Incident Learning: What happened?

Date: 12 September 2019

MEDICAL TREATMENT CASE

BRIEF DESCRIPTION OF THE INCIDENT

A business partner (contractor) was tasked to spread a flange in the De-Asphalting (PDA) unit at South 3 in order to remove a block valve.

The employee was tasked to remove the block valve for replacement. After the flange was broken for removal of the valve, a few minutes later there was a release of residual product onto the employee which resulted in a cold Burn on the neck area (Similar to a dry ice burn).

What are the learnings for implementation?

1. Ensure that the system is depressurised and made safe before the workers can start working.

2. Ensure lines/equipment is checked prior to breaking flanges, by means of connecting a steam hose/N2 hose and purging system to ensure no pluggages.