

Hand Nearly Pulled into Pinch Point

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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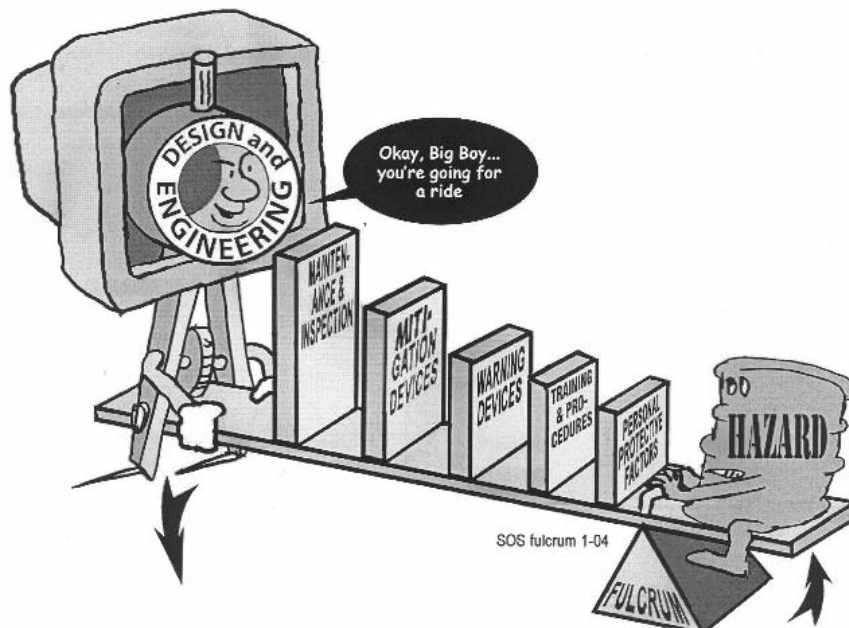
Background Information

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 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.

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Lessons Learned Statement:

Working on and around moving equipment with inadequate guarding and the lack of a good lockout/tagout program provides a atmosphere for an accident. *Systems of Safety* are utilized to provide prevention from this type of situation.

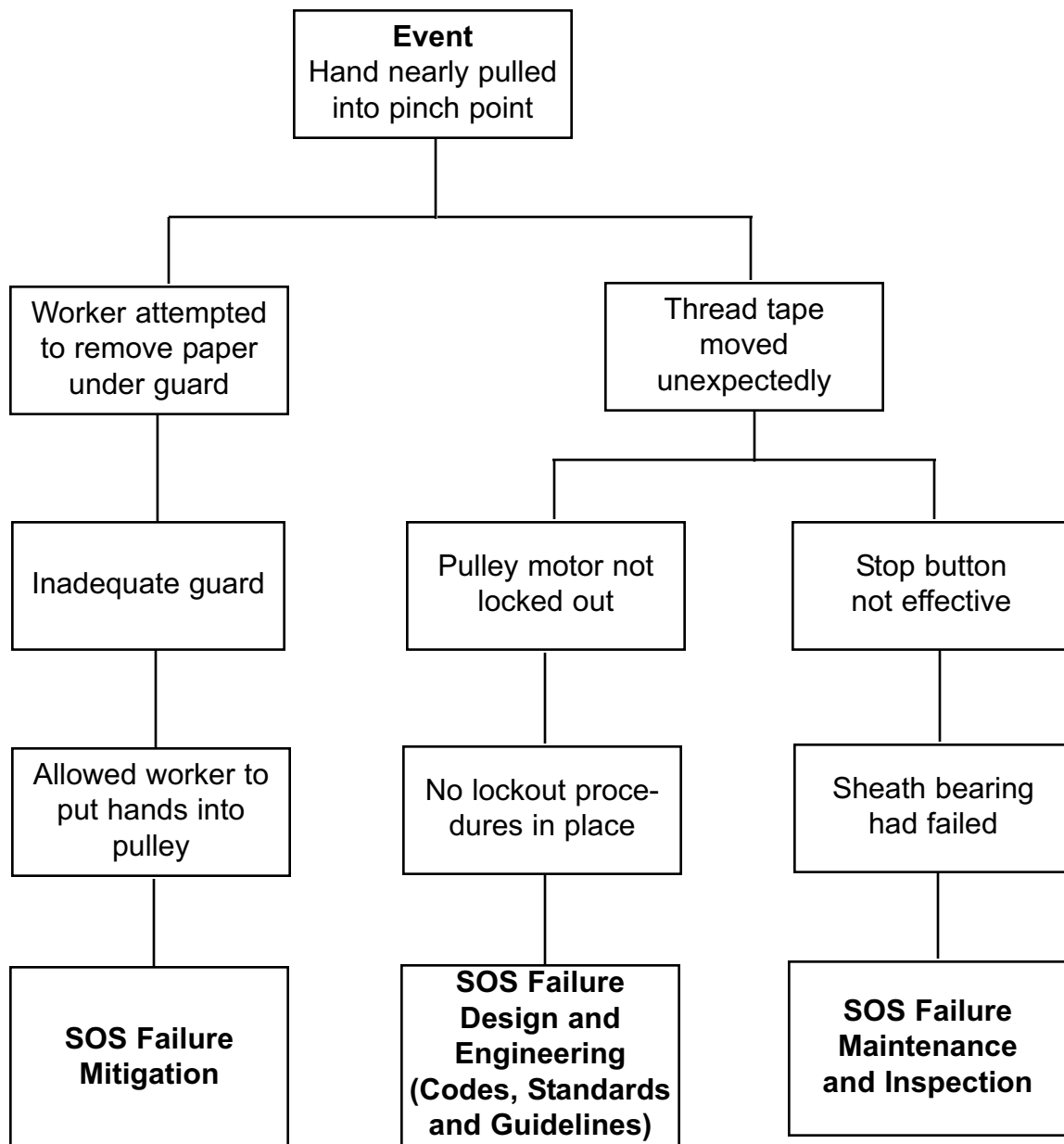
A lockout/tagout program would have eliminated this incident through the use of the **Design and Engineering System of Safety**. Adequate guarding could have reduced the risk to workers through the **Mitigation System of Safety**. A good maintenance and inspection program could also have greatly decreased hazards for the workers.

Discussion:

Workers were attempting to thread the paper sheet through the Coater after a sheet break. One worker went to the reel end of the Coater to remove the paper from the thread tape before the tail reached the last pulley. The Coater was in thread mode and was not locked out. When the paper tail reached the other end of the Coater, the worker pressed the stop button to stop the thread tape. When the button is pressed, the thread tape moves about 12 inches before stopping. There is a guard protecting a nip point at the sheave. The worker did not press the stop button fast enough for the tape drive to stop in time to prevent the tail from jamming into the last pulley. Once the thread tape was stopped, the worker placed both hands under the guard to remove the paper tail which was stuck in the guard. With both hands under the guard, the worker attempted to remove the jammed paper tail. The thread tape started moving and the worker immediately pulled his hands away from the tape and pulley and tried to press the stop button again but could not reach it. The thread tape moved about eight feet and then stopped. The worker stated that it was not the first time that the thread tape started on its own. The stop button does not disable the movement of the thread tape. There are two buttons to start up the thread tape. The Coater Operator did not start the thread tape. There is no switch in the Operator's booth that can restart the thread tape. Upon further investigation, it was determined that a sheave bearing had failed and could have contributed to the movement of the pulley and tape.

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. Develop lockout procedure that will not allow access to moving equipment. Train all workers.
2. Design and install a guard that will not allow access to pulley and tape.
3. Develop a Maintenance and Inspection program which includes regular checking of sheave bearings.
4. Consider a design change for the “stop button,” which would actually stop the equipment.

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 actions or recommendations participants discussed pursuing at their workplace(s).

Thank you for completing this form.

EVALUATION

Lessons Learned: Hand Nearly Pulled into Pinch Point

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:

<p>If you are a TOP Site (excluding DOE TOP Sites)</p>	<p>Send to: Steve Cable 2915 Gradient Drive St. Louis, MO 63125</p>
<p>All other sites (including DOE TOP Sites)</p>	<p>Send to: Doug Stephens United Steelworkers 3340 Perimeter Hill Drive Nashville, TN 37211</p>

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

Sign-in Sheet



Name of Class _____ Date of Class _____

Instructors: _____

Please Check One*		Print Name	Signature
H	M		

*H = Hourly Worker
M = Management or Salaried Worker

