

Key Lessons

Burn Injury and risk of suffocation

Date of Incident: 2016-03-30

Site: Back Lane Asphalt Plant

Country: United Kingdom

Main hazard/ Risk: Other

Description of Event:

Due to recent inclement weather, a blockage occurred in a chute that historically would be cleared by an operative opening the door and barring away at the blockage externally (photo 1). To perform this task a standard risk assessment was reviewed and deemed sufficient. On this occasion the blockage would not clear and it was agreed with the supervisor to continue the task by entering the hopper to rod the blockage from a better angle (photo 2).

When in the hopper, aggregate fell from above and the operative panicked thinking he would become trapped or suffocate. In trying to escape he had to pass through a curtain of hot material and this caught between his overalls & helmet, burning the back of the neck and behind his ears.

Photographs:



Photo 1



Photo 2

Key Lessons after Incident Investigation:

At recent workshops the principles of the “Stop Assessment” have been discussed and shared. This task changed from being accessed externally, to working inside a confined space. That SIGNIFICANT change was the opportunity to step back and apply the “Stop Assessment” process. By applying these principles to this incident, this incident may not have occurred or would have been far less serious.



| Root Causes | Category | Corrective and Preventive Actions |
|---|------------------------------------|--|
| Not considering the environment that the task was going to occur within. | 4. Culture, Perception and Beliefs | Coaching / Training in regards to risk perception |
| Clear and consistent categorization of Confined and Restricted Spaces/ WAH. | 1. Physical Conditions | Reassess and reengineer where possible, also ensure rescue plans are updated and communicated |
| Inside a restricted space with only one point of access/egress | 3. Management System | Restricted space not adequately assessed as a team, so perception of risk was low. Reassess restricted space on plant |
| No STOP assessment once the task had significantly changed | 3. Management System | No perception of the significant risks when entering the bin as they had done this before and possibly "normalized" the task. More emphasis on risk management and change in tasks |

1. Physical Conditions Examples include: Controls, Visibility, Upset Conditions, Noise/Vibrations, Equipment Facility design, Warnings, Environment

2. Human Factors Examples include: Cognitive, Psycho-Behavioral, Physical/Mental Limitations, Perceptual, Self-imposed stress, Personnel

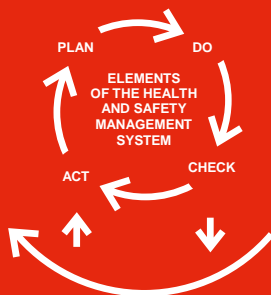
3. Management System Examples include: Training, Accountability, Communications, Planning & Evaluation, Rules and Procedures, Supervision, Incident Investigation

4. Culture, Perception and Beliefs Examples include: Risk Tolerance, Visible Leadership, Employee Engagement, Value for Safety, Norms, Drift, Goals



Communication Principles

- Determine a country wide process for distribution of this document, including appropriate corrective actions for all levels of the organization.
- Communication should include discussions in Team Meetings, Toolbox Talks, posting on Notification Boards, email distribution, and developing and sharing relevant action plans



Important Actions

- Perform a gap analysis based on the information in this document.
- Establish the action plan including objectives and processes necessary to ensure a similar incident will not occur at your sites.
- Implement the action plan, execute the process, close the gaps.
- Collect data to track implementation until completion