



Employee Receives Second Degree Burn to Forearm

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.



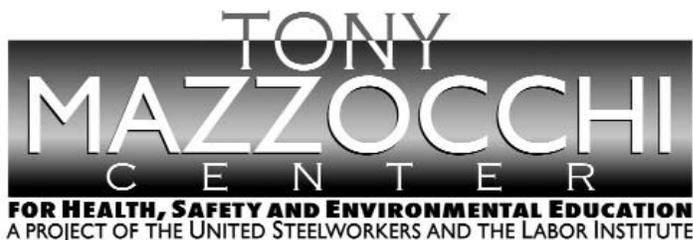
Major Safety System	Design & Engineering	Maintenance & Inspection	Mitigation Devices	Warning Devices	Training & Procedures	Personal Protective Factors
Level of Prevention	Highest—the first line of defense	Middle—the second line of defense			Lowest—the last line of defense	
Effectiveness	Most Effective	←————→				Least Effective
Goal	To eliminate hazards	To further minimize and control hazards				To protect when higher level systems fail
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 subsystem 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 subsystems 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:

Personnel working in areas of confined space and limited access should be trained on the potential exposure hazards and the associated risks. Along with the potential for burns, cuts and scrapes, a big factor to consider is ergonomic issues of injuries caused by straining and pulling when the body position is not normal. *Systems of Safety* are utilized to provide prevention from this type of incident. The **Training and Procedures System of Safety** addresses these safety issues. Workers should be made aware of these potential hazards.

Despite the recognition that steam was still flowing through the piping of the steam heater located in the crossover housing and that this was a reliable indication that the isolation valves were not holding, work was allowed to continue in this area and the workers were not protected from this potential hazard. The **Maintenance and Inspection System of Safety** failed in this incident as there was no attempt to replace or repair the steam valves before the job was started. Also, no review was made within the **Training and Procedures System of Safety**. An administrative policy is needed that states the job will not begin or that the job will be discontinued at the first failure of any mechanism that provides maximum protection through this safety system. This training would have helped the workers recognize that the level of PPE they were using for the job was not adequate and they were exposing themselves to unnecessary risks; i.e., the use of latex gloves in a potential exposure to heat hazard.

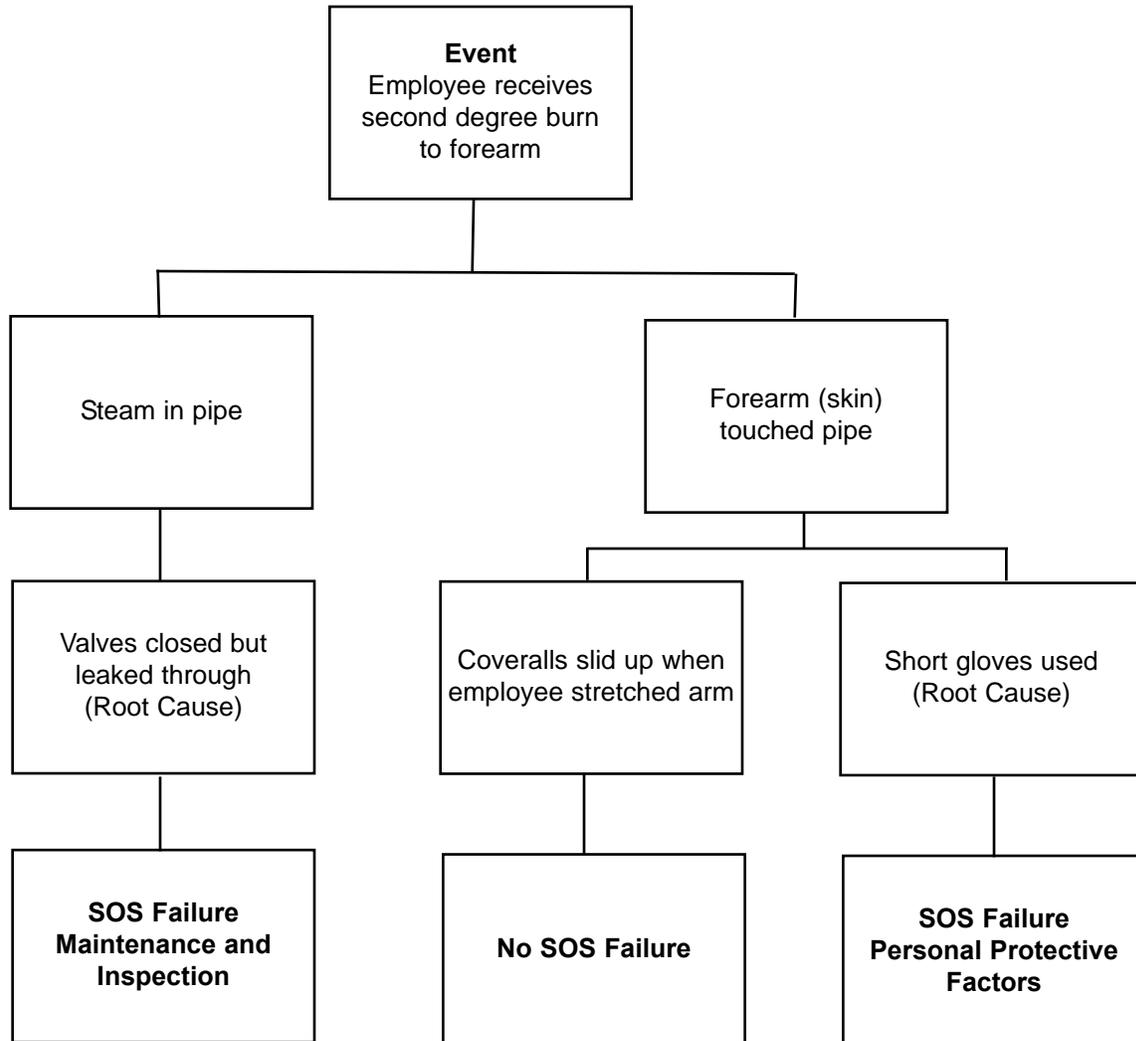
Discussion:

A Front Line Manager (FLM) was assisting a Production Process Operator (PPO) in performing post-maintenance testing following a valve replacement. A maintenance work crew completed changing the subassembly on a valve located inside the crossover housing. A pre-job briefing was conducted by the FLM and the PPO which included a review of the requirements for a confined space entry permit. Per permit requirements, personnel were dressed in coveralls, latex gloves and full-face respirators.

The steam supply valves for the heaters in the crossover area had been closed but there was indication of some seat leakage. Working in the close confines of equipment housing, the FLM received a burn on his forearm when he attempted to reach around the steam supply piping and the sleeve of his company-issued coveralls rode up, exposing his arm. The bare skin contacted the hot pipe resulting in the injury.

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. Personnel working in areas of confined space and limited access should be trained on the potential exposure hazards and the associated risks.
2. If the PPE (personal protective equipment) is not adequate to perform the assigned task, workers should be trained that the job should be halted and not continued until the proper PPE can be secured and/or the work conditions better prepared. An example in this case would be that the workers should have used long, cuffed, heavy gloves for the protection factor against hot surface hazards.
3. Equipment isolation procedures, safety guides and pre-work review discussions should include the recognition of the hazards that workers will be exposed to for the current job assignment. The review and discussion of the proper PPE should be a vital step in this process. A Safety Bulletin regarding work in close proximity to hot components should be issued.
4. When equipment isolation and lockout devices such as the steam valves in this example, are not working properly or in need of repair to the point that they cannot adequately isolate a worksite, the task should not be performed until every available means to isolate the piece of equipment has been exhausted.

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: Employee Receives Second Degree Burn on Forearm

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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 United Steelworkers International Union
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 Nashville TN 37211

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

