Learning from Accidents

S Beddegenoodts

Learning from incidents workgroup

- Rather than counting incidents – by severity – the contributing companies decided to share learnings from real incidents in an anonymised format:

Title

Description of the incident/accident

On the 2nd December 2009 a …

Root causes

- … and there was no hot work permit in place.
- … had no site drawings available on site ...
- …had not been definitively established.

Picture

.

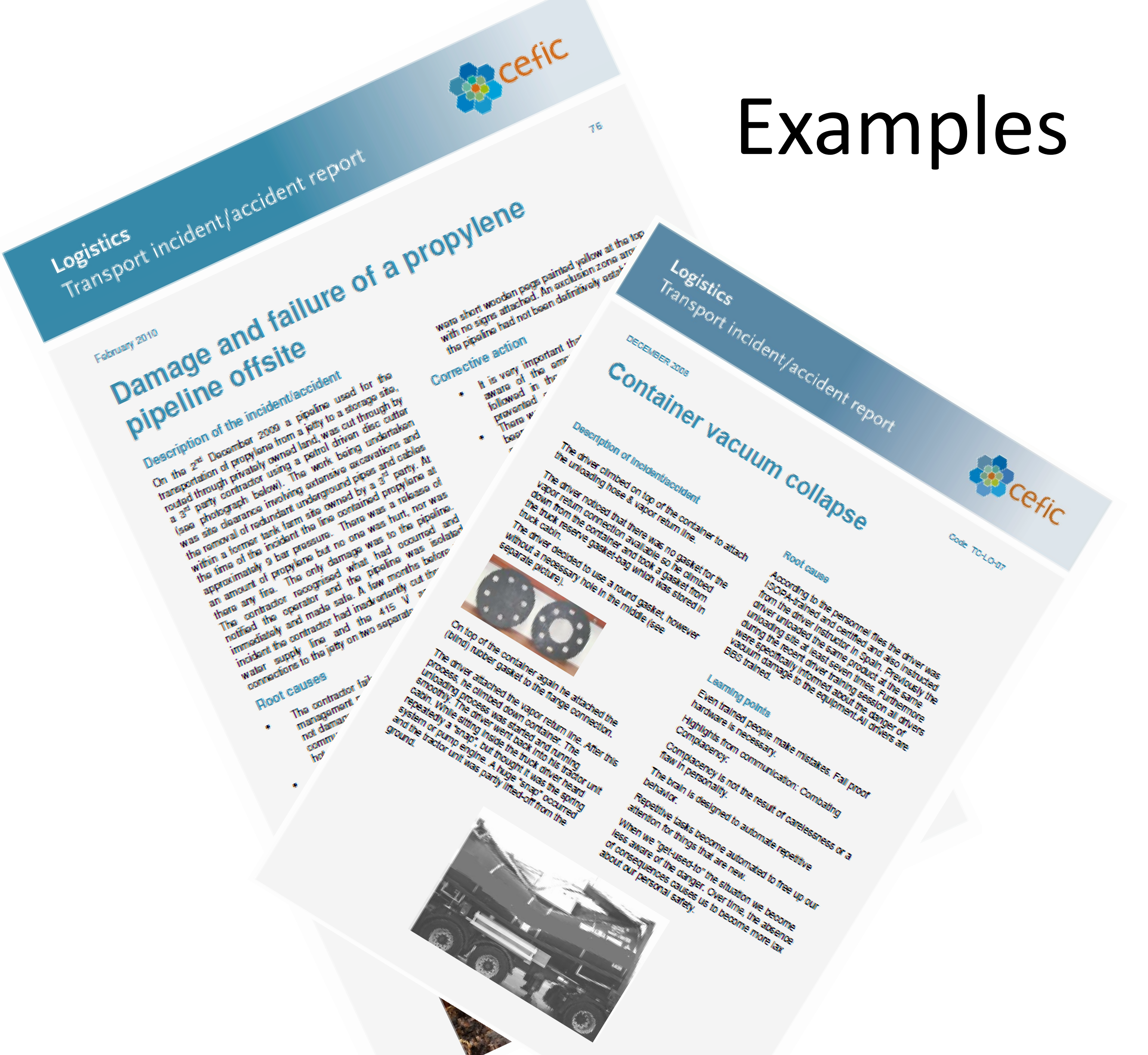
Corrective action

- … is aware of the emergency procedures to be followed ...
- There were additional barriers that could have
- The knowledge and awareness ...

Recommendations

- Raise the awareness of the risks … http://www.ukopa.co.uk/p...
- Maintain …

Examples



Logistics
Transport incident/accident report

cefic

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February 2010

Damage and failure of a propylene pipeline offsite

Description of the incident/accident

On the 2nd December 2009 a pipeline used for the transportation of propylene from a jetty to a storage site, routed through privately owned land, was cut through by a 3rd party contractor using a petrol driven disc cutter (see photograph below). The work being undertaken was site clearance involving extensive excavations and the removal of redundant underground pipes and cables within a former tank farm site owned by a 3rd party. At the time of the incident the line contained propylene at approximately 9 bar pressure. There was a release of an amount of propylene but no one was hurt, nor was there any fire. The only damage was to the pipeline. The contractor recognised what had occurred and notified the operator and the pipeline was isolated immediately and made safe. A few months before the incident the contractor had inadvertently cut out the water supply line and the 415 V separate connections to the jetty on two separate

Root causes

were short wooden pegs painted yellow at the top with no signs attached. An exclusion zone around the pipeline had not been definitively established.

Corrective action

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DECEMBER 2008

Container vacuum collapse

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Code: TC-LO-07

Description of incident/accident

The driver climbed on top of the container to attach the unloading hose & vapor return line.

The driver noticed that there was no gasket for the vapor return connection available so he climbed down from the container and took a gasket from the truck reserve gasket-bag which was stored in truck cabin.

The driver decided to use a round gasket, however without a necessary hole in the middle (see separate picture).

On top of the container again he attached the (blind) rubber gasket to the flange connection.

The driver attached the vapor return line. After this process, he climbed down container. The unloading process was started and running smoothly. The driver went back into his tractor unit cabin. While sitting inside the truck driver heard repeatedly a "snap" but thought it was the spring system or pump engine. A huge "snap" occurred and the tractor unit was partly lifted-off from the ground.

Root cause

According to the personnel files the driver was ISOPA-trained and certified and also instructed from the driver instructor in Spain. Previously the driver unloaded the same product at the same unloading site at least seven times. Furthermore during the recent driver training session all drivers were specifically informed about the danger of vacuum damage to the equipment. All drivers are BBS trained.

Learning points

Even trained people make mistakes. Fail proof hardware is necessary.

Highlights from communication: Combating Complacency.

Complacency is not the result of carelessness or a flaw in personality.

The brain is designed to automate repetitive behavior.

Repetitive tasks become automated to free up our attention for things that are new.

When we "get-used-to" the situation we become less aware of the danger. Over time, the absence of consequences causes us to become more lax about our personal safety.

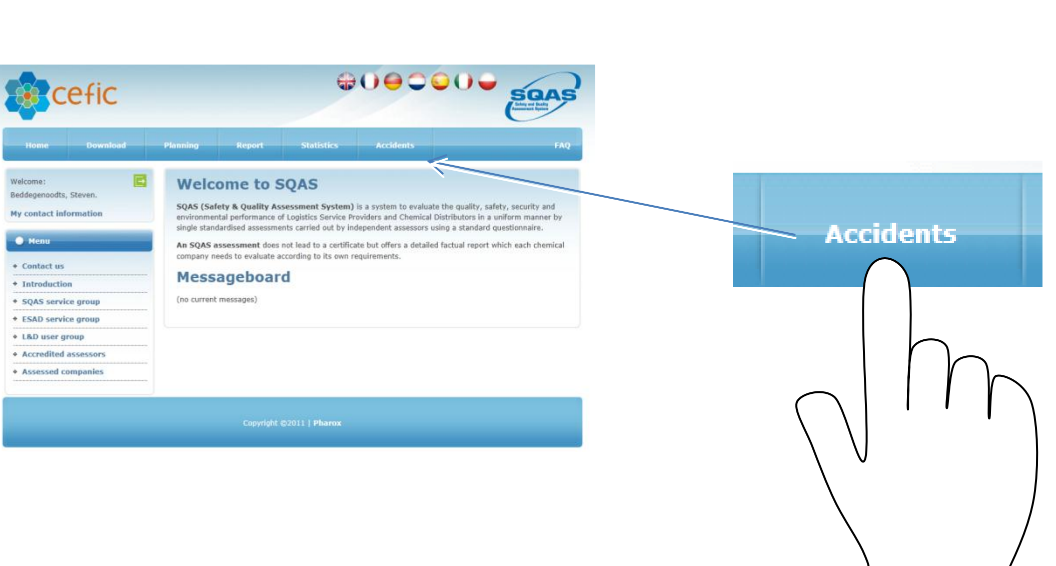
Contribute ?

SQAS database of accidents

Use?

- When you are member of the SQAS user group or the L&D user group:
- Login to www.sqas.org

loginname/reportnumbe
Login
Password forgotten



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- Packaging -
- Other activit

Total list of incid

Logistics
Transport incident/accident report

DECEMBER 2008 Code TT-TR-13

Traffic accident with a plastic roadtank

Description of incident/accident

A bulk liquid carrier with +/- 24 tons of hydrochloric acid (UN1789 – HCl 35%), was involved alone in a traffic accident.

Due to the shock, the fibre-reinforced plastic (polyester) tank was separated from the cab and has been broken in two parts. Hydrochloric acid spilt on the road, producing a "toxic" cloud but fortunately, nobody was injured.

The cleaning up of the area took several hours and during this time, the traffic was blocked.

Root cause

Transport chartered by the customer : safety issue

Although the fibre-reinforced plastic tank is authorized by the ADR regulations, the impact resistance of this material seems to be not sufficient enough to maintain the integrity of the tank (ageing process for the plastics?).

No more filling of plastic tanks of more than 15 years old.

Transport chartered by the customer : safety issue

Implementation of the BBS program for the driver.

reports

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rt - Transport

fatigue

plastic roadtank

ccident

fatigue

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Cefic Learning from Accidents Database