



Number	2024-09	Date of Issue	26.03.2024
Date of Incident	08.03.2024	Incident Classification	Near Miss HiPo

Summary:

On a UK EFW Plant, the HZI Deputy Shift Team Leader was undertaking plant checks when they came across an open ash discharger door whilst the plant was in operation. The door was closed and the event was investigated using CCTV and the Plant operating system (DCS). The CCTV footage showed a release of dust lasting up to 10 seconds from the ash discharger door found in the open position. The DCS demonstrated a change in pressure around the same time. The released dust and gas that escaped could have been up to around 800°C. Luckily no one was in the area at the time but the release this could have resulted in serious injury. On inspection the other ash discharger door bolts were found to be loose.

Outcome:

Near Miss HiPo – Could have resulted in significant injury to one or more persons.

Right hand ash discharger door being pushed open and ash being released.



Contributory Factors and Root Cause	Lesson Learned
<p>Contributory factors</p> <ul style="list-style-type: none"> • Unforeseen overpressure event in the combustion cycle. • Previous carried out by the Client inside ash dischargers and the procedures did not include ensuring the doors were appropriately resecured. • Visual inspection of doors carried out prior to start up – not sufficient as left hand door was also found to be loose. Doors and locks to be physically checked for tightness. • Competency and hazard awareness– personnel carrying out the task were Site Attendance team who would be unaware of the impact of leaving the door unsecured. • Pre start up inspections were not carried out. General plant checks had been but were not sufficient – doors only visually inspected. <p>Root Cause</p> <ul style="list-style-type: none"> • MANAGEMENT SYSTEM - Procedure Not Used / Followed - No Procedure 	<ul style="list-style-type: none"> • Procedures should be reviewed to ensure plant is returned to achieve safety of the system. • Doors should be physically checked as well as visually inspected – Implement Checklist • Hazard awareness, all personnel put to work should be fully briefed and trained on how to identify additional hazards. The procedure documented was not followed and this was not highlighted by the party carrying out the activity. Personnel closing the door looked to protect the plant but didn't recognise the risk associate with closing a door that is open whilst in operation. • Plant Checks to be reviewed to ensure they are sufficient. Never assume another party has secured an area and check prior to start up. • No emergency procedure for finding doors unsecured whilst the plant is in operation. Emergency card to be implemented.



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

