

Caution Bulletin

Inadequate Safety Practices Cause Severe Injury

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Summary: While unloading well casings from a truck, a worker's foot was struck by an extremely heavy well casing. Organizations with strong safety standards and expectations must coach and mentor those practices for less prepared organizations. Doing so raises the safety bar for everyone. All personnel; management and workers, must maintain situational awareness of the hazards around them and look out for the safety of their team and themselves.

Discussion of Activities: On October 4, 2007, an employee was injured when a 10-foot section of 8-inch threaded casing (piping) weighing 300 lbs. fell off a truck and struck a worker's foot during an unloading process. Though the employee was wearing approved steel toe footwear, all five toes were fractured upon impact. Eventually several toes required amputation. A review of the incident revealed that the rows of casing were sufficiently strapped into place to prevent shifting during DOT transport, but there were no pipe chocks in place to prevent the casing from rolling when the securing strap was removed.

Analysis: The well casings, although strapped to the truck, were not properly chocked or blocked to prevent the casings from moving once the strapping was removed. The employees worked for a subcontracted company. Not all workers were operating to corporate expectations. This resulted in different expectations on how to safely load and unload vehicles. It is typical for the standards of safety practices used by some companies to be lower than those employed at DOE facilities. Work practices must be consistent across organizational boundaries.

When the casings were initially loaded they were properly strapped for transport, but were not properly chocked. One employee at the unloading site, without the required protective equipment, remained in the vehicle without assisting the unloader. The required blocking materials and protective equipment must always be available and used by employees to perform their work safely. In this case, the final two barriers, among many, that could have prevented this event were nonexistent.

Based on the above, two root causes were identified. First, there was not any identification or recognition and control of the hazards by subcontractor personnel. The employees did not take the necessary steps to mitigate the hazard.

Second, the safety expectations, for chocking were not implemented or enforced, e.g., the employees failed to implement the section of the Job Safety Analysis related to preventing



rolling of casings, and their management did not enforce its expectation for chocking.

Recommended Actions:

- Pre-planning the activity must take into consideration the potential hazard associated with “runaway” material, especially any type of tubular, roll stock or wheeled material that has a tendency to slide if not properly chocked or blocked. Such control will prevent accidental shifting during handling that can result in a falling or sliding object.
- Safety rated footwear (as with other forms of PPE) should not be selected or depended upon as the primary means of hazard control. Always use established and time-proven engineering-type controls as the method of choice.
- All personnel, management and workers, must maintain situational awareness of the hazards around them and look out for the safety of their team and themselves. Look at the hazards; determine if the right thing and way of doing the activity is being used. Whenever performing any work activity look for worst case scenarios and apply the prevention techniques that should be used to prevent them.
- Organizations with strong safety standards and expectations must coach and mentor those practices for less prepared organizations. Doing so raises the safety bar for everyone.

Cost Savings/Avoidance: Not Evaluated

Work Function: OS&H

Hazards: Personnel Injury

Keywords: NA

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References: RL—PHMC-GPP-2007-0006