5. There was one nut that could not be turned by hand and used a 1 5/8" open end wrench to turn it.
6. As he pushed the wrench for a third turn (less than one complete revolution of the nut) the nut broke free of the burr on the bolt.
7. knuckle struck a nearby pipe resulting in a sharp pain in his hand for about two minutes.
8. When the pain subsided completed the work at the filter.
9. When the work was completed Dave noticed swelling in his hand and went to the lab for first aid.
10. He was taken to the hospital for x-rays and two broken bones in his left hand were discovered.
11. returned to work on Sunday for his scheduled shift.

FACTS SURROUNDING THE INCIDENT

1. The filters are routinely changed on a monthly basis by the area operators, with Dave having done them numerous times.
2. The proper tools were being used.
3. Some of the nuts can only be turned one flat of the nut at a time due to other obstructions.
4. Dave was not rushed to finish the job.

MANAGEMENT SYSTEMS INVESTIGATION

1. There has been instruction in the proper use of tools at our plant.
2. safety performance is unsatisfactory.

CONCLUSION

This injury was avoidable by exercising more caution and repositioning himself in order to pull the wrench away from rather than push it towards the pipe.

J W Kent

J. W. Kent

Suspension

OSHA REC.

REPORT OF MINOR INJURY

SECTION #1

EMPLOYEE NAME: BFG DEPT.# 5163

EMPLOYEES JOB TITLE: CONSOLE TECHNICIAN

WHEN EMPLOYEE CAME FOR TREATMENT. DATE: 7-4-92 TIME: 10:15 (A.M.) F.M.

DATE OF INJURY: 7-4-92 TIME: 09:45 (A.M.) F.M.

STATE NATURE OF INJURY AND INCLUDE EMPLOYEE'S STATEMENT.

STATED HE WAS TIGHTEN LID DOWN ON A FILTER HOUSING WHEN WRENCH SLIPPED CAUSUL HIM TO JAM HIS LEFT HAND - HAND SWOLLEN AND SORE IN LITTLE FINGER AREA (ABOVE 1ST JOINT)

TREATMENT ADMINISTERED: ICE PACK - HOSPITAL FOR XRAY

FRACTURE

EMPLOYEE SENT: WORK ___ HOME ___ DOCTOR ___ (2) HOSPITAL X (1)
(IF SENT TO DOCTOR OR HOSPITAL, INDICATE NAME.)

EMPLOYEE SIGNATURE: _____ DATE: 7-4-92

FIRST AIDER SIGNATURE: M Truitt DATE: 7-4-92

COPY TO LEAD TECH/ALLIED SUPERVISOR

SECTION #2

LEAD TECH/ALLIED SUPERVISOR

LEAD TECH/ALLIED SUPERVISOR REMARKS & CORRECTIVE ACTION: This job is done on a monthly basis - didn't see any problem in the way the job was being done, J (an Engr) was working with him

LEAD TECH/ALLIED SUPERVISOR SIGNATURE: J. Engr DATE: 7-4-92

SECTION #3

AREA MANAGER

AREA MANAGER REMARKS: This injury could have been prevented by paying more attention to the job at hand. should have either repositioned himself or his hand to avoid hitting the piping.

AREA MANAGER SIGNATURE: Bill Wagner DATE: 7/10/92

RETURN TO SAFETY DEPARTMENT WITHIN TWO WORKING DAYS

DATE: _____

JSS-063
2-18-88

NGC 13692

DATE: August 3, 1992

TO: F. M. Schuler

FROM: D. C. Hicks

RE: **VCM EXPOSURE IN EXCESS OF PEL**
LOUISVILLE PLANT

Summary

Two pipefitters were exposed to VCM in excess of the PEL while connecting/disconnecting VCM tankcars. Respiratory protection was not worn.

Board of Review

A Board of Inquiry was conducted on June 23, 1992, in the Engineering Conference Room to discuss the incident. Those in attendance were:

S. Deetsch	-	Engineering Supervisor-LPA
D. Hicks	-	Engineering Supervisor-Utilities
B. Kinslow	-	Tank Farm Foreman
H. Kletke	-	Plant Manager
R. Mueller	-	Manufacturing Manager-LPA
	-	Pipefitter
	-	Pipefitter
F. Schuler	-	Plant Engineer
A. Simpson	-	Manager, Health, Safety & Environmental

Corrective Action

1. Communicate and enforce respiratory requirements during tankcar work. (Hicks/Barnes by 5-15-92 - Complete)

2. Review VCM training requirements with all pipefitters. (Barnes by 8-15-92)

3. Post a warning sign at the VCM unloading area indicating mandatory use of respirators. (Kinslow by 8-1-92)

4. Reroute breathing air lines/hoses at the VCM unloading stations to make it less cumbersome to perform work with respiratory protection. (Camm/Kinslow by 6-15-92 -- Complete)

5. Investigate engineering controls to minimize/eliminate VCM exposures. (Deetsch by 9-1-92)

REDACTED

Narrative

Personnel monitoring for VCM exposure indicated that pipefitter , was exposed to a Time Weighted Average (TWA) of 1.08 ppm on April 20 and 1.20 ppm on May 4 while performing the VCM tank farm job. , another pipefitter performing the same job, was exposed to a TWA of 1.23 ppm on May 11. Neither were wearing respirators during the connecting and disconnecting of VCM tankcar unloading nipples and hoses.

Facts Surrounding the Incident

1. Respirators have not been worn consistently during VCM tankcar hook-ups.

2. Respiratory protection was not re-established as an actively enforced requirement until May 15, 1992.

Management Systems Investigation

1. Management failed to enforce the requirement of wearing respiratory protection.

2. Poor communication of personnel monitoring results over the last several years promoted deterioration of enforcement.

Conclusion

Two pipefitters were exposed to levels of VCM that exceeded the permissible limits for an 8-hour TWA because they were not wearing proper respiratory protection.

D. C. Hicks

sjm