



FUEL CELLS AND HYDROGEN
JOINT UNDERTAKING

**Statistics, lessons
learnt and
recommendations
from the analysis of
HIAD 2.0 database**

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Outline

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- Background
- Overview of the analysis approach
- Statistics
- Lessons learnt
- Recommendations
- Access to HIAD 2.0 and reporting of new events

Background

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- The Hydrogen Incidents and Accidents Database (HIAD) was firstly developed within the HySAFE Network of Excellence by the Joint Research Centre of the European Commission (JRC) .
- Updated by JRC as HIAD 2.0 in 2016.
- Since its launch in 2017, the EHSP has been working closely with JRC to enlarge and improve HIAD 2.0.

Sources of HIAD 2.0:

- public, from scientific literatures, news.
- Other public not hydrogen-specific databases such as French ARIA, European (SEVESO) eMARS, US CSB, NTSB ,OHSA national nuclear authorities, etc.



HAID 2.0 frontpage

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JOINT RESEARCH CENTRE

HIAD 2.0 : Event Selection

[European Commission](#) / [EU Science Hub](#) / [ODIN](#) / [HIAD 2.0](#) / [Event Selection](#)

SELECT

LIST OF EVENTS

EVENT DETAILS



Event classification

- Hydrogen system initiating event
- Non-Hydrogen system initiating event
- Not yet specified

Physical Consequences

- Jet Fires and Explosions
- No Hydrogen Release
- Unignited Hydrogen Release

Application stage

- Chemical/Petrochemical industry
- Commercial Use
- Hydrogen production
- Hydrogen refuelling station
- Hydrogen transport and distribution
- Laboratory / R&D

CURRENT EVENT COUNT: 593

ADVANCED SELECTION ▾

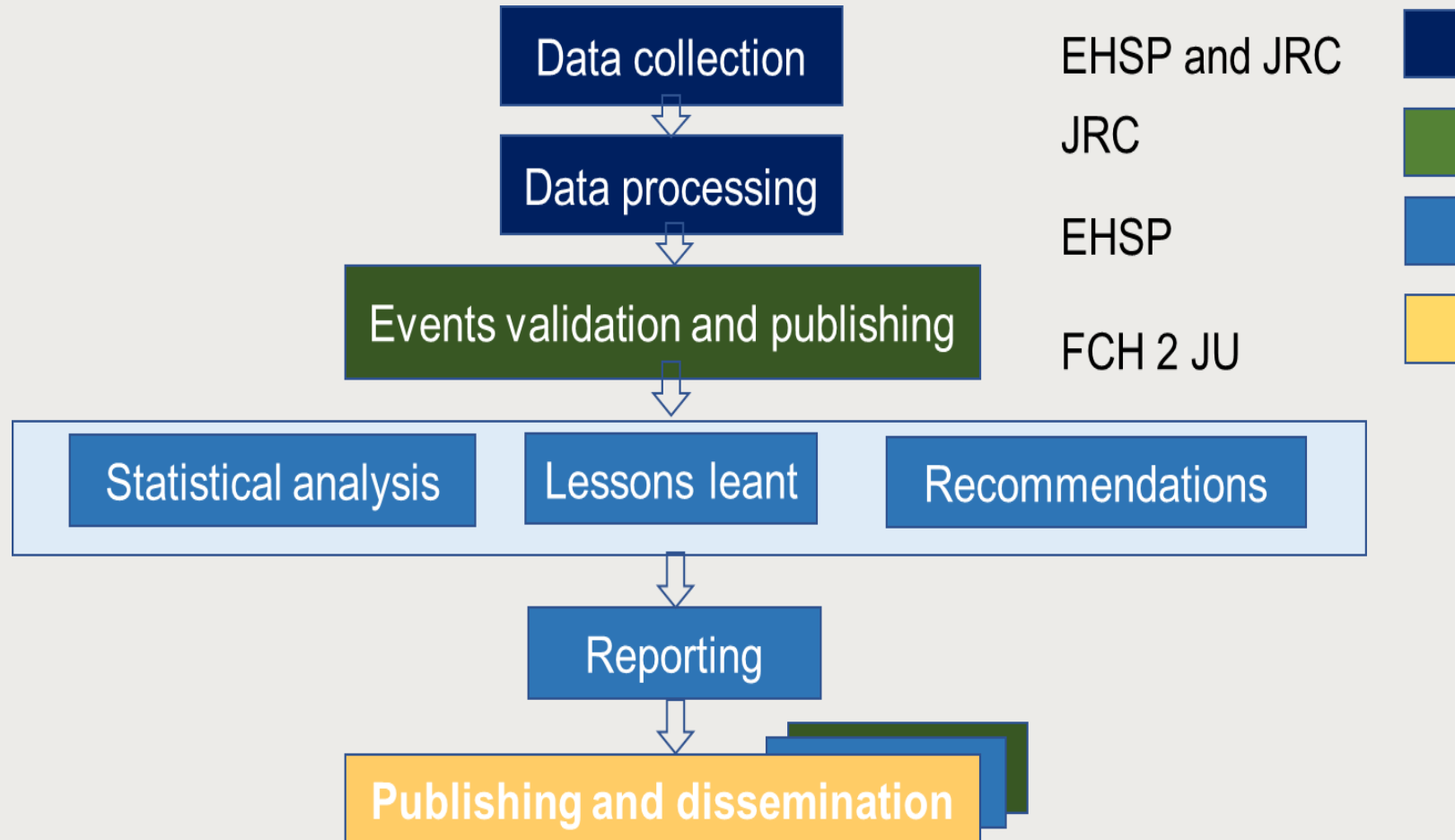
RESET SELECTION ↺

GENERATE REPORT ↻



Overview of the data collection and assessment process

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The methodology

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- **Severity** (based on European scale of industrial accidents <https://www.aria.developpement-durable.gouv.fr/wp-content/uploads/2014/08/European-scale-of-incidents.pdf>)
 - Quantities of hydrogen involved (Seveso threshold or the amount of hydrogen involved)
 - Human consequences (fatalities, injured with hospitalisation, slightly injured)
 - Economic consequences (property damage or economic cost)
- **Nature** of event (explosion, fire, unignited release, near miss)
- **Cause** (system design error, material/manufacturing error, installation error, job factors, Individual/human factors, organization and management factors)
- **Recommendations** (based on EHSP safety principles https://www.fch.europa.eu/sites/default/files/Safety_Planning_for_Hydrogen_and_Fuel_Cell_Projects_Release1p31_20190705.pdf)

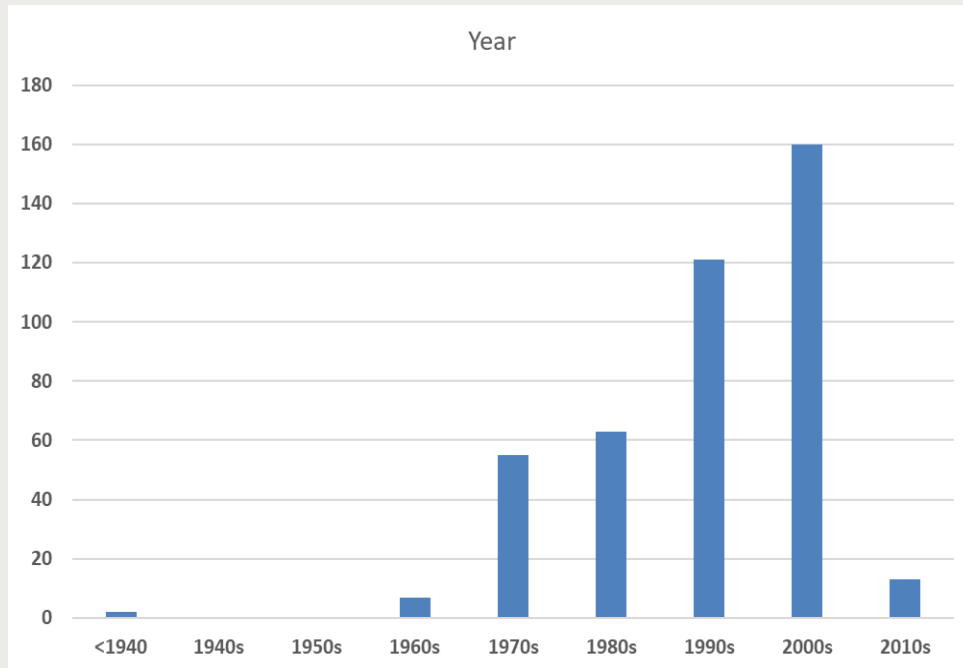
Results from the statistics analysis (1)

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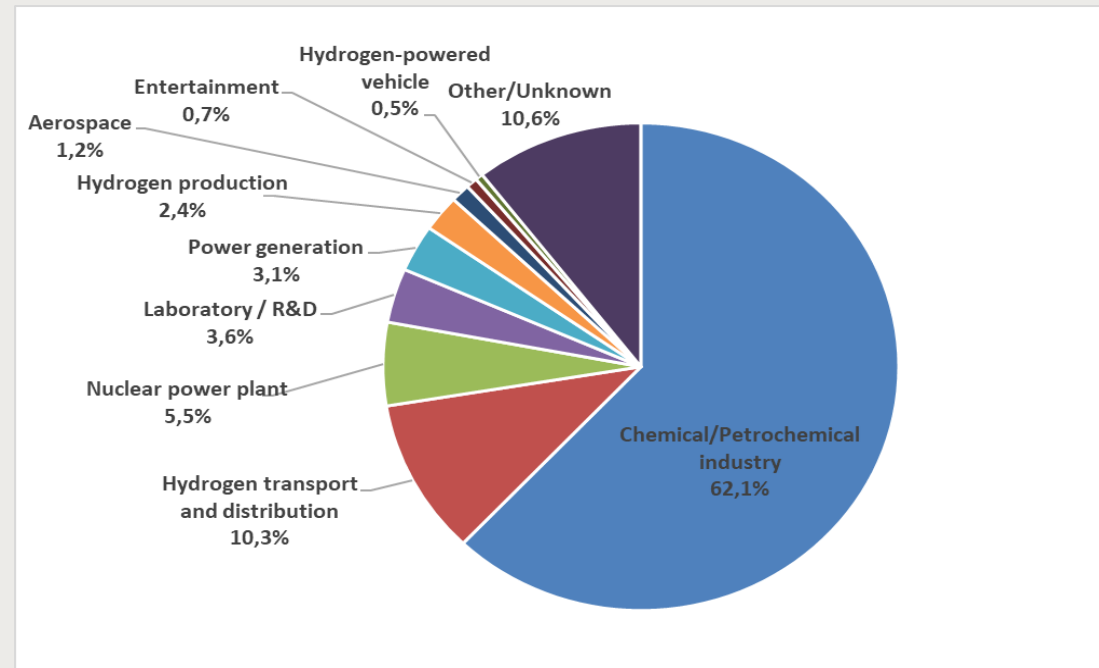


The current analysis is based on the 485 incidents available in the database in July 2020. Of which, 426 events were statistically relevant.

Years



Industrial sectors

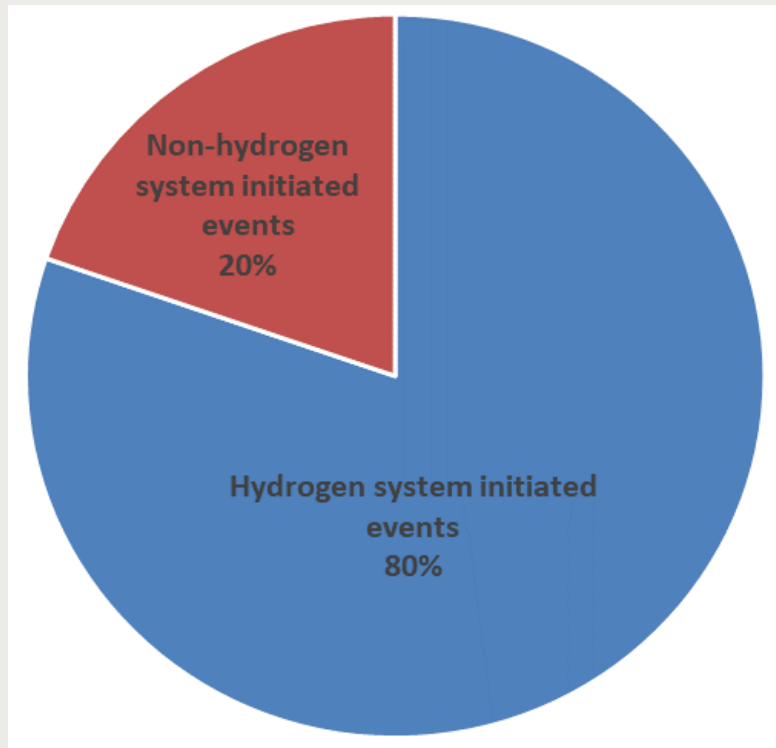


Results from the statistics analysis (2)

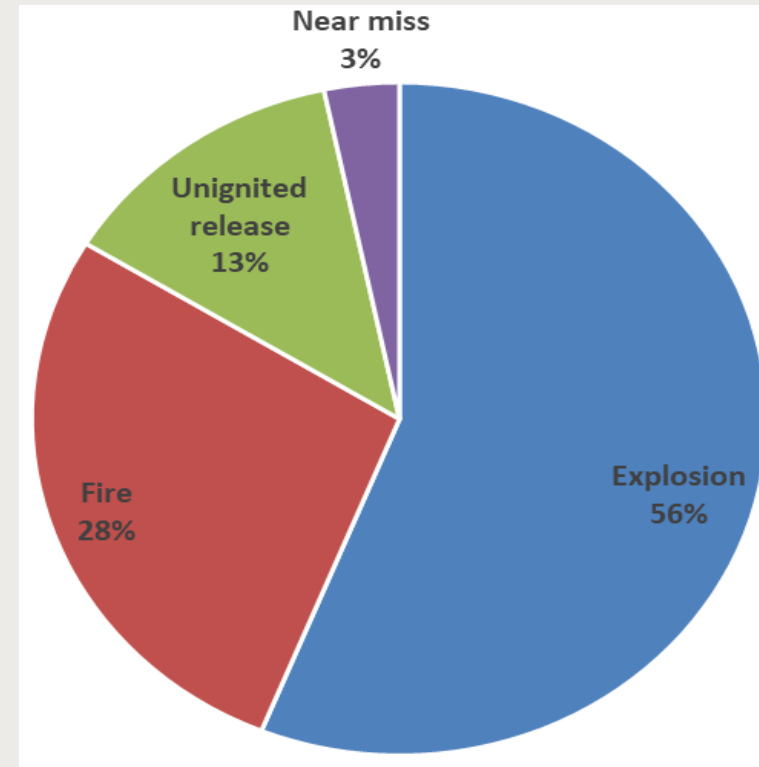
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Hydrogen systems/non-hydrogen systems



Physical consequences

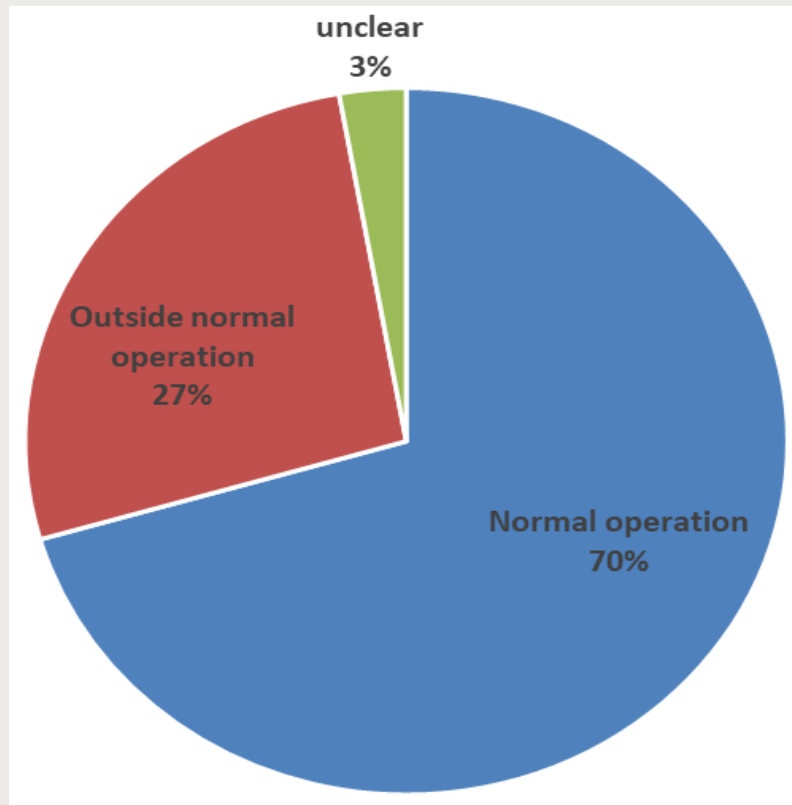


Results from the statistics analysis (3)

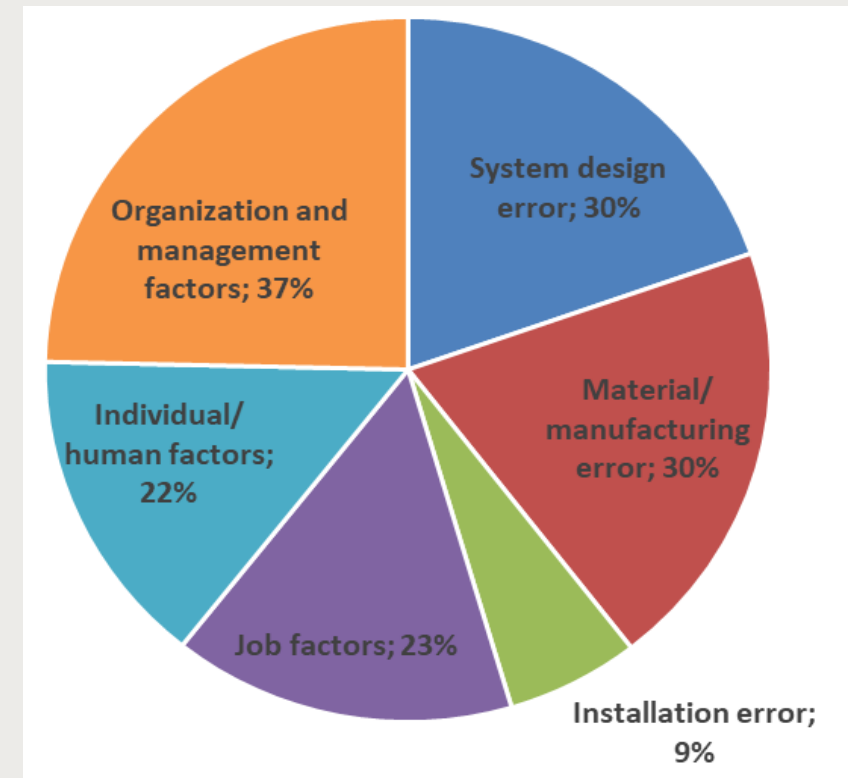
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Operational mode



Causes (multiple entries per incident possible)

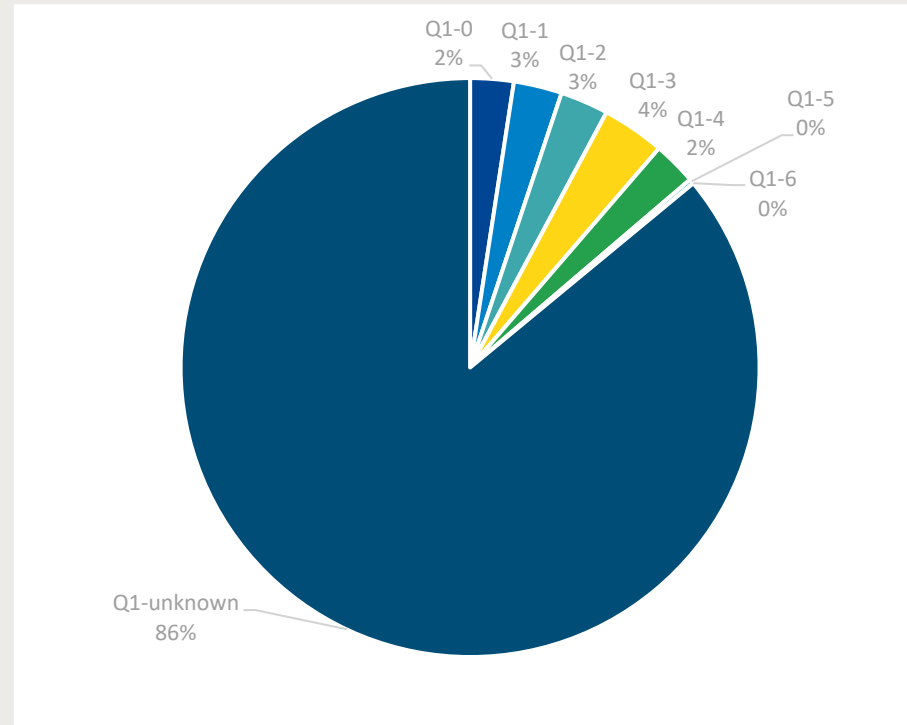


Results from the statistics analysis (4)

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Percentage of events classified by quantity of hydrogen

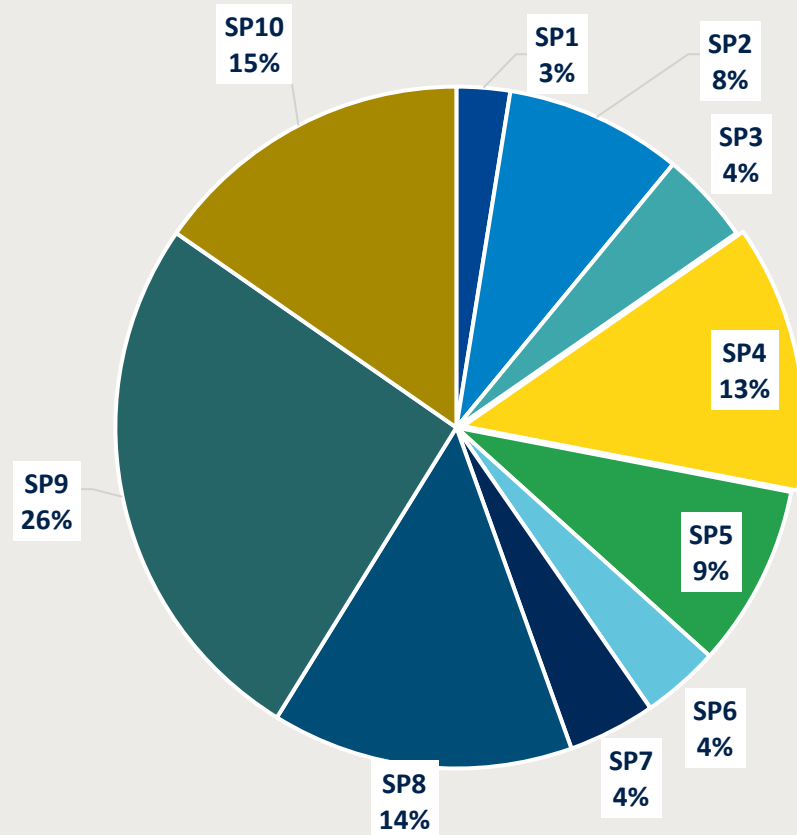


The severity of the incidents has been assessed according to the European scale of industrial accidents which is based on the Seveso directive: <https://www.aria.developpement-durable.gouv.fr/wp-content/uploads/2014/08/European-scale-of-accidents.pdf>

Quantities of dangerous substances		1	2	3	4	5	6
		□□□□□□	□□□□□□	□□□□□□	□□□□□□	□□□□□□	□□□□□□
Q1	Quantity Q of substance actually lost or released in relation to the "Seveso" threshold*	$Q < 0.1\%$	$0.1\% \leq Q < 1\%$	$1\% \leq Q < 10\%$	$10\% \leq Q < 100\%$	1 to 10 times the threshold	≥ 10 times the threshold

Statistics related to EHSP identified safety principles (SP#)

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Number	Safety Principle https://www.fch.europa.eu/sites/default/files/Safety_Planning_for_Hydrogen_and_Fuel_Cell_Projects_Release1p31_20190705.pdf
SP1	Limit hydrogen inventories, especially indoors, to what is strictly necessary.
SP2	Avoid or limit formation of flammable mixture, by applying appropriate ventilation systems, for instance.
SP3	Carry out ATEX zoning analysis.
SP4	Combine hydrogen leak or fire detection and countermeasures.
SP5	Avoid ignition sources using proper materials or installations in the different ATEX zones, remove electrical systems or provide electrical grounding, etc.
SP6	Avoid congestion, reduce turbulence promoting flow obstacles (volumetric blockage ratio) in respective ATEX zones.
SP7	Avoid confinement. Place storage in the free, or use large openings which are also supporting natural ventilation.
SP8	Provide efficient passive barriers in case of active barriers deactivation by whatever reason.
SP9	Train and educate staff in hydrogen safety.
SP10	Report near misses, incidents and accidents to suitable databases and include lessons learned in your safety plan.

Lessons learnt – approach of the analysis in a nut shell

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Main categories	System design	System manufacturing, installation and modification	Operator errors			First responders
			Job factors	Individual/human factors	Organization & management factors	
Sub-categories	Design related	Material compatibility	Maintenance and inspection	Bypassing key interventions	Out of date inspection plan	Insight of H ₂ safety and accident scenarios
	Corrosion related	Venting system	Safety device during maintenance	Inadequate training of H ₂ truck drivers	Inspection of safety equipment	Delay in limit inventories
	Fatigue	Weak points	Safety practice and procedures	Monitoring pressure of the filter	Procedures for plant modification	Training
	Pressure relief valve	System installation	Lack of clear instructions	Irregular purging of the system	Safety supervision during repairing	Emergency response inhibited by poor drainage
	Equipment factor		Chemical compounds prone to H ₂ generation	Verification of design and operation conditions	Procedures for fast isolation of release sources	Lack of sufficient evidence gathering
	H ₂ generation due to malfunction		Insufficient check after repair	Emergency procedure not followed	Guidance about lifetime of critical components	Extinguishing fire before H ₂ release stopping
	H ₂ accumulation		Insufficient purging before re-using	Guidance to prevent unwanted H ₂ generation	Explosivity control before maintenance	Efficient safety crew
	Venting			Handover between shift and day staff	Distinction between emergency and operating alarms	
	2 nd order redundancy on critical systems			Mindful of volatile hydrocarbon pressure in tanks		
				workplace safety violation		

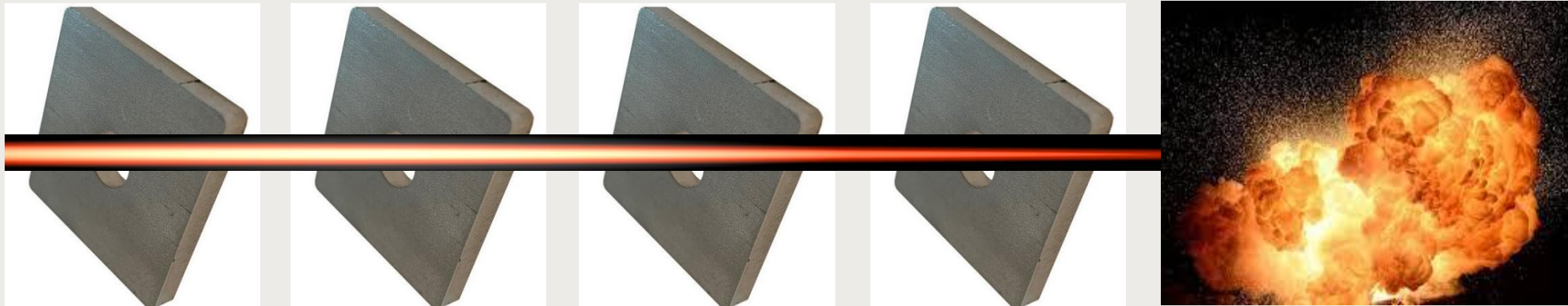


Lessons learnt in relation to cascading effects

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Cascading effects of minor events could result in extremely serious consequences



Example of recent incident ID477: An explosion of hydrogen storage tanks of a small fuel-cell power system in Gangneung (South Korea) in 2019

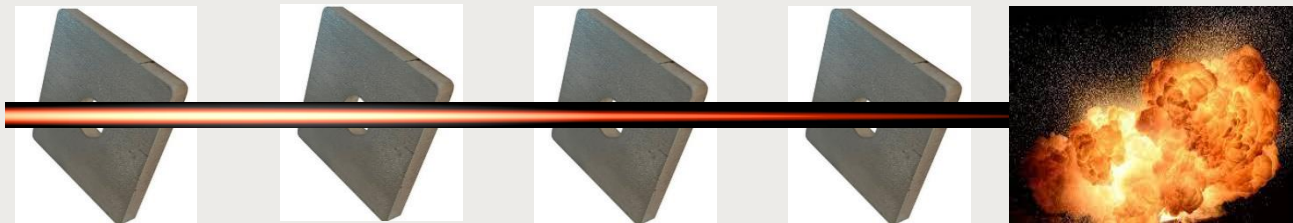
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Prosecutor's report on Gangeung Hydrogen Tank Explosion Accident (adapted from the English translation by INERIS)

Contributing factors:

- Oxygen removing component omitted in the system ...
- Buffer tank static spark remover was omitted during construction...
- Operator made fault by running water electrolysis system lower than operation power level, which induced increase of O₂ concentration...
- The O₂ concentration was detected as > 3%, which required O₂ detector and remover. However, the operator ignored this issue and continued operation to reach 1000 hours of required experiment validation time.
- Safety management team did not follow safety regulation to daily test hydrogen quality.

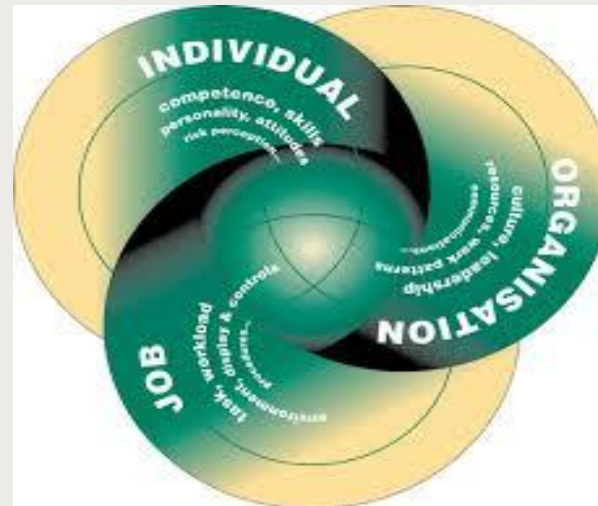


Lessons learnt related to job factor

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- Lack of regular maintenance or inspection, special attention for safety devices during maintenance
- Reoperation after repair
- Individual/human factors, lack of clear instructions
- Reusing tanks or pipes previously containing flammable liquid or gas without thorough purging.



Example of recent incident: Hydrogen fuelling station explodes in Norway

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Nel investigation into explosion at Kjørbo hydrogen station. Fuel Cells Bulletin 2019; 2019(7): 7

- The incident was attributed to an **assembly error** of a specific plug in a high-pressure hydrogen storage tank.
- It started with a **hydrogen leak** from a plug in one of the tanks in the high-pressure storage unit.
- This leak created a **mixture of hydrogen and air** that ignited and created a pressure wave.
- The specific source of ignition is yet to be identified.
- The low-pressure steel and composite storage units were neither the source of the leak, nor the ignition source, and no tanks ruptured in the incident.



<https://www.petrolplaza.com/news/22174>

Structure of recommendations at a glance

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Recommendations	<i>Operational mode</i>		
	<i>Industrial sectors</i>	Hydrogen energy	H ₂ transport and distribution
			H ₂ powered vehicle
			Laboratory / R&D
			Power generation
			Entertainment
	<i>Other industrial sectors</i>		Nuclear
			Aerospace
			Chemical/petrochemical sector
	<i>Other sectors</i>		
<i>Human errors</i>			

Recommendations for different operational modes

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- Adequate training of personnel is key (SP9) - training of new personnel as well as periodic updated training of existing personnel.
- Both passive and active safety measures should be appropriately considered (SP7, SP8).
- Leak detection (SP4) and ATEX zoning (SP3, SP5) should be applied to improve safety.
- Regular inspection and maintenance.
- When operational/equipment changes are made, the maintenance/inspection procedures should also be updated accordingly.



<https://eta-safety.lbl.gov/content/integrated-safety-management-ism>

Recommendations for hydrogen energy applications – system design

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- Perform Process Hazard Analysis for any new/updated installations (SP1-10);
- Use materials which are compatible with hydrogen services. In some incidents, such problem resulted in the need to change standards and codes for pressure vessels;
- Install adequate leak detection and mitigation barriers (SP4, SP8) for critical systems.



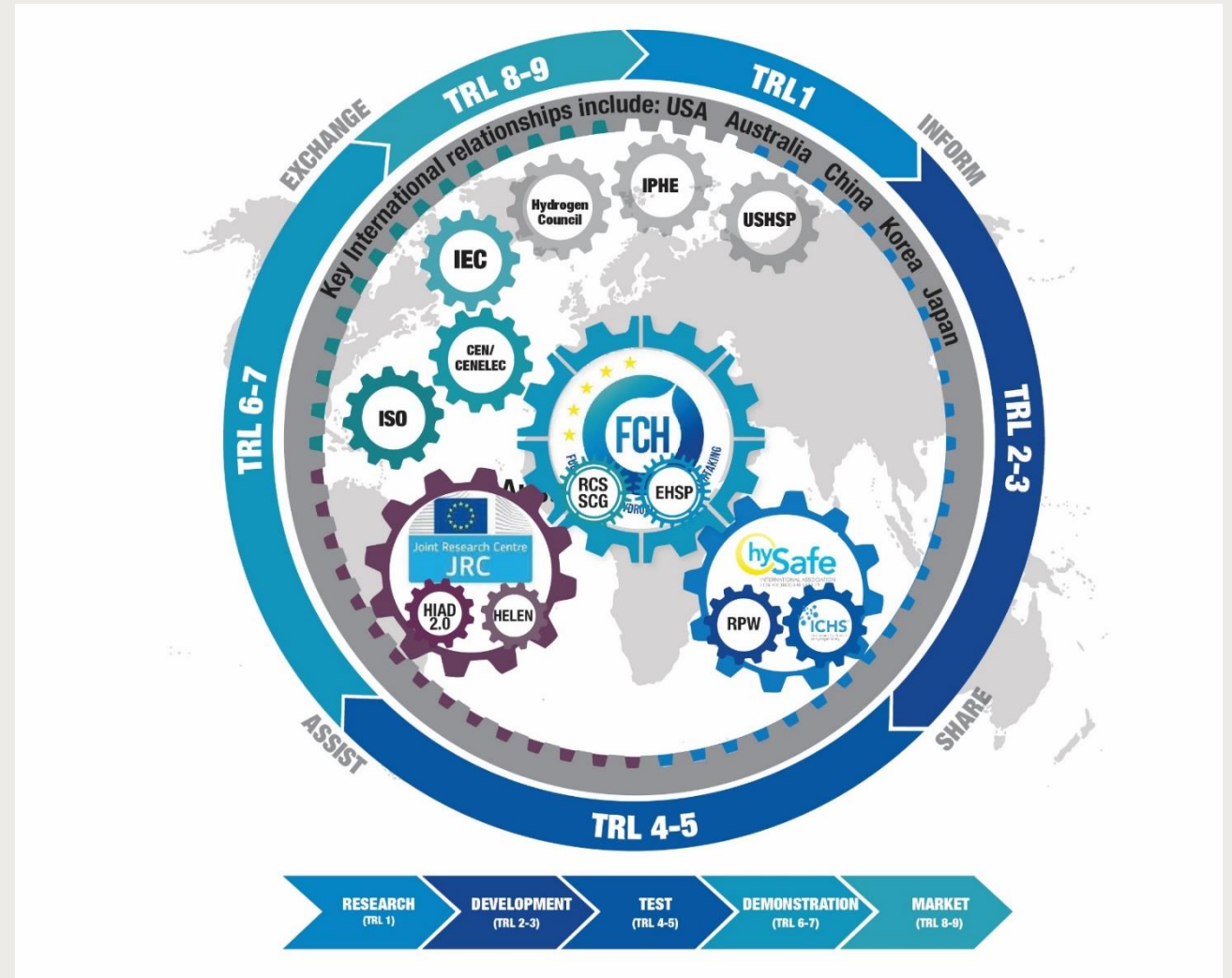
<https://risk-engineering.org/safe-design/>

Concluding remarks

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- HIAD is being continuously enlarged and enhanced by EHSP and JRC
- Currently 593 events have been validated through quality checking
- In 2020, EHSP analysed 485 incidents which were in the database then. The detailed report on the statistics, lessons learnt and recommendations will be published on the FCH 2 JU web site <https://www.fch.europa.eu/page/european-hydrogen-safety-panel>



Access to HIAD 2.0 and reporting of new events

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- While HIAD 2.0 database is offline due to maintenance, those who need to access the information should contact pietro.moretto@ec.europa.eu
- Potential event providers can report to HIAD through an ad-hoc EUSurvey: https://ec.europa.eu/eusurvey/runner/HIAD_v2_event_report
- Event providers using EUSurvey should notify pietro.moretto@ec.europa.eu as the system does not send him automatic notification of a new entry.