



## Worker's Nose Fractured

### 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 16

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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
<b>EXAMPLES OF SAFETY SUB-SYSTEMS**</b>	<b>Technical</b>	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	
	<b>Organizational (must address a root cause)</b>				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:**

In a work environment where heavy lifting and lowering is required, *Systems of Safety* have not been recognized or implemented to assure a safe approach to the tasks at hand.

By using the **Training and Procedures** approach, training on the importance of using proper equipment and the need for clear and precise communication could have eliminated the hazards associated with heavy loads. Also, retraining of individuals doing the task, would have given more insight on using the right tools for the job.

By utilizing the **Maintenance and Inspection System of Safety**, the cranes could have been properly maintained to ensure the availability and integrity of the before mentioned tool to complete the task at hand.

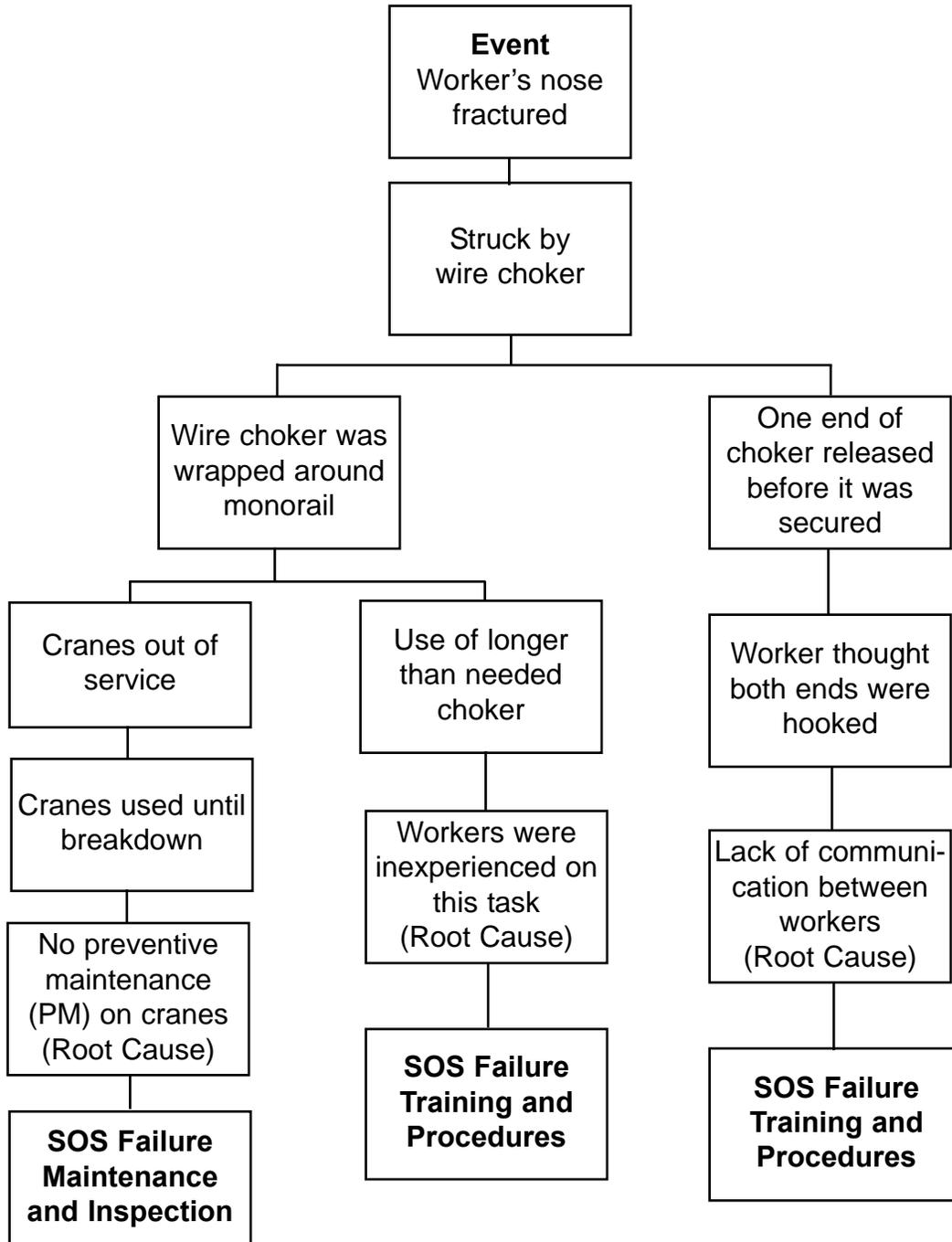
**Discussion:**

Two mechanics were preparing to lower parts to the floor and remove them. When doing this, a monorail is used to aid in the lowering and raising of heavy parts. This monorail is made of a two-inch diameter pipe that is 6-8 feet long, has a curve of about 45 degrees and is bolted in place. When the parts are being removed, they are attached to the pulley glide that is hanging on the monorail which can be rolled out of the way. Usually a crane is used for this type of work; but it was out of service at this time. Because of this scenario, they proceeded to secure a chain fall to the monorail by using a wire choker; wrapping it around the monorail and attaching each end of the choker to the chain fall. Due to its excessive length, the mechanics wrapped the wire choker around the monorail, about three turns. Mechanic #1 attached his end of the choker to the chain fall. Mechanic #2 put the eyelet of his end of the choker on the chain fall hook but let go before Mechanic #1 had released the safety latch to secure both ends to the chain fall hook. The spring tension on the wire choker uncoiled the loose end of the choker rapidly hitting Mechanic #1 on the nose; resulting in a fracture to the nose.

**Note:** Due to recent moves within the Maintenance Department, the two mechanics had not performed this task for several years

**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. Maintain usable cranes.
2. If crane is not available, use cloth choker or proper length wire choker.
3. Ensure maintenance personnel performing these or similar tasks have applicable hoisting/rigging and safety training.
4. Ensure work package is accurate for scope of work considering the availability of a crane.

### **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.

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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: Worker's Nose Fractured

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?

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**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.



