

## Perception vs. Reality in Safety Response

### Author

Barry J. Momyer, President, AM Health and Safety Inc., Pittsburgh, Pa., USA

Hazards are ever-present in the steel plant environment, and a heightened awareness and emphasis on safety is a necessary priority for our industry. This monthly column, coordinated by members of the AIST Safety & Health Technology Committee, focuses on procedures and practices to promote a safe working environment for everyone.

This article discusses what can leave a safety professional in the dark, which can lead to unintended consequences, improper case management or unnecessary incident escalation. Often, incomplete information can be provided, whether the source is not knowledgeable as to what information should be conveyed, or out of fear of discipline. When investigating near misses, incidents or injuries, it is vital to visit the location of the event in a timely manner. As time passes, the evidence at the scene can change or be moved, memories tend to drift, and stories can be coordinated among employees to hide what transpired. The anecdote on page 33 from a safety professional illustrates the importance of gathering evidence and investigating immediately after an incident.

It is common that complacency; failure to report damaged equipment, tools and materials; or insufficient procedures lead to events that could have been remedied with little investment of time and cost. It should be standard procedure to ask about the details regarding incident reporting and documentation. Utilizing the 5-Y method can also uncover crucial

information that is either left out or deemed not important enough to report. Details matter when reporting incidents, and it is often better to provide more information than feels necessary, and what is valuable and what is not can be sorted out during the investigation. Don't assume that the full story has been told by the individual reporting the incident; interview them in person, at the scene and as soon as possible. Ensure upset condition reporting is acted upon, as reporting tends to decrease when corrective actions are not taken.

Although this anecdote was from the 1970s in a steel mill, this is an example of an event that continues to occur even today. If the leaking carboy had been reported, an employee would have likely not lost their life.

As with any safety concern, the application of good or best practices and procedures can eliminate the potential of these events so the information should never be required, and management and employees never need to experience tragedies.

### Comments are welcome.

If you have questions about this topic or other safety issues, please contact [safetyfirst@aist.org](mailto:safetyfirst@aist.org).

Please include your full name, company name, mailing address and email in all correspondence.

## “My First Fatality Investigation”

I still remember getting that phone call early one Sunday morning from a guard at the blast furnace where I had been working for less than a year. I had the weekend call for the EH&S Department and the guard was asking me if being exposed to methanol vapors for a short time posed any hazard. I told him that as long as the workers were not experiencing any dizziness or nausea they would be fine after getting some fresh air. As I hung up the phone, something in my gut told me something didn't seem right and I decided to go to the plant anyway.

Walking into the mill from the parking lot, I ran into the plant's assistant general manager, who asked what I was doing there. I told him I got a call from the guard about workers being exposed to methanol vapors and decided to investigate further. I soon learned that phone call was an understatement. A lab worker from the water quality lab was on his way to the nearby hospital's burn unit. The workers reportedly exposed to the vapors were, in fact, other lab personnel who were able to catch the worker who had caught on fire and douse the flames with their coats. They were mostly uninjured, suffering only minor burns to the hands.

During the investigation, we learned the lab worker was performing a common water quality check on boiler water involving 100 ml of methanol. The methanol was stored in a five-gallon plastic carboy dispenser stored on the edge of the lab bench. Because the carboy dispenser valve had a tendency to drip, a trash can filled with paper towels was positioned below to catch and evaporate the leaking methanol. The lab was a no-smoking area, and it was suspected that someone had tossed their cigarette into the trash can. A short while later, the lab worker saw flames from the trash can licking at the bottom of the five-gallon methanol container. Realizing this was a problem, he tried sliding the container out of the flames, but when he did this, the sloshing methanol burst the heat-softened plastic, resulting in a huge fireball that engulfed the worker. He ran down the hallway and was tackled by two co-workers, who put out the flames. The lab worker was then transported to the hospital. Despite burn treatments, he unfortunately passed away three days later.

Our management at the plant spent days discussing ways to make this lab operation safer. Word also spread to other blast furnace operations across the company. Additionally, sharing details of fatalities and lost-time injuries throughout the steel industry was what we did back then and hopefully that practice continues today. This gentleman was my first but not my last fatality or lost-time injury investigation – and one I'll never forget. My one regret after all these years was that I cannot remember his name. ♦