

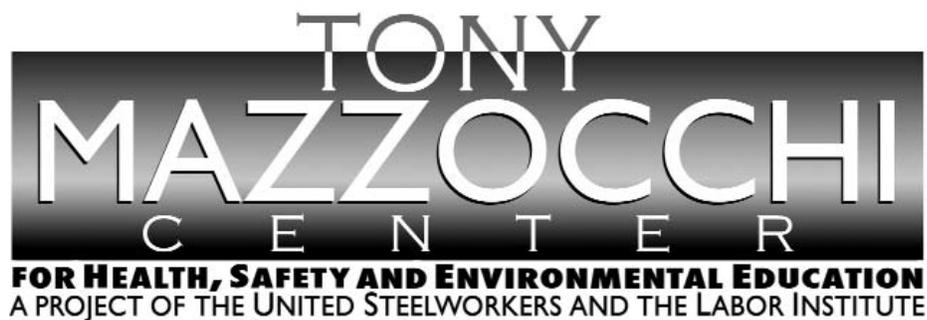


Groin Injury from Shoveling Overflowing Muck from Mining

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 8

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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.



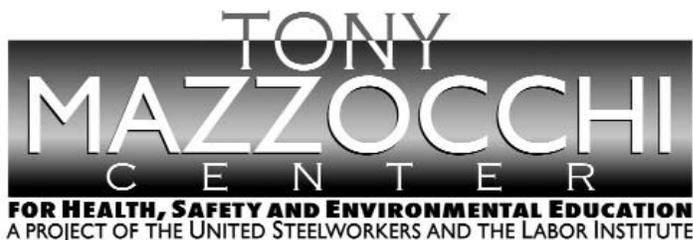
Major Safety System	Design & Engineering	Maintenance & Inspection	Mitigation Devices	Warning Devices	Training & Procedures	Personal Protective Factors
Level of Prevention	Highest—the first line of defense		Middle—the second line of defense			Lowest—the last line of defense
Effectiveness	Most Effective		←————→			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:

When we think about **Maintenance and Inspection**, we usually picture work being done on equipment that is shut down. But some operations require continuous monitoring and inspection throughout the operation; and adjustments are made accordingly. It is imperative that workers are given ample time to do such inspections and to make the required adjustments.

When we have *Systems of Safety* in place, we can deal with the unexpected in a safe manner. A properly **designed and engineered** work area can accommodate an emergency situation without putting the worker in harm's way. A quick release mechanism on containers that hold overflow can allow a worker to empty the container without undue effort or exposure to hazards.

When needed, ergonomically-**designed** tools can reduce or eliminate muscle strains and pulls.

One of the sub-systems in the **Training and Procedures System of Safety** is *Communication*. This is especially important when a process involves several departments or an operation that is continuous throughout the facility. All means of communication have to be operating properly and all workers need access to the radios or phones available.

Discussion:

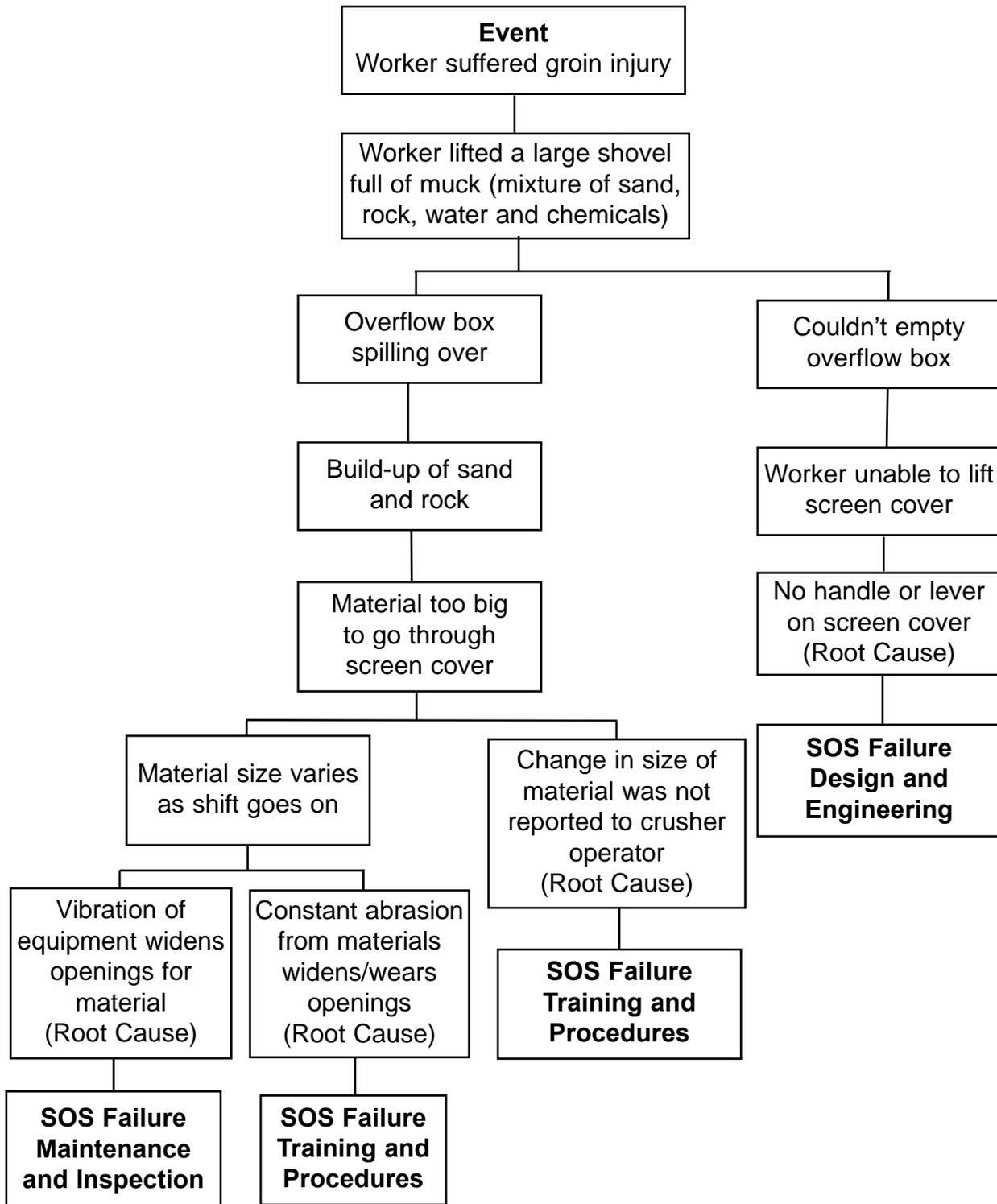
A ball mill in a mining operation is a large cylinder filled with steel balls that tumble inside the cylinder with water and chemicals to break down muck (sludge like material left over from the operation) from mining. There is an overflow box connected to the ball mill in case of excess flow of material.

An overflow alarm on one of the ball mills started sounding and a worker rushed to the mill to see what was wrong and prevent further spilling of muck. The material being mined goes through a series of crushers to break down the material into smaller particles. In this particular case, the gauging of the material took place at the beginning of the shift. After several hours, the vibration of the crushers and the constant abrasion of the material passing through it had widened the openings for material and some of the material was too large to go through the overflow screens.

The worker attempted to open the screen on the overflow box to release the excess material. The screen wouldn't budge and could not be opened. The worker started shoveling to remove the excess muck because the material keeps coming, even though it is overflowing. The worker felt a sharp pain in his groin area but continued his task and then reported the incident to his foreman.

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. Redesign all of the screens with a handle or lever to move the screen when needed.
2. When there is a change in the size of the material being sent through the series of crushers, crusher operators need to be notified immediately so they can make adjustments and get material back down to the size needed.
3. All crusher and ball mill parts need to be inspected on a regular basis; replacing worn parts as needed.
4. Get ergonomically-designed shovels that ease the strain on the body while shoveling. These shovels have a curved or bent handle, which brings the load closer to the body, thereby easing strain on the body.
5. Advise workers to limit the load on the shovel and avoid awkward positions.

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: Groin Injury from Shoveling Overflowing Muck from Mining

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
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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.

