

## Worker Strains Back Lifting Bale

#### **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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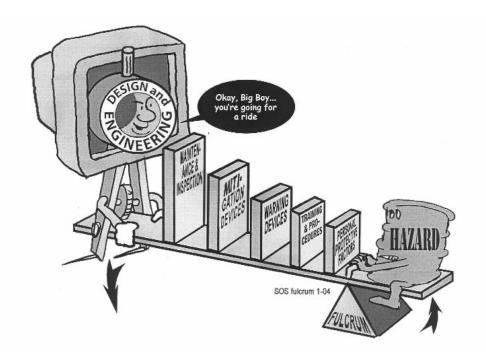
#### **Background Information**

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 seco	nd line of defense		Lowest—the last line of defense
Effectiveness	Most Effective	<b>—</b>			<b>→</b>	Least Effective
Goal	To eliminate hazards	7	o further minimize	and control hazard	ls	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 SchedulingHF 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  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.

**Revised October 2006** 

<sup>\*\*</sup> 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.





Title: Worker Strains Back Lifting Bale

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#### **Lessons Learned Statement**

An inadequate air supply and worn equipment resulted in a strained back injury to a worker. *Systems of Safety* are utilized to provide prevention from this type of incident.

Despite previous investigations into this type of incident, no action was taken in the **Design and Engineering** *System of Safety* to replace the air lines with more sufficient piping to allow for proper operation of the mechanical hoist, or to seek a dedicated air supply for the hoist in that particular area of the facility. Also, no review was made within the **Design and Engineering** *System of Safety* to seek an alternative to the air compressor type of hoist, such as an electric-powered hoist.

Adequate equipment and sufficient manpower to replace worn equipment are essential in avoiding manual lifting of bales. Keeping a spare hoist on site and adequate staffing to replace the hoist would be **Design and Engineering** *System of Safety* fixes that would eliminate part of the problem.

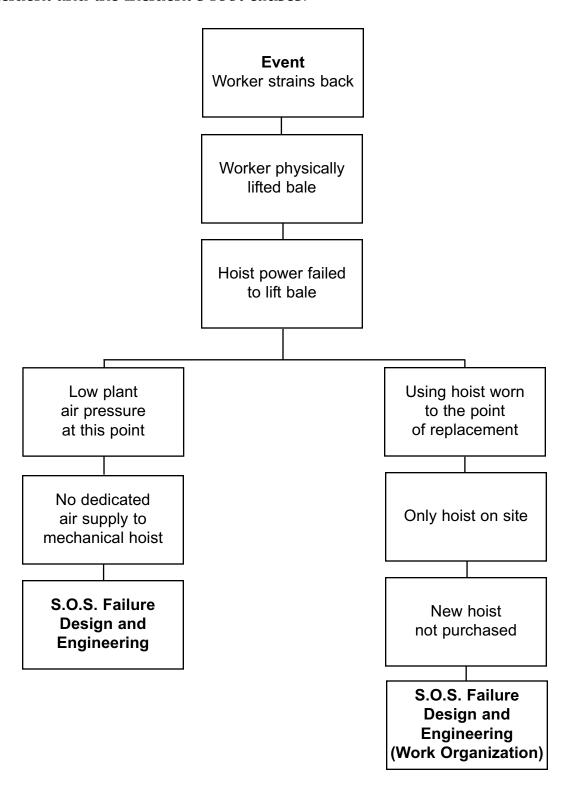
#### Discussion

A worker was lifting the last of three bales onto the stack when the worn mechanical hoist began to fail and lower the bale back down. The hoist, powered by air pressure, was located in an area of the plant where the air pressure was often too low to properly run it. The hoist was also worn to the point of replacement and no replacement hoist was onsite.

Two other workers positioned themselves on either side of the bale to lift it on top of the other two bales. One of the workers who helped to manually lift the bale began to feel a strain in his lower back. Previous investigations had been performed to identify the issues with this mechanical hoist and no actions had been taken.

#### **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. Install a dedicated air compressor for the mechanical hoist to increase air supply to this particular area of the plant.
- 2. Keep a spare motor on site.
- 3. Install a new type of hoist system with an electric motor.

#### **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.

	list all).
2.	Date of LL training
3.	LL number used in today's Training
4.	Your name

1. Site name (if there are participants from more than one site, please

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.



# Lessons Learned: Worker Strains

Please answer the two questions below:

1.	How important is this lessons learned to you and you			
	workplace? (Circle one.) Rate on a scale of 1 to 5,			
	with 5 being the most important.			

1	2	3	4	5

2.	2. What suggestions would you make to improve this Lessons Learned?			

#### **End of Training Trainer's Instructions**

Please complete the information below.
Frainer's Name
(Please Print)  Date of training:
No. of Participants: Total Hourly Management
Location of Training:
JSW Local #
end:
1. This page;
2. The Education Exercise (page 8);
2. The Taring of II Comments on (1997)

- 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.

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## SIGN-IN SHEET (Please print clearly.)

Class Title:		Class Completion Date:		
Loc	cation (City, State)/Facility:			
Grant Program:				
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	Name (print first and last)	Che	ck one:	
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