

Incident Summary (# 5615530)

SUPPORTING INFORMATION	Incident Date		December 30,2016	
	Location		Surrey	
	Regulated industry sector		Refrigeration system	
	Impact	Injury	Qty injuries	1
			Injury description	Heavy head ache ; Burning nose
			Injury rating	Moderate
	Damage		Damage description	None
			Damage rating	None
Incident rating		Moderate		
Incident overview		Ammonia was purged by air to do a maintenance work on a refrigeration system. A worker moved the hose used for purging and became exposed to ammonia.		
INVESTIGATION CONCLUSIONS	Site, system and components		Ammonia is a refrigerant used in refrigeration system. It needs to be removed from system to do the maintenance work. Large amount of ammonia is isolated in the system. Only small amount of residual ammonia is purged under 5 PSI through a hose to water filled tote with lid. Hose is weighed and dipped into water to absorb purged vapour ammonia. All new employees received orientation which includes ammonia awareness training.	
	Failure scenario(s)		The ammonia was released to water filled tote located in open area. The area was not secured. The forklift driver working in open area asked what was happening. He was told by maintenance personnel that ammonia was being released and to stay away from the tote. The same forklift driver later went to the tote and removed the lid and pulled the hose out the tote. He was exposed to the ammonia vapour.	
	Facts and evidence		<p>First Aid Report</p> <ul style="list-style-type: none"> Date and Time of incident Worker involved Description of injury <p>Interview statement</p> <ul style="list-style-type: none"> The forklift driver employment start date: May13, 2016 The forklift driver received orientation from first aid attendant Ammonia hose was weighted down with metal shackle. Tote was covered by lid The forklift driver was told to stay away from the tote Witness saw the forklift driver lift the lid and pull the hose out. 	
	Causes and contributing factors		The lack of securing of open area which ammonia was released to and the lack of identification of ammonia release hazard was likely the cause of incident.	

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Photos or diagrams (if necessary)



Water filled tote(similar to the plastic tote used)



