

Lessons Learned

More Information

Industry Sector

Oil & Gas

Lessons Learned Database Individual Incident Summary Report



Special Interest Group			Special Interest Group
Incident Title		Coke Drum Fire During Coker	Unit Restart
Incident Type		Fire	
Date		25 th November 1998	
Country		USA	
Location		Puget Sound, WA	
Fatalities		Injuries	Cost
6		0	Unknown
Incident Description Credit: US Chemical Safety Board	The Delayed Coker Unit (DCU) incorporates 2 large vertical coke drums ("and "B") which normally operate at ~ 496 °C (~ 925 °F) on a 15 or 16 hr cycl A switchover valve diverts feed in the charge heater outlet (transfer) line fro the first drum (when full) to the second (empty) drum. The full drum contain petroleum coke and unconverted oil which is removed by steam when take off-line. The coke bed is then cooled by injecting water into the drum. After depressuring the drum to the blowdown system and venting to atmospher the top and bottom heads are removed and the solid mass of coke is cut with a high pressure water drill into chunks which fall into a pit below. The empedrum is then air-freed with steam and warmed ready for the next switchover.		
ncident Analysis	Power was restored at ~ 02:00 hrs. Steam production resumed at ~ 12:30 hrs. DCU operations were interrupted ~ 1 hr into the normal charging cycle. Feel had switched to on-line drum "A" (now partially full) but did not have enough time to convert to coke, so it remained a hot liquid. Off-line drum "B" was full and being cooled. Tarry oil in the heater transfer and drum feed lines hat solidified during the outage so operators were unable to cool drum "A" with steam and water. On the morning of 25-Nov-98, after more attempts to inject steam into drum "A", operators erroneously interpreted relatively low drum temperatures to mean its contents had cooled sufficiently. A work permit water issued to dehead the drum. The top head was removed without incident by when the bottom head was lowered, an eruption occurred expelling the drum contents in a few secs. The hot oil auto-ignited, engulfing 6 workers in flames. Basic cause was an uncontrolled release and autoignition of unconverted hot oil due to premature deheading of the partially-full coke drum "A". Critical factors included: 1) The control panel for the hydraulic lift used to		
	lower co the cok emptyin full coke spewed foremar sufficier days w	poke drum bottom heads onto the edrums, 2) No operating proceeding a partially-filled coke drum, 3) In edrum, a torrent of water and a gold out, requiring a major cleanup of the decided ambient air cooling of the to make it safe for emptying (postulated by the total determine the actual temperature.	deheading cart was located belo lure was available for cooling ar a 1996, while deheading a partially coey mixture of heavy oil and col- the DCU, 4) Remembering this, the coke drum "A" for just 37 hrs was t-incident analysis revealed sever manager failed to enlist technic
	(hydrau procedu awaren manage cooling) skin ten foremar	auses included: 1) Failure to apply lic lift controls too close to coke ure (cooling and emptying partially ess (residual heat in core of co ement of change (MoC) review (a b, 5) Inadequate job knowledge (instance) and perature sensor limitations), 6) Inn, 7), Inadequate control of work (drums), 2) Absence of operating full coke drum), 3) Lack of hazard coke ball), 4) Failure to conduction cooling versus steam and water sulating properties of coke, externandequate training (operators and

Process Type

Coking

verifying drum temperature), 8) Inadequate leadership (operations oversight).

1) Abnormal operations requiring deviation from approved procedures should

be subjected to a rigorous management of change (MoC) review process. 2) Automatic deheading (slide) valves minimise operator exposure to hazard. 1) US Chemical Safety Board (CSB) Safety Bulletin 2001-04-SB: Case Study.

Incident Type

Fire