SAFETY BULLETIN

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HANGAR 75 POST INCIDENT AND LESSON LEARNED

ALERT MESSAGE !!!

INTRODUCTION

On Saturday, February 3, 2024, at approximately 12 noon, a fire incident occurred at Hangar 75 while third-party repair activities were underway on the rooftops of that particular hangar. The unfortunate event took place during the use of a welding torch as part of the dismantling process for the structure's roof area on the hangar's roof. The Airport Fire and Rescue Service (AFRS) exhibited prompt and efficient responsiveness, swiftly extinguishing the fire and effectively preventing its escalation to a broader area. This proactive approach successfully mitigated the potential for more extensive damage, and control was fully established by 12:40 pm.

DAMAGE CAUSED

Fortunately, there were no injuries reported among the personnel, and the aircraft situated in the vicinity of the fire remained undamaged. The impact was confined to the specific rooftop of Hangar 75 where the welding repair activities were being carried out, resulting in limited damage to that particular area. The electrical conduit sustained damage, impacting the wiring on the roofs due to a fire incident. Consequently, in order to prevent electrical short circuits and mitigate potential further damage to the overall electrical system, it became necessary to shut down the electrical power supply at Hangar 75. In addition to the aforementioned, it was discovered that some of the items, including chairs, office computers, and carpets within the affected area were damaged. There is a suspicion that certain electrically powered equipment and other facilities within the hangar may have incurred slight damage as a result of the water discharged by the Aircraft Rescue and Firefighting Service (AFRS).

OUTCOME FROM THE INCIDENT

Following the fire incident at Hangar 75, several outcomes have ensued. ADE staff members were required to cease their work temporarily, necessitating a pause in their ongoing maintenance activities. Additionally, there was a need for the relocation of the affected line due to the repercussions of the incident. In addition, the ceiling within the technical representative room experienced a collapse, resulting in damage to various items within the office space. Moreover, a potential risk of roof leakage looms over the impacted area of Hangar 75, which could result in adverse consequences such as water damage to equipment, structural integrity issues, and the need for extensive repairs. The hangar floor of Hangar 75 was left in disarray following the fire incident, scattered with burnt residue from the ceilings.

WHY IT HAPPENS (TRIGGERING FACTORS)

- This category of fire incident may arise when a hot permit task is undertaken without the necessary risk assessment. It is imperative to conduct a preliminary risk assessment before initiating any hot permit activity to identify and evaluate potential hazards. This proactive approach enables the identification of risks associated with the task, allowing for the implementation of appropriate safety measures and precautions. Failure to perform a comprehensive risk assessment increases the likelihood of fire incidents, underscoring the importance of prioritizing safety.

- Furthermore, the contractors lack awareness of updated procedures. It is crucial to ensure that contractors are well-informed about the latest protocols and guidelines relevant to their tasks. Failure to provide updated information can lead to inefficiencies, misunderstandings, and potential safety hazards.in hot permit tasks to prevent potential harm and ensure a secure working environment.

- The absence of a safety induction raises concerns about the level of preparedness and awareness among personnel regarding safety protocols and emergency procedures. A comprehensive safety induction is essential for familiarizing individuals with potential hazards, safety measures, and evacuation protocols specific to the work environment.

- There has been a failure to issue a Permit to Work (PTW) for third-party activities before their commencement. This oversight raises concerns about the lack of formal authorization and safety checks for external entities engaging in tasks within AIROD premises. This absence increases the risk associated with the work being performed.

- Moreover, there is a notable failure in ensuring that the personnel initiating the hot work task possess the requisite competence for the specific job at hand. It is imperative to confirm the competency of individuals before the commencement of any tasks to mitigate the risk of mishaps and ensure the overall safety of the operation. This oversight highlights the importance of thorough assessments and qualifications checks for personnel involved in hot work, emphasizing the need for a stringent process to validate their ability to handle the task proficiently.

ROOT CAUSE

The absence of a comprehensive impact aspect study for the task involving the use of a weld torch to cut the structure has resulted in a critical oversight. This oversight has led to the exposure of plastic laminate concealed beneath the metal roof, causing it to absorb and melt due to the intense heat generated during the welding process, ultimately igniting a fire. The rapid spread of the fire was escalated by the combination of the laminated plastic and the presence of electrical conduit, creating a highly flammable environment that facilitated the swift escalation of the flames within a remarkably short time frame.

LESSON LEARNED

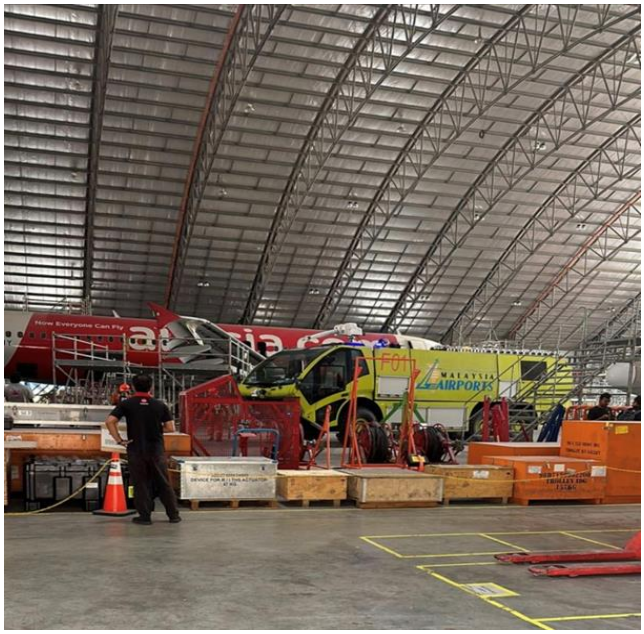
The Hangar 75 fire incident provides significant lessons, reinforcing the importance of adhering to mandatory procedures and maintaining the fire system in optimal condition. One key lesson is the critical need for rigorous adherence to safety protocols, particularly when undertaking tasks such as hot work. The incident highlights the potential consequences of not conducting or neglecting comprehensive risk assessments before initiating activities. To address this, it is imperative to establish a robust system that mandates thorough risk assessments for all tasks, with a specific focus on potential fire hazards.

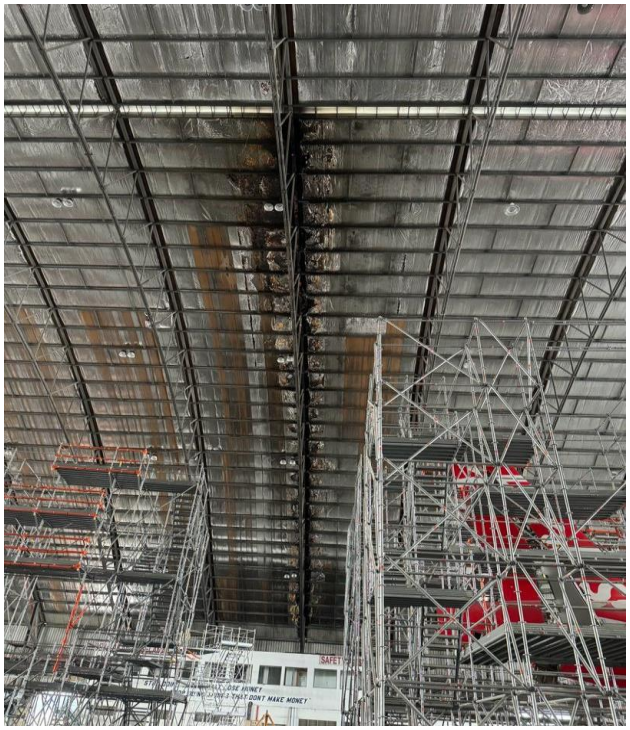
Another crucial takeaway involves the importance of ensuring that personnel involved in hot work tasks are competent and adequately trained. Implementing a stringent verification process to confirm the competence of individuals before task initiation is vital. This ensures that only qualified personnel handle specific tasks, reducing the risk of accidents and enhancing overall safety.

In addition, the incident underscores the necessity of keeping all contractors and personnel updated on the latest safety procedures. Regular training sessions and effective communication channels are essential to disseminate information about new protocols and guidelines. This proactive approach contributes to a well-informed workforce, fostering a safety-conscious culture within the organization.

Maintaining the fire system in optimal condition emerges as a key point in the aftermath of the incident. Regular inspections, testing, and preventive maintenance are imperative to ensure that the fire suppression and detection systems are operational when needed. Establishing a comprehensive maintenance schedule and promptly addressing any identified issues is crucial in preventing or mitigating fire incidents.

The Last but not least, the incident highlights the importance of issuing Permits to Work (PTW) for third-party activities. Formal authorization and safety checks for external entities operating within the operational space are essential. Implementing a systematic PTW process ensures that third-party tasks align with safety standards and regulations, reducing the risk of accidents and enhancing overall safety.





This incident highlights the imperative of fostering a pervasive safety culture within the organization. Integrating these lessons into operational practices is vital for enhancing workplace safety and preventing similar incidents, emphasizing the priority of personnel well-being and asset protection.

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