



HENGYI (BRUNEI) SAFETY MONTH POSTER

REFLECTION ON INCIDENTS

FOR INTERNAL USE ONLY

MAY 2026 EDITION I

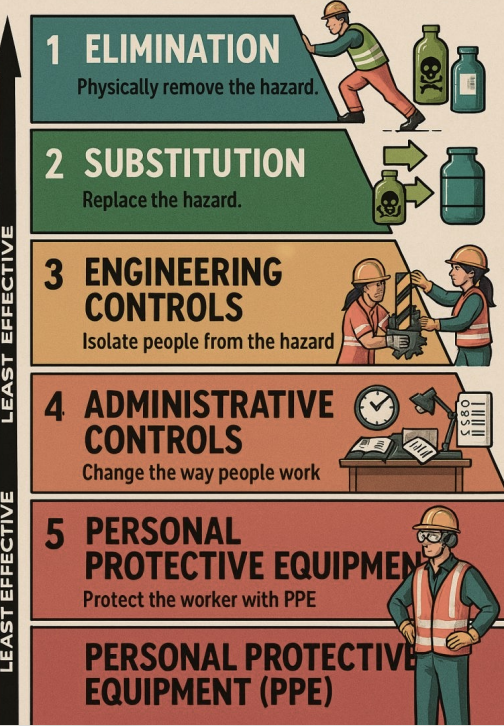


Safety is not just a requirement – it is a responsibility that protects lives. Every Standard Operating Procedure (SOP) exists for a reason: it is built on lessons learned from past incidents and real experiences. These procedures are not merely guidelines, but safeguards designed to prevent harm and ensure that everyone returns home safely.

“EVERY INCIDENT IS PREVENTABLE”

However, incidents continue to occur – not because safety systems do not exist, but because they are sometimes

HIERARCHY OF CONTROL



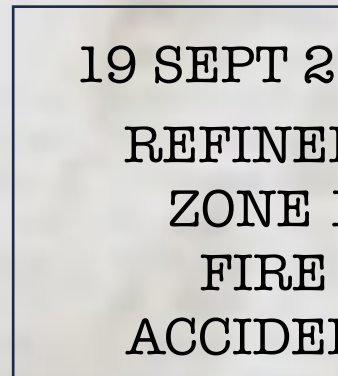
overlooked, underestimated, or bypassed in daily work. In many cases, it is not complex failures that lead to accidents, but small decisions made in routine situations: a missed step, a shortcut taken, or a moment of reduced attention.

This Safety Month, we reflect on real incidents from 2024 to 2026 to remind ourselves that safety is never optional. The consequences of unsafe actions are real, and their impact can be immediate, long-lasting, and sometimes irreversible – affecting not only individuals, but also families, teams, and the organization as a whole.

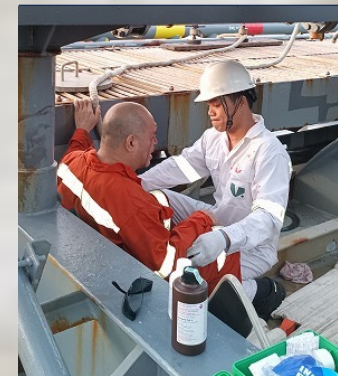
Each case is a reminder that risks are always present, and that safety depends on the choices we make every day – especially when no one is watching.



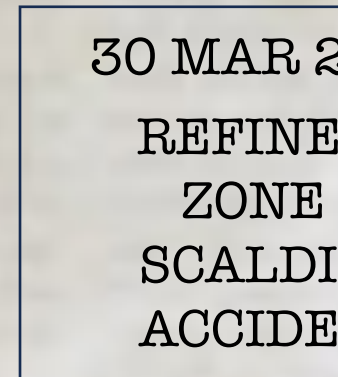
30 MAY 2024
REFINERY
ZONE 2
FIRE ACCIDENT



19 SEPT 2024
REFINERY
ZONE 1
FIRE
ACCIDENT



06 JAN 2025
PORT & STORAGE
PERSONNEL
INJURY ACCIDENT



30 MAR 2026
REFINERY
ZONE 4
SCALDING
ACCIDENT





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DIRECT REASONS

Rapid and significant temperature fluctuation at the reactor outlet caused flange seal failure, leading to leakage and fire.

INDIRECT REASONS

The incident was primarily driven by human and procedural factors. During DCS operation, the operator made an incorrect adjustment, which led to abnormal temperature conditions in the reactor. In the subsequent handling process, proper operating procedures were not followed, particularly in managing abnormal temperature excursions. In addition, a critical safety interlock was bypassed without proper authorization, preventing the protection system from functioning as intended. These actions reflect gaps in adherence to process discipline, operational control, and safety management practices.

“THE INCIDENT WAS NOT CAUSED BY EQUIPMENT FAILURE ALONE – IT WAS DRIVEN BY UNSAFE DECISIONS AND PROCEDURAL VIOLATIONS”

REFINERY ZONE 2 “530” FIRE ACCIDENT



IMPACT ON COMPANY

The incident resulted in a fire that led to an immediate shutdown of the affected unit, causing disruption to normal production operations. Significant damage was sustained to equipment, pipelines, and instrumentation, requiring extensive repair and replacement efforts.

LESSONS LEARNT

This incident highlights the importance of strictly following operating procedures at all times, especially during abnormal conditions. Operators must maintain full situational awareness and avoid shortcuts or unauthorized actions such as bypassing safety interlocks.





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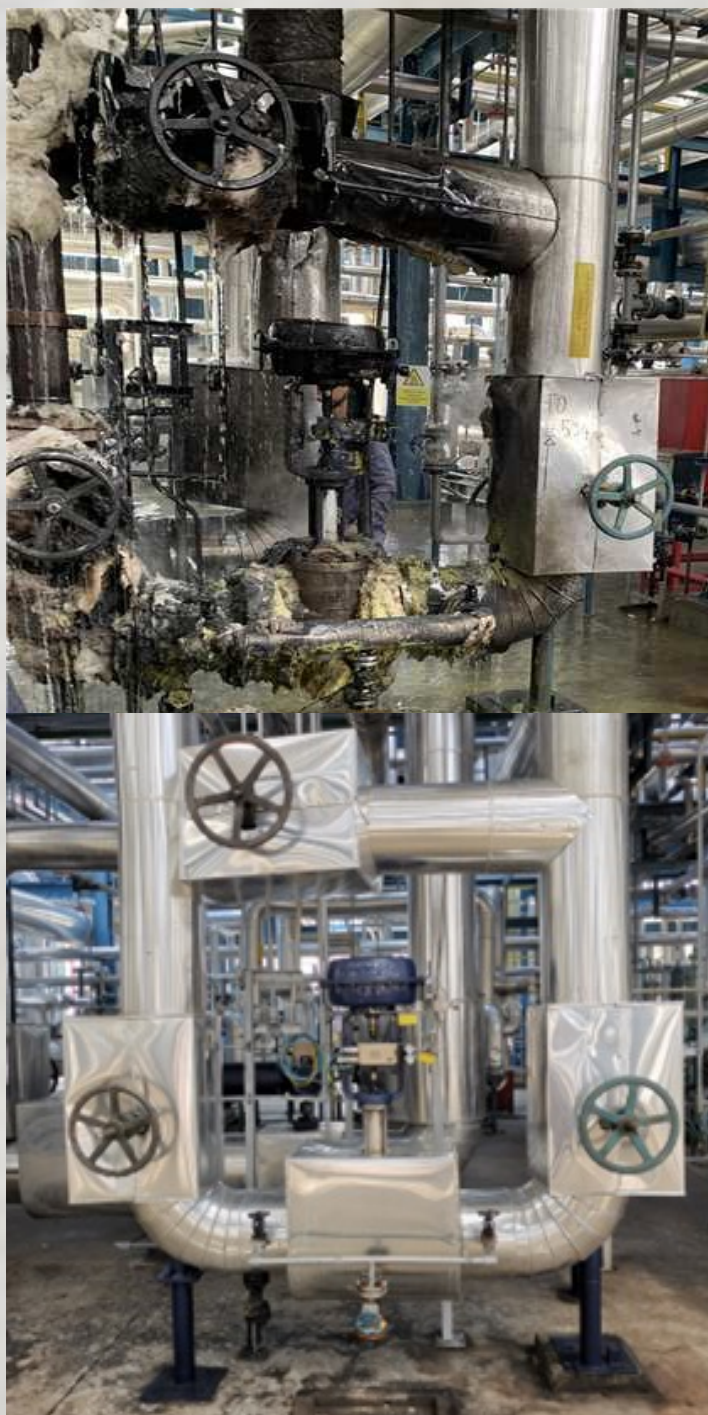
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UNSAFE CHANGES TO STANDARD PROCEDURES TURN ROUTINE WORK INTO HIGH-RISK OPERATIONS

REFINERY ZONE 1 "919" FIRE ACCIDENT

High-temperature oil sprayed out from the sampling line and ignited spontaneously due to improper sampling operation. The incident was mainly caused by improper changes to the sampling method, which did not comply with standard procedures for handling high-temperature media. There were no established or approved sampling procedures, and necessary safety precautions were not implemented. In addition, supervision and process management were inadequate, as the modification of the sampling device was not properly reviewed or controlled, allowing unsafe practices to be carried out during routine operations.



The incident resulted in a fire at 11:31AM during routine sampling work operations, causing injury to personnel and damage to sampling valves. The IP sustained second-degree burns to both hands and face. Site emergency response actions were activated, leading to operational disruption. This particular incident highlighted weaknesses in company process control, operational discipline, and management of change within the organization.

This incident highlights the importance of strictly controlling any modification to operating methods and ensuring all procedures are properly established and approved before any implementation. Operations involving high-temperature media must follow standardized procedures with adequate safety precautions in place. Also, strengthening supervision, enforcing process discipline, and improving change management control are essential to prevent similar incidents from recurring.



Burns on face and hands



After 6 weeks of recovery



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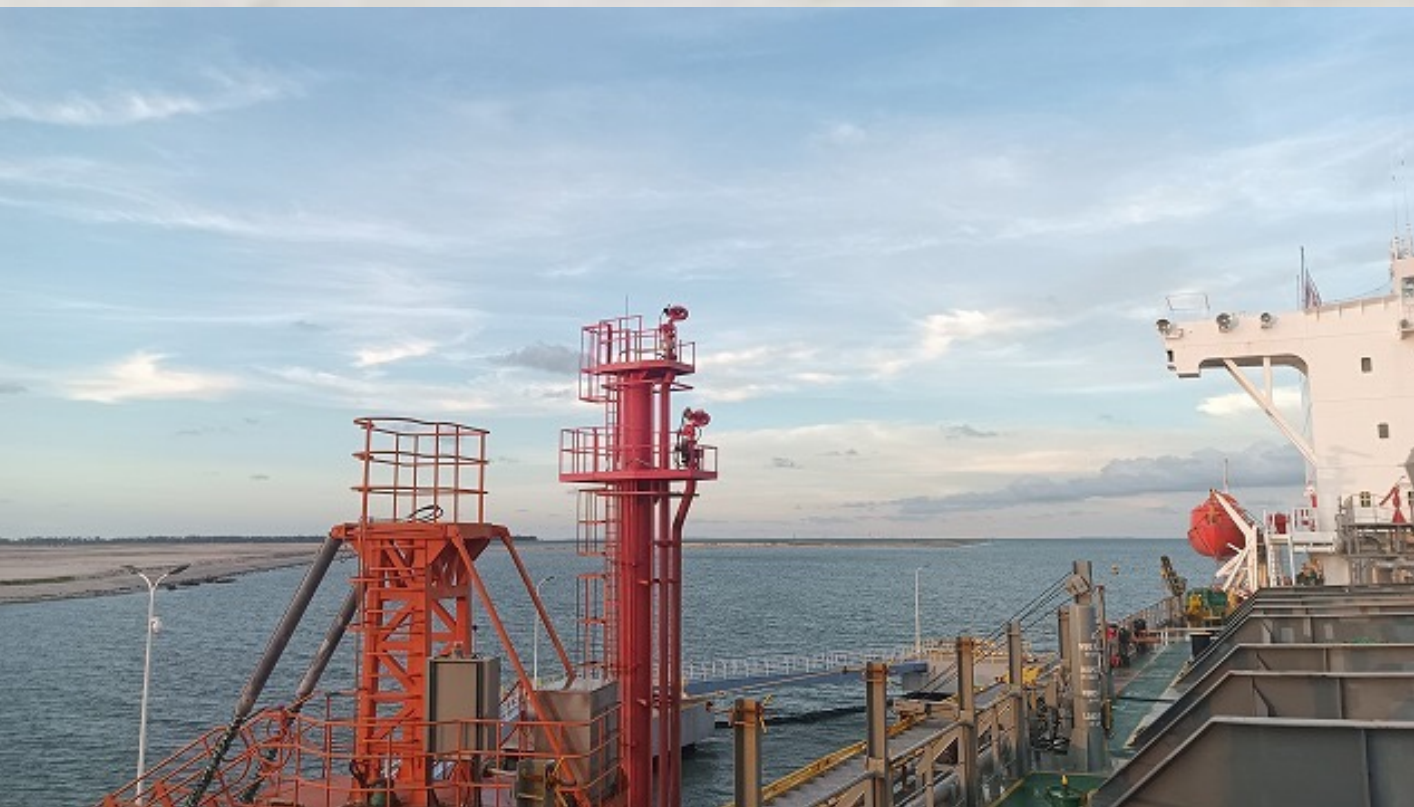
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PORT & STORAGE "106" CREW PERSONNEL INJURY ACCIDENT 2025

The incident occurred at Jetty #4 during routine testing of firefighting equipment while a vessel was actively conducting unloading operations. At the time, crew members were working near the vessel manifold area, creating a high-risk environment due to simultaneous operations (**SIMOPS**). The presence of multiple activities in the same area increased the complexity of the work environment and required strict coordination, communication, and control measures.



During a fire monitor test, the operator mistakenly activated the water discharge, and the high-pressure water jet struck a vessel crew member, causing severe injuries.



IMPACT ON COMPANY

The incident resulted in severe injuries to the vessel crew member, which ultimately led to a fatality. This caused significant impact on the company, including the need for substantial compensation and follow-up handling.

LESSON LEARNT

The incident was driven by a combination of human error and management gaps. The operator failed to confirm the surrounding work environment and did not ensure that no personnel were within the discharge range before starting the test. In addition, the test was conducted while a vessel was berthed, indicating poor work arrangement and lack of risk awareness for simultaneous operations. Existing procedures were unclear and lacked specific guidance for fire monitor testing, while training and supervision were insufficient. Furthermore, risk identification and assessment for such operations were not adequately carried out, allowing unsafe conditions to persist.

This incident highlights the critical importance of verifying work conditions before any operation and strictly controlling testing activities in active operational areas. Fire monitor testing must not be conducted when vessels are present, and clear, detailed procedures must be established and followed.





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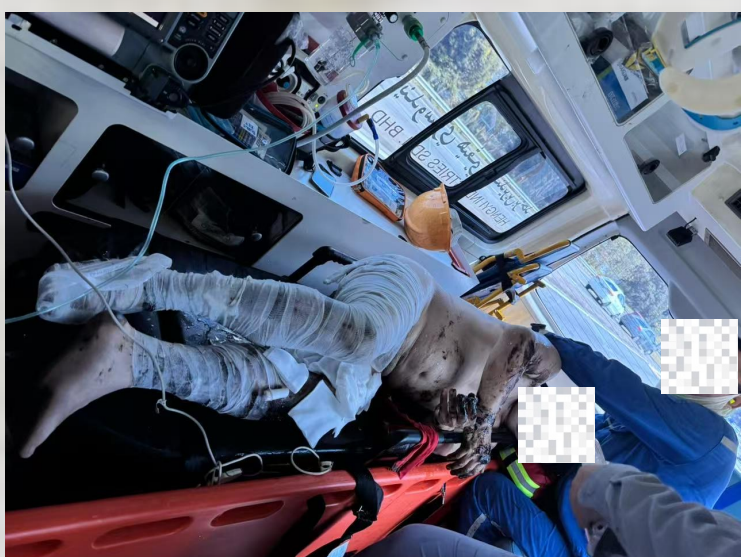
FLEXICOKING UNIT "330" SCALDING ACCIDENT 2026



Following an emergency shutdown of the flexicoking unit on the 30th of March, maintenance work was arranged to clean and isolate the SR102B filter through blind plate installation. During the operation, additional cleaning of coke deposits inside the pipeline was introduced, creating a change in the original work scope.

The incident was caused by incomplete process isolation and inadequate risk identification. Residual oil slurry remained under pressure due to insufficient purging, creating a hidden hazard.

When coke deposits were cleared, the resistance in the pipeline decreased, resulting in sudden release and splashing of high-temperature oil slurry. In addition, the change in work scope was not properly assessed, and no new risk analysis was conducted. Personnel proceeded with the task without adequate heat protection measures, reflecting gaps in change management, risk assessment, and operational control. The incident resulted in personal injuries, where one worker sustained burns from hot oil slurry and another suffered a foot fracture while evacuating the area. The case led to operational disruption, medical treatment costs, and increased safety management pressure. It also exposed weaknesses in process handling, emergency shutdown management, and work control practices.



This incident highlights the importance of ensuring complete isolation and verification before any maintenance work. Any change in work scope must trigger a new risk assessment and approval process. High-temperature systems require strict confirmation of zero pressure and adequate protection measures before intervention. Strengthening JHA quality, enforcing change management, and maintaining strict operational discipline are critical to preventing similar incidents.



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Reflecting on Safety Through Incidents

Every incident is not an isolated event – it is the result of accumulated risks and a series of unsafe decisions. Looking back at past incidents, we see more than injuries.

We see equipment damage, financial loss, operational disruption, and lasting impact on the company’s reputation and credibility.

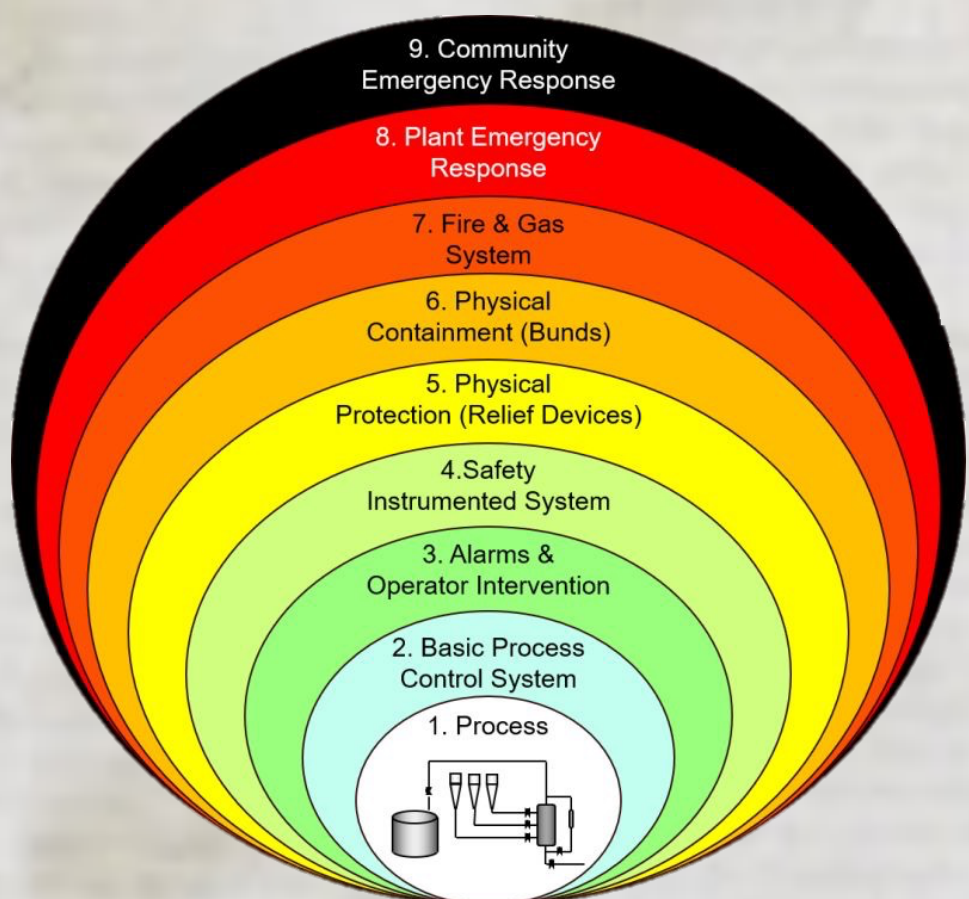
In a high-risk industry, a single mistake can affect not just one task, but the stability of operations, team performance, and even the future of the organization.



Without safety, there is no productivity.
Without safety, there is no stability.
Without safety, there is no future.

Safety is never an optional condition – it is the foundation of everything we do.

Every procedure exists for a reason. Every requirement is written to prevent history from repeating itself.



The risks we face may not always be visible, but they are always present – and they can escalate at any moment.

Before every task, take a moment to pause, observe, and think. This is not about slowing down work – it is about doing the work correctly, with full awareness of the risks.

Safety first is not just a principle – it is a decision made at every moment that matters.



恒逸（文莱）公司安全月活动宣传海报

反思事故过往，铭记事故教训

仅供内部使用

2026年5月 第一期



安全不仅是一项要求，更是一种守护生命的责任。每一项标准操作规程（SOP）的制定都有其来源：它来源于过往事故的教训与真实经验的积累。这些规程不仅仅是指导原则，更是为了防止伤害、确保每一位员工安全回家的重要保障。

“每一起事故都是可以预防的”

然而，事故仍然时有发生——并不是因为缺乏安全管理体系...



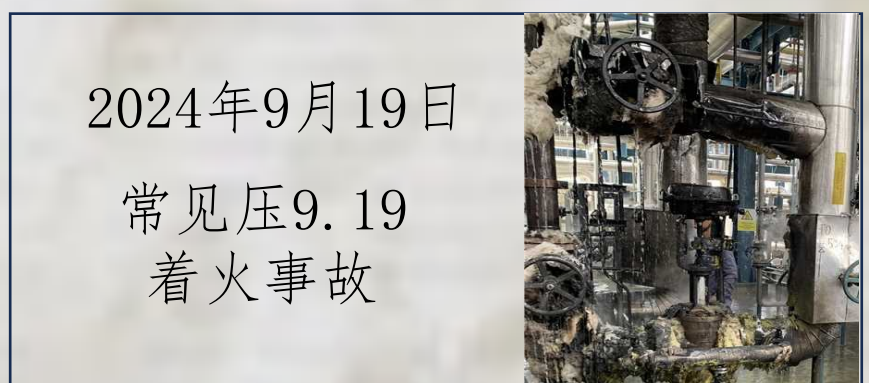
而是在日常工作中，这些体系有时被忽视或低估。在很多情况下，事故并非源于复杂的系统失效，而是来自于日常作业中的一些细小决策：一个步骤的遗漏，一次图方便的简化，或是短暂的注意力松懈。

在本次安全月，我们通过回顾2024年至2026年的典型事故，提醒自己：安全从来不是可选项。任何不安全行为所带来的后果都是真实存在的，其影响可能是即时的、长期的，甚至是不可逆的——不仅影响个人，也影响其家庭、团队以及整个组织。

每一个案例都在提醒我们：风险始终存在，而安全取决于我们每天所做的每一个选择——尤其是在无人监督的时候。



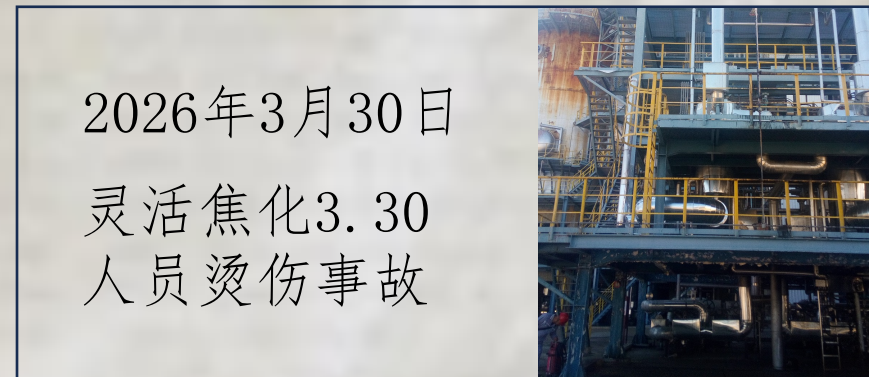
2024年5月30日
加氢裂化5.30
着火事故



2024年9月19日
常见压9.19
着火事故



2025年1月6日
港储部1.06
船员人身伤害事故



2026年3月30日
灵活焦化3.30
人员烫伤事故



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直接原因

反应器出口温度在短时间内剧烈波动，导致法兰密封失效，引发介质泄漏并起火。

间接原因

本次事故主要由人为因素及操作管理不到位引起。在DCS操作过程中，操作人员发生误操作，导致反应器温度异常。在后续处置过程中，未严格按照操作规程执行，尤其是在应对温度异常波动时未采取规范措施。此外，关键安全联锁在未经授权的情况下被擅自摘除，导致保护系统未能按预期发挥作用。上述行为反映出在工艺纪律、操作控制及安全管理执行方面存在明显不足。

“本次事故并非仅由设备故障引起——更是由不安全决策和违反操作规程所导致”

加氢裂化“5.30” 着火事故



对公司的影响

事故引发着火，导致相关装置紧急停工，对正常生产运行造成影响。设备、管线及仪表受到较大损坏，需进行大规模检修与更换。

经验教训

本次事故表明，在任何情况下，特别是在异常工况下，必须严格执行操作规程。操作人员需始终保持高度的风险意识，避免简化步骤或采取未经授权的操作行为，如擅自摘除安全联锁等。





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未经规范管理的作业变更，将显著提升作业风险

常减压 “9.19” 着火事故

高温介质在取样过程中从取样管线喷出，并因操作不当发生自燃。本次事故主要由于取样方式被不规范更改，且未符合高温介质操作的要求。现场未制定完善的取样操作规程，也未落实必要的安全防护措施。监督管理及工艺管控不到位，对取样装置的改动未进行有效审核与控制，导致不安全操作。



本次事故表明，必须严格管控操作方式的任何变更，确保所有作业在实施前均已建立并完成审批流程。涉及高温介质的操作必须严格遵循标准化作业规程，并落实安全防护措施。应加强现场监督，强化工艺纪律，以防止类似事故再次发生。

本次事故于上午11:31在常规取样作业过程中引发着火，造成人员受伤。伤者双手及面部遭受二度烧伤。现场随即启动应急响应，对正常生产运行造成影响。该事故暴露出公司在工艺控制、操作纪律及变更管理方面存在薄弱环节。



双手及面部遭受二度烧伤



六周后恢复情况



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港储部“1.06” 船员人身伤害事故

事故发生于4#码头，在船舶进行卸料作业期间开展消防水炮例行测试。当时船员正在船舶歧管区域作业，现场属于典型的交叉作业（SIMOPS）场景。多项作业在同一区域同时进行，增加了作业环境的复杂性，对现场的协调、沟通及风险管控提出了更高要求。



在消防水炮测试过程中，操作人员误操作开启出水，高压水流击中船员，造成严重伤害。



对公司的影响

事故导致船员严重受伤，最终造成人员死亡，对公司产生重大影响，包括需承担较大金额的赔偿及后续处理工作。

经验教训

本次事故由人为失误与管理缺陷共同导致。操作人员在启动测试前未对周边作业环境进行确认，未确保喷射范围内无人员。同时，在船舶靠泊期间开展测试，反映出作业安排不合理，对交叉作业风险认识不足。现有操作规程不完善，缺乏针对消防水炮测试的具体指导，培训及现场监督也存在不足。此外，该类作业的风险辨识与评估未有效开展，导致不安全条件持续存在。

本次事故表明，在开展任何作业前，必须充分确认作业环境，并严格管控在运行区域内的测试活动。船舶靠泊期间严禁进行消防水炮测试，同时需制定并严格执行清晰、完善的操作规程。





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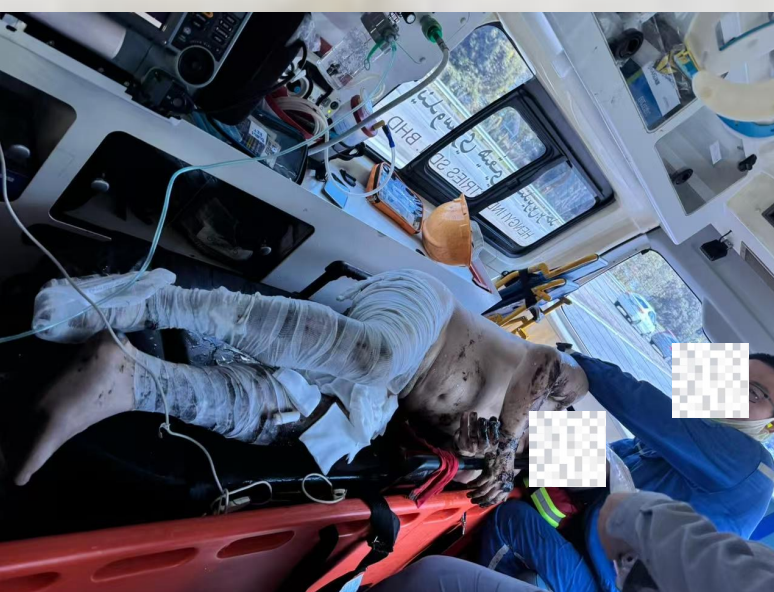
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灵活焦化“3.30” 人员烫伤事故



2026年3月30日灵活焦化装置紧急停工后，安排开展SR102B过滤器清理及盲板隔离作业。在作业过程中，由于发现管线内存在焦粉堵塞，临时增加了清理焦粉的作业内容，导致原有作业范围发生变更。本次事故主要由于工艺处置不彻底及风险辨识不足引起。由于吹扫不充分，设备内仍存在带压的残余油浆，形成潜在隐患。

在清理焦粉过程中，随着管线阻力降低，高温油浆在压力作用下突然喷出并发生飞溅。同时，作业人员在未采取充分防烫措施的情况下继续作业，反映出在变更管理、风险评估及作业控制方面存在明显不足。事故造成人员伤害，其中一名人员被高温油浆烫伤，另一名人员在紧急撤离过程中脚部扭伤并骨折。



在开展任何检维修作业前，必须确保工艺隔离彻底并完成有效验证。作业内容一旦发生变更，必须重新开展风险评估并履行相应审批流程。涉及高温系统时，必须严格确认无残压状态，并落实充分的防护措施后方可作业。同时，应加强JHA质量，严格执行变更管理制度，并强化操作纪律，以有效防止类似事故再次发生。



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从事故中反思安全

每一起事故的发生，
都不是偶然，而是多个风险叠加、
多个决策偏差的结果。

回顾过往事故，我们看到的，
不仅是人员受伤，
更是设备损坏、财产损失、生产中断，
以及对企业声誉和形象的持续影响。

在高风险行业中，
一次失误，可能带来的不仅是瞬间的损失，更可能影响整个装置运行、团队稳定，甚至企业发展。



没有安全，
就没有效益。
没有安全，
就没有稳定。
没有安全，
就没有未来。

安全，从来不是附加条件，
而是所有工作的前提。



每一项规程的背后，都是教训；
每一个要求的存在，都是为了避免重演事故。

我们所面对的风险，
可能不明显，但始终存在；
可能不严重，但随时可能放大。

在每一次作业前：
停一停、看一看、想一想，
不是放慢节奏，而是在确保每一步都走在正确的方向上。

安全第一，不是一句口号，
而是每一位员工在关键时刻做出的选择。