

# LESSONS WE CANNOT

— **FORGET** —

Learning from ARLANXEO's  
Most Serious Incidents

By: Wael Abdelgalil

Learn from the past.  
Act in the present.  
Protect the future.

ARLANXEO

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# FOREWORD

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This publication, **LESSONS WE CANNOT FORGET: Learning from ARLANXEO's Most Serious Incidents**, brings together the most significant incidents that occurred between 2020 and 2026. It is not a record of failures or a document of blame. **It is a record of learning.**

Each case reminds us that accidents rarely result from a single mistake. They occur when hazards are not fully understood, risks are underestimated, or the barriers designed to prevent harm are weakened or fail.

Our responsibility is to understand not only what happened, but also why it happened and what must change to prevent it from happening again. The strongest organizations are those that learn openly, share knowledge freely, and continuously improve their systems, processes, and behaviors.

As you read these case studies, I encourage you to ask yourself:

- Could this happen at my site?
- Do we have similar hazards or conditions?
- Are our critical controls effective and verified?
- What actions can we take today to strengthen our safety measures?

Safety excellence is built on learning before incidents occur not after. Let these experiences challenge our assumptions, strengthen our decisions, and reinforce our commitment to protecting our people, our communities, and our business.

Every lesson learned is an opportunity to prevent the next accident. Let us ensure these lessons become lasting improvements across every operation.



“

*Safety is not a slogan for a single day. It is a core value that must guide every decision we make. Our commitment is clear: we do it safely or we don't do it at all. There is no compromise.”*

---

**Stephan van Santbrink**  
CEO



“

*Every major accident leaves behind more than damage and loss. It leaves behind lessons. Whether those lessons prevent the next accident depends on our willingness to learn from them and apply them consistently across our organization.”*

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**Kalaivanan Krishnan**  
Global Head HSSEQ

# 1. ACETONITRILE EXPOSURE DURING CONFINED SPACE ENTRY SARNIA 2020



## 1.1 WHAT HAPPENED?

On Saturday, April 18, 2020, two contractors entered a butadiene extraction tower to carry out planned maintenance after the equipment had been isolated, drained, and prepared for confined space entry. The tower had normally contained acetonitrile, the solvent used in the extraction process, but all parties believed it had been made safe for the work.

The work was completed without incident, and the contractors left the vessel. Several hours later, two of the workers began to feel unwell. Their symptoms became severe enough

that one was transported to hospital by ambulance, while the other sought medical treatment with the assistance of a family member.

Medical evaluation confirmed that one of the contractors had been exposed to acetonitrile and required treatment. As a precaution, two other contractors who had worked inside the same vessel were also examined at the hospital. Fortunately, they showed no signs of illness and were discharged the same day. The two affected workers recovered and were released from hospital after several days.

The incident raised an important question: **How could workers be exposed to a hazardous chemical after a vessel had been drained, prepared, tested, and declared safe for confined space entry?**

## 1.2 IMMEDIATE RESPONSE

Once the illness was identified, all further work inside the extraction tower was stopped.

A safety stand-down was conducted to prevent additional exposure and allow the circumstances to be reviewed.

The affected contractor received initial treatment on site before being transported to hospital for further medical assessment and treatment. Other potentially exposed workers were also sent for medical evaluation as a precaution.

The relevant authorities were notified, and a formal investigation was initiated.

These actions were necessary and appropriate. They addressed the immediate consequences, protected other workers, and initiated the process of understanding why the incident had occurred.

However, the most important questions were not about the emergency response.

They were about the decisions made before anyone entered the tower.

Why had the normal preparation procedure been changed? Why was a contractor with no previous experience performing this type of inert entry at the site selected? And why had equipment and protective clothing been accepted without adequately verifying their suitability for the chemicals present?

## 1.3 WHAT WENT WRONG?

### 1. Production Pressure Influenced a Safety-Critical Decision

The plant faced significant operational pressure. C4 storage caverns were nearly full, and stopping the incoming flow from NOVA could have resulted in an emergency cracker shutdown, with serious safety, environmental, and financial consequences.

An alternative method was therefore selected to prepare the tower and clear the blockage. However, the process for approving this deviation was not robust enough to fully evaluate the additional risks.

The failure was not the decision to change the procedure, but the failure to adequately assess the risks introduced by that change.

## **2. Contractor Approval Was Mistaken for Competence**

The contractor was approved to work at the site and had experience with similar inert-entry operations in the oil and gas industry. However, it had never performed this specialized activity at the facility.

The contractor expressed confidence in its capabilities, but these claims were not sufficiently verified. The selection process failed to recognize that experience in similar work does not automatically establish competence for a different chemical environment.

**An approved contractor is not necessarily a competent contractor for every task.**

## **3. Chemical Hazards Were Not Adequately Assessed**

The contractor relied on previous experience without fully considering the specific hazards of acetonitrile.

The selected personal protective equipment was not chemically compatible with acetonitrile. Furthermore, the gas detection equipment, although suitable for certain inert-atmosphere hazards, could not detect acetonitrile at its lower explosive limit.

The risk assessment failed to identify these critical weaknesses before entry.

**The equipment was suitable for the type of work but not adequately suited to the chemical hazards involved.**

## 4. Contractor Capabilities Were Not Independently Verified

The company relied heavily on the contractor's stated expertise, while the contractor assumed its existing methods and equipment were adequate.

Neither party sufficiently challenged the assumptions behind the work plan. Critical questions about chemical compatibility, atmospheric monitoring, and exposure risks remained unresolved.

The responsibility for safety was shared, but the verification of critical controls was inadequate.

**The work was approved based on confidence in the contractor rather than demonstrated effectiveness of the safeguards.**

Ultimately, this incident was not the result of one isolated mistake. It was the consequence of operational pressure, inadequate evaluation of procedural changes, unverified contractor competence, and insufficient understanding of chemical hazards.

The most important lesson is simple: **Experience creates confidence, but only verification creates assurance.**

### 1.4 LESSON LEARNED

**A different method is a different job.** Whenever the planned method cannot be followed, the alternative should be treated as a change and subjected to a formal risk assessment.

**Operational pressure should never compromise the quality of risk assessment.** Production, commercial, or schedule pressures can influence decisions, but they should not reduce the rigor of hazard evaluation.

**Management of Change applies to work methods as well as equipment.** A change in how the work is performed can introduce new hazards, even when the process and equipment remain unchanged.

**Experience in similar work does not guarantee competence in a different application.** Contractors should be evaluated for the specific hazards and conditions of the task they are being asked to perform.

**Contractor approval is not task approval.** An approved contractor may still require additional technical review when introducing new methods, equipment, or technologies.

**Question assumptions.** Similar does not mean the same. Differences in process conditions, chemicals, equipment, or operating environment can significantly change the level of risk.

**When conditions change, stop and reassess.** The safest decision is often to pause the work, review the hazards, and confirm that the planned controls remain effective before proceeding.

**The best decisions are made before the work starts.** Investing time in planning and understanding the hazards is always preferable to managing the consequences of an unforeseen event.

# 2. HIGH-PRESSURE WATER JET INJURY DURING CLEANING LA WANTZENAU - FRANCE 2021



## 2.1 WHAT HAPPENED?

On Saturday, May 01, 2021, A During a planned high-pressure water cleaning activity in the coagulation section, three contractor teams were cleaning equipment using different high-pressure water cleaning techniques. One team was unable to remove heavy fouling from a cone sieve using the planned cleaning method. To assist,

another team decided to use a flexible hose and nozzle assembly ("Furet"), a different cleaning technique, to complete the task.

The first attempt to clean the sieve from the top was unsuccessful. The team then repositioned the hose and attempted to clean the equipment from the bottom.

The first attempt to clean the sieve from the top was unsuccessful. The team then repositioned the hose and attempted to clean the equipment from the bottom.

As the operator directed the hose into the cone, he heard a metallic noise. Seconds later, the hose and nozzle suddenly shot back out of the equipment under high pressure and struck his leg below the knee.

A nearby colleague immediately activated the emergency stop, shutting down the high-pressure water supply. However, the injury had already occurred. The contractor received first aid on site before being transported to hospital, where he underwent emergency surgery. Despite several medical interventions, the severity of the injury ultimately required an above-the-knee amputation.

The incident raises an important question:

**Why did a routine cleaning activity suddenly become an uncontrolled release of a high-pressure hose?**

## **2.2 IMMEDIATE RESPONSE**

The injured contractor received immediate first aid at the scene before being transported to hospital.

Emergency medical treatment was provided, and the injured worker underwent surgery.

Despite medical intervention, the severity of the injury required an above-the-knee amputation to prevent life-threatening complications.

Work was stopped, the area was secured, and an investigation was initiated to determine why the hose became detached and how similar incidents could be prevented.

## **2.3 WHAT WENT WRONG?**

The investigation found that the work gradually drifted away from the planned method. Although a work permit, risk assessment, and high-pressure water cleaning guideline were in place, these controls did not govern the work once unexpected conditions were encountered.

The heavy fouling inside the equipment made the planned cleaning method ineffective. Rather than stopping the job and consulting the supervisor to review the situation, the team relied on their experience to find another solution. Over time, experience had become the primary basis for decision-making, while the requirements of the work permit and cleaning procedure became secondary.

This was not the result of one poor decision. It reflected a working environment in which experienced operators were accustomed to adapting the job to suit changing conditions. As a result, changes to the

work method were not consistently communicated to, or reviewed by, supervision before they were implemented.

The investigation also found that the roles and responsibilities within the team had become blurred. Operators made operational decisions that should have been escalated through the supervisory chain. When difficulties were encountered, the normal process for seeking direction was bypassed, and the team proceeded with an alternative method without a formal review of the associated risks.

The decision to use a different cleaning technique was influenced by a genuine desire to complete the work efficiently, minimize delays to other teams, and return the equipment to service. However, changing the cleaning method also changed the hazards. That change was never formally assessed.

This incident highlights a lesson that: **procedures do not fail because they are unavailable, they fail when people believe that experience is a better guide than the procedure.** Experience is valuable, but it should never replace a systematic assessment of risk when conditions change.

Whenever the planned method cannot be followed, the work should stop until the change has been evaluated, approved, and communicated. A different method is not simply another way of doing the job. it is a new job with new hazards.

## 2.4 LESSON LEARNED

**When the planned method no longer works, stop and reassess.** An alternative method should never be introduced without understanding the new hazards it creates.

**Experience should complement procedures, not replace them.**

Experienced workers often find practical solutions, but those solutions must be evaluated before they are adopted.

**Changing the work method changes the risk.** Any significant change to the way a task is performed should be reviewed, approved, and communicated

before the work continues.

**Work permits and risk assessments remain valid only while the work is carried out as planned.** If the job changes, the permit and risk assessment should be reviewed to ensure they still reflect the actual work being performed.

**Supervisors should be involved whenever unexpected conditions are encountered.** Escalating concerns early provides an opportunity to identify hazards before they lead to an incident.

**Efficiency should never replace risk assessment.** The desire to save time, support other work crews, or restore production should never influence decisions involving safety-critical work.

# 3. UNEXPECTED RELEASE OF HOT WATER

## SINGAPORE - 2023



### 3.1 WHAT HAPPENED?

On Friday, November 03, 2023, Maintenance work was being carried out on the recirculation line of the halogenation coagulator after the line had become plugged. The equipment had been isolated, locked out, tagged out, and the necessary work permits had been issued before the piping was opened. Once the blockage had been removed, the maintenance crew began reinstalling the spool piece and valve.

The work was still in progress when a valve located on the level above the

maintenance crew was unlocked and partially opened. The valve had not yet been returned to service, and the maintenance activity had not been completed.

As the valve opened, hot water was released through the open piping onto the workers below. The release was recognized immediately, and the valve was quickly closed. However, the maintenance workers had already been exposed to the hot water.

Three maintenance workers suffered burn injuries and required medical treatment.

The incident raises an important question:

**How could hazardous energy be reintroduced into equipment while maintenance work was still in progress?**

## 3.2 IMMEDIATE RESPONSE

The release of hot water was stopped immediately by closing the valve.

The three injured maintenance workers removed their contaminated clothing and washed themselves before being transported to hospital for medical assessment and treatment.

One worker sustained second-degree burns over approximately 25% of the lower body. Two other workers sustained second-degree burns over approximately 13% of the upper body.

The work area was secured, and the maintenance activity was suspended.

A formal investigation was initiated to determine how hazardous energy was reintroduced before the work had been completed

## 3.3 WHAT WENT WRONG?

The maintenance work began correctly. The line was isolated, locked out, tagged out, and work commenced only after the necessary permits had been issued. The accident did not occur because the isolation process was absent—it occurred because the isolation was removed before the work had been completed.

A supervisor obtained the personal lock keys from the maintenance crew, removed their personal locks, restored the isolation, and partially opened a valve while workers were still reassembling the piping below. The fundamental principle of personal lockout had been broken **only the person exposed to the hazard can decide when it is safe to remove their lock.**

This incident illustrates why personal locks exist. A personal lock is not simply a procedural requirement; it is the worker's final protection against the unexpected release of hazardous energy. Once another person can remove that lock, the protection is lost.

The investigation also identified weaknesses in the isolation strategy. Once the piping had been removed, only a single isolation valve separated the process from the maintenance activity. Should that valve be opened inadvertently, nothing remained to prevent the release of hazardous fluid. A blind flange or other positive isolation would have provided an additional independent barrier.

The work itself had also changed. A leak test was introduced before the maintenance activity had been completed, using hot process water rather than a safer test medium. This changed both the hazards and the conditions under which the original work permit had been issued. However, the change was not formally recognized, and the permit and risk assessment were not reviewed to reflect the new work.

The investigation also found that production pressures had begun to influence decision-making. A prolonged process upset had increased the urgency to restore the equipment to service. Senior operational personnel remained on site well beyond their normal working hours and became directly involved in the maintenance activity. Although intended to support the team, their presence created a perception that completing the work quickly had become the priority.

Finally, the organization had unknowingly weakened one of its most critical safety systems. During the COVID-19 pandemic, changes were made to the lockout process to reduce the number of people accessing the lock box. Those temporary arrangements remained in place after the pandemic without a formal Management of Change review to assess their impact on hazardous energy control.

Accidents rarely occur because one barrier fails. They occur when several independent barriers are weakened at the same time. In this case, the principles of personal lockout, positive isolation, permit-to-work, Management of Change, and work supervision all failed to provide the protection they were intended to deliver.

### 3.4 LESSONS LEARNED

Personal locks are personal. They should only be applied and removed by the individual performing the work.

Hazardous energy must never be restored until every person has completed the work and confirmed that it is safe to do so.

When dismantling piping leaves only a single valve between the process and the work area, additional positive isolation should be provided wherever practicable.

A leak test changes the conditions of the work. It should be treated as a new activity requiring a review of the permit, risk assessment, and communication between all parties.

Temporary changes to critical safety systems should never become permanent practice without a formal Management of Change review.

Operational urgency must never influence decisions involving hazardous energy control. Production can wait; restoring hazardous energy before the work is complete can have irreversible consequences.

Strong safety systems rely not only on procedures, but on disciplined execution, effective supervision, and respect for the purpose of every critical control.

# 4. EXPLOSION DURING HIGH-PRESSURE CLEANING OF A BUFFER TANK

## LA WANTZENAU – FRANCE 2024



### 4.1 WHAT HAPPENED?

On Thursday, July 04, 2024, A water–acetonitrile (ACN) buffer tank was taken out of service to allow its scheduled internal inspection. The tank had been isolated from the process, drained of liquid, and prepared for cleaning before the inspection.

To remove the remaining solid deposits, an automated high-pressure cleaning system was used. The cleaning campaign began on 25 June 2024 and continued over several days.

On 4 July 2024, while the cleaning operation was still in progress, an explosion occurred inside the tank. A flammable atmosphere had developed

within the vessel and was ignited by an ignition source.

The force of the explosion caused the tank roof to separate along its designed weak seam. The roof was projected into undeveloped land adjacent to the production unit. Fortunately, no personnel were inside or near the tank at the time of the explosion, and there were no injuries.

The incident raises an important question:

**How could an isolated, drained, and cleaned tank develop a flammable atmosphere capable of exploding?**

## 4.2 IMMEDIATE RESPONSE

The four high-pressure cleaning contractors working in the area were evacuated and assessed at the site infirmary. No injuries were reported.

A foam blanket was applied to the open tank to minimize volatile organic compound (VOC) emissions.

Atmospheric monitoring was carried out around the tank to verify acrylonitrile concentrations and confirm that the surrounding area remained safe.

The tank area was isolated and secured to prevent unauthorized access.

## 4.3 WHAT WENT WRONG?

The tank had been isolated from the process, drained, and prepared for cleaning. Attention was focused on preventing exposure to toxic acrylonitrile vapours outside the tank, and controls were implemented to protect workers from this well-known hazard.

However, another hazard had not been recognized.

Neither the site personnel nor the high-pressure cleaning contractor was aware that high-pressure water cleaning at pressures above 500 bar can generate electrostatic charge, even when the equipment is properly grounded. Consequently, the possibility of static discharge acting as an ignition source was not considered during the risk assessment, the job safety analysis, or the work planning process.

At the same time, cleaning activities disturbed residual deposits inside the tank, allowing a flammable atmosphere to develop. The focus on toxic exposure outside the tank diverted attention from the possibility of a flammable atmosphere forming inside it. The explosion occurred when these two conditions a flammable atmosphere and an ignition source came together.

The investigation also identified weaknesses in the design and management of the cleaning process. Fouling inside the tank had become a recurring operational issue, yet the elimination or reduction of fouling had not been considered during the design of the installation. As a result, high-pressure cleaning became a routine maintenance activity for a problem that had never been engineered out of the process.

The cleaning method had also evolved over time. Ventilation arrangements had been changed from previous practices without a formal Management of Change review or a multidisciplinary assessment of the new risks.

**Changing the way a job is done is changing the process itself.** Every significant change, no matter how small it appears, must be evaluated with the same discipline applied to changes in plant design.

Finally, the investigation found that contractor controls were not sufficiently robust. The contractor's job safety analysis did not identify the potential for electrostatic ignition during high-pressure cleaning, and deficiencies in the grounding arrangement were not recognized during site verification. Both the contractor and the site relied on existing experience and accepted practices, but neither recognized a hazard that was not yet understood.

This incident demonstrates that accidents do not always occur because hazards are ignored. Sometimes they occur because the hazard is unknown. Once the hazard becomes known, it must become part of the organization's collective knowledge so that future work is planned differently.

## **4.4 LESSONS LEARNED**

A vessel that has been drained and isolated may still develop a flammable atmosphere during cleaning activities.

High-pressure water cleaning can generate electrostatic charge capable of igniting flammable atmospheres, even when conventional grounding measures are in place.

Risk assessments should consider all hazards introduced by the cleaning method, not only the hazards associated with the process material.

Managing one hazard must not divert attention from another. Toxicity and flammability should always be assessed together where both are possible.

Recurring maintenance activities often indicate an underlying design issue. Where practicable, the process should be modified to eliminate or reduce the need for hazardous cleaning operations.

Changes to cleaning methods, ventilation arrangements, or contractor work practices should be treated as Management of Change and subjected to a formal multidisciplinary review.

Contractor competence includes understanding the hazards of the specific task being performed, not simply experience with similar work.

Unknown hazards become repeat accidents only when organizations fail to learn from them. The knowledge gained from this incident must be incorporated into procedures, training, risk assessments, and future designs across all sites.

# 5. AMMONIA RELEASE DURING LINE BREAK – WHEN “ISOLATED” WAS NOT PROVEN SAFE

## LA WANTZENAU – FRANCE



### 5.1 WHAT HAPPENED?

A contractor was preparing to remove a blind flange from an ammonia line as part of a BMR project tie-in.

The task involved opening process equipment, a line break, and therefore depended on one critical condition: the line had to be proven free from hazardous energy and ammonia before the flange was disturbed.

It was not.

Zero energy had not been verified at the point of work, and the equipment owner was not present when the line break began.

The contractor started removing the blind flange. Once the flange was opened, ammonia that remained in or could reach the system found a way out.

Approximately 1.6 tons of ammonia ( $\text{NH}_3$ ) was released, producing a toxic vapor cloud in the work area.

Five workers were exposed. Two suffered ammonia exposure serious enough to result in Lost Time Injuries (LTIs). One worker required First Aid, while two others were medically evaluated and released without treatment.

The flange was the last physical boundary between the workers and the ammonia.

It was removed before the people doing the work had proved what was on the other side.

The incident raises an important question:

**How do we confirm that a line is truly safe before breaking containment?**

## **5.2 IMMEDIATE RESPONSE**

Gas detection systems responded to the release and emergency shut-off valves activated. The site emergency response plan was initiated, and water screens were deployed to help capture and control the ammonia vapor.

The five exposed contractors were removed from the area and sent for medical evaluation. The affected area was brought under emergency control, and an investigation was initiated to understand how a planned line break had resulted in a major ammonia release.

The emergency safeguards helped limit the consequences.

## **5.3 WHAT WENT WRONG?**

This event was not simply the result of someone removing the wrong flange or failing to follow one step. Several barriers that should have prevented the release were either missing or ineffective.

**Zero energy was assumed rather than demonstrated.**

Isolation alone does not make equipment safe to open. Before breaking containment, the line must be drained, depressurized, purged or otherwise made safe as appropriate, and most importantly the safe condition must **be verified at the point of work**. The final question is not “Has the line been isolated?” but “How do we know there is nothing hazardous behind this flange?”

**The line-break control was incomplete.**

Removing a blind flange from an ammonia system is a high-hazard activity. The authorization to begin work should depend on positive

confirmation that the process conditions required for opening the equipment have been achieved. That confirmation was not effective.

### **The equipment owner was absent at a critical moment.**

The person responsible for the process equipment was not present for the line break. This removed an important opportunity to challenge assumptions, verify the correct equipment and isolation, confirm process conditions, and authorize the first opening of containment.

### **The contractor was exposed to a process hazard that should have been controlled by the operating organization.**

A contractor can follow instructions, permits and drawings, but should not have to discover whether an Ammonia line contains ammonia by loosening its flange. The organization controlling the process must establish and demonstrate that the equipment is safe before handing it over for intrusive work.

### **The final barrier became the worker.**

Gas detectors, emergency shutdown valves, water screens and emergency response reduced the consequences after the release began. They did what they were intended to do. But none of them replaced the preventive barriers that should have stopped the release from occurring.

The incident therefore illustrates an important distinction:

**Isolation is an action. Zero energy is a condition. Verification is the evidence that the condition exists.**

## **5.4 LESSONS LEARNED**

### **Never break containment on the strength of an assumption.**

Before the first bolt is loosened, the absence of pressure, hazardous material and other forms of stored energy must be **positively verified using an approved method.**

A valve being closed, a blind being installed elsewhere, or a permit being

signed does not by itself prove that the equipment is safe to open.

**Treat the first opening as the critical step.**

The first break of containment deserves particular attention because it is the moment when an incorrect isolation or unexpected inventory becomes an exposure.

For hazardous services such as ammonia, the first opening should be controlled, deliberate and performed only after all required verification and authorization have been completed.

**The equipment owner must participate in the handover.**

For high-hazard line breaks, ownership cannot end with issuing a permit.

The responsible equipment/process owner should confirm the isolation boundary, verify that the equipment has been drained, depressurized and made safe as required, and ensure that the agreed zero-energy verification has been completed before authorizing the line break.

**Verify at the point of work.**

Do not rely solely on drawings, valve positions, control-room indications or statements that the system has been cleared.

Where practicable, establish a means of proving the condition at **or as close as possible to the location being opened.**

Ask:

**“If our isolation is not effective, how will we know before we remove the flange?”**

If the answer is “We will know when we open it,” the job is not ready to start.

**Contractor management does not transfer process ownership.**

Contractors must be trained, competent and authorized for their work, but knowledge and control of the process hazard remain with the operating organization.

The contractor should receive equipment that has been placed in a demonstrably safe condition not be expected to prove the condition by exposure.

**Emergency protection is not a substitute for prevention.**

Gas detection, automatic shutdown, water screens and emergency response were valuable and helped mitigate this event.

**But successful mitigation should never be mistaken for successful prevention.**

# FINAL REFLECTION

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Every incident in this publication has one thing in common: **it was preventable.**

The people involved were not careless. They came to work to do their jobs safely. Yet, despite procedures, permits, training, and experience, accidents still occurred. Not because one person made a mistake, but because weaknesses in our systems, our decisions, and our safeguards came together at the same time.

The purpose of this publication is not to remember the accidents. **It is to remember the lessons.**

Every chapter represents an opportunity to ask ourselves:

- Could this happen at my site?
- Do we have similar equipment or work practices?
- Are our safeguards strong enough?
- What assumptions are we making?
- What can we improve before the next job begins?

Learning is only valuable when it changes the way we work. A lesson that is documented but not applied is a lesson that will eventually be learned again often at a much higher cost.

Organizations do not learn from accidents simply because they investigate them. They learn because people understand the lessons, share them openly, and apply them every day.

Let this publication become part of our organizational memory. Read it. Discuss it. Challenge it. Most importantly, use it before the next job not after the next accident.

**Learn from the past. Act in the present.  
Protect the future.**

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DIFFERENT  
PEOPLE,  
DIFFERENT SITES.  
THE SAME  
POTENTIAL.

---

A SAFER  
TOMORROW  
DEPENDS ON  
WHAT WE DO  
TODAY.



# EVERY LESSON CAN CHANGE WHAT HAPPENS NEXT.

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*Lessons We Cannot Forget* brings together real stories, real people, and real lessons from serious injuries across ARLANXEO.

Each incident is different. But the warning signs, assumptions, and decisions that shape them often have more in common than we realize.

By understanding what happened and why, we can recognize the warning signs, strengthen our safeguards, and make better decisions before the next job begins.

Because a safer future is not a matter of chance.  
**It is a choice we make every day.**

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LEARN FROM THE PAST.  
ACT IN THE PRESENT.  
PROTECT THE FUTURE.

ARLANXEO

PEOPLE.  
SOLUTIONS.  
A SAFER  
TOMORROW.

