



## Oil Tank Overflow

### 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**

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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:**

Improper communication, failure to report near-misses and inadequately designed equipment are recipes for worker injury and an environmental disaster that could reach far beyond the workplace.

The proper reporting of any and all near-misses would help to protect workers, the community and the environment.

A well-engineered off-loading station with the correct equipment, materials and processes is a **Design and Engineering/Technical Systems of Safety** approach to preventing incidents.

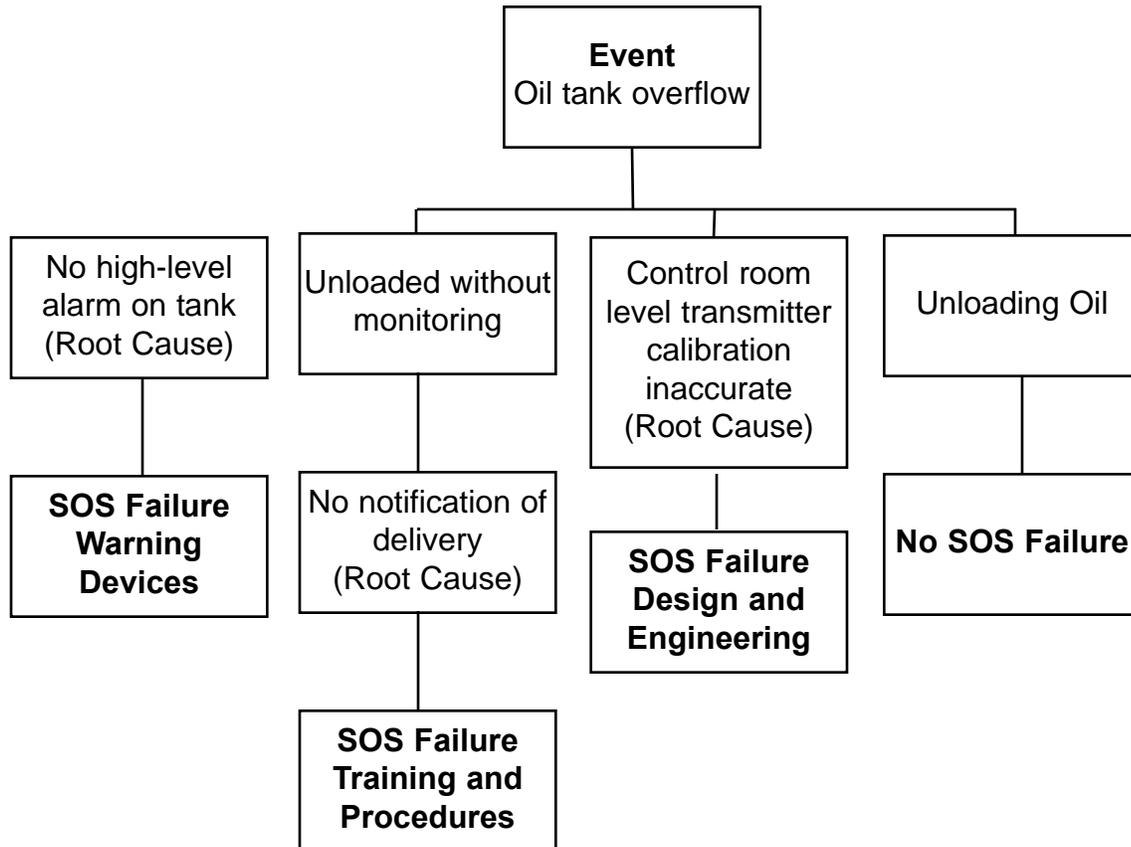
The proper forms and reporting procedures provide the necessary communication in the **Training and Procedures System of Safety**.

**Discussion:**

A tank truck was unloading oil into a oil holding tank and overfilled it. The hookup to unload the oil goes through a wall. The oil tank is located in a basement on the other side of the wall, out of sight. There is no device for the driver/unloader to monitor the level of the tank. The tank truck is unloaded by air pressure regulated at 18 to 20 psi, from the plant air pressure, that is regulated at 27 to 30 psi. The driver/loader must stay at the truck to check air pressure every few minutes, so the tanker is not over-pressurized. There is a level gauge in control room, but the gauge is not always watched by an operator. It was found that the calibration of the level transmitter was inaccurate. The specific gravity was set for water, not oil. Unloading history indicates possible overflows with every delivery, but this was never reported.

**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. Ensure operator is available to help monitor the off-loading of oil.
2. Update level transmitter spec sheet.
3. Update chemical unloading form to include statement that and operator must be present before unloading.
4. Install a high-level alarm to notify the driver/unloader.
5. Recalibrate level transmitter.
6. Begin a program of using Lessons Learned from previous incidents to prevent future ones.

### **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: Oil Tank Overflow

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.



