

COS SAFETY SHARE

WHAT WILL WE DO TO PREVENT THIS FROM HAPPENING HERE?

UNEXPECTED HYDROCARBON RELEASE DESPITE FOLLOWING PROCEDURES

What happened?

While removing the header equalization line during a scheduled turnaround (TAR), hydrocarbon fluid was released from between the compact valve and connection flange. The line had been isolated and double-blocked and bled prior to work commencing. Zero pressure was measured on the gauge. Two Workers removing the bolts on the flange were sprayed with a small amount of hydrocarbon fluid, and the nearby gas detector was activated. Both Workers reported to the Medic and Medical Control Physician for evaluation. First aid was provided, and both Workers returned to work without restrictions.

The OIM, Production Supervisor, and Production Lead surveyed the scene of the release to ascertain that all isolations were in place and adequate. The bleed line was disassembled and found to be unobstructed.

What went wrong?

There was no bleed point located low enough on the header system to ensure that all residual fluid had been bled off prior to breaking containment.

Why did it happen?

The Leads who were responsible for bleeding the system and verifying isolation did not consider the possibility that residual fluid could be contained above the flange due to the high location of the bleed point; therefore, the risk assessment overlooked this.

What areas were identified for improvement?

Reviewed all similar isolations for the TAR to look for any other possibilities of hydrocarbon release due to residual static pressure. As a result, updates were made to the risk assessment for replacing hydrocarbon piping to identify any trapped fluids and whether they can be removed through activation of lower valves to move trapped fluids to other areas not included in isolation.

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