

Hoist Chain Hits Generator Causing an Arc Flash

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 SH-17045-08-60-F-42 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 products or organizations imply endorsement by the U. S. Government.

Lessons Learned

Volume 08, Issue 38

© 2008 The Labor Institute

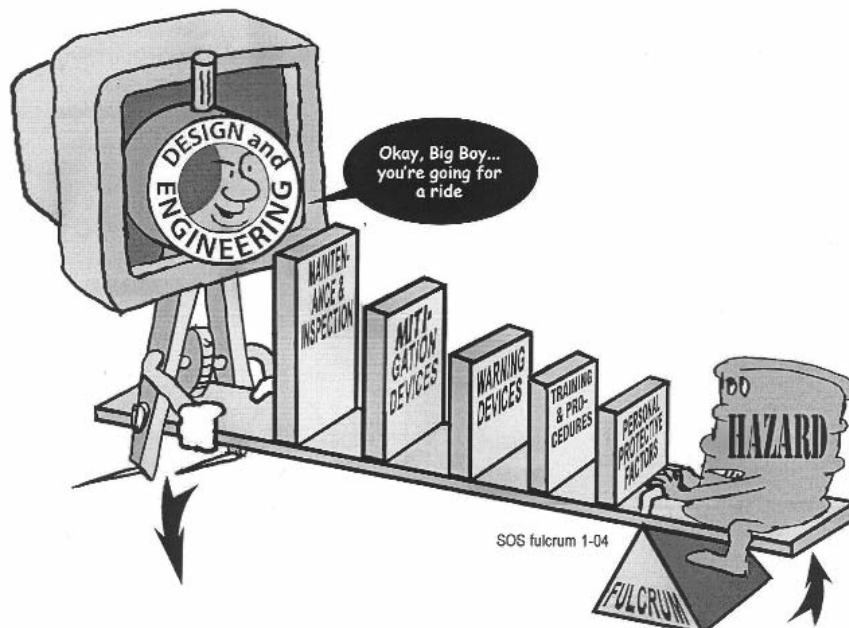
Background Information

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 Design and Engineering of Equipment, Processes and Software Management of Change (MOC)** Chemical Selection and Substitution Safe Siting Work Environment HF	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
	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**					

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: Hoist Chain Hits Generator Causing an Arc Flash

Identifier: Volume 08, Issue 38

Date Issued: December 28, 2008

Lessons Learned Statement:

This arc flash and equipment shutdown could have easily been prevented by utilizing *Systems of Safety*. A *System of Safety* design of equipment is of utmost importance. This incident or similar incidents do not have to happen. *Systems of Safety* are put into place to provide prevention for this type of incident.

Due to the lack of a designed method of storing hoist pull chains and insufficient guarding around the generator, conditions were right for this incident. A designed method of storing the hoist pull chain and a proper guard around the generator would have prevented this incident through the proper implementation of the **Design and Engineering** and **Mitigation Systems of Safety**.

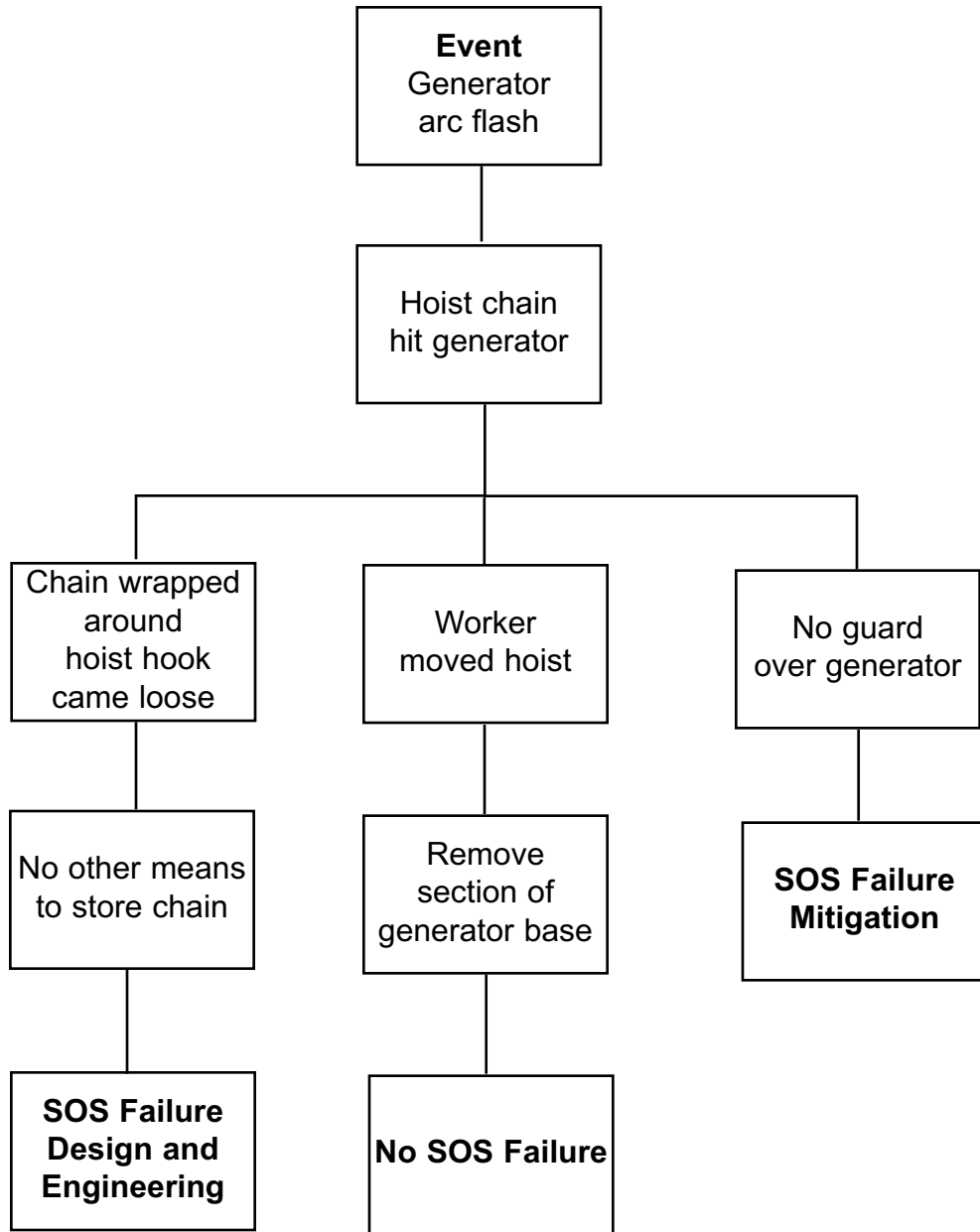
Discussion:

A masonry worker was moving a chain-driven hoist from one side of a substation generator room to the opposite end. The worker needed the hoist to remove some cement from a section of the generator base. Two chains, positioned on each side of the hoist, are used to move the crane. The worker started pulling on one of the chains to position the hoist when the other chain that was wrapped around the hoist hook slid out of the hook, swinging and striking the running generator, causing an arc flash. A five-foot high gate surrounded the generator, but the chain was able to roll over the top of the gate and onto the generator because there is no guard over the generator. The worker recognized that there may be some danger because, when he had used this hoist in the past, the chain had done the same thing while the generator was not running.

After the incident occurred, the worker tried to remove the chain from inside the gate with a broom handle, but could not because it was stuck. He then went to get an electrician, who in turn notified a supervisor. The paper machine was shut down in a controlled fashion and the chain was removed. In the past, an electrician would have been around when work was being performed in the substation, but no policy or procedure currently exists and an electrician was not present at the time of the incident.

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. Design method to store hoist pull chain in a safe manner.
2. Install proper guarding around generator.

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: Hoist Chain Hits Generator Causing an Arc Flash

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:

<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

