

Information Bulletin

Misinterpretation of Authority Causes Rigging Problem

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Summary: Even tasks which are considered routine will be different depending upon circumstances. Factors such as personnel and their behavior on a given day, conditions, location, equipment, etc., all affect the task. All tasks, whether they are viewed as routine or not, need to be thoroughly evaluated prior to performance. Develop a habit of focusing more on the elements of the task than on the goal, allowing the actual dangers or deficiencies to be recognized.

Discussion of Activities: On August 14, 2007, preparations were being made to unload the T-3 Cask transport trailer from another trailer in the Maintenance and Storage Facility (MASF). Two 'piggy-backed' (stacked) cask transport trailers were placed in the MASF to be unloaded. Three ironworkers, a crane operator and the Rigging Designated Leader/Supervisor were assigned to the task. The task involved lifting the stacked trailer, allowing the other trailer to be driven out from underneath, and then setting the lifted trailer down in the spot just vacated. This was viewed as a routine task by all those involved. As the crane operator moved the hook up the sling caught on the sharp edge of the placard support and ripped. The three ironworkers inspected the sling and agreed that the only damage was to the outer protective coverings. This was discussed with the Rigging Designated Leader/Supervisor and he gave approval to continue with the lift. The trailer was then lifted without incident. After completing the task the damaged sling was set aside and management was notified of the incident.

Analysis: This incident actually consists of the two separate events; ripping the outer protective cover on the sling, and continuing the task with equipment that should have been removed from service.

There were several precursors leading up to the ripping of the sling:

- Lack of communication between spotters, Rigging Designated Leader/Supervisor, and the crane operator.
- The task was viewed as routine - created a "mind-set" that caused a higher degree of focus on the raising of the hook versus other aspects of the lift, i.e. taking the slack out of the sling. This attitude promotes an inaccurate perception of risk and can lead individuals to ignore unusual situations or hazards, potentially causing them to react either too late or not at all.

Additionally, the personnel involved misinterpreted their authority and continued using the slings when out-of-service criteria was met. The misinterpretation of their authority was with the requirements contained in DOE-RL-92-36, Hanford Site Hoisting and Rigging Manual, as well as the manufacturer's criteria for removing a sling from service.

Recommended Actions:

- When any aspect of a task does not go as expected - stop and immediately inform management of the situation. If an evaluation of the conditions indicates it is okay to continue, don't, there may be other factors that were not considered which can effect the task.
- Develop a habit of focusing more on the elements of the task than on the goal, allowing the actual dangers or deficiencies to be recognized.

Cost Savings/Avoidance: Not Evaluated

Work Function: Conduct of Operations - General, Hoisting and Rigging

Hazards: NA

ISM Core Functions: Analyze Hazards

Keywords: sling

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References: Event Report: FFTF-2007-0004