



## Falling Load From an Overhead Crane Results in a Fatality of a New Employee

A new employee, with approximately four months of service, was working alone while operating an overhead crane with a pendant control. The employee sustained fatal injuries when a falling bundle of steel bars, weighing approximately 3,000 pounds, broke free and landed on him. The new employee was moving a bundle of steel bars from a staging area onto an entry roll table of an annealing furnace. The bundle of steel bars were not attached to the overhead crane's load block by a means of slings or other approved devices. Instead, it was standard practice to use the overhead crane's double-leg chain sling to lift bundles of steel bars by using the bundle's carbon tie wires (that wraps the bundles of steel bars together for storage purposes) to quickly lift the bundles into position. One of the carbon tie wires on the bundle broke free from the chain sling causing the load to fall.



### Recommendations:

- Provide approved slings and lifting devices so loads are attached to a crane's load block. All practices of using carbon tie wires as a makeshift lifting device must end.
- Provide crane safety lights projecting down creating safe perimeters around a suspended load.
- Provide 'no-touch' tools/taglines for general control, and maintain safe distances from a load.
- Develop/deliver training materials, videos, photos, etc., in a manner/language workers understand to aid in hazard identification/controls needed as a qualified rigger, and upset conditions.
- All employees new to the job, process, and task must be provided with written procedures, training and education. Note: Training sign-in sheets do not mean compliance, only attendance.
- Training quality must be based on experience, not the number of hours and calendar days.
- Ensure trainers have the proper training and experience, are provided with the tools, skills and knowledge needed to train and educate other employees new to the job and tasks.
- Provide effective training and education for new employees/job transfers, even if a worker has previously held the job classification, along with frequent evaluations by a competent person.
- Evaluate Management of Organizational Change processes to ensure downsizing, transfers, and staffing issues that impact the line-of-progression, training and manning cushions, don't result in negative consequences on safety. This applies to the whole organization, and it involves employees and their representatives. If the proposed changes are not safe, the change must not be made - making change is for safer future-fitting, not retrofitting changes that are not safe.
- Utilize a union-management safety committee, as well as a training committee to assess and focus on staffing issues that lead to 'green-on-green' hazards. Include seasoned, intermediate, and newer employees in addressing 'green-on-green' issues and understaffing.
- Increase staffing to ensure "qualified" employees are available to train and educate new employees to their jobs and tasks, and cover any employee absences.
- Negotiate 'working alone' provisions in contracts with employers so no employee is working alone in areas where hazardous conditions exist, where they cannot communicate with others, or they cannot be heard or be seen, per a union-management risk assessment.
- Provide all hourly and salary employees with a Right-To-Act process and annual retraining. All employees must have a procedure and process to report hazards, stop unsafe/unhealthy jobs/tasks, and shut down any process without the fear of retaliation.
- Provide and have new employees wear green hats until they're fully qualified on the jobs/tasks.



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This hazard alert is based on an actual incident, and reflects our best understanding of the incident at the time it was written. However, many incidents have multiple causes; this alert may not cover all of them. The purpose of the alert is to illustrate workplace hazards; it is not intended to be a comprehensive report on the incident.