

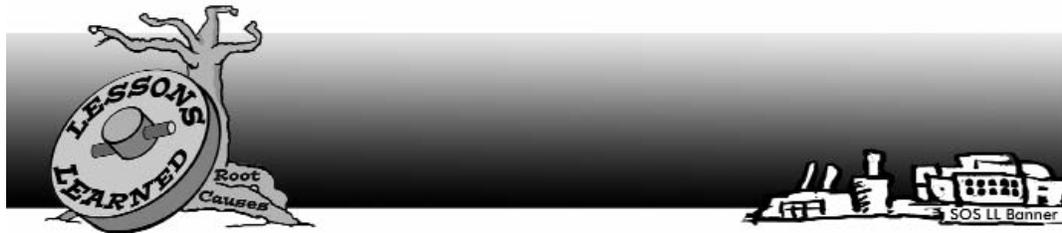


## Lack of Air Flow to Air Line Respirator

### 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 08, Issue 20**

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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.



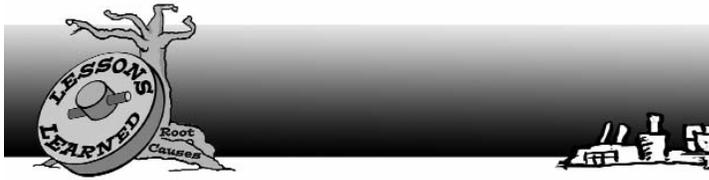
Major Safety System	Design & Engineering	Maintenance & Inspection	Mitigation Devices	Warning Devices	Training & Procedures	Personal Protective Factors
Level of Prevention	Highest—the first line of defense		Middle—the second line of defense			Lowest—the last line of defense
Effectiveness	Most Effective		←————→			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 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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**Title:** Lack of Air Flow to Air Line Respirator

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**Lessons Learned Statement:**

Jobs that require the use of any type of respirators should be reviewed. The **Design and Engineering System of Safety** looks at ways to make *Chemical Substitutions* or less toxic paints available. *Management of Change, Safe Siting* and *Work Environment* also come from the *Technical* category. If substitutions can be made, the use of respirators is no longer required.

Placing the bottle cart in a controlled environment eliminates the possibility of the regulator freezing. This is an example of *Safe Siting*. We should strive for all fixes to come from the **Design and Engineering System of Safety**.

Training bottle cart attendants and respirator users in the proper use of air line equipment per the manufacturer's directions and procedures comes from the **Training and Procedures System of Safety**. Proper training helps ensure workers perform their jobs safely.

**Discussion:**

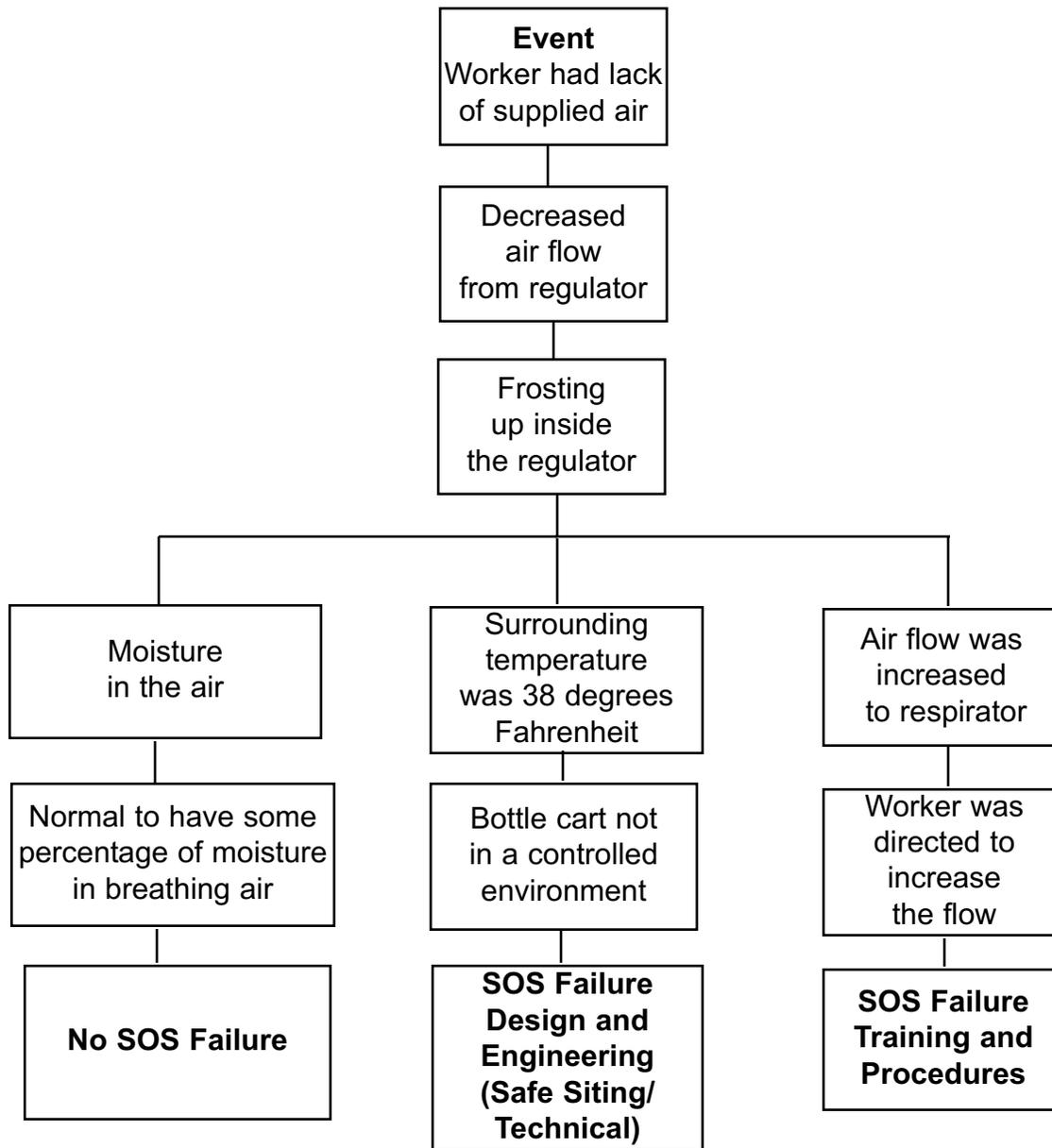
Workers had been assigned to work in an environment that would require air line respirators. The pre-job briefing covered all the reasons they were required to wear air line respirators and associated PPE. There were no discussions on procedures about using the bottle cart in near freezing temperatures.

The workers had been working for a short while when the foreman noticed that one of the workers motioned to him that he was not getting enough air. The foreman went to investigate and found that the regulator was frosting up. The foreman went to find a heat gun to thaw the regulator which would allow the air flow to resume to a normal flow. He directed a worker to increase the air flow on the bottle cart so the other worker could continue to work while he was gone.

When the worker increased the air flow, he may have exceeded the manufacturer's limits. As the air flow was increased, the air passing through the orifice actually creates an air pressure drop. This caused the moisture in the air passing through the regulator orifice to freeze. This effect slowly builds up ice; shutting off the air flow. As the untrained worker increased the air flow, he was actually decreasing it. The foreman returned with a heat gun and thawed the regulator. The heat from this gun could damage the regulator which may cause a malfunction.

**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. Place the bottle cart in a controlled environment.
2. Train bottle cart attendant and respirator users on the manufacturer's requirements and procedures.
3. Require bottle cart attendants to have in-hand procedures while operating the bottle cart.
4. Never use heat guns or any external source of heat on regulators, as this may damage the regulator.

### 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.)

## 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).

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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: Lack of Air Flow to Air Line Respirator

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:

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

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



