

Key Lessons

Eye Injury Resulting in Lost Time Injury

In the last 7 Working Days we have had multiple incidents resulting in potential eye injuries. These could have all resulted in serious injury or even loss of sight.

A common theme with all these incidents is the appropriate selection of eye wear for the task. This has not been captured in the “Stop Assessment” before the task has started or even in the Risk Assessment/ Method Statement when the task is being planned.

We should remember that PPE is one of the lowest levels of control in the Hierarchy of Hazard Control Measures. These are:

Eliminate
Reduce
Isolate
Control
Personal Protective Equipment
Discipline

Out of all the recent incidents, the most significant has been shared with you here.

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

Key Lessons

Date of Incident: 2016-08-10

Site: Greenwich, London Concrete

Country: United Kingdom

Main hazard/ Risk: Other

Description of Event:

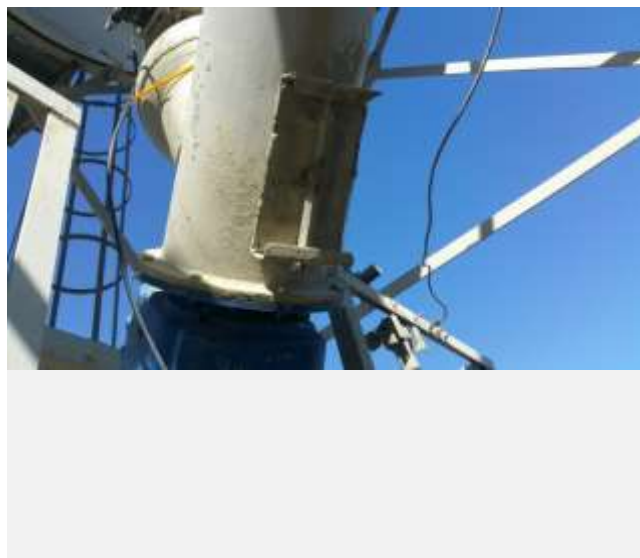
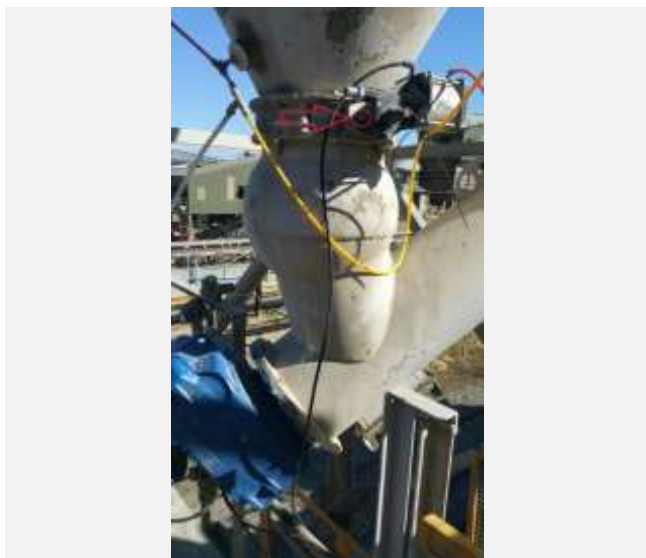
On the 10th August an incident occurred resulting in a lost time eye injury to an employee.

The incident involved a fitter who was replacing a gearbox on the cement screw. The screw was isolated and purged of material and the butterfly valve had been visually checked to ensure it was in closed position. The access hatch was opened to access the screw and what was thought to be a small quantity of cement dust fell to the floor. The cement still continued to flow and the fitter attempted to shut the hatch, he was unable to do this and material splashed back and entered his eye. He was able to move the butterfly valve manually by approximately 5mm and the flow of material stopped.

He received first aid at site and visited the local eye clinic that cleaned his eye thoroughly.

Cement is classed as an irritant and this incident could have resulted in a serious eye injury or loss of sight.

Photographs:



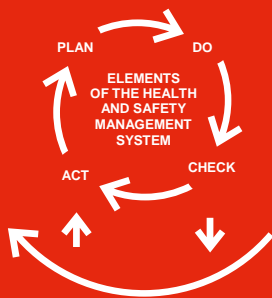
Key Lessons after Incident Investigation:

Root Causes	Category	Corrective and Preventive Actions
Maintenance task only planned with one operative and full cement silo	2. Human Factors	Better planning of maintenance task to consider all aspect of a task and the upstream and downstream impacts.
Access hatch single bolt and slide mechanism	2. Human Factors	Review design of the access hatch and look at hinged solution.
No possible way to test and prove that the butterfly valve is fully closed.	1. Physical Conditions	Further investigation into appropriate alternative system.
Appropriate PPE for the task – Eye Protection	4. Culture, Perception and Beliefs	Risk Assessment should consider and specify appropriate PPE for the task. e.g. Goggles



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