

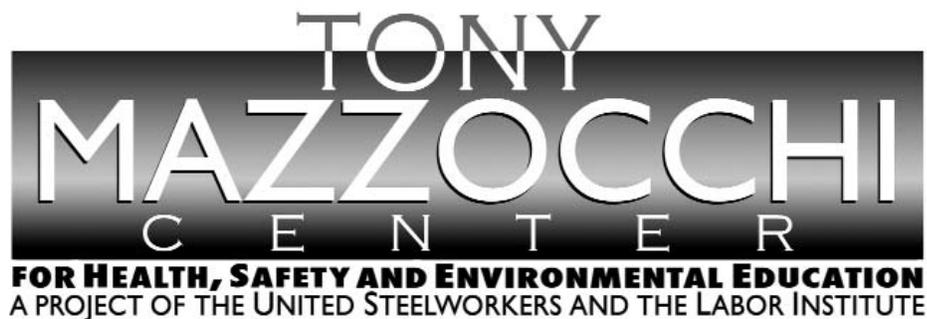


Glovebox Breached

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.



This material was produced by the Labor Institute and the United Steelworkers International Union under grant number 46DO-HT11 Susan Harwood Training Grant Program, for the Occupational Safety and Health Administration, U.S. Department of Labor. It does not necessarily reflect the views or policies of the U.S. Department of Labor, nor does mention of trade names, commercial product or organizations imply endorsement by the U.S. Government.

Lessons Learned

Volume 07, Issue 91

© 2007 The Labor Institute

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		
Workload						
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 subsystems 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 systems, not Design and Engineering.

Revised October 2006



Title: Glovebox Breached

Volume 07, Issue 91

Date Issued: December 6, 2007

Lessons Learned Statement

Systems of Safety thinkers realize no job is routine. They are always asking themselves "what if." Through **Training and Procedures**, they know the importance of a thorough Job Hazard Analysis even for tasks considered "skill-of-the-craft;" such as repairing windows on a glovebox.

By using the **Design and Engineering Safety** subsystem *Safe Siting*, it is ensured that the work area is safe for all who enter it or could possibly enter it.

Maintenance and Inspection requires that integrity of equipment be mechanically maintained and structurally sound. It is important to keep even inactive equipment in a configuration that poses no harm to workers.

Discussion

Workers were assigned the task of sealing and resealing cracked windows on top of an inactive glovebox.* The task would require a worker to climb on top of the glovebox and retape an existing plywood cover over a cracked window and cover and tape other cracked windows. This task was considered “skill-of-the-craft” and no formal Job Hazard Analysis (JHA) was performed. The need for fall restraint was identified and used by workers.

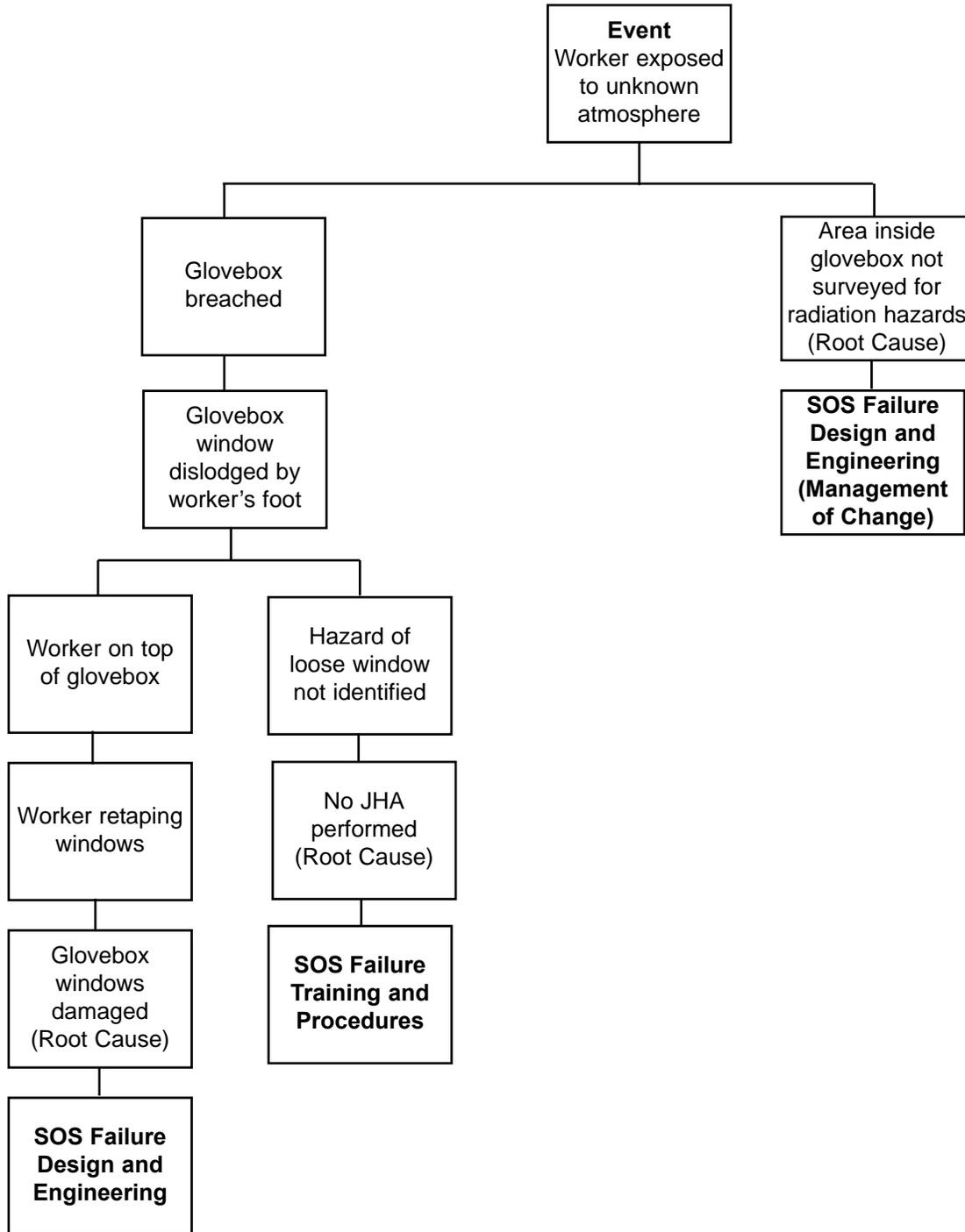
While retaping the existing cover, the worker’s foot brushed an adjacent window and the window dropped into the glovebox. The opening was immediately covered using a plywood cover previously cut for the job and radiological surveys were performed. No workers were contaminated and no contamination was found in the work area.

The glovebox in this event was used in the past for chemical processing of radioactive waste and was slated for Decontamination and Decommissioning (D&D). If a JHA had been performed, other potential hazards, i.e., radiological and chemical hazards, may have been evaluated. When an area/structure involved in work is not designed to be walked on, the structural integrity should be addressed.

*A glovebox is a sealed structure that allows radioactive or toxic substances to be handled safely using gloves attached to openings in its sides.

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. Perform a formal Job Hazard Analysis on all job tasks.
2. Ensure structural integrity of all working surfaces that are not designed to be walked on.
3. Maintain equipment slated for Decontamination and Decommissioning (D&D) in a safe configuration.

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: Glovebox Breached

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
---	---	---	---	---

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:

Doug Stephens
 United Steelworkers
 3340 Perimeter Hill Drive
 Nashville, TN 37211

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

