- There was no regulation regarding unauthorized use of equipment.
- The freight handler was not from this foreman's department.
- A grinding wheel of this type is proper for sharpening bale hooks.

Possible Solutions for Case II

1. It should be obvious to the group that the primary cause of this incident was one or more unsafe procedures. The foreman made a mistake by assuming the freight handler knew how to use a bench grinder. The freight handler committed several unsafe procedures. First, he did not use the eye protection that was available. Second, he must have put the hook in a position that let the point slip between the tool rest and the wheel.
2. While you may get such comments from the group as "fire the foreman," the solution should focus on a rigidly enforced rule, "no unauthorized use of equipment."
3. The following procedures can also be set up:
   a. a policy regarding the sharpening of tools, such as returning tools to the tool crib for sharpening or replacement
   b. a training program if the freight handlers are to do the sharpening
   c. a lockout device interlocked with the starting switch to prevent the wheel from operating when the eye shield is not in the proper position

Summary

Point out to the group that the two cases, Case I and Case II, bring out the importance of unsafe conditions and unsafe procedures as the causes of incidents. Stress the importance of searching for all possible causes.

Point out that in Case II there were a number of places where the incident prevention program needed tightening in order to prevent similar incidents in the future.

Emphasize the importance of checking procedures and conditions in advance to prevent incidents of this type. Mention the importance of a job safety analysis as a tool for preventing incidents.

CASE III

A tool truck driver, making his routine crib stops, picked up a crib attendant.

The attendant had requested a ride to another part of the facility because he knew the driver would be going in that direction.

The truck driver deviated from his aisle route and angled through a cleared but darkened area. This area was being prepared for new machinery installation and at that time of night was not fully lighted.

The attendant, who was sitting on the right side of the cab, suddenly noticed that the truck was headed for a steel building column. Before he could warn the driver, the left front corner of the truck struck and glanced off the column.

The impact threw the driver against the column and about 15 ft (4.6 m) away from the truck. The truck continued for approximately 50 ft (15.3 m) before the rider could get behind the wheel to apply the brakes and bring the truck to a stop.

The driver suffered a skull fracture, concussion, and severe injuries to the left arm and chest. He was taken immediately to the local hospital, where he died from a blood clot about three weeks later.

What could have been done to prevent this incident or similar incidents in the future?

Guide and Background Information for Case III

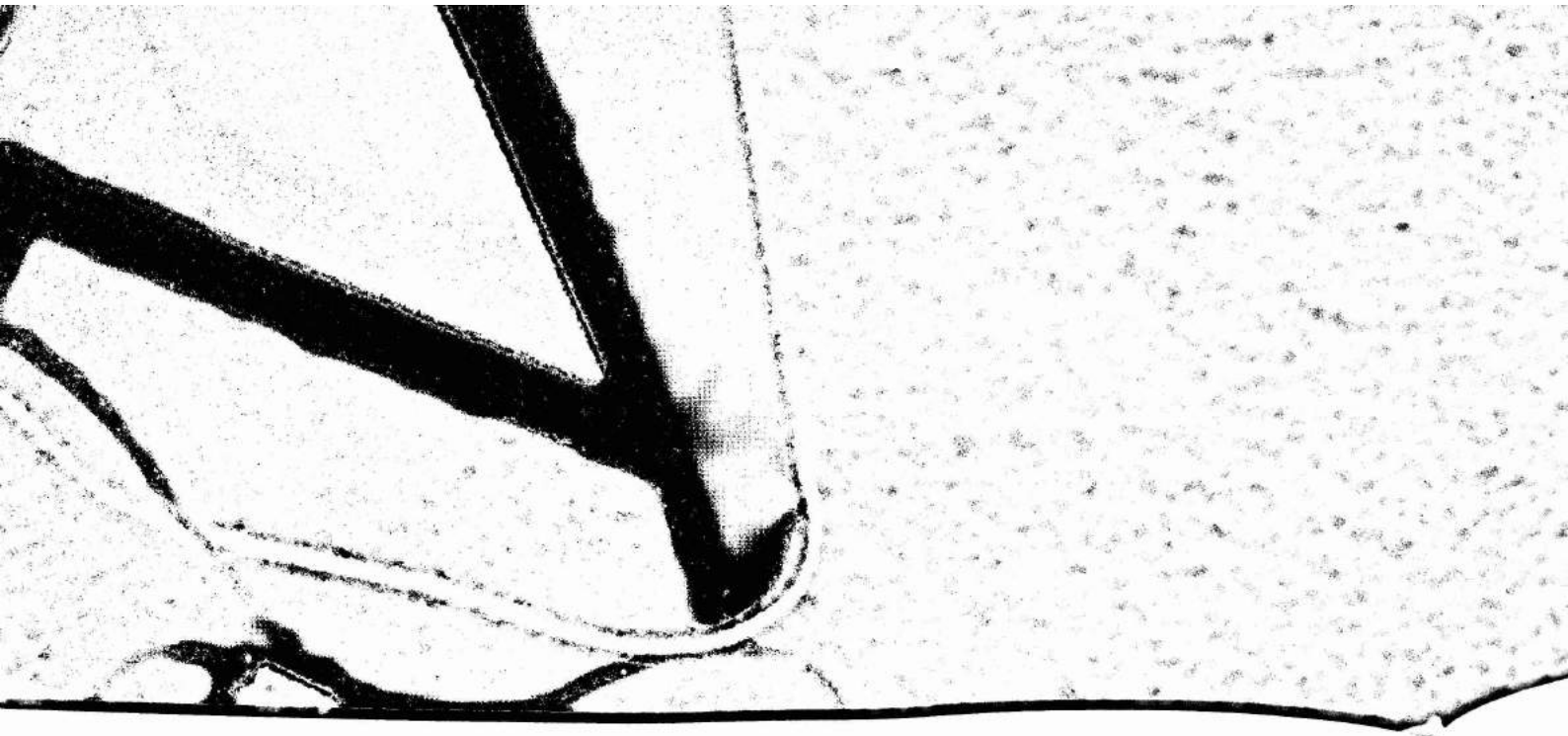
Explain to the group, if asked, that these trucks are not designed to carry passengers. In order for a rider to sit on the seat, the driver must move over, which puts him or her in an awkward position.

Following are other pertinent facts:

- The aisles were not marked in this particular area.
- The area was not "roped off" and there were no signs to indicate equipment was being installed.
- The truck was not equipped with a seat belt.
- The incident happened on the second shift (about 10 p.m.).
- The machinery installation had been going on for an extended period of time.
- There were no rules concerning riders.
- The driver was experienced.

Possible Solutions for Case III

1. The driver's failure to stay within the main aisle was an important factor in the incident. Properly marked aisles might have prevented the driver from taking a shortcut.



2. When there are properly marked aisles, truck drivers should be instructed and trained in proper procedures.
3. Better illumination might also have prevented the incident. Because the installation had been going on for some time, the area should have been properly illuminated.
4. The area could have been roped off or marked.
5. A rigidly enforced rule against "no riders" should have been instituted.
6. Installation of seat belts in equipment of this type is a possibility, but because of the nature of the work, not generally done.

Summary

Stress to the group that the incident was caused by a combination of factors:

- The unsafe conditions were poor lighting, unmarked aisles, and lack of signs.
- The unsafe procedures were the driver's "shortcutting" and picking up a rider. The lack of a rule against riders did not exonerate the driver because he had to make room for the rider and had to be aware that he was not in the best position to control the truck. The rider also must have been aware of the situation when he moved into the seat.

CASE IV