Hitachi Zosen INOVA

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LESSON LEARNED

FAC – UNCONTROLLED SPILL OF RESIDUE ASH

Number	2023-03	Date	31.01.2023

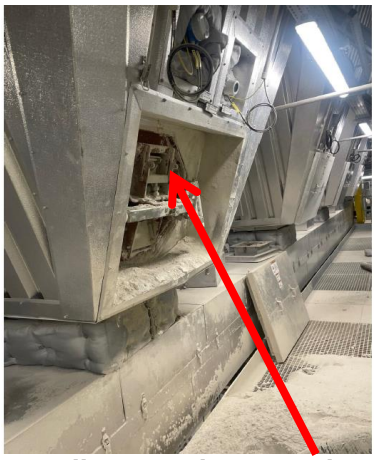
Summary:

A first Aid Case incident occurred at a UK EFW Plant during Commissioning. The Injured Person (IP) was working on site for an industrial cleaning contractor who were working on a Filter Bag Hopper Cell 7 with a HZI Commissioning Engineer and two fellow Operatives. The work scope was clean out a blockage in the hopper cell using an industrial vacuum unit. A permit to work was in place to clean the cell opening the small inspection opening and using a hose. Once the work was complete the Commissioning Engineer decide to open the large door to inspect the inside of it for residue. He assumed the cell was clear as he could not see any ash through the small inspection hatch. When he opened the door a bridge of ash which had formed above it dropped and came out of the door. Approximately 1.5 tons of ash was released onto the FGT structure and the FGT floor.

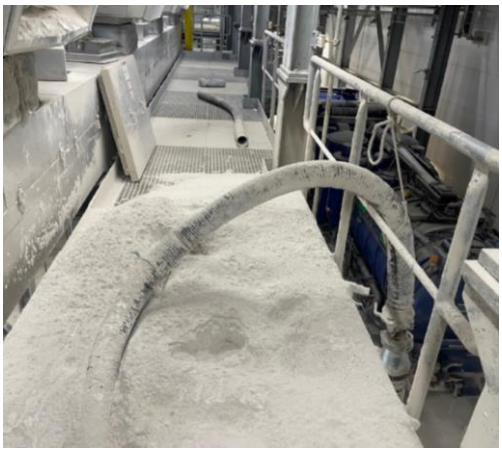
Outcomes:

The IP was wearing light eye protection but some ash went into his eye causing irritation. He visited the local walk in center where he received first aid treatment before returning to site.

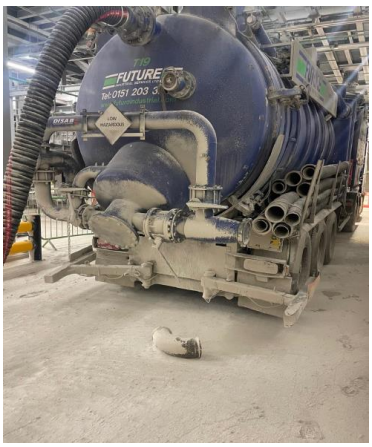
Incident Classification: Level 1 First Aid Case



Small Inspection Opening



Walkway Under Door



FGT Ground Floor Level

Root Causes and Contributory Factors	Action and Lesson Learned
• Error of judgement – the commissioning Engineer should not have opened the large door. • Failure to follow the correct procedure and obtain a further permit to work which would specify additional controls if the large door was to be opened. • The roller shutter door were opened after the spill causing the ash to become airborne. • It was windy at the time the roller shutter doors were opened.	• The Commissioning Engineer is to face disciplinary action. • Additional locks to be retro fitted to the large doors to stop unauthorised entry. • When investigating APCR blockages those involved are to wear either full-face visors and FFP3 or Air Fed Hoods as a minimum • FGT are at all levels is to be clear before door is open • These controls are to be communicated to the commissioning team and site management • Due to this not being an isolated incident HZI senior management to workshop the decision making process and engineering controls to prevent reoccurrence.

Every Lesson Learned is an opportunity to avoid recurrences.
What have you done to avoid a similar incident on your project?