



## Driver Injured by Falling Load

### Purpose

To share “lessons learned” gained from incident investigations through a small group discussion method format.

To understand “lessons learned” through a Systems of Safety viewpoint.



This material was produced by the Labor Institute and the United Steelworkers International Union under grant number 46DO-HT11 Susan Harwood Training Grant Program, for the Occupational Safety and Health Administration, U.S. Department of Labor. It does not necessarily reflect the views or policies of the U.S. Department of Labor, nor does mention of trade names, commercial product or organizations imply endorsement by the U.S. Government.

**Lessons Learned**

**Volume 07, Issue 85**

**© 2007 The Labor Institute**

## Background Information

Before beginning this Lessons Learned, please review this and the next page which contain information that will introduce the concepts of Lessons Learned and Systems of Safety.

Creating a safe and healthy workplace requires a never ending search for hazards that sometimes are not obvious to us. These hazards exist in every workplace and can be found by using various methods. Lessons Learned are just as the name suggests: learning from incidents to prevent the same or similar incidents from happening again.

**Systems Are Not Created Equal: Not equal in protection and not equal in prevention.**

Using our Systems Focus to uncover system flaws or root causes is only one part of controlling hazards. We also need to look at the systems involved to decide on the best way to deal with the problem. The most effective way to control a hazard is close to its source. The least effective is usually at the level of the person being exposed. The system of safety in which the flaw is identified is not necessarily the system in which you would attempt to correct the flaw.



Major Safety System	Design & Engineering	Maintenance & Inspection	Mitigation Devices	Warning Devices	Training & Procedures	Personal Protective Factors
Level of Prevention	Highest—the first line of defense		Middle—the second line of defense			Lowest—the last line of defense
Effectiveness	Most Effective		←————→			Least Effective
Goal	To eliminate hazards	To further minimize and control hazards				To protect when higher level systems fail
<b>EXAMPLES OF SAFETY SUB-SYSTEMS**</b>	<b>Technical</b>	Inspection and Testing	Enclosures, Barriers Dikes and Containment	Monitors	Operating Manuals and Procedures	Personal Decision-making and Actions HF
	Design and Engineering of Equipment, Processes and Software	Maintenance	Relief and Check Valves	Process Alarms	Process Safety Information	Personal Protective Equipment and Devices HF
	Management of Change (MOC)**	Quality Control	Shutdown and Isolation Devices	Facility Alarms	Process, Job and Other Types of Hazard Assessment and Analysis	Stop Work Authority
	Chemical Selection and Substitution	Turnarounds and Overhauls	Fire and Chemical Suppression Devices	Community Alarms	Permit Programs	
	Safe Siting	Mechanical Integrity	Machine Guarding	Emergency Notification Systems	Emergency Preparedness and Response Training	
	Work Environment HF				Refresher Training	
	<b>Organizational (must address a root cause)</b>				Information Resources	
	Staffing HF				Communications	
	Skills and Qualifications HF				Investigations and Lessons Learned	
	Management of Personnel Change (MOPC)				Maintenance Procedures	
	Work Organization and Scheduling HF				Pre-Startup Safety Review	
	Work Load					
	Allocation of Resources					
	Buddy System					
	Codes, Standards, and Policies**					

HF - Indicates that this subsystem is often included in a category called Human Factors.

\* There may be additional subsystems that are not included in this chart. Also, in the workplace many subsystems are interrelated. It may not always be clear that an issue belongs to one subsystem rather than another.

\*\* The Codes, Standards and Policies and Management of Change subsystems listed here are related to Design and Engineering. These subsystems may also be relevant to other systems; for example, Mitigation Devices. When these subsystems relate to systems other than Design and Engineering, they should be considered as part of those other systems, not Design and Engineering.

**Revised October 2006**



**Title: Driver Injured by Falling Load**

**Volume 07, Issue 85**

**Date Issued: July, 2007**

### **Lessons Learned Statement**

A driver was hurt by part of a load that fell off a flat bed truck when the load binders (straps and bungee cords) were removed.

The load was made up of components of many different sizes and shapes. Most of the items were loose and not secured to pallets. Pallets would have acted as a **Mitigation Device**, preventing movement of the components. The **Mitigation System of Safety** does not eliminate the hazard but acts as a barrier between the hazard and the worker.

Every effort should be made to try to eliminate the hazard with the **Design and Engineering System of Safety** or to at least try to lesson the hazard with **Mitigation Devices**.

The "Stop Work Authority" that is afforded to workers must be used and it needs to also apply to all who enter the facility. Even though no one suspected the driver would be in danger, he still needs the authority to stop the job if needed.

### **Discussion**

A workplace was receiving new equipment that was being shipped by two flatbed trucks. This equipment was made up of components in a variety of shapes and sizes, including several pieces of 12-inch diameter duct work.

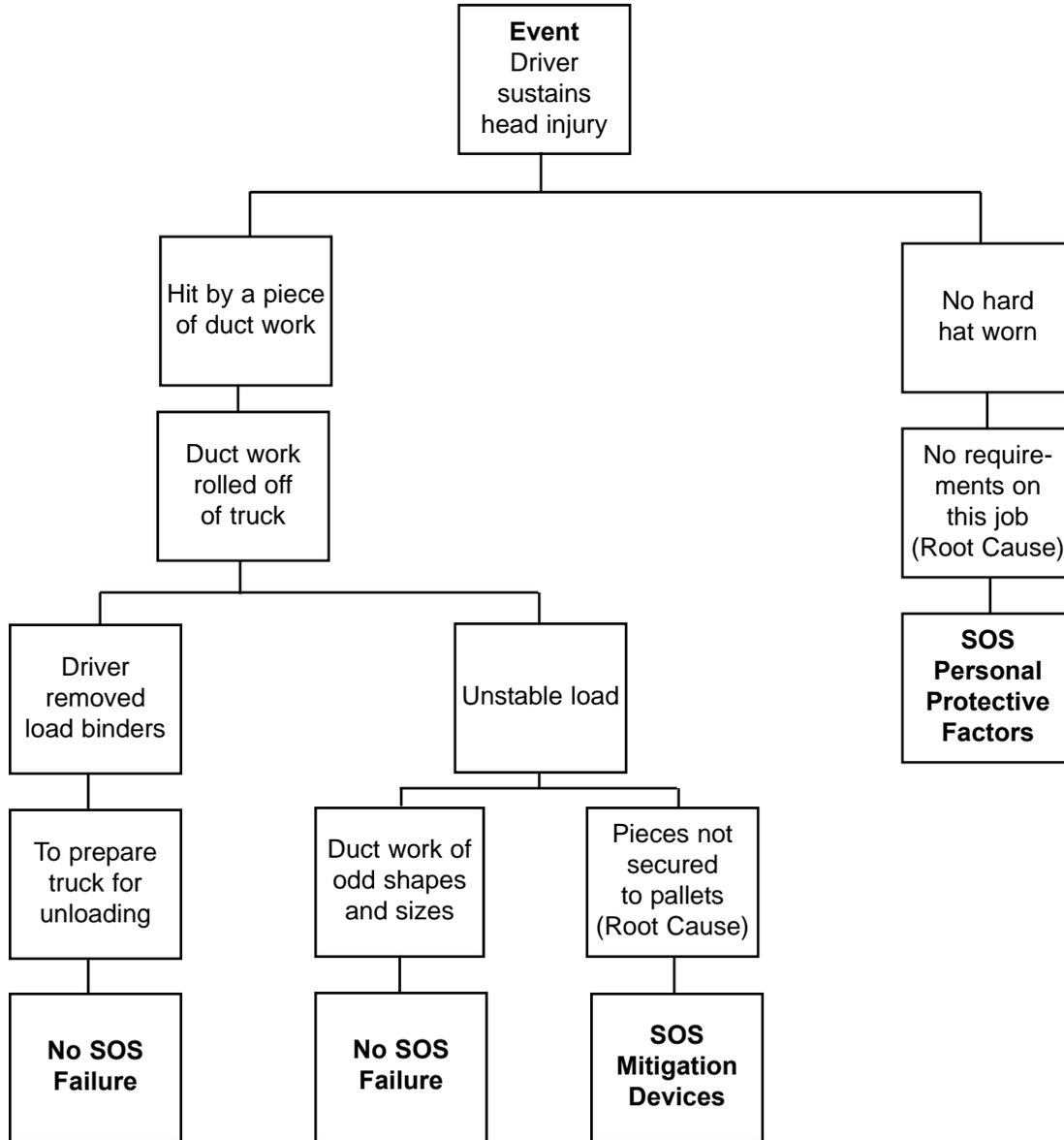
On arrival at the staging and delivery area, the driver proceeded to remove load binders (straps and bungee cords), which was standard practice for drivers delivering to this site. As he was gathering bungee cords from the ground, a piece of duct work rolled off the vehicle, striking him in the head.

The trailer load met DOT regulation requirements when the load was secured with load binders. However, the complex configuration of the load with its intertwined components rendered it unsafe for unloading. A few items were on pallets and smaller items were placed inside larger ones. While it was recognized that there was the potential for an incident in unloading this equipment, no one thought the driver would be exposed to any hazards while unsecuring the load.

Although there were PPE requirements for the workers employed by the company, application of these requirements for drivers was not considered. Even if they had been, there was no requirement for hard hats because removing straps and bungee cords was not considered "overhead work."

**Analysis**

**The Logic Tree** is a pictorial representation of a logical process that maps an incident from its occurrence, “the event,” to facts of the incident and the incident’s root causes.



**Recommended Actions**

1. When transporting odd-shaped equipment and piping, every item must be secured to a pallet.
2. Contact all vendors and delivery services to inform them of the requirement to secure items to pallets.
3. Refuse delivery of items which are not secured.
4. Have the removal of load binders done by two people so they can keep an eye on the load and each other while removing straps, etc.
5. Add outside contractors and drivers to the "Stop Work Authority" rules.
6. Add the requirement for hard hats while removing straps and binders from flat bed loads.
7. Review all procedures and rules with outside contractors and demand compliance.

### Education Exercise

Working in your groups and using the Lessons Learned Statement, Discussion, Analysis and Recommended Actions, answer the two questions below. Your facilitator will give each group an opportunity to share answers with the large group.

1. Give examples of ways to apply the Lessons Learned Statement at your workplace.

---

---

---

---

---

---

---

2. Of the examples you generated from Question 1, which will you pursue in your workplace? (**Note:** When we say something you may pursue, we mean a joint labor-management activity or a union activity rather than an activity carried out by you as an individual.)

## Trainer’s Lessons Learned Success Inventory

Following a Lessons Learned (LL) session, **the trainer who led the LL** should complete this form. This information will: 1) Help you reflect on the successes and challenges of the session; 2) Help USW with new curriculum development; and 3) Help USW as a whole better understand how the LL Program is supporting their workers.

By reviewing LL from different sites or from other areas of their workplaces, workers are able to analyze the information and apply these lessons to their own workplaces in order to make their workplaces healthier and safer.

1. Site name (if there are participants from more than one site, please list all).

---

2. Date of LL training \_\_\_\_\_

3. LL number used in today’s Training \_\_\_\_\_

4. Your name \_\_\_\_\_

5. **Summary of Education Question 1:** Please summarize participants’ examples of ways to apply this LL Statement to their workplace.

**Please continue on reverse side.**

- 6. Summary of Education Question 2:** Please summarize which actions or recommendations participants discussed pursuing at their workplace(s).

**Thank you for completing this form.**

# EVALUATION

## Lessons Learned: Driver Injured by Falling Load

Please answer the two questions below:

1. How important is this lessons learned to you and your workplace? (Circle one.) Rate on a scale of 1 to 5, with 5 being the most important.

1	2	3	4	5
---	---	---	---	---

2. What suggestions would you make to improve this Lessons Learned?

---

---

---

---

---

---

---

---

**End of Training Trainer's Instructions**

Please complete the information below.

Trainer's Name \_\_\_\_\_  
(Please Print)

Date of training: \_\_\_\_\_

No. of Participants: Total \_\_\_\_\_ Hourly \_\_\_\_\_ Management \_\_\_\_\_

Location of Training: \_\_\_\_\_

USW Local # \_\_\_\_\_

Send:

1. This page;
2. The Education Exercise (page 8);
3. The Trainer's LL Success Inventory form (pages 9 and 10);
4. The evaluation for each participant (page 11); and
5. The Sign-in sheet (page 13) to:

Doug Stephens  
United Steelworkers  
3340 Perimeter Hill Drive  
Nashville, TN 37211

Thank you for facilitating the sharing of this  
Lesson Learned with your coworkers.



