

REMEDIATION MANAGEMENT HSSE Lessons Learned One-Pager



Type of Incident: Material Release
Business Unit: Northwest Region
Location of Incident: Whitney Canyon Gas Plant,
Evanston, WY
Date/Time: May 14, 2008 3:30 p.m.

Brief Account of Incident: On May 14, 2008 at approximately 3:30 p.m., a release of approximately 10 barrels of a 28 percent mixture of Ethylene Glycol (E.G.) and Anchor Brand Rig Soap (Soapy) Water occurred at the Whitney Canyon Gas Plant during De-Oil, De-energize, and Isolate (DDI) activities. An open valve during flushing the Ethylene Glycol System led to the release.

Actual Outcome: Upon discovery of the release and the critical path a portion of the material was heading, the team proceeded to get ahead of the material and built a small earthen dam with shovels. The work team then took absorbent pads and soaked up the solution until the snowmelt runoff water was clear again indicating all the ethylene glycol was either absorbed or dissolved. The team believed it had captured all recoverable material that left the site. The spill area was marked by paint to delineate the spill location for future remediation reference, if necessary. Wyoming Department of Environmental Quality was contacted to report the spill.

What Went Well:

- Release was caught before entering sensitive areas and was reported immediately
- The crew held an additional meeting to verify system was shut down and closed to the outside before flushing

What Went Wrong:

- System was not originally designed for DDI.
- Incorrect information provided – valve not closed.

Immediate Causes:

4.5 –Unintentional Human Error. Supervisor had routinely shut valves per the procedure the team had discussed. He believed he had shut the valve.
4.6 – Routine Activity Without Thought. Employee had routinely shut the valve after draining each dead leg.

System Cause:

22.1 – Lack of SPP For The Task. There was a procedure developed for the draining of the EG systems, but it did not include flushing of the EG system.

- Develop checklist and or flagging procedure for DDI activities to document position of valves.
- Communicate to NAG and other BUs designing facilities the need to design for end of project life (decommissioning).
- Go through comparison of NAG and RM activities to determine which policies/procedures are more stringent.
- Develop detailed task specific JSEAs and/or SOPs for DDI tasks.

Lessons Learned:

1. Design and SOPs for DDI needs to be accounted for during design phase of a new plant
2. Afterthoughts (Change), even if very good ones, need to be recognized and the same process (or MoC process) followed that the original task(s) followed
3. Monotonous tasks open the door for overlooking and/or complacency



If you have any questions, please contact Steve Ferry,
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Corrective actions: