

# What happened?

## Event:

An instrument impulse line of a flow transmitter was repaired and three weeks later the impulse line dislodge from a T-piece in the system releasing a mixture of hydrogen and diesel



# Learnings

## Key findings:

- The flow measurement system was replaced as part of the ESD replacement the previous shutdown.
- Repairs was done  $\pm$  3 weeks prior to the incident.
- No QCP was followed to confirm that the repairs was done properly.
- The impulse line was too short to ensure completeness of box-up

## Learnings:

- QCPs to be develop and used for repairs to impulse lines
- Training of artisans regarding impulse lines standard to be of a high quality
- No spot checks done on repair work by supervisor
- All work done by the artisan in the past six months to be rechecked