



Piston Crushes 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 38

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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:

The failure to use the *Management of Change (MOC)*, the lack of a well-defined procedures and lack of a better design in the physical location of limit switches, added up to crushed and bruised fingers of a employee.

Systems of Safety are utilized to provide prevention from this type of incident.

A well-designed system and the protection by the issuance of a *MOC* is a well defined **Design and Engineering System of Safety** approach to minimize and eliminate hazards.

Having well-developed and clear, defined procedures is the **Training and Procedures System of Safety** approach to further minimized and eliminate hazards.

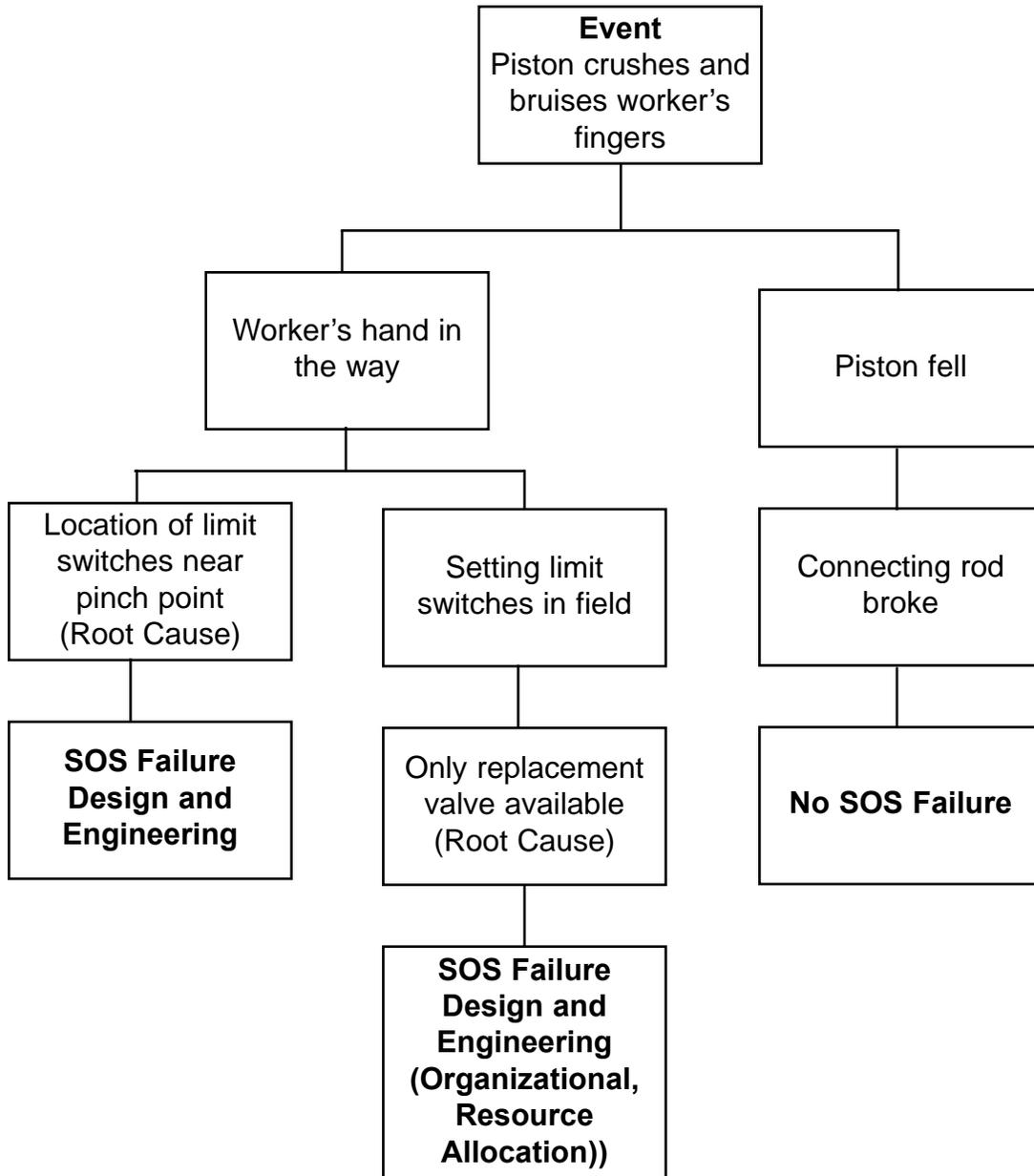
Discussion:

Mechanical technicians were working on a Jet Pump Pacific valve in place to get it back on line. (The pump is used to blast coke out a drum using high pressure water.) The Mechanical technicians requested Electronic and Instrumentation (E&I) technicians to set the high and low limit switches. The lower limit (no flow) was set without incident. The E&I technician began working on the upper limit switch while a Mechanical technician was pulling on the positioner spring to keep the valve in the upper position (full flow). The connecting rod on the piston broke which cause the stem section connected to the actuator to suddenly come down crushing the E&I technician's middle finger and bruising the ring finger.

Further investigation revealed the valve had broken on two previous occasions. There was no spare valve to replace the one in the field. There was no Management of Change (MOC) to repair the valve with all-thread material. The method used to set the limit switches was incorrect.

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 evaluate moving and mounting the limit switches away from pinch points. Brackets need to be extended out past valve movement to avoid injury.
2. Review and correct the method for setting limit switches on High Pressure Jet Pumps valves.
3. Classify the Pacific valve as a critical spare and have spare parts on hand.
4. Production teams look at other options for different types of actuators.
5. Consider revising design of piston stem to a solid non-threaded assembly at the coupling.
6. Share incident in safety meetings on the importance of an MOC when using a temporary means to repair equipment when parts are not available.

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.)

Trainer’s Lessons Learned Success Inventory

Following a Lessons Learned (LL) session, **the trainer who led the LL** should complete this form. This information will: 1) Help you reflect on the successes and challenges of the session; 2) Help USW with new curriculum development; and 3) Help USW as a whole better understand how the LL Program is supporting their workers.

By reviewing LL from different sites or from other areas of their workplaces, workers are able to analyze the information and apply these lessons to their own workplaces in order to make their workplaces healthier and safer.

1. Site name (if there are participants from more than one site, please list all).

2. Date of LL training _____
3. LL number used in today’s Training _____
4. Your name _____
5. **Summary of Education Question 1:** Please summarize participants’ examples of ways to apply this LL Statement to their workplace.

Please continue on reverse side.

- 6. Summary of Education Question 2:** Please summarize which actions or recommendations participants discussed pursuing at their workplace(s).

Thank you for completing this form.

EVALUATION

Lessons Learned: Piston Crushes 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
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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:

1. This page;
2. The Education Exercise (page 8);
3. The Trainer's LL Success Inventory form (pages 9 and 10);
4. The evaluation for each participant (page 11); and
5. The Sign-in sheet (page 13) to:

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

