COS SAFETY SHARE

WHAT WILL WE DO TO PREVENT THIS FROM HAPPENING HERE?

Poor Communication Leads to Total Facility Shutdown

What happened?

A total facility shut-in occurred because of an inadvertent activation of ESD (Emergency Shutdown Device) hand switch station located on the production module east crane pedestal.

An operations deck operator was stationed at the Lease Automatic Custody Transfer (LACT) unit on the production module testing Public Address and General Alarm (PAGA) push button stations with a designated control room operator. The operations team members were utilizing a compliant Job Safety Analysis (JSA) and three-way communication for the task.

What went wrong?

While in route to the East crane, a maintenance team member observed the operations team testing push button stations near the LACT unit on the production module. While ascending the east crane pedestal stairs, the maintenance team member identified PAGA and ESD push button stations located on an elevated deck area of the crane pedestal.

The maintenance team member then attempted to verbally communicate to the deck operator below by yelling from the elevated deck of the crane pedestal instead of using his radio.

The deck operator interpreted that the maintenance team member was asking if there were stations on the crane pedestal to be tested and responded “yes.” The maintenance team member interpreted that the operations team member was giving approval to test the push button station, so he pushed the ESD switch station and caused a facility shutdown.

Why did it happen?

The east crane pedestal and LACT unit are in proximity of each other on the production module. The maintenance team member was not clear which stations were being tested - PAGA or ESD stations.

What areas were identified for improvement?

Inadequate verbal communication- Individual failed to establish three-way communication with operations team members both on deck and in the control room.

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