



# GIIGNL

International Group Of Liquefied  
Natural Gas Importers

## **Technical Study Group**

### **Incident identification database**

**Osaka, Sept 29th – Oct 2nd 2025**

# General background information

- Link to access the secure web-based platform : <https://incidents-giignl.org>
- Accessible by PC, laptop or smartphone
- Recommended navigators : Chrome and Firefox
- Video on the website menu explaining how to create and search an incident as well as guidelines and flowchart
- Possibility to attach drawings or pictures (Word, PowerPoint, PDF,...) to the incident description
- The information is recorded anonymously and is validated by a regional coordinator.



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## Incident Identification Database Tutorial

Heure de début de la réunion : 11 octobre 2019 15:23:38  
Organisateur : DEMOURY Vincent (ENGIE SA)

# Current Status of the Database

- 490 incidents registered in the database
- Number of data base connections in 2025 & number of creations in 2025

**Number of database connections  
in 2025**

Asia	30
Americas	4
Europe	73

**Number of incidents created by  
region in 2025**

Asia	1
Americas	3
Europe	2

# Latest incidents recorded : incident N° 1937

- Incident N° 1937 is related to a rollover that occurred in a Moss-type LNG carrier in 2008. Heavy LNG was reloaded from a regas terminal, with a significant LNG heel of light LNG.
- It was believed that rollover would be unlikely to occur in a Moss-type tank because the spherical shape of the tank would aid the migration of the warmed liquid along the tank wall.
- Tank pressures were maintained within the design parameters.
- The incident demonstrated that :
  - Stratification can develop on board ships particularly when loading a higher density LNG into a tank containing a lighter cargo.
  - Ship movement cannot be relied upon to mix layers.
  - Increase in tank levels and reduction in boil-off gas generation may be indications of stratification.

# Latest incidents recorded : incident N° 1939

- Incident N° 1939 concerns a scheduled Uninterruptible Power Supply annual testing. Incorrect tools (uninsulated) used for tightening nuts were used. Short circuit was caused by the contact of the uninsulated tool and the energized elements. Arc was detected by F&G system.
- Develop tool list that every site and electrical technician should have
- Revise battery connection procedure with additional safety measures

TAKEAWAY



# Latest incidents recorded : incident N° 1940

- Incident N° 1940 is related to a LNG truck tanker loading bay. Dry break couplers experienced multiple leakages. The leak was caused by the female coupler interface seals.
- The female coupler interface seals failed from:
  - Inner lip seal spring lost initial preload. Over time, a gap developed between inner lip and coupler bush providing a leak path
  - Outer lip seal is susceptible to cuts during connection/disconnection which lead to leaks if the cut is deep.
- The mitigation method retained for the above issues is monthly dry break coupler rotation and interface seal replacement.



# Latest incidents recorded : incident N° 1942

- Incident N° 1942 concerns an inadvertent valve maneuver.
  - During planned severe cold weather preparations (-10° F / -20° C), maintenance mechanics were requested to wrap low pressure steam hoses around fuel gas regulator piping to add heat.
  - While performing the work activity, one of the mechanics unknowingly bumped a sensing line valve to the fuel gas regulator with a hose.
  - The closure of the sensing line valve caused the regulator to overpressure downstream piping, resulting in a safety valve venting.
  - This extended downtime, along with extreme thermal conditions, resulted in various valve packing leaks.
- The terminal has since created a procedure to cool down and pressurize all vaporization systems prior to the start of the winter season to identify any issues in advance.

# Latest incidents recorded : incident N° 1943

- Incident N° 1943 is related to a lightning strike igniting tank vents, but Operations Team was unaware of one of the vent fires because of a blocked camera.
  - The scaffolding blocking the camera had not been identified as a concern when the scaffolding had been erected.
  - The flame was eventually starved as the vent valve automatically cycled from open to closed to maintain the tank pressure setpoint. Operations did not realize the Heated Vent Stack fire had occurred until video footage from additional camera angles was reviewed the following day.
- Operations is now more aware of the risk of blocked cameras and will identify them as a concern when appropriate.



# Current Status of the Database

- **A significant increase in the number of declarations compared to previous years.**
- **Bravo to the contributors who took the necessary time to write these accident reports and thereby contribute to the community.**
- **We must now continue this positive trend.**