

## Change Analysis Activity

### Maintenance Accident

#### Description:

A Maintenance Tech incurred OSHA-recordable injuries while replacing a failed drive chain on a 50 ft. high bucket elevator at a northern Michigan plant. The incident occurred at 2:35 am on 2/21/20 during an emergency call-out. While installing the master link, the Tech's hand slipped and impacted the edge of the drive base. While climbing down the caged ladder, the Tech slipped and fell the last 6-feet, spraining his ankle. The injuries required 8-stitches and 2-weeks away from work. Since the job wasn't finished, two Maintenance Techs finished replacing the drive chain after daybreak using standard operating procedures and supervision.

#### Exercise:

Complete Change Analysis worksheet to determine possible contributing factors that could have led to this incident.

| Change factor   | Difference/Change   | Effect   | Questions to answer  |
|---|---|--|--|
| <b>What</b><br>(conditions, occurrence, activity, equipment)                          | <ol style="list-style-type: none"> <li>Cut hand</li> <li>Sprained ankle</li> </ol>  | <ol style="list-style-type: none"> <li>OSHA recordable injuries</li> <li>Severe injury possible</li> </ol>   | <ol style="list-style-type: none"> <li>Was a work order written?</li> <li>Was a task analysis done prior to starting the job?</li> </ol>   |
| <b>When</b><br>(occurred, identified, plant, status, schedule)                        | <ol style="list-style-type: none"> <li>Night</li> <li>Plant down</li> <li>Unplanned work</li> </ol>                       | <ol style="list-style-type: none"> <li>Skeleton crew</li> <li>Stressful situation</li> <li>Higher risk</li> </ol>  | <ol style="list-style-type: none"> <li>Why weren't 2 people called in?</li> <li>Is production more important than safety?</li> <li>Did they assess risks?</li> </ol>                         |
| <b>Where</b><br>(physical location, environmental conditions)                         | <ol style="list-style-type: none"> <li>Outside temperature</li> <li>Dark</li> <li>Difficult communication</li> </ol>      | <ol style="list-style-type: none"> <li>20°-30°F colder at night</li> <li>Poor visibility</li> <li>Difficult to call for help</li> </ol>  | <ol style="list-style-type: none"> <li>Did the cold weather cause the tech to take shortcuts?</li> <li>What source of lighting was used?</li> <li>Was a portable radio available?</li> </ol> |
| <b>How</b><br>(work practice, omission, extraneous action, out of sequence procedure) | <ol style="list-style-type: none"> <li>Did not use SOP</li> <li>No help</li> </ol>  | <ol style="list-style-type: none"> <li>Variability in work execution</li> <li>Difficult climbing down the ladder with 1 hand</li> </ol>  | <ol style="list-style-type: none"> <li>Why didn't the tech use the SOP?</li> <li>Did the tech try to get help?</li> </ol>  |
| <b>Who</b><br>(personnel involved, training, qualification, supervision)              | <ol style="list-style-type: none"> <li>On-call Maintenance Tech</li> <li>Working alone</li> <li>No supervision</li> </ol> | <ol style="list-style-type: none"> <li>Tech not familiar with the equipment</li> <li>At-risk hauling tools and parts up/down the ladder</li> <li>Shortcuts were taken</li> </ol> | <ol style="list-style-type: none"> <li>Was the Maintenance Tech trained?</li> <li>What is the policy for working alone in remote locations?</li> <li>Non-routine work policy?</li> </ol>     |

Source: DOW Root Cause Analysis Guidance Document, 1992