injuries is just a cost of doing business. One forward-thinking heavy truck manufacturer contracted with O/E to change this mindset. After only one year, the heavy truck manufacturer has achieved remarkable financial, operational, and cultural results. The hard work and dedication of the heavy truck manufacturing plant has transformed its culture, improved its efficiency, and saved it millions of dollars.