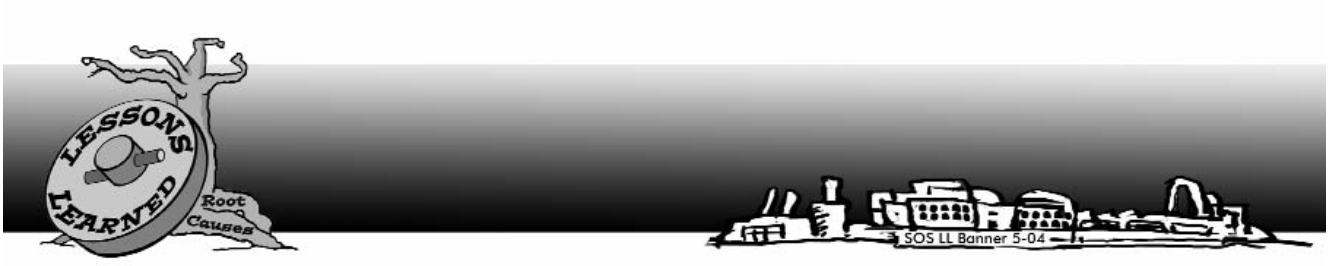

Potential Fall Hazard Threatens Employee

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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FOR HEALTH, SAFETY AND ENVIRONMENTAL EDUCATION
A PROJECT OF THE UNITED STEELWORKERS AND THE LABOR INSTITUTE

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Lessons Learned

Volume 08, Issue 24

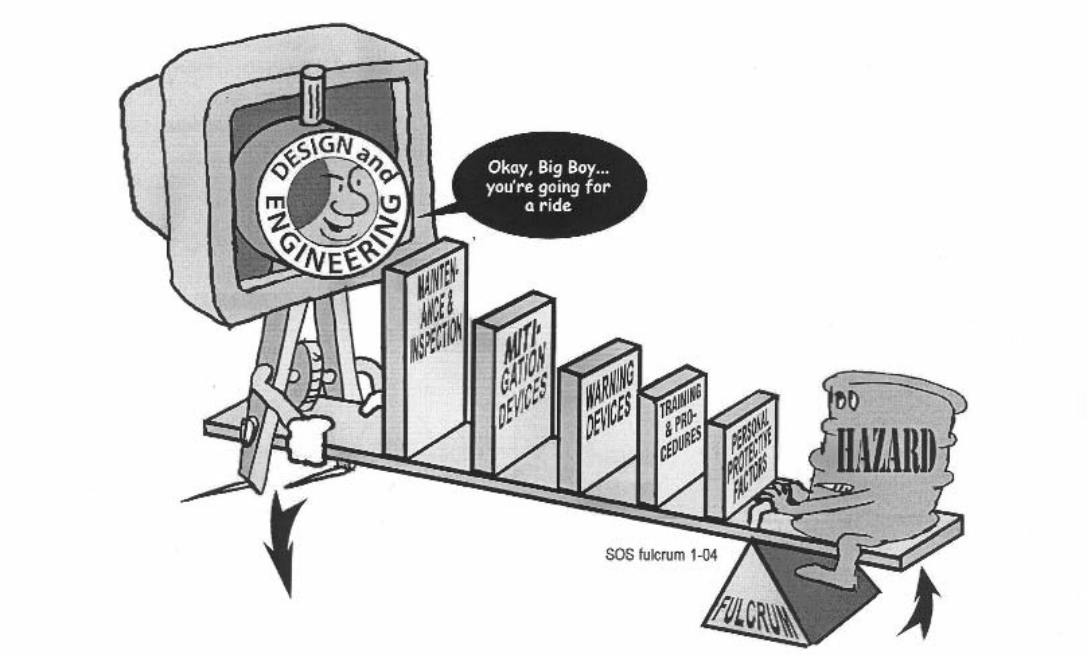
Background Information

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** Design and Engineering of Equipment, Processes and Software Management of Change (MOC)** Chemical Selection and Substitution Safe Siting Work Environment HF **Organizational *(must address a root cause)*** Staffing HF Skills and Qualifications HF Management of Personnel Change (MOPC) Work Organization and Scheduling HF Work Load Allocation of Resources Buddy System Codes, Standards, and Policies**	Inspection and Testing Maintenance Quality Control Turnarounds and Overhauls Mechanical Integrity	Enclosures, Barriers Dikes and Containment Relief and Check Valves Shutdown and Isolation Devices Fire and Chemical Suppression Devices Machine Guarding	Monitors Process Alarms Facility Alarms Community Alarms Emergency Notification Systems	Operating Manuals and Procedures Process Safety Information Process, Job and Other Types of Hazard Assessment and Analysis Permit Programs Emergency Preparedness and Response Training Refresher Training Information Resources Communications Investigations and Lessons Learned Maintenance Procedures Pre-Startup Safety Review	Personal Decision-making and Actions HF Personal Protective Equipment and Devices HF Stop Work Authority

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: Potential Fall Hazard Threatens Employee

Identifier: Volume 08, Issue 24

Date Issued: June 6, 2008

Lessons Learned Statement:

A poor understanding of a site Fall Protection System Policy and inadequate planning of a non-routine job task led to a worker's potential fall. ***Systems of Safety*** are utilized to provide prevention from this type of incident.

The current plant Fall Protection Policy was not well understood by workers and did not address the safe working distance from a roof edge; part of a good **Training and Procedures** ***System of Safety*** approach. Workers did not think fall protection was needed when working on the roof.

Better pre-job planning **(Training and Procedures** ***System of Safety*****)** would have avoided the start of this job until either the scissors man-lift normally used was repaired (**Maintenance and Inspection** ***System of Safety***) or until a tie-off point for the workers' fall protection harnesses could be installed on the roof (**Mitigation** ***System of Safety***).

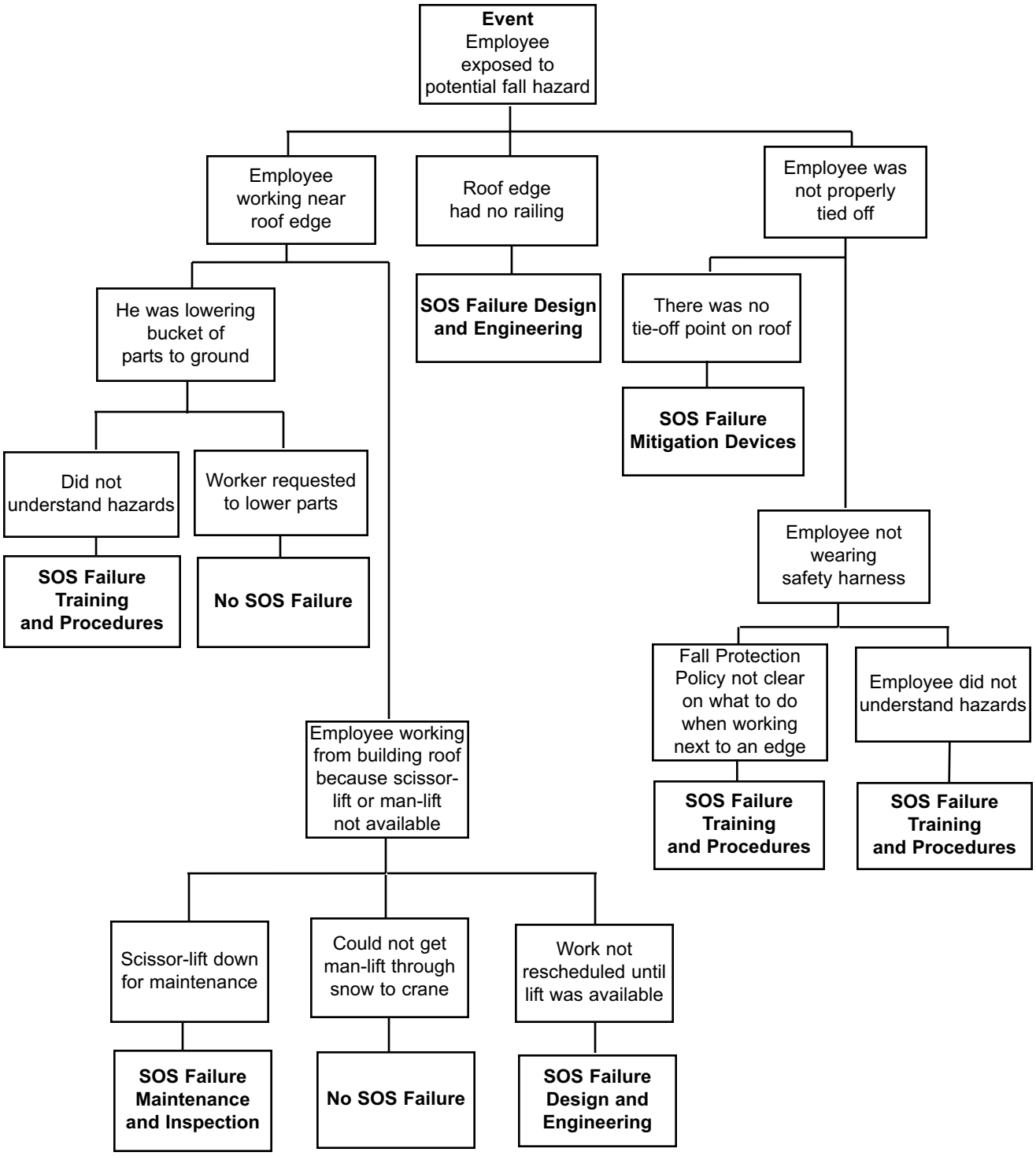
Discussion:

A maintenance crew was assigned the task of changing the motor on a reel crane. Normally they would work from a scissors man-lift, but it was down for maintenance. As a result, the workers had to work from the roof of an office building.

One of the workers was lowering a pail of brake parts to the ground. The pail was not heavy. The roof was not protected by a railing and the worker said he came to within two and one-half to three feet away from the roof edge. Other witnesses reported it might have even been closer. He was told to put on his safety harness, and did so, but there was no place on the roof to tie off the harness.

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. Amend Plant Fall Protection Policy to include a specific distance from the edge of a roof before having to wear a safety harness.

2. Communicate revised Fall Protection Policy to all affected employees.

3. Repair or replace battery on scissors man-lift so the Maintenance Department can use it when needed.

4. Job tasks should not be assigned until the job can be done safely. In this case, either the unavailable scissors man-lift or the lack of a tie-off point and employees' understanding of the Fall Prevention Policy should have been addressed before the crane repair began.

5. *If a roof is to be used as work surface,

    - Install tie-off point on roof to tie off safety harnesses.
    - Install permanent railings around perimeter.

Other Observations

*If a roof is to be used as a work surface, it must be analyzed by Engineering to assure it is safe to do so. The roof rating should be posted at all access points to the roof.

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: Potential Fall Hazard Threatens Employee

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:

If you are a TOP Site (excluding DOE TOP Sites)	**Send to: Steve Cable 2915 Gradient Drive St. Louis, MO 63125**
All other sites (including DOE TOP Sites)	**Send 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.

Sign-in Sheet

Name of Class_____ Date of Class_____

Instructors: _____

Please Check One* H	M	Print Name	Signature

***H = Hourly Worker**
M = Management or Salaried Worker