

Lessons Learned Database

Individual Incident Summary Report



Incident AnalysisBasic cause of fatalities was deprivation of oxyge of co-ordination followed by loss of strength, and ultIncident AnalysisCretical factors and did not specify use of special breathing appar not mention nitrogen hazard, 3) Second worker worker without "fresh air" breathing equipment.Root causes atmosphere also present above reactor manway control of work (jobsite inspection and permitry), rescue procedure (stay safe distance away and call	ay. The reactor was being and vented to atmosphere advertently been dropped tion tray about 1.5 m (5 ft) tried recovering the duct but either fell in or climbed nurriedly inserted a ladder	
Country USA Location Delaware City, DE Fatalities Injuries 2 0 Incident Description Two contract workers were preparing to "box up" a reinstating the piping inlet elbow at the top manware purged with nitrogen (N2) from a temporary supply a through the open manway. A roll of duct tape had in into the reactor, landing on a vapour/liquid distribut below the manway opening. One of the workers tape from outside the reactor with a long wire hook into the reactor and passed out. A second worker from the reactor, but both were unresponsive and the manway, observed the 2 workers lying motionle and radioed for emergency assistance. The stricke from the reactor, but both were unresponsive and Basic cause of fatalities was deprivation of oxyge of co-ordination followed by loss of strength, and ult Critical factors included: 1) Work permit did not and did not specify use of special breathing appar not mention nitrogen hazard, 3) Second worker worker without "fresh air" breathing equipment. Root causes included: 1) Inadequate hazard awa atmosphere also present above reactor manway control of work (jobsite inspection and permitry), rescue procedure (stay safe distance away and call	Unknown a hydrocracker reactor by ay. The reactor was being and vented to atmosphere advertently been dropped tion tray about 1.5 m (5 ft) tried recovering the duct but either fell in or climbed nurriedly inserted a ladder	
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Image: constraint of the sector is the sec	ay. The reactor was being and vented to atmosphere advertently been dropped tion tray about 1.5 m (5 ft) tried recovering the duct but either fell in or climbed nurriedly inserted a ladder	
of co-ordination followed by loss of strength, and ultCritical factors included: 1) Work permit did not and did not specify use of special breathing appar not mention nitrogen hazard, 3) Second worker worker without "fresh air" breathing equipment.Root causes included: 1) Inadequate hazard awa atmosphere also present above reactor manway control of work (jobsite inspection and permitry), rescue procedure (stay safe distance away and call	reinstating the piping inlet elbow at the top manway. The reactor was being purged with nitrogen (N ₂) from a temporary supply and vented to atmosphere through the open manway. A roll of duct tape had inadvertently been dropped into the reactor, landing on a vapour/liquid distribution tray about 1.5 m (5 ft) below the manway opening. One of the workers tried recovering the duct tape from outside the reactor with a long wire hook but either fell in or climbed into the reactor and passed out. A second worker hurriedly inserted a ladder and climbed into the reactor to attempt a rescue. A third worker approached the manway, observed the 2 workers lying motionless on the distribution tray, and radioed for emergency assistance. The stricken workers were recovered from the reactor, but both were unresponsive and could not be revived.	
atmosphere also present above reactor manway control of work (jobsite inspection and permitry), rescue procedure (stay safe distance away and call	 Basic cause of fatalities was deprivation of oxygen initially resulting in loss of co-ordination followed by loss of strength, and ultimately respiratory failure. Critical factors included: 1) Work permit did not mention nitrogen hazard and did not specify use of special breathing apparatus, 2) Warning sign did not mention nitrogen hazard, 3) Second worker attempted rescue of first worker without "fresh air" breathing equipment. 	
 Inadequate company training programmes and i hazards of oxygen-deficient atmospheres in and a 	opening), 2) Inadequate 3) Failure to follow safe for qualified rescue crew), ndustry good practices on	
Lessons Learned1) Nitrogen (N2) is a colourless, odourless, tast ambient conditions and can displace oxygen (O2) i 2) Deprivation of oxygen can cause impaired per dizziness, nausea, loss of consciousness, coma, re depending on the extent of oxygen deficiency and 3) Permit signatories should visit the job site to disc 4) Warning signs should be posted on any process purged with nitrogen to alert personnel to the po threatening oxygen-deficient atmosphere. 5) All access and egress points around vessels be should be barricaded and an access control syste all personnel entering/leaving the barricaded area. 6) All personnel entering the barricaded area sho monitor with an audible and visible alarm set at 19 7) Never enter a confined space alone to attempt to resulted in death of would-be rescuers in 34 of 88 8) Only properly trained personnel with all appropri protection should attempt a rescue in oxygen-defici standard respiratory equipment is only suitable for upper 	n air. Proception and judgement, espiratory failure or death, duration of exposure. uss hazards and controls. equipment or piping being tential presence of a life- eing purged with nitrogen m should be set up to log puld wear a personal gas % O ₂ concentration. escue (misguided bravery cases studied – Ref. 1). fate safety equipment and ent atmospheres (refinery	
More Information1) "Case Study: Confined Space Entry - Worker Asphyxiated", US Chemical Safety and Hazard In Report No. 2006-02-I-DE. 2) "Hazards of Nitrogen and Catalyst Handling", B 6 th Edition, IChemE (2006), ISBN: 978-0-85295-54		
Industry Sector Process Type	vestigation Board (CSB), P Process Safety Series,	
Oil & Gas Hydrocracking	vestigation Board (CSB), P Process Safety Series,	
	vestigation Board (CSB), P Process Safety Series, .0-6.	
Not equipment-related Not applicable	vestigation Board (CSB), P Process Safety Series, .0-6. Incident Type	