## Pulp and Paper Safety Association

Major Injury Prevention David W. Wilbanks, MPH, CSP, CRSP



## Preliminary Risk Analysis

For all non-routine work, contractor or own internal personnel.

#### Supporting Concepts & Peer Reviewed Research





MOONWALKIN
WITH
EINSTEIN



RISK ASSESSMENT



The magical number 7 +/-2: Some limits on our capacity for processing information

George A. Miller,

The Psychological Review, 1956





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# Preventing Major Injuries

### Observations on Theory, Models & a Path Ahead

#### By David W. Wilbanks

ajor injury events occur in every type of workplace, large and small, sophisticated or otherwise. Those performing maintenance (Reason, 1990), construction and installation services are especially at risk after consideration is •Virginia: Worker died from head injuries after being struck by an excavator arm while trimming trees.

•Michigan: Worker installing insulation killed after falling 25 ft from roof.



#### Rate of fatal work injuries, 2006–2012

Fatal work injury rate (per 100,000 full-time equivalent workers)



The rate of fatal work injuries in 2012 was 3.4 fatal work injuries per 100,000 full-time equivalent workers, down slightly from 3.5 in 2011.

Note: Rate = (Fatal work injuries/Total hours worked by all workers) x 200,000,000 where 200,000,000 = base for 100,000 full-time equivalent workers (FTEs) working 40 hours per week, 50 weeks per year. The total hours worked figures are annual average estimates of total at work multiplied by average hours for civilians, 16 years of age and older, from the Current Population Survey (CPS).

In 2008, CFOI implemented a new methodology, using hours worked for fatal work injury rate calculations rather than employment. For additional information on the fatal work injury rate methodology, please see <a href="http://www.bls.gov/iif/oshnotice10.htm">http://www.bls.gov/iif/oshnotice10.htm</a>.

Source: U.S. Bureau of Labor Statistics, U.S. Department of Labor, Current Population Survey, Census of Fatal Occupational Injuries, and U.S. Census Bureau, 2014.



Consolidated from "Census of Fatal Occupational Injuries," Bureau of Labor Statistics, 2013, and "Statistics on Fatal Injuries in the Workplace 2011/12," by Health and Safety Executive, 2013.





## **OSHA.gov** Work Fatalities

- ► 3/2/14 Ohio: Worker killed in maintenance shop fire.
- ▶ 3/3/14 Colorado: Worker died from exposure to oil tank fumes.
- 3/5/14 Michigan: Worker inspecting parts crushed when injection molding machine activated.
- ▶ 3/8/2014 Iowa: Worker killed in fall from frost covered roof.
- 3/12/2014 Kentucky: Worker was caught and killed in a press while trying to retrieve a hammer.
- ▶ 3/12/2014 Arkansas: Temporary worker killed in fall from rooftop.
- > 3/13/2014 New York: Worker died from carbon monoxide poisoning.
- 3/25/2014 Kansas: Two workers killed when a wireless communications tower collapsed.
- 3/27/2014 Georgia: Worker died in a grain storage silo after becoming entrapped by sweep auger.
- 4/2/2014 Texas: Worker electrocuted when bucket contacted energized powerline.
- ▶ 4/6/2014 New York: Worker died from carbon monoxide poisoning.
- ▶ 5/17/2014 Wisconsin: Worker struck and killed by a falling tree.

#### **1.** Major Injury **Accidents Still Occur**

The hazards are known and controllable

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#### Numbers From SMA through May 2012

**Steel Industry Fatalities** 





Critical Risk Standards Conformance. KPI requires minimum 85% overall avg & no standard < 80%,

<u>Critical Risk</u> Process Flow	2014 Target	Dog Status	Bright Bar	с	North	South	West	Rail	Wire
Pedestrian Path	90.0%	92.5%	88%	95%	96%	93%	85%	98%	94%
Mobile Equipment	85.0%	83.2%	82%	83%	85%	85%	78%	86%	87%
Lockout/Tryout	95.0%	96.8%	98%	96%	98%	97%	96%	98%	98%
Confined Space	95.0%	95.7%	96%	95%	96%	98%	100%	93%	96%
<u>Overhead Crane</u>	82.0%	82.1%	82%	83%	83%	82%	79%	83%	86%
Rail	90.0%	<mark>92.0%</mark>	na	na	91%	91%	97%	91%	na
Working At Heights	86.0%	87.7%	92%	87%	89%	87%	86%	89%	89%
Overall Score	89.0%	89.0%	90%	89%	91%	89%	86%	91%	91%

# We need to talk more about *Risk*, and less about *pyramids*

Impact



#### 1. Major Injury Accidents Still Occur

The hazards are known and controllable

#### 2. All Hazards ARE NOT Equal!

We need a *way* to identify major injury hazards

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Major Injury Prevention



Conclusions to major injury events often assume workers had adequate understanding and means to control hazards.

Frequently Not True.









#### James Reason, 2000

One of the most common accident scenarios involves the deliberate disabling of engineered safety features by operators in pursuit of what, at the time, seems a perfectly sensible goal....

Another happens when the defenses are breached because the operators are unaware of (hazards) because they have an erroneous perception of the system state. (Something has changed)



James Reason published in 2000

## Hitting the *SWEET* spot

The moment between (the worker) having enough information to assess the risk and the moment of exposure.



#### **1.** Major Injury **Accidents Still Occur**

The hazards are known and controllable

#### 2. All Hazards ARE NOT Equal!

We need a *way* to identify major injury hazards

**3. Critical Error Moments can be Anticipated & Controlled** 

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Adapted from "Incidence Rates of Non Fatal Occupational Injuries and Illnesses by Case Type and Ownership, Selected Industries," by *Bureau of Labor Statistics*, 2010, Table 1. *Workplace Injuries and Illness*. 2012.

## Learning.....



#### January 15, 2009

THE CHECKLIST MANIFESTD - HOW TO GET THINGS RIGHT ATUL GAWANDE BESTSELLING AUTHOR OF BETTER AND COMPLEXATIONS Copyright Manual The Checklist Manifesto



## Roll-Up Door - Repair

**Bas lin** 

Task: A roll-up door is broken. What must you do to perform the work safely?

5/20/2010 IL – Worker was repairing a large overhead hanger door, and was later found caught in the folded door. OSHA.gov

#### **1.** Major Injury **Accidents Still Occur** The hazards are known and controllable

#### 2. All Hazards ARE NOT Equal!

We need a *way* to identify major injury hazards

3. Crital Errors cân be Controlled

#### 4. Checklists Are Critical

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Learning: The Magic # 7 +/-2

#### George Miller, 1956, The Psychology Review



<u>The Magical Number Seven,</u> <u>Plus or Minus Two:</u>

### Some Limits on Our Capacity for Processing Information

My problem is that I have been persecuted by an integer. For seven years this number has followed me around, has intruded in my most private data, and has assaulted me from the pages of our most public journals. This number assumes a variety of disguises, being sometimes a little larger and sometimes a little smaller than usual, but never changing so much as to be unrecognizable. The persistence with which this number plagues me is far more than a random accident. There is, to quote a famous senator, a design behind it, some pattern governing its appearances. Either there really is something unusual about the number or else I am suffering from delusions of persecution.



**English →** Electrical raffic **Pirates** 
Pneumatic Equipment Hate 🛶 Hydraulic Getting 
Gravity Energy Stuck 
Solids Listening 
Liquids C<sup>3</sup>hemicals, Ghost 🔿 Gases **Stories →** Springs (kinetic) confined spaces, combustion eights



# Human Performance Tools

#### Engaging Workers as the Best Defense Against Errors & Error Precursors

By Jan K. Wachter and Patrick L. Yorio

"Concurrent Verification Peer Checking"

## Clive Thompson



"Our brains have always been terrible at remembering details.

When it comes to quickly retrieving information on the fly, all day long, ...we rely on other people."

From <u>Smarter Than You Think:</u> <u>How Technology Is Changing Our</u> <u>Minds for the Better</u>."

#### Transactive Memory the art of storing information in the people around us..



Groups relying on each other to recall information performed better than those who didn't use *transactive* memory.

Transactive groups don't just remember better: They also analyze problems more deeply....

From <u>Smarter Than You Think: How Technology Is Changing Our Minds</u> for the Better."

## **1.** Major Injury **Accidents Still Occur** The hazards are known and controllable

#### 2. All Hazards ARE NOT Equal!

We need a way to identify major injury hazards

3. Errors can be Anticipated & Controlled

4. Checklists Are Critical

5. Teams Impact Results faster than rules

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## Preliminary Risk Analysis

For all non-routine work, contractor or own internal personnel, involving a major injury /illness hazard(s)