

**SAFETY ALERT**

**Contractor Medical Treatment Incident - HEE Ducting Installation, BNL 22/1/09**

**DESCRIPTION:**

A Technician of an HEE company in BNL was installing new HEE air ventilation ducting on site and had to cut to specific lengths. He used an angle grinder to cut the lengths and in doing so this left sharp edges/burrs on the ducting. When lifting a section into position to join other ducting, a sharp edge punctured his glove and he received a cut to his little finger. He drove himself and alone to the hospital where 3 stitches were applied. He returned to work thereafter.



Shots show the type of ducting used clearly showing the jagged edges, which caused the cut  
Below is a shot of the work area.



Gloves used are similar to these leather gloves, below.



**WHY DID IT HAPPEN?**

- The **hazard** of sharp edges after adjusting the length of the section was **not removed**
- **Wrong** type of **glove** worn by employee,
  - A lower rated leather glove (3242) was used; this did not offer the best possible protection against cut or puncture elements compared with other types of gloves available to the worker.
  - A detailed JSA for the type of work was not available, leaving the glove choice with the Technician
  - Technician's understanding of different type of gloves and consequent use, not adequately ensured by contractor

**WHAT COULD HAVE PREVENTED THE INCIDENT / LESSONS LEARNED:**

- Perform a LMRA before you put your hands at any risk
- Ensure Technicians understand the training and toolbox packages on the selection and appropriate use of the various types of gloves, offered by the contractor
- Provide JSA with specific reference to best practice glove types for every job step
- An installation and manual handling method which improves grip on the duct segments without having to hold the edges, when exerting force to join to segments

**CASE MANAGEMENT:**

- When injured, **do not drive yourself** to hospital or local medical center.
- Ensure your supervisor is notified as soon as possible, even if the outcome or severity has not yet been confirmed. Always agree with other members of the crew / site staff, who will do the notification, **prior** to leaving the site.

**The Last Minute Risk Assessment is a **continuous** process because....**

**Every Minute can be your last one**

Date of issue 5-2-09



# SAFETY ALERT

## Cut to Head - Stitches

### Incident Description:

A subcontractor in was tasked to replace two furnaces in a car wash. The workers were using a genie lift to remove the old units. The injured worker was reinstalling safety pins while moving the stabilizing bars from horizontal to vertical position to aid in maneuvering the genie lift through the doorway. The injured worker claimed that he was bent over, installing the safety pins, his hard hat fell off; and one of the stabilizing bars dropped forward and hit him on the forehead causing the injury. He was taken to hospital by a co-worker and received 8 stitches.

### Investigation Findings:

- Due to a breakdown in communications between the general contractor and the subcontractor, a crew was dispatched with no instructions or training relating to IOL's safety program.
  - The worker failed to adequately assess the risks, utilizing LMRA techniques, leading to his personal injury.
  - Safe Work Permit, Job Safety Analysis, Lock Out/Tag Out and POST training were **not** completed in accordance with IOL's Contractor Safety Program.
  - On site attendant indicated he had observed **no** PPE in use on the day of the incident.
  - There was a breakdown in virtually **all** required safety management practices directly contributing to this incident.



### Conclusion:

- Workers need to understand and apply LMRA techniques
- General contractors need to ensure sub contractors are trained and verify use of behavior based safety tools and procedures
- Sub contractor was not permitted to complete this job and will not be doing further work at our sites

### REMEMBER:

- The circumstances leading up to this incident clearly indicate the importance of our Behaviour Based Safety (BBS) program.
- While the consequences in this case were not serious, with no safety managing system in place, results could have been much worse.

**NEVER** forget to **Stop & Think**



**ExxonMobil**

**Mobil**

**Nobody Gets Hurt**

#73 January 2009

## Hand Cut Incident

### DESCRIPTION:

Contractor worker cut his right hand with a power saw. Cut was from the middle to the little finger and required surgical treatment by specialized doctors. Over 50 micro-stitches required as part of treatment. Incident happened at a c-store equipment replacement project, while cutting Corian countertop (to accommodate a larger deli unit). Contractor selected a 7" DeWalt hand grinder, with diamond cutting disc, for the job. The safety guard had been removed at some point in time. The person normally in charge of handling Corian cutting was not available and the crew foreman assigned a temporary helper, with only a few days on the job, to perform the cut. The helper started the cut and felt that the grinding disc was bent. He took it off and tried to fix it. He placed the disc back on the power tool but did not notice that it was rotating in the opposite direction needed for safe equipment usage. To get a better grip of the machine trigger, the worker decided to remove his right hand glove and proceeded with the cut. When the disc touched a wood structure under the Corian cutting surface, the grinder kicked back towards his face. Instinctively, the man placed his right hand on the way of the machine to protect himself and blocked the power tool. The injured was taken to the closest hospital for immediate medical attention. At the time of the incident, the worker was using the following PPE: clear safety glasses, hard hat, boots and leather glove on the left hand only. There was a JSA for the task, however the development team was not specialized on the task. The Corian manufacturer recommends this task should be performed with another power tool known as "Router".



### Lessons Learned:

- The tool that was selected by the contractor to cut the Corian counter top was not the appropriate and safest choice for the job.
- Work must only be conducted by trained, experienced and capable personnel.
- JSAs should be developed by a team of experts in the task and it should include the appropriate tool and worker training requirements.
- Workers/crew must conduct LMRA when performing a task, in order to assess potential risks and take action to eliminate or control them.

**REMEMBER** – Safe Behaviors, Hazard Recognition and Proper PPE