



Worker Burned by Steam from Pipes

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-18800-09-60-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 10, Issue 14

© 2010 Tony Mazzocchi Center

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.

Revised October 2006



Title: Worker Burned by Steam from Pipes

Identifier: Volume 10, Issue 14

Date Issued: April 2010

Lessons Learned Statement

The use of second-rate equipment and a poorly designed piping system led to the second-degree burn of a worker. *Systems of Safety* are utilized to provide prevention from this type of accident.

A productive and safe work environment begins with equipment that can perform the job and has built-in safety features for the workers using the equipment. Although the mechanical problems with the piping were well-known and work orders had been issued to modify and reroute the piping, no steps were taken in the *Work Organization* subsystem of the **Design and Engineering System of Safety** to insure that the changes were made in a timely manner. Because the pump did not have a built-in pressure relief valve, steam hot enough to burn a worker built up in the pump. When choosing equipment, one should opt for the equipment designed with the best safety features, rather than the basic equipment that would get the job done.

Executing the work orders to modify and reroute the piping would have been a good fix within the **Maintenance and Inspection System of Safety**.

Working within the **Training and Procedures System of Safety** by modifying an existing procedure or writing a new one to address the poly material buildup in the pit would lessen the likelihood of overflow problems in the future.

Discussion

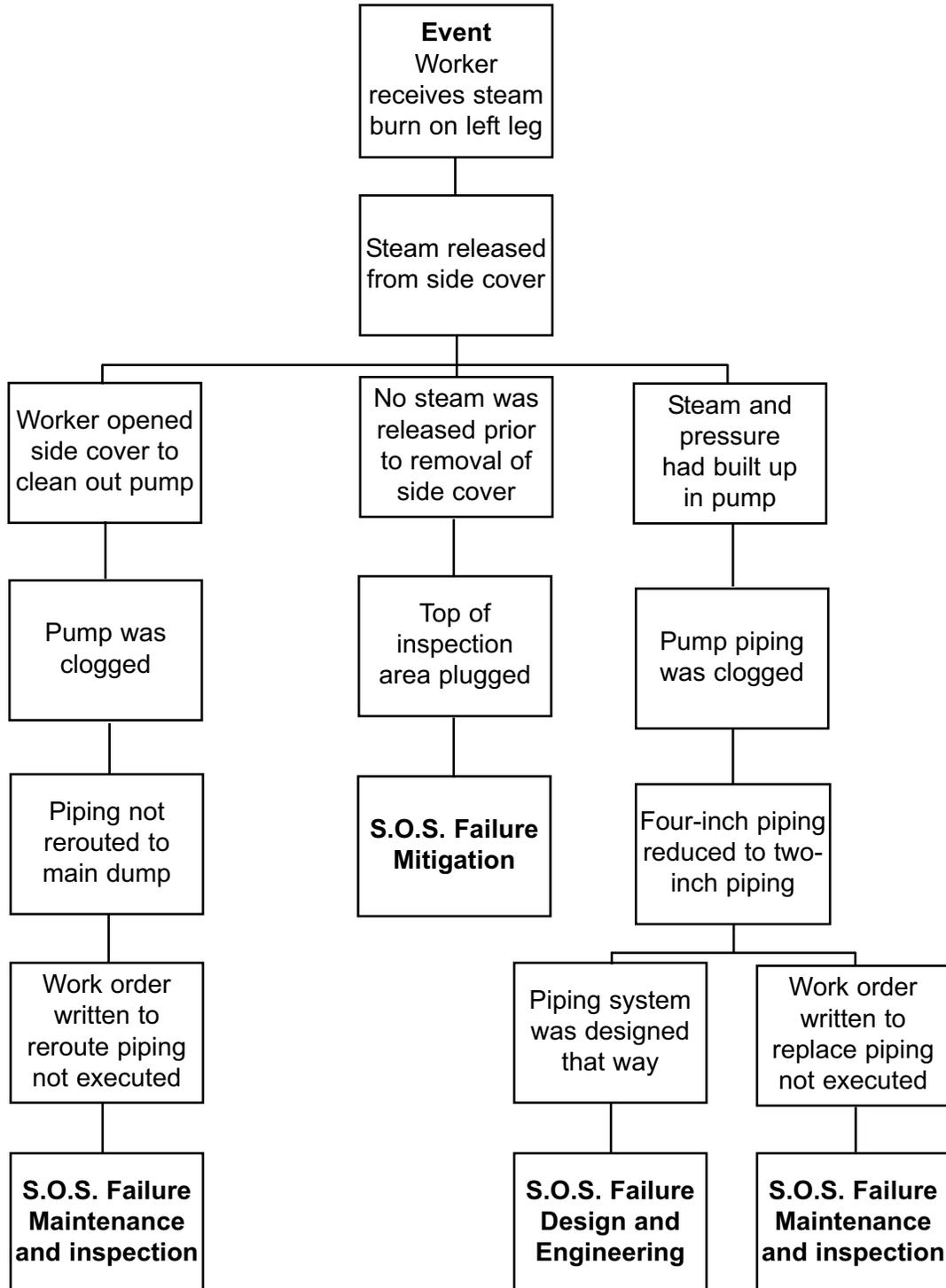
While relieving steam pressure from a sump pump, a worker received second-degree burns to his left leg. The sump pump piping had begun to clog even though the equipment had only been installed for six months. The pit into which the sump pump was emptying began to overflow because there was too much poly material in the pit.

The piping was clogged due to a reduction from four-inch piping to two-inch piping. A work order had been written to replace the smaller piping so that there would be no reduction in the piping at all, and to reroute the piping from the pit to a main dump chest to prevent the overflow. But neither had been done. This clog had caused pressure and steam to build up in the sump pump.

The worker began the process of shutting down the pump; a task with which he was familiar. He unbolted the bottom mounting bolts before he opened up the top plate. He then proceeded to open the top inspection plate. As he opened the top, no steam was released. As he opened the side cover, the buildup of pressure and steam caused the steam to shoot out at full-force. The worker was burned on his leg and a coworker was nearly burned on his face.

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. Replace two-inch pipe with four-inch pipe.
2. Reroute pipe to go straight to main dump, using sump pit as a back-up.
3. Install new pump that is durable and capable of handling the job it is designed to do. This pump should also have an automatic pressure relief valve so that steam will not build up.
4. Improve work organization so that work orders are executed in a timely manner.
5. Create or modify existing procedure to address poly material buildup in the pit.

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: Worker Burned by Steam from Pipes

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 *(Please print clearly.)*

Class Title: _____ **Class Completion Date:** _____

Location (City, State)/Facility: _____

Grant Program: _____ **Dist. & LU #:** _____

Instructors: 1) _____ **2)** _____

3) _____ **4)** _____ **5)** _____

Name (print first and last)

Check one:

		Hourly	Management
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			

