SAFETY BULLETIN

No 02/001

Date 30 Jul. 02

METAL PARTICLE IN EYE

During cleaning operations on an air cooled condenser, an engineer had his overalls covered in dust through having to lie underneath the coils to clean them. When he stood up a nearby condenser started up and blew the dust into his face, a metal particle in the dust became lodged in his eye. This entailed a visit to hospital and time off work.

This accident was avoidable if the engineer had removed his overalls or at least brushed himself down before taking off his goggles.

Another safety point is that when carrying out this type of work a dust mask should be worn.

J&E Hall Limited

SAFETY BULLETIN

No 02/002

Date 31-Jul-02

REFRIGERANT BURNS

When detaching a connecting hose between a manifold and a Schrader valve on a chiller system, the service engineer found that the Schrader valve would not re-seat. Due to the pressure in the system he could not re-attach the hose and whilst he was attempting this he received refrigerant burns to his hand. The engineer was wearing gloves but the refrigerant had got between the glove and his hand.

This accident may well have not happened if a Schrader valve core tool had been used.

J&E Hall Limited

SAFETY BULLETIN

No 02/003

Date 6-Aug-02

AMMONIA REFRIGERANT BURNS

After pumping down an ammonia system a service engineer started to replace some filters, due to the construction of the filter housing it was very difficult to remove the bolts wearing gloves. Whilst removing one end cover there was a sudden rush of liquid ammonia and he received ammonia burns to his hands.

The cause of the incident was liquid ammonia being trapped in a short length of pipe and unable to escape because of the filter being blocked by pieces of rubber, possibly from an ‘o’ ring.

It is difficult to see how the leak could have been prevented as there was no way of knowing of the trapped ammonia in the pipe, however, it should be possible to remove nuts and bolts wearing gloves if the correct tools are used.

J&E Hall Limited

SAFETY BULLETIN

No 02/004

Date 07.08.02

DISLOCATED KNEE

Whilst working on site an engineer found his route to the work area obstructed by oil drums, when taking another route he caught his leg on a unistrut which caused him to fall and dislocate his knee. An avoidable accident, if the engineer had looked where he was going.

J&E Hall Limited

SAFETY BULLETIN

No 02/005

Date 07.08.02

BRUISED KNEE

An engineer was carrying a partially dismantled electric motor when the rotor started to slide out, in attempting stop it falling out the rotor spiked his arm, this resulted in him dropping the motor which hit leg causing bruising and swelling.

This accident could have been avoided if the engineer had either carried the motor in a receptacle or as separate items.

J&E Hall Limited

SAFETY BULLETIN

No 02/006

Date 07 Aug. 02

CUT TO FINGER

A Service engineer was cutting copper pipe using pipe cutters when the pipe slipped out of the cutters and cut his finger, the finger was stitched but became infected and the engineer had to have several days off work.

Although using the correct tools the engineer was not wearing gloves and the pipe was not secure in the cutter.

J&E Hall Limited

SAFETY BULLETIN

No 02/007

Date 07 Aug. 02

REFRIGERANT BURNS

An engineer received burns to his neck and face when residual refrigerant left in pipework caused liquid to spray onto his face and neck. The engineer was working on the high side of the system and the refrigerant had been vented to the low side, but insufficient checks had been carried out to ascertain whether any refrigerant remained ,this was the cause of the accident.

J&E Hall Limited

SAFETY BULLETIN

No 02/008

Date 07 Aug. 02

CUT TO FINGER

A Service engineer was assisting others to remove an oil separator when it moved unexpectedly and a sharp edge sliced his finger, the cut required 16 stitches. The engineer was not wearing gloves which, if he had been ,would have either reduced the severity or the accident would not have happened.

J&E Hall Limited

SAFETY BULLETIN

No 03/009

Date 10 Jan. 03

POTENTIAL EYE DAMAGE

A service engineer was tasked to clean evaporator tubes with a chemical cleaner. Whilst filling the applicator the top came off and splashed the cleaner into his eye. The engineer was not wearing eye protection.

The engineer immediately used an eye wash and attended hospital and was lucky not to have had permanent damage to his eye as the cleaner is quite corrosive.

This is not the first incident of personnel having potential eye damage through not wearing eye protection. The company provides PPE for your benefit so please use it.

J&E Hall Limited

SAFETY BULLETIN

No 04/010

Date 22-Apr-04

ENTERING AMMONIA FILLED PLANT ROOM

Two service engineers were called out to an Ammonia leak in a plant room, the leak was visible through a window in the plant room door. The Fire Brigade in attendance did not wish to enter the plant room to isolate the leak but allowed the engineers to go in using respirator masks and a lifeline. The leak was isolated successfully.

These actions are against company policy and normal Fire Brigade rules. The engineers could have been seriously gassed or burnt as they were not wearing protective clothing.

J&E Hall Limited

SAFETY BULLETIN

No 04/011

Date 19 Feb 03

REFRIGERANT BURNS

Following two incidents relating to refrigerant burns from liquid refrigerant trapped in pipework suddenly and unexpectedly escaping, a set of guidelines have been introduced to ensure good practice.

1. Where fitted, always open solenoid valves etc. manually with the jacking spindle, when pumping down sections of pipe.

2. Where fitted, Valve flanges should be carefully parted to check if sections of pipe are clear of refrigerant.

3. Where none of the above are fitted, all pipework valves are to be opened when decanting, to a point where the system can be opened to atmosphere to check if a section of pipe is clear of refrigerant. This may, in certain circumstances, require the decanting of the refrigerant charge from evaporators etc. or in the worst case decanting the whole system.

4. Engineers should wear the correct PPE when carrying out these operations in particular goggles should be worn.

SAFETY BULLETIN

No 04/012

Date 25 Feb. 04

SHOULDER STRAIN

A service engineer damaged his shoulder after falling whilst climbing through a window . He used the window to access the building after working on the roof.

This is yet another accident from engineers using inappropriate access , when carrying out a risk assessment to do the work engineers must check their access points and make appropriate arrangements.

SAFETY BULLETIN

No 04/013

Date 05 MAR 04

TRAPPING INCIDENT IN COLD STORE

A service engineer was trapped between a fire door and its frame by a Forklift truck driver pushing pallets up to the door.

The engineer suffered bruising to the upper part of his body.

At the time there was not a safe system of work in place either for the FLT drivers or the service engineer as the engineer had to use the fire door to access the store.

When working in this type of environment engineers should ensure that they have a safe route to access all parts of the store.

SAFETY BULLETIN

No 05/014

Date 05 Jul. 05

MATING THREADS ON R23 CYLINDER OUTLET VALVES

A service technician noted that there was an anomaly in the mating threads between the standard connectors and a R 23 cylinder outlet valve size ½" BSP BS 341 No 8 , therefore a standard cylinder connector , manifold gauge or gauge lines should not be used. Also the normal recovery units are not suitable for this refrigerant, a special seamless type of cylinder must be used for recovery.

If any other engineers have noted this can they get in touch with P Carter.

SAFETY BULLETIN

No 06/015

Date 16 May. 06

REFRIGERANT BURNS.

Due to a brazed connection failing during repair work on a refrigeration system an engineer had liquid refrigerant sprayed over his chest . The high pressure forced the press studs of his overalls apart and he suffered burns to his chest.

J&E Hall Limited

SAFETY BULLETIN

No 08/016
Date FEB. 08

ICE BUILD UP ON COOLERS

We have had two recent events where severely iced up coolers have been put on defrost and large lumps of ice have fallen several feet to the ground.
No one has been injured but it is very important to take all the necessary precautions to prevent any injury to your selves or to other individuals that could walk beneath the defrosting coolers.
Please inform the responsible site contact and cordon off the area beneath any cooler whilst such defrosts are taking place.

Regards

Stas Glogowski

J&E Hall International

SAFETY BULLETIN	No 08/017
	Date JULY. 08

GAUGE ADAPTOR

Following a recent e-mail identifying a potential safety Issue from the British Refrigeration Association (BRA). It has been suggested in a Summit skills meeting that an adaptor is available that allows low pressure gauges to be fitted to high pressure (eg: 410A) circuits. There is then the possibility of the gauge faces blowing with attendant safety implications.

Is anyone aware of this issue?

The BRA is asking for further information throughout our industry, as this is the only information currently available and in addition they wish to reduce the hazard by preparing a fact finder.

Please could you forward to me any information you have about this. You all can appreciate the potential consequences of using such a device, therefore please ensure at the earliest opportunity all engineers are aware of this.

Your prompt reply is appreciated.

Regards

Andrew Bowden

HSQE Manager

J&E Hall International

SAFETY BULLETIN	No 08/018
	Date NOV. 08

WORKING AT HEIGHT

Incident

There was a recent incident involving a contractor who was lifting plant / equipment through the trapdoor in the floor of a mezzanine plant room, the work was carried without cordoning off the area below the trapdoor.

Sainsbury's have now decided that all contractors undertaking this task in future must always request a 'Working at Height Permit' from the Store Manager before undertaking this task. This is to ensure that the area beneath the trapdoor is always properly cordoned off, and that Sainsbury's management and colleagues working in the area are always aware that the lifting activity is going on.

Contractors are also reminded that Sainsbury's Contractor Handbook contains the following instruction "ALL overhead works MUST have a fixed cordon placed under the ENTIRE working area at all times from the start of the works until final completion".

Actions

All Contractors are to instruct their personnel that a "Working at Height Permit" is obtained from the Store Manager before carrying out ANY works through the trapdoor of a mezzanine plantroom.

All Contractors are to remind their personnel that when they sign in to Sainsbury's Contractors Log book they are agreeing to all Sainsbury's safety procedures.

All Managers must ensure that this procedure is adopted at any Sainsbury's Site's and in addition please familiarise yourself with any other specific site safety procedures at all sites within your responsibility.

Regards

Andrew Bowden

HSQE Manager

J&E Hall International

SAFETY BULLETIN	No 09/019
	Date FEB. 09

AMMONIA LEAK

Incident

There was a recent incident involving J&E Hall Service Engineers with an accidental emission of AMMONIA Refrigerant whilst working on a Halls Screw compressor package.

The compressor was isolated at the suction & delivery valves and also the liquid injection was isolated via a ball valve prior to commencing work.

In accordance with company procedures two engineers were working on the compressor, one at the gland seal assembly and one at the rear of the compressor. To work on the gland seal assembly the engineer had to lean over the liquid injection pipe work. At one point, one engineer received an overpowering smell of ammonia directly from the rear of the machine. The engineers quickly vacated the plant room. The plant room was ventilated and the leak was detected. Upon review it was found that whilst working on the gland seal assembly the engineer had inadvertently knocked the liquid injection ball valve which allowed the passage of ammonia into the compressor where the other engineer was working.

Actions

The engineers removed the handle from the ball valve, preventing a re-occurrence.

Upon review, it is recommended that engineers remove the handle from the Ball valve when used for isolation purposes. This approved method should be identified in the permit to work system within the methods of isolation.

This also re-affirms the importance of our company safe working instructions, where two engineers must be present whilst breaking into an ammonia system.

All Managers and safety representatives, must ensure that this Safety Bulletin is communicated throughout.

Regards

Andrew Bowden

HSQE Manager

J&E Hall International

SAFETY BULLETIN	No 09/020
	Date AUG 09

WORKING WITH SOLENOID VALVES

To all Offshore Engineers,

Incident

We have in the last couple of days had a reportable incident on Gryphon platform offshore operator Maersk Oil North Sea UK Ltd, which lead to a General Alarm and platform shut down. The incident in question relates to a solenoid coil being removed from the solenoid valve and a magnet fitted to lift the coil during a refrigerant charging operation.

The service procedure was carried out and the plant charged but the coil was not replaced, the consequence being the following day when there was an increase in duty on the plant and the coil energised the coil over heated and actually caught fire.

Actions

The incident has been thoroughly investigated and the only conclusion as to stop a repeat of this incident occurring offshore again is to make any removal of an electrical solenoid coil on an offshore installation, is to make the work scope a work permit process to ensure when the permit is closed, the plant has been reinstated to is original configuration.

If any clarification or further information is required, please contact Mr Ted Quarry, Offshore Business Development Manager.

All Managers and safety representatives, must ensure that this Safety Bulletin is communicated throughout.

Regards

Andrew Bowden

HSQE Manager

J&E Hall International

SAFETY BULLETIN

No 09/021

Date SEPT 09

INCIDENT WITH VACUUM GAUGE

Incident

A vacuum gauge was fitted to a plant that had been on vacuum for 6-7 hours. It was connected to the liquid injection purge down point. It was found that nitrogen had been trapped between a liquid solenoid and a non-return valve which was out of sight on the other side of the plant. The subsequent pressure increase pressurised the gauge causing the glass front to explode into the face of the engineer.

The engineer suffered superficial cuts by glass to the face & small lacerations to both eyes.

Actions

1. All Engineers must familiarise themselves with the Plant prior to pressure testing and identify all solenoid valves. Where applicable all valves must be opened, electrically operated valves must be opened using a permanent magnet coil.
2. Before fitting the gauge to the plant, the applicable valve must be opened to check / release any stored pressure.
3. Engineers must ensure they wear the appropriate Personal Protective Equipment.
4. All engineers must familiarise themselves with specific Safe Working Instructions Eg R100 prior to Pressure testing.
5. All Engineers must familiarise themselves with the Plant Instruction Manual. Section D - 6.5 page 11 of 20 *(Preparing the plant for pressure testing)* specifically addresses this issue.

   The information detailed above is available on Engineers Resource section on the company website.

If any clarification or further information is required, please do not hesitate to contact me.

All managers and safety representatives must ensure that this Safety Bulletin is communicated throughout.

Regards

Andrew Bowden

HSQE Manager

J&E Hall International

SAFETY BULLETIN	No 10/022
	Date Feb 10

ADR REGULATIONS 1ST JANUARY 2010
(THE CARRIAGE OF DANGEROUS GOODS AND USE OF TRANSPORTABLE PRESSURE RECEPTACLES REGULATIONS 2009)

Incident

Under the ADR regulations, from 1st January 2010
It has become apparent that control measures have been placed which restrict the transportation of dangerous goods through tunnels. Refrigerant & flammable gasses are applicable.
The following tunnels Have been classified; A, B, C, D, & E.

Tunnel	Category
Dartford	C
Mersey	D
Clyde	D
Ramsgate	A
Lime house	E
Rotherhithe	E
Black wall	E
East India Dock Road	E
Tyne	D
Medway	

The following guidance must be adhered to when carrying pressure receptacles;

A. No restrictions
B, C, D. Restrictions apply
E. Do not enter tunnel (Find an alternative route.)

Actions

At point of entry to (B,C,D.) tunnel a brief description of what gas is being carried must be communicated at the toll booth, explaining that we are aware of the restrictions & that the gas being carried is under their requirements.

J&E Hall International

Below is a guide to some, but not inclusive of the types & maximum quantity of gas allowed through the listed tunnels; A. B. C & D

Product	**UN Number**	**Quantity Allowable**
R409A	UN3163	**up to 20 cylinders per vehicle**
R134A	UN3159	**up to 20 cylinders per vehicle**
R404	UN3337	**up to 20 cylinders per vehicle**
R407C	UN3340	**up to 20 cylinders per vehicle**
R410A	UN3163	**up to 20 cylinders per vehicle**
R22A	UN1018	**up to 20 cylinders per vehicle**
Nitrogen	UN1066	**up to 20 cylinders per vehicle**
Oxygen	UN1072	**up to 50kg per vehicle**
Acetylene	UN1001	**up to 50kg per vehicle**

Any Refrigerant or Flammable gas not specified above, please use the 20 Cylinder limit for Refrigerant and 50kg for flammable or compressed gas as maximum permitted limits.

I would like to take this opportunity to remind all Engineers of the legal requirement to display the following signage on their vehicles when carrying pressurised receptacles

Flammable gas

warning no ventilation

Compressed gas

These signs must then be removed when no gas is being carried.

Please note vehicles which are not fitted with a ventilation system additional care is to be taken & the above warning “no ventilation sign” must be displayed on the loading door of the vehicle.

If any of the above signs are required, Engineers are to contact their Service Centre Manager. Service Centre Managers can obtain the signs from the HSQE Function

If any clarification or further information is required, please do not hesitate to contact me.

All managers and safety representatives must ensure that this Safety Bulletin is communicated throughout.

Regards

Kevin Gratton
HSQE Officer

SAFETY BULLETIN	No 10/023
	Date Feb 10

Waste Battery & Accumulator Regulation 2009

These Regulations set out requirements for waste battery collection, treatment, recycling and disposal for all battery types including arrangements by which the UK intends to meet waste portable battery separate collection targets of 25% by 2012 and 45% by 2016.

As part of the Environmental Management System BS EN ISO 14001: 2004 J&E Hall International, have introduced a new waste stream for recycling battery's
This shows our continual commitment to comply with requirements & improve the effectiveness of the environmental management system.

Batteries to recycle include

4.5-volt, D, C, AA, AAA, 9-volt, SR41/AG3, SR44/AG13
Mobile phone
Lap top
Drills ect
This list is not fully inclusive.

Any batteries leaking or suspected to leak there content, other arrangement must be made for safe disposal.

Actions

The battery collection point is positioned at location 7 (waste stream site plan Derby) all waste batteries must be taken to the collection point.

Other business locations

The senior manager is to ensure that a suitable storage device is available for the disposal of batteries
The senior manager must consult the HSQE Function to arrange disposal

Regards

Kevin Gratton
HSQE Officer