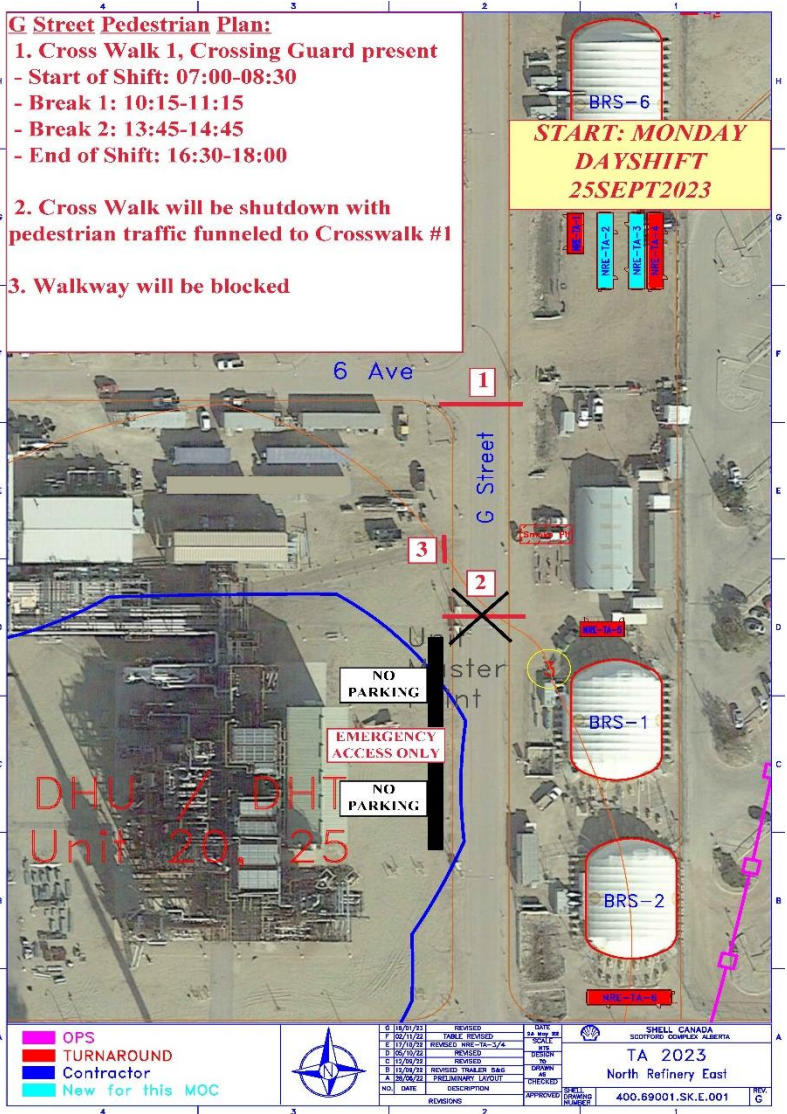




| | | | | | |
|------------------------|-----|--------------------------------|----|---|------------|
| OVERALL EVENT PROGRESS | 14% | Goal Zero Shifts (EOD Sept 23) | 17 | Money Raised for Charity You Can Ride 2 | \$8,500.00 |
|------------------------|-----|--------------------------------|----|---|------------|

| TURNAROUND STATS | LAST 24 | OVERALL |
|----------------------------|---------|---------|
| No Treatment Case | 0 | 1 |
| Occupational Illness | 0 | 0 |
| First Aid | 0 | 0 |
| Medical Aid | 0 | 0 |
| Recordable | 0 | 0 |
| Life-Saving Rule Violation | 0 | 0 |
| Near Miss | 0 | 0 |
| Motor Vehicle Incident | 0 | 0 |
| Dropped Object | 0 | 0 |
| Hi Potential Incident | 0 | 0 |
| SIF | 0 | 0 |
| Env (Other/Spill) | 0 | 1 |
| LOPC (<100kg) | 0 | 0 |
| LOPC (>100kg) | 0 | 0 |
| Environmental Non-Comp. | 0 | 0 |



Please note: the pedestrian plan for G Street will change Dayshift, Monday 25 Sept 2023.

This change is being made to reduce the number of pedestrian crossings on G Street. In turn this will reduce the potential exposures between pedestrians and vehicles. The crosswalk at 6th Ave and G Street will have a Crossing Guard on Dayshift for peak crossing times.





SCOTFORD GOAL ZERO WEEKLY AND TURNAROUND TIMES MONDAY, SEPTEMBER 25, 2023



For the duration of the Turnaround, we will be publishing a combined Goal Zero Weekly/Turnaround Times. Your One-Stop-Shop for all things Safety and TA at site!

NO HARM (Site)

FAC 20-Sept-23 Worker received foreign body in eye.

STEP UPDATE - TOP AT-RISK BEHAVIOURS:

WALKING/WORKING SURFACES

- Multiple observations of cords, hoses, and other material in walkways creating trip hazards.
 - Do you see any trip hazards in your area? Do you check often to be sure nothing has changed?

LINE OF FIRE

- Pedestrian traffic has been a big story this past week. (see page 1 for changes to crosswalks) Many interactions concerning folks crossing without activating crosswalk lights, crossing in the wrong spot, or stopping to discuss work in congested areas.
 - Use the crosswalks, push the buttons, slow down and don't put yourself at risk!

HOUSEKEEPING/STORAGE/TOOL USE AND STORAGE AT HEIGHTS

- Multiple interactions due to the condition of work zones. Materials not stored in correct containers or locations. Missing stop the drop precautions.
 - How can you ensure that you have a clean, organized work area? What steps will you take tomorrow?

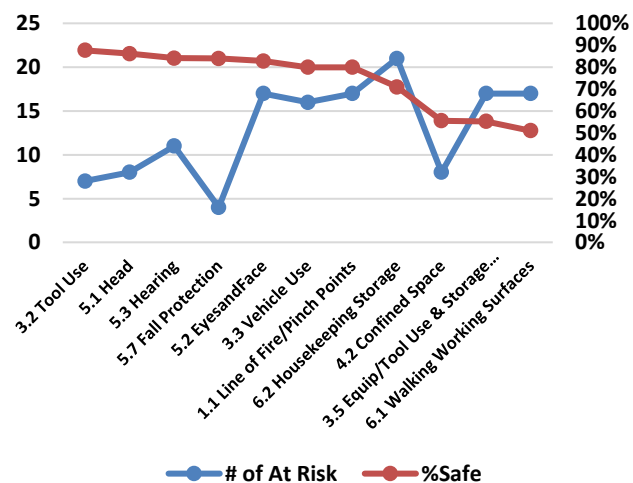
VEHICLE USE

- Parked truck jutting into traffic. Non-TA vehicles causing excess congestion and risk in TA areas. No spotter in congested areas. Just a few of the observations around vehicles.
 - Are you familiar with the area where you are driving? Do you need to be in a heavy traffic area? Do you take risks because you've normalized the act of driving?

EYE/FACE PPE

- Safety glasses, face shields...do you know when to wear them and the type you should be wearing. An easy thing to forget that can have a huge impact!

Observed At-Risk Behaviours - Sept 17 - 23



Please look at the STEP/BBS information and then use the conversation starters in orange to have a team conversation or for personal reflection.

Information that is not used is not of use. Information that leads to change is invaluable!

Scotford Learning from Incidents - Go & Engage

HSSE INVESTIGATE AND LEARN

PP-416 Pumps Running with MOV-4507 closed (Sphera ID: 1096554)

TARGET AUDIENCE

- Personnel supporting plant operations, Production and Distribution.

WHAT HAPPENED & WHY

- Between May 3rd and May 4th, from 21:20 hrs to 08:20 hrs, Styrene loading pump PP-416A operated in a reduced flow condition (~135-150 LPM). Shortly after, between 08:20 hrs and 09:15 hrs, the loading pump operated in a virtually no flow condition. Smoke was witnessed from pump PP-416A system and Production staff responded including activating Emergency Services to support.
- On May 4th, after 08:20 hrs and before 09:15 hrs, it was believed that the PP-416A pump was switched off in order to troubleshoot the reduced flow. This caused the Motor Operated Valve (MOV-4507) to close and a failure of the valve caused it to remain closed when the PP-416A was restarted.
- It was believed that MOV-4507 failed to fully travel open when the pump PP-416A was restarted and PP-416A remained running because MOV-4507 actuator was faulty and the limit switch was not operating as expected.

ENGAGEMENT QUESTIONS

- How do you recognize the need to initiate an impairment?
- How do you ensure the running status of the equipment in your unit?
- How do you manage information flow across multiple interfaces related to operating conditions?

INSIGHTS

- To facilitate Styrene loading, PP-416A was allowed to run with a reduced flow condition but within operating limits. There are several potential causes for the reduced flow condition including line fouling, offline pump check valve bypass or MOV-4507 was partially opened.
- The Distribution Team member believed MOV-4507 functioned as expected and closed when PP-416A was shutdown.

Scotford

Date Issued : August 2023



KEY TAKEAWAYS

- Recognition of functional impairment of safety interlocks is critical to understand any required mitigating actions (Process Safety Fundamental #3).
- Walk the line (Process Safety Fundamental # 5).
- Strong communication between teams is imperative while collaborating to maintain barriers while working to achieve the task at hand.

Scotford Learning from Incidents - Go & Engage

HSSE INVESTIGATE AND LEARN

WHAT HAPPENED

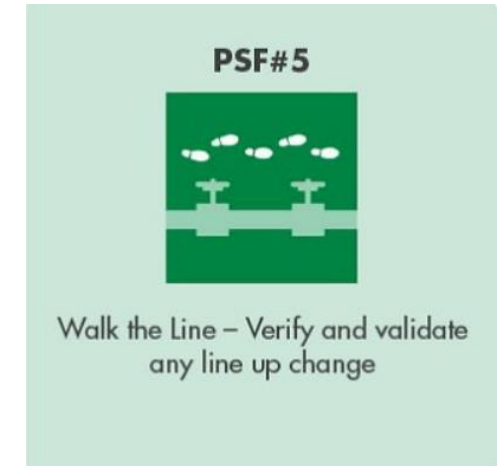


MOV-4507 was believed to be operated in remote mode and open torque limit switch allowed the valve, MOV-4507 to open or partially open. System was believed to be functional, but due to MOV-4507 component failures may have been functionally impaired.



Visual markings were added on the transparent stem to record and observed full opening of the MOV-4507. It was believed to operated at 100% when loading was completed.

WHAT GOOD LOOKS LIKE



ENGAGEMENT INSIGHTS

1. Reflect on the engagement questions and how they apply within your roles.
2. Teams to discuss insights they have after learning from this incident.

FOLLOW UP FROM REFLECTIVE ENGAGEMENT

1. Teams to determine if there are similar risks with their work and take necessary action to mitigate those risks.