



Hot Pipe Burns Worker's Finger

Purpose

To share "lessons learned" gained from incident investigations through a small group discussion method format.

To understand "lessons learned" through a Systems of Safety viewpoint.



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Lessons Learned

Volume 07, Issue 5

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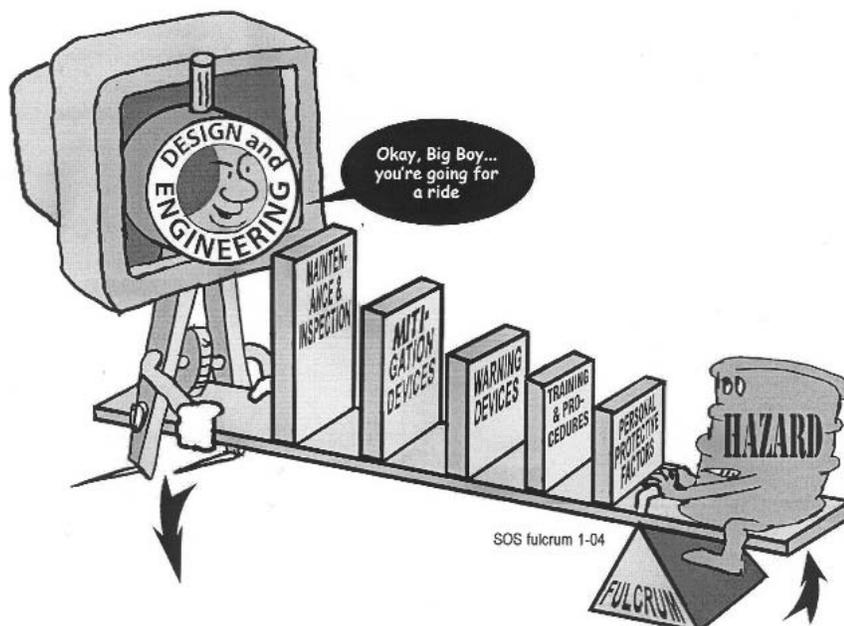
Background Information

Before beginning this Lessons Learned, please review this and the next page which contain information that will introduce the concepts of Lessons Learned and Systems of Safety.

Creating a safe and healthy workplace requires a never ending search for hazards that sometimes are not obvious to us. These hazards exist in every workplace and can be found by using various methods. Lessons Learned are just as the name suggests: learning from incidents to prevent the same or similar incidents from happening again.

Systems Are Not Created Equal: Not equal in protection and not equal in prevention.

Using our Systems Focus to uncover system flaws or root causes is only one part of controlling hazards. We also need to look at the systems involved to decide on the best way to deal with the problem. The most effective way to control a hazard is close to its source. The least effective is usually at the level of the person being exposed. The system of safety in which the flaw is identified is not necessarily the system in which you would attempt to correct the flaw.



| Major Safety System | Design & Engineering | Maintenance & Inspection | Mitigation Devices | Warning Devices | Training & Procedures | Personal Protective Factors |
|---|---|---|--|--------------------------------|--|--|
| Level of Prevention | Highest—the first line of defense | | Middle—the second line of defense | | | Lowest—the last line of defense |
| Effectiveness | Most Effective | | ←————→ | | | Least Effective |
| Goal | To eliminate hazards | To further minimize and control hazards | | | | To protect when higher level systems fail |
| EXAMPLES OF SAFETY SUB-SYSTEMS** | Technical | Inspection and Testing | Enclosures, Barriers Dikes and Containment | Monitors | Operating Manuals and Procedures | Personal Decision-making and Actions HF |
| | Design and Engineering of Equipment, Processes and Software | Maintenance | Relief and Check Valves | Process Alarms | Process Safety Information | Personal Protective Equipment and Devices HF |
| | Management of Change (MOC)** | Quality Control | Shutdown and Isolation Devices | Facility Alarms | Process, Job and Other Types of Hazard Assessment and Analysis | Stop Work Authority |
| | Chemical Selection and Substitution | Turnarounds and Overhauls | Fire and Chemical Suppression Devices | Community Alarms | Permit Programs | |
| | Safe Siting | Mechanical Integrity | Machine Guarding | Emergency Notification Systems | Emergency Preparedness and Response Training | |
| | Work Environment HF | | | | Refresher Training | |
| | Organizational (must address a root cause) | | | | Information Resources | |
| | Staffing HF | | | | Communications | |
| | Skills and Qualifications HF | | | | Investigations and Lessons Learned | |
| | Management of Personnel Change (MOPC) | | | | Maintenance Procedures | |
| | Work Organization and Scheduling HF | | | | Pre-Startup Safety Review | |
| | Work Load | | | | | |
| | Allocation of Resources | | | | | |
| | Buddy System | | | | | |
| | Codes, Standards, and Policies** | | | | | |

HF - Indicates that this sub-system is often included in a category called Human Factors.
 * There may be additional subsystems that are not included in this chart. Also, in the workplace many subsystems are interrelated. It may not always be clear that an issue belongs to one subsystem rather than another.
 ** The Codes, Standards and Policies and Management of Change sub-systems listed here are related to Design and Engineering. These subsystems may also be relevant to other systems; for example, Mitigation Devices. When these sub-systems relate to systems other than Design and Engineering, they should be considered as part of those other system, not Design and Engineering.

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Lessons Learned Statement:

Applying a *System of Safety Design and Engineering Technical* approach to a job would provide workers with the proper equipment to check process temperatures which would have prevented this incident. If the equipment gave temperature readings, there would be no need to touch lines; and also the gauge would provide a warning of high temperature.

Establishing **Training and Procedures** to indicate when Personal Protective Equipment (PPE) should be worn is a *System of Safety* method to protect workers from injuries. PPE is the last line of defense to protect workers and should only be considered if engineering and administration controls cannot eliminate the hazard.

Establishing a procedure under the **Training and Procedures System of Safety** that requires an inspection of valve positions before restarting a process would have prevented this injury

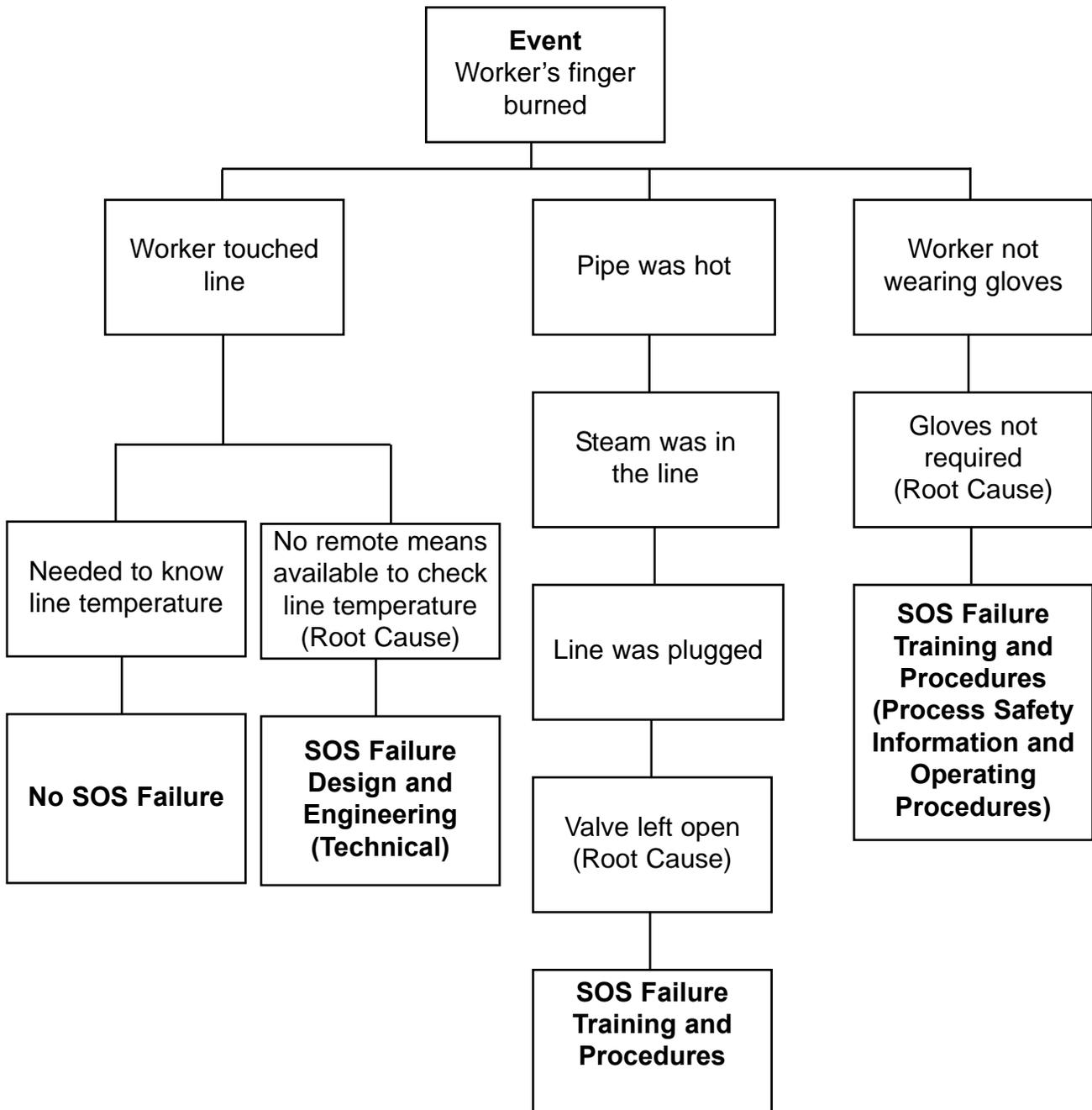
Discussion:

An operator was attempting to transfer a chemical (Endothal) from one vessel to another. For the transferring process, Endothal must be maintained at a certain temperature to stay in a liquid slurry state. During this process the operator found that the line to be used was plugged. The valve on the vessel the operator was transferring from had been left partially open. The partially opened valve allowed the material from the vessel to slowly leak into the line, cool down and solidify prior to starting transferring.

Because of the properties of Endothal, the line had to be heated internally by steam to return it to a liquid slurry state. It was during this steaming process the operator was moving his bare hand along the line to see how the heating was progressing. The line went from cold to hot in a short period of time. The line became hot enough to burn the operator's finger.

Analysis

The Logic Tree is a pictorial representation of a logical process that maps an incident from its occurrence, "the event," to facts of the incident and the incident's root causes.



Recommended Actions

1. Engineering should evaluate and recommend an adequate means of checking line temperature (example: heat temperature gun or a heat temperature stick).
2. Develop a procedure for the type and kind of PPE to be worn when performing job functions.
3. Develop procedure for restarting equipment with emphasis on valve positions.
4. Immediately train all employees on the dangers of using parts of the body to check line temperatures.

Education Exercise

Working in your groups and using the Lessons Learned Statement, Discussion, Analysis and Recommended Actions, answer the two questions below. Your facilitator will give each group an opportunity to share answers with the large group.

1. Give examples of ways to apply the Lessons Learned Statement at your workplace.

2. Of the examples you generated from Question 1, which will you pursue in your workplace? (**Note:** When we say something “you” may pursue, we mean a joint labor-management activity or a union activity rather than an activity carried out by you as an individual.)

EVALUATION

Lessons Learned: Hot Pipe Burns Worker's Finger

Please answer the two questions below:

1. How important is this lessons learned to you and your workplace? (Circle one.) Rate on a scale of 1 to 5, with 5 being the most important.

| | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|

2. What suggestions would you make to improve this Lessons Learned?

End of Training Trainer's Instructions

Please complete the information below.

Trainer's Name _____
(Please Print)

Date of training: _____

No. of Participants: Total _____ Hourly _____ Management _____

Location of Training: _____

USW Local # _____

Send this page **plus the Education Exercise and Evaluation for each participant and the Sign-in sheet** to:

**Doug Stephens
United Steelworkers International Union
3340 Perimeter Hill Drive
Nashville TN 37211**

Thank you for facilitating the sharing of this
Lesson Learned with your coworkers.

