



Naval Safety Center

LESSONS LEARNED



LL 21-21

CUTTING CORNERS

Cutting corners will get you to the place you don't want to be quicker.

Cutting corners – to perform some action in the quickest, easiest, or cheapest way, according to Webster's Dictionary online – is observed as a causal factor in far too many mishaps in our database. Cutting corners is typically associated with knowingly skipping steps on a procedure for convenience or to save time, but it usually provides the opposite outcome intended by said corner cutter. In this lesson, we highlight some of the latest examples of the potential consequences of cutting corners, and add some reminders (*some from previous lessons*) to show that no community or duty status is immune.



A Naval Surface Forces study, “The Six Traits of a Mishap Ship,” found that one common trait was that “one, or usually many, watchstanders decided not to, or did not perform specific required actions or protocols that they had been trained, qualified, and certified to perform.” In short, the watchstanders cut corners. The study found that routinely cutting corners on a ship was an indicator of a potential future mishap.¹ It may take time for some deliberate omissions or ignoring rules to catch up, but in many cases, the payback is instant. In either case, time, property, and even lives were lost needlessly due to Sailors, Marines, and civilian employees trying to shave some effort or time off a task. Please read and discuss the examples of cutting corners below with your teams, and learn how mayhem was only one step away from being avoided.

- No worries, this will only take a minute. Two shipyard mechanics were assigned and briefed to arc weld remnants from the overhead deck. They were instructed to get a Ship's Force (SF) fire watch, prep the space to perform the hot work, and wait for the foreman to approve the space before performing any hot work. Mechanics #1 & #2 discussed the short duration the job would take and **decided not to get a SF fire watch and proceeded to start arcing without the supervisor approving the job site.** With no fire watch in the space, Mechanic #2 starting arcing. When he needed to reposition himself, he noticed a chair on fire outside the containment. By the time he could reach a fire extinguisher, the smoke was too heavy and he exited the space. Both SF and external fire departments responded and extinguished the fire. — *“It'll only take a minute,” are infamous last words.*
- Hang on, this will just take a sec. A Sailor was on the well deck ladder on an Amphibious ship attempting to rig a line on a pipe; he slipped from the ladder and fell onto the well deck approximately 25 feet below. **The report notes that he was not wearing the required safety harness.** The Sailor suffered a fractured hip, fractured ribs, and a dislocated elbow. — *Five days in the hospital and 30 days sick in quarters were certainly not worth saving a minute to put on a safety harness.*
- Just sign it off. On an aviation detachment, a group of maintainers was conducting maintenance on an aircraft. A step in the maintenance procedures required a piece of equipment that the detachment did not have on hand. Two Sailors asked the detachment's maintenance leadership how they should proceed. **Their supervisor alluded to a series of options including, “just signing it off,”** which the two maintainers chose as their course of action. It later became apparent that the maintenance in question didn't need to be completed while the detachment was in its current environment, but the maintainers (and supervisor) didn't know that when they elected to sign it off as if they had completed the

¹For a copy of “The Six Traits of a Mishap Ship” study or LL 19-23 of the same name, contact us at NAVSAFECEN_CODE522_LESSONS_LEARNED@navy.mil.

procedure. — *Fortunately, this cut corner didn't result in a serious mishap, but it wasn't worth the Non-Judicial Punishment (NJP) that followed for those involved.*



- This looks about right. Upon initiating a timed fuse at a Marine demolition range, the Range Safety Officer, two senior assaultmen, and combat engineers moved to an alternate firing position that was miscalculated well inside the fragmentation distance from the charge. **The unit paced off what they figured was 200 meters, but their real distance was only 160 meters. Even with the misestimated footsteps, the correct distance for the charges used was actually 300 meters.** Debris struck one of the assaultmen, who was attempting to observe the

detonation. — *The Marines' overconfidence in their knowledge of the standoff distance and the accuracy of their not-so-calibrated footsteps ended up injuring a fellow Marine. Take the time to review the doctrine – and measure the distance ... before you start blowing stuff up.*

- Is this thing on? While working on an electrical system at his home, a Sailor touched a hot wire causing electrical burns to his hands and arm. The report confirms that the Sailor was aware of the danger of working with the electricity on, but he didn't secure it because he "didn't think he would touch a hot wire." — *His burns and 24 days on light duty would say otherwise. It only takes a second to secure power or to burn yourself. Choose wisely.*
- Eyeballing it. A Sailor was at home using a wire brush attachment on a rotary tool to clean car parts (and not wearing eye protection). A bristle from the wire brush was ejected and struck the Sailor's right eyeball, requiring surgery to remove the bristle. The Sailor admitted that he knew eye protection was required, but "didn't feel the need to take the extra precaution." — *We suspect the eye surgery changed his mind for future wire brushing. Saving a few seconds by not getting your eye protection will cost you hours, days, or weeks instead (not to mention the pain).*

Key Takeaways / Lessons Learned

Each of the examples in this lesson could have been avoided by simply following the rules or by taking the extra time to do the job correctly, with the proper PPE. Sometimes, experience can get in the way of safety when you've performed a task hundreds of times without incident and certain precautions and protective gear seem like overkill. But, then the inevitable mishap occurs to remind us why those safety precautions are in place. There's a reason for the saying, "safety regulations are written in blood," because it's largely true. Behind most safety procedures and PPE requirements is some history of mishaps occurring without them. Cutting corners will eventually catch up to you, so take a minute to read and internalize these takeaways.

1. **Cutting corners only creates more corners.** In all of the narratives above (and there are many more examples), the corner cutters proved exactly why safety procedures exist in the first place. The causes of the mishaps and missteps were a direct result of blowing off safety protocols. They knew the right thing to do, but they decided not to. So the next time you begin to think, "this will just take a second," remember that mishaps only take a second too. Safety procedures are part of the job, so include the time it takes to do it safely. None of these examples occurred in a tactical or combat situation. There was no urgent time constraint warranting skirting the rules. Take the time to do the job *right*, not just *right now*.
2. **No checklist says, "If you're in a hurry, scrap the PPE."** We get it, you're in the kitchen and only need to drill one small hole, but your eye protection is out in the garage. That extra few seconds to go get it can save you a trip to the emergency room and possibly your eyesight. In many of the mishaps we see, members skipped a step, like donning a safety harness, only to find out the hard way why they needed it. Some didn't live to regret their poor decision. Please learn from their experiences.

And remember ... "Let's be careful out there."