

PROCESS SAFETY AN TOÀN QUÁ TRÌNH

CHAPTER 1: INTRODUCTION

AIMS & OBJECTIVE OF THIS COURSE

- introduce **fundamental principles** and **application** of chemical process safety
- theory backgrounds on toxicology
- source and dispersion models
- fire and explosion basics
- different methods to identify and estimate risk and safety level

ASSESSMENT

- Homework and Assignment: 20%
- Midterm Test: 30%
- Final Examination: 50%

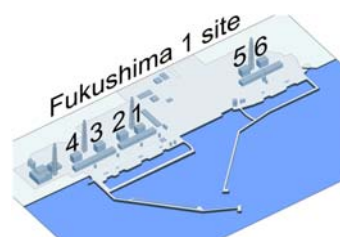
TEXTBOOK & REFERENCES

- Daniel A. Crowl; Joseph F. Louvar, Chemical Process Safety: Fundamentals and Applications, 2nd edition, Prentice Hall PTR, 2002. (TEXTBOOK)
- Roy E. Sanders, Chemical Process Safety: Learning from Case Histories, Butterworth-Heinemann, 1999.
- Dow's Chemical Exposure Index Guide, New York: American Institute of Chemical Engineers, 1994.
- Dow's Fire and Explosion Index Hazard Classification Guide, 7th ed., New York: American Institute of Chemical Engineers, 1994.
- Frank P. Lees, Loss Prevention in the Process Industries, 2d ed., London: Butterworth-Heinemann, 1996

SCHEDULE

- Introduction (W1)
- Toxicology and transport models (W2-4)
- Fire and Explosion (W5-8)
- Safety relief valve system (W9-11)
- Hazard identification and risk assessment (W12-13)
- Case Studies (W14)

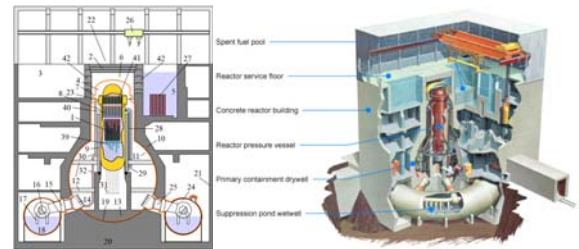
FUKUSHIMA DISASTER



THE FUKUSHIMA DAIICHI REACTORS

- Boiling water reactors (BWR) (1960s) 460 MWe
- Operation since 1971
- The fuel assemblies : 4 m long, 400 pcs
- 60 fuel rods containing the uranium oxide fuel within zirconium alloy cladding
- Normally at 286°C, 6930 kPa at core and 115-130 kPa dry containment
- Design base: 8240 kPa and 300°C at core , 500 kPa for containment (PCV)

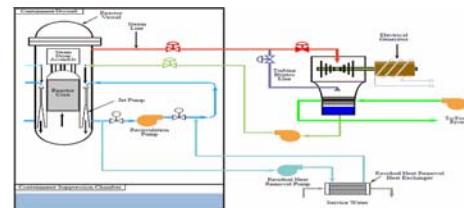
REACTOR 1



PHYSICAL PROTECTION LAYERS

- Control rods (39)
- Reactor Pressure Vessel (8)
- Biological Shield (9)
- Embedded shell region (19)
- Concrete embedment (13) & Secondary concrete shield wall (10)
- Reactor building (21)

OPERATION



WHAT WENT WRONG

- **Friday, 11 March**
- 14:46: 9.0 magnitude earthquake strikes off the Tohoku area
- 14:52: Reactor 1 emergency cooling system, running without external power, turns on automatically.
- 15:03: Reactor 1 emergency cooling system is manually shut down.
- 15:27: The first tsunami strikes the plant.
- 15:30: The emergency condenser designed to cool the steam inside the pressure vessel of the No. 1 reactor fails.
- 15:46 (approximate): A 14-metre (46 ft) tsunami
 - inundating the Fukushima facility
 - disabling the backup diesel
 - washing away their fuel tanks.
 - loss of all electrical power supply
 - most of the emergency core cooling system failed

WHAT WENT WRONG

- 18:00: The falling water level and the core temperature starts climbing.
- 18:18: Reactor 1's emergency cooling system is once again back on.[6]
- 19:30: The fuel in reactor 1 becomes fully exposed
- 21:00: An evacuation within a radius of 3 kilometres
- 21:05: The pressure inside reactor unit 1 more than twice normal levels
- **Saturday, 12 March**
- 05:30: the decision is taken to vent some of the steam to reduce the pressure
- 06:50: the core of reactor 1 has now completely melted and falls to the bottom of the reactor pressure vessel
- 15:36: A massive explosion because of hydrogen

WHAT WENT WRONG

- 19:00: Sea water injection into reactor 1 is started.
- 21:40: The evacuation zone around Fukushima I is extended to 20 km
- **Sunday, 13 March**
- 11:01: The unit 3 reactor building explodes, injuring six workers
- **Monday, 14 March**
- 06:00 An explosion damaged the 4th floor rooftop area of the Unit 4 reactor



SAFETY DATA

- 1967: Changing the layout of the emergency-cooling system
- 1976: Falsification of safety records by TEPCO
- 1991: Back-up generator of reactor 1 flooded
 - instead of moving the generators to higher ground, TEPCO installed doors to prevent leaking water
- 2006: the Japanese government opposed a court order to close a nuclear plant in the west part
- 2008: Tsunami study ignored
- Mar-2011: TEPCO submits a report to Japan's nuclear safety agency to reject the Tsunami study



INTRODUCTION

- The recent processes
 - More complex
 - Higher pressure
 - More reactive chemicals, and exotic chemistry
- More complex processes require more complex safety technology
- Safety & Production are equally considered
- Safety has developed into a scientific discipline
- that includes many highly technical and complex theories and practices



THE MEANING OF SAFETY

- The older strategy of "safety" emphasizes on worker safety
 - The use of hard hats, safety shoes
 - A variety of rules and regulations
- Recently, "safety" means "loss prevention" includes
 - Hazard identification,
 - Technical evaluation,
 - Design of new engineering features to prevent loss



DETERMINATION

- Safety or loss prevention
 - the prevention of accidents through the use of appropriate technologies
 - to identify the hazards of a chemical plant and
 - eliminate them before an accident occurs.
- Hazard
 - a chemical or physical condition that has the potential to cause damage to people, property, or the environment.
- Risk
 - a measure of human injury, environmental damage, or economic loss in terms of both the incident likelihood and the magnitude of the loss or injury.



SAFETY PROGRAM

- Requires a **SYSTEM**
 - to record what needs to be done
 - to do what needs to be done
 - to record that the required tasks are done
- A positive **ATTITUDE**
 - the willingness to do some of the thankless work.
- Understand **FUNDAMENTALS**
 - chemical process safety in the design, construction, and operation.
- Learn from the **EXPERIENCES** of history
 - Understands case histories of past accidents
 - Ask colleagues for experiences and advices
- Safety takes **TIME**
 - to study, to do the work, to record, to share experiences, and to train or be trained
- YOU should take the responsibility to contribute the safety



ACCIDENT & LOSS STATISTICS

- important measures of the effectiveness of safety programs.
- determining whether a process is safe
- or whether a safety procedure is working effectively
- these statistics must be used carefully.
- statistics only **averages** and do **NOT** reflect the potential for **single episodes**
- This course considers the following statistics
 - OSHA incidence rate,
 - fatal accident rate (FAR), and
 - fatality rate, or deaths per person per year

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA)

- The OSHA incidence rate is based on cases per 100 worker years.
- A worker year contains 2000 hours (50 work weeks year x 40 hours/week).
- Therefore it based on 200.000 hours of worker exposure to a hazard
- Calculation

$$\text{OSHA incidence rate (based on injuries and illness)} = \frac{\text{Number of injuries and illnesses} \times 200,000}{\text{Total hours worked by all employees during period covered.}}$$

OSHA (CONT.)

- An incidence rate can also be based on lost workdays instead of injuries and illnesses

$$\text{OSHA incidence rate (based on lost workdays)} = \frac{\text{Number of lost workdays} \times 200,000}{\text{Total hours worked by all employees during period covered.}}$$

FAR

- FAR is used mostly by the British chemical industry
- The FAR reports the number of fatalities based on 1000 employees working their entire lifetime
- The employees are assumed to work a total of 50 years.
- Thus the FAR is based on 10^8 working hours.
- The resulting equation is

$$\text{FAR} = \frac{\text{Number of fatalities} \times 10^8}{\text{Total hours worked by all employees during period covered.}}$$

FATALITY RATE

- The fatality rate or deaths per person per year
- This system is independent of the number of hours actually worked
- reports only the number of fatalities expected per person per year

$$\text{Fatality rate} = \frac{\text{Number of fatalities per year}}{\text{Total number of people in applicable population.}}$$

COMPARISON OF STATISTICS

- OSHA and FAR depend on the number of exposed hours.
- A FAR can be converted to a fatality rate (or vice versa)
 - if the number of exposed hours is known.
- OSHA cannot be converted to a FAR or fatality rate because
 - it contains both injury and fatality information.

Industry	OSHA Incident rate (cases involving days away from work and deaths)		FAR (deaths)	
	1985 ¹	1986 ²	1986 ³	1990 ⁴
Chemicals and allied products	0.49	0.35	4.0	1.2
Motor vehicles	1.08	6.07	1.3	0.6
Steel	1.54	1.28	8.0	
Paper	2.06	0.81		
Coal mining	2.22	0.26	40	7.3
Food	3.28	1.35		
Construction	3.88	0.6	67	5.0
Agricultural	4.53	0.89	10	3.7
Meat products	5.27	0.96		
Trucking	7.28	2.10		
All manufacturing		1.68		1.2

¹Accident Facts, 1985 ed. (Chicago: National Safety Council, 1985), p. 30.

²Injury Facts, 1999 ed. (Chicago: National Safety Council, 1999), p. 66.

³Frank P. Lees, *Loss Prevention in the Process Industries* (London: Butterworths, 1986), p. 177.

⁴Frank P. Lees, *Loss Prevention in the Process Industries*, 2d ed. (London: Butterworths, 1996), p. 279.

EXAMPLE 1

• Example 1-1: A process has a reported FAR of 2. If an employee works a standard 8-hr shift 300 days per year compute the deaths per person per year.

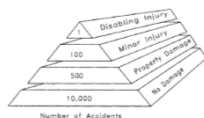
• **Solution**

• Deaths per person per year =

• $(8\text{hrs/day}) \times (300\text{days/yr}) \times (2\text{ deaths}/10^6\text{hr}) = 4.8 \times 10^{-5}$

ACCEPTABLE RISK

- Cannot eliminate risk entirely.
- Every chemical process has a certain amount of risk
- the design stage needs to decide if the risks are "acceptable"
- Engineers must make every effort to minimize risks within the economic constraints of the process



Type of death	1998 Deaths
Motor-vehicle	
Public nonwork	38,900
Work	2,100
Home	200
Subtotal	41,200 (43.5%)
Work	
Nonmotor-vehicle	3,000
Motor-vehicle	2,100
Subtotal	5,100 (5.4%)
Home	
Nonmotor-vehicle	28,200
Motor-vehicle	200
Subtotal	28,400 (30.0%)
Public ²	20,000
Subtotal	20,000 (21.1%)
Total accidental deaths	92,200 ³

NATURE OF ACCIDENT PROCESS

- Most accidents follow a three-step sequence:
- initiation (the event that starts the accident),
- propagation (the event or events that maintain or expand the accident), and
- termination (the event or events that stop the accident or diminish it in size).

Step	Desired effect	Procedure
Initiation	Diminish	Grounding and bonding Inerting Explosion proof electrical Guardrails and guards Maintenance procedures Hot work permits Human factors design Process design Awareness of dangerous properties of chemicals
Propagation	Diminish	Emergency material transfer Reduce inventories of flammable materials Equipment spacing and layout Nonflammable construction materials Installation of check and emergency shutoff valves
Termination	Increase	Firefighting equipment and procedures Relief systems Sprinkler systems Installation of check and emergency shutoff valves

THREE TYPES OF ACCIDENTS

Type of accident	Probability of occurrence	Potential for fatalities	Potential for economic loss
Fire	High	Low	Intermediate
Explosion	Intermediate	Intermediate	High
Toxic release	Low	High	Low



INHERENT SAFETY

- Inherent safety mentions chemistry and physics to prevent accidents
- The major approaches to inherently safer process designs
 - Intensification
 - Reducing the amount of hazardous material present at any one time
 - e.g. by using smaller batches
 - Substitution
 - Replacing one material with another of less hazard
 - e.g. cleaning with water and detergent rather than a flammable solvent
 - Attenuation
 - Reducing the strength of an effect,
 - e.g. having a cold liquid instead of a gas at high pressure,
 - or using material in a dilute rather than concentrated form
 - Limitation of effects
 - Designing and locating equipment so that the worst possible condition gives less danger,
 - e.g. gravity will take a leak to a safe place
 - Simplification/error tolerance
 - Keep piping systems neat and visually easy to follow
 - Design control panels that are easy to comprehend
 - Design plants for easy and safe maintenance

INDEPENDENT PROTECTION LAYER



- process design
- process control system
- critical alarms and operator supervision/response
- automatic shutdown and interlocks (SIS)
- physical protection
 - (e.g. pressure relief valve, containment)
- plant emergency response
 - (e.g. fire fighting)
- community emergency response (e.g. notification, evacuation)