Safety Share

Incident Title:
A SCAFFOLDER DIED AFTER FALLING INTO A PROCESS VESSEL AT A REFINERY

Date:
December 2015

What happened?
On the day of the incident, a five-man scaffolding team had established a ladder at the bottom entry of a digester that still contained scaffold. The scaffolder had gone up a series of stairways over three levels, with another team member, to the top level of the digester bank to enter through the top manway of the digester being worked on. However, he inadvertently entered a manway into an adjacent digester, from which the scaffold had already been removed, and fell about 12 metres.

Left: Manway into a digester with mechanical guard fitted. Right: Manway entry for the digester without scaffolding (tape placed by emergency response team).

High risk activities involved

- Confined space Entry

Contributing Factors (Organisational, Task, Team, Individual)

- A digester has two manways. The company procedure required a mechanical guard to be fitted on each manway when the doors were opened for maintenance to proceed but did not address how guards were to be removed and replaced during and after the work.
- On the day of the incident, not all guards were in place.
- The company procedure for scaffolding did not address how scaffolds were to be constructed in process vessels and how to access them. There was confusing terminology in the company procedures regarding confined spaces.
- There was a lack of appropriate signage, and digester entry points were not identified or differentiated with a number or name.

Key Learnings

- There was no device or guard on the open manway to prevent inadvertent access to the digester from which scaffolding had been removed.