COS SAFETY SHARE

WHAT WILL WE DO TO PREVENT THIS FROM HAPPENING HERE?

INCORRECT GASKET + MISSING HANDWHEEL + NO VERIFICATION = METHANOL LEAK DEBACLE

What happened?

Following facility restart after planned shutdown and maintenance on a compressor cylinder, a methanol gas leak occurred on the compressor valve covers due to the incorrect gasket installation. The compressor was shut down to investigate cause of release. Liquid was observed coming out of the compressor and identified to be methanol the following day.

What went wrong?

Isolation plan involved 29 isolation points including a 4-inch valve which was missing a handwheel and required a pipe wrench to close. The isolation assistant was unable to close the valve with a missing handwheel, and the change in isolation plan was not approved by the appropriate individual nor was a secondary verification of isolation completed prior to the isolation being identified as "in place".

Why did it happen?

Neither secondary nor independent verifications of isolation were completed.

MOC was not initiated for change in isolation plan when broken 4-inch valve could not be closed.

Incorrect gaskets installed on compressor, believed to be replacement in kind.

Energy isolation training did not impart the required competencies, prerequisites not defined, and post training competency was not documented.

What areas were identified for improvement?

Define requirements for work management roles and which roles cannot be combined/filled by a single individual.

Establish a process where supervisors are performing periodic audits of isolations and acting as the independent verifier.

Individuals in isolation roles need additional competencies - review work management roles to ensure correct competencies are defined, define prerequisites for attending energy isolation training, and develop role roadmaps in training system to track competency.

Maintain a bill of materials for non "run-to-failure" equipment.

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