

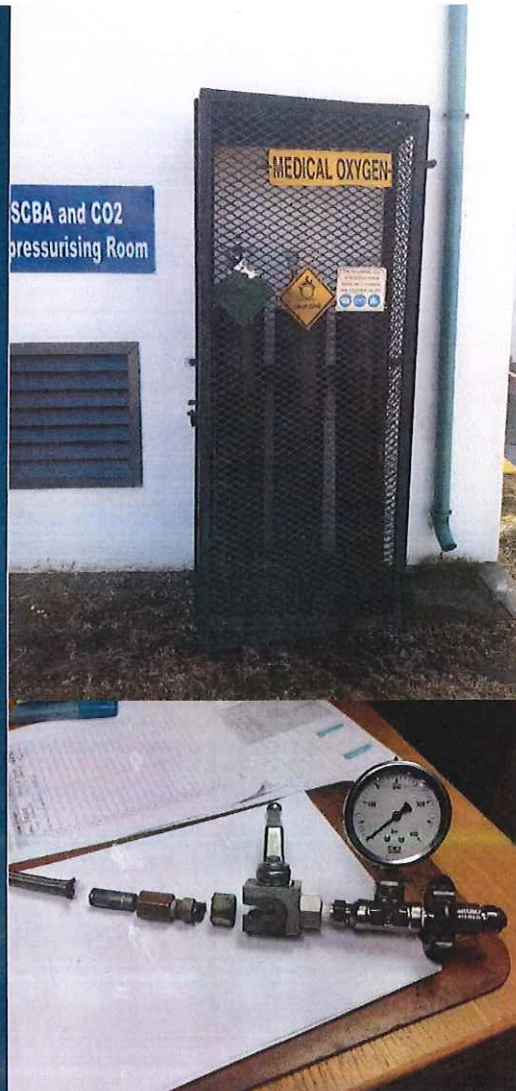
Natref SHE Learning

Learning number	FY21-3 (HSI)											
Operating Entity	Natref											
Date of incident	3 June 2021											
Incident type	Occupational Safety	Process Safety	Environment	Product Transportation	Health	Security	Equipment Damage	PSF				
	X											
Relevant Life Saving Rules												
Relevant Process Safety Fundamentals												
							X					
Key Undesirable Event	None											
Description of the incident	While an employee was testing the medical oxygen decanting system, a flash fire occurred, resulting in burns to his upper torso.											
Underlying and root causes	<ul style="list-style-type: none"> The change management process was not followed when re-instating the medical oxygen decanting service as well as the change related to the new gauge installation. The change was deemed to be kind for kind, and changes (adding a pressure gauge to the decanting assembly) were therefore not identified. The procurement process was inadequate, as it allowed for the appointment of a non-qualified supplier to provide the decanting hose assembly. 											
Key learning and control improvement recommendations	<ul style="list-style-type: none"> Enforce the utilisation of the MOC & risk assessment processes in non-operational areas. Perform a comprehensive review of the procurement processes and practices followed, adopt the appropriate Sasol procurement processes and follow the necessary MOC process. Assess the client-supplier relationship between VDS and EMS Review process of transportation of patients in case of an emergency. Assess the need for specialised psychological support for EMS personnel. Review the maintenance processes in EMS, considering outsourcing where possible for specialised tasks. Assess the current situation of lack of resources in the EMS department. In the handling of oxygen cylinders review and confirm the process, including the correct fire-retardant undergarments. Review the process of refilling of medical oxygen cylinders, including the supply chain process. 											

Identification of standard or good practice related to the incident

- General dedication of EMS employees
- Openness and transparency of EMS employees during investigation
- Honesty by injured person
- Assistance by injured person despite still recovering from injuries
- The fast response by all bystanders at the time of the incident resulted in a reduced impact

Add pictures



To prevent future incidents, it is recommended that this incident learning is appropriately shared and implemented by relevant persons in your Operating Model Entity, where applicable.

Together towards ZERO HARM and SUSTAINABILITY