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### Railcar Loading Incidents – Same Safety Standards for logistic operations and for process units?

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Maastricht, 13<sup>th</sup> of December 2023

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## **Railcar Loading Incidents**



- Logistic operations like loading/unloading of railcars are routine operations in process industries
- Risk factors and considerations:
  - Loading/unloading is often operated with a high frequency (normally daily operations)
  - High volumes of hazardous substances are handled
  - A lot of manual handling is required during loading/unloading
  - Loading/unloading operations are directly linked with several hazard factors like overfill open, loading/unloading of wrong product, etc.
- Hazardous

substances

- Nevertheless, we see that the safety standard at loading stations is often lower than in process units
  - Lack of "state of the art-safety equipment"
  - Safety critical devices not really protected against bypassing
  - Loading personnel not always on the same qualification level as "normal operators"!
- See 2 examples on serious incidents at loading facilities!
- Check your loading facilities, could this happen as well?

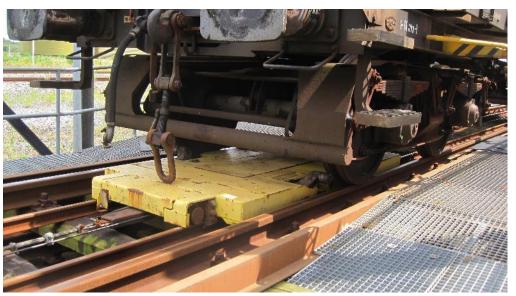


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## Example 1: Damage of railcar loading station

### **Loading Station**

- Loading station for railcars with Vinyl Chloride Monomer (VCM), loading can be done at 2 stations simultaneously
- Rail tank wagon (A) was in the loading process, liquid and gas loading arms installed
- Another rail tank wagon (B) on the same track had finished loading and weighing;
- Loading operator wanted to move tank wagon (B), although this is according to the procedures not allowed.
- A transport unit (TU) is used to move the tanks and can be set to either pass under wagons or move them.
- The TU can only move when loading arm is in parking position, this triggers a safety interlock (safety contact).







## Example 1: Damage of railcar loading station

### What happened:

- An operator moved the safety contact and bypassed the safety system!
- To move away filled wagon B, TU needed to pass wagon A (in loading).
- TU was not set to the correct position to allow it to pass freely under the wagon A (transport hook was extended)
- When TU passed wagon A, it pulled wagon A along the track, resulting in bending the loading arms.
- Incident was spotted by operator; the emergency stop button was pressed and the system shut down into a safe state.
- Rail tank wagon A and liquid and gas loading arms were significantly damaged!
- No release of VCM or injuries were reported!





11/12/2023



## Example 1: Damage of railcar loading station

### Why:

#### **Direct Causes:**

- Safety interlock System was intentionally bypassed
- TU was not brought to the correct position to pass below the rail wagon

### Indirect Causes:

- Breach of Work instruction:
  - Move of TU not allowed during loading!
- Bypassing of safety interlock common practice in the logistics team!
- Operators wanted to complete the job quickly
- Construction of safety contact "easy to bypass"

### **Conclusions:**

- Poor safety behaviour in the logistic team
- Employees were transferred to logisitcs team which were seen as "low performers" (especially in SHE)!
- Limited supervision and poor leadership by the direct supervisors!



Safety contact not bypassed -> TU cannot be moved



Safety contact bypassed -> TU can be moved



## Example 1: Damage of railcar loading station

### Learnings:

- Unauthorised Bypassing of any safety device is not acceptable!
- Bypassing of safety devices can lead to fatalities or major releases.
- Regular audits and check required if all employees are working according to the rules and operation instructions
- Well trained and educated operators and supervisors are required for logistics operations as well!
- Design safety systems in a way that they cannot easily bypassed
- Specific action for loading station:
  - Design of safety interlock system was adapted (see pictures of new interlock)





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### Loading Station and situation description

- VCM Loading asset with 8 loading stations -> daily loading of a VCM railcar train
- Engine (locomotive) enters loading area during loading of VCM-Railtank wagons
  - Only possible after bridging the derailing interlock in front of the loading area access gate



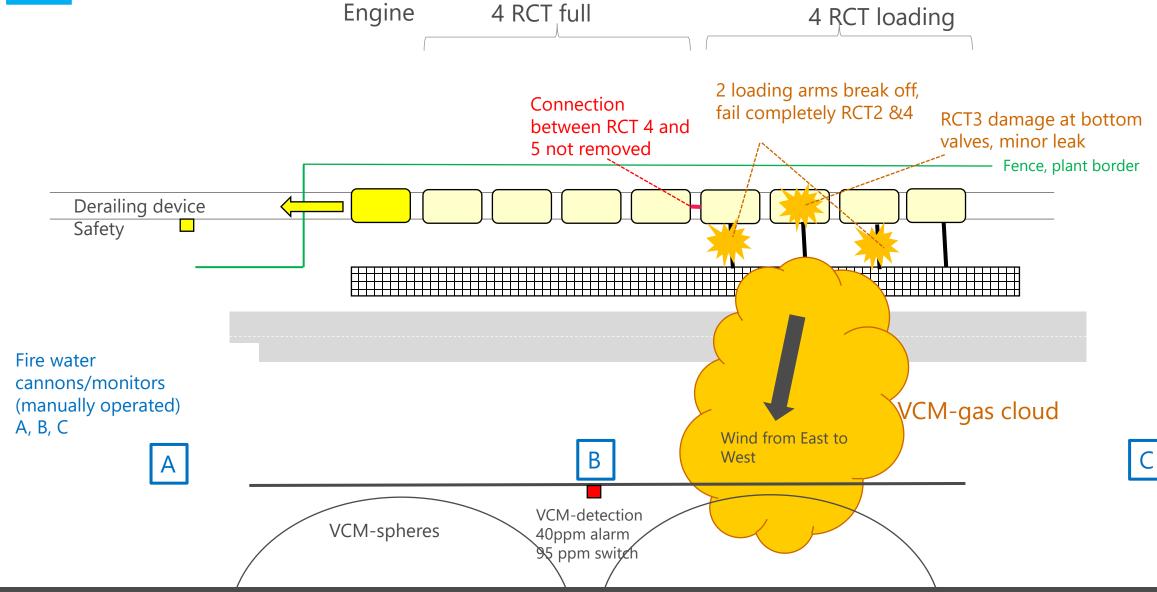
Loading Area

### What happened:

- 8 rail wagons in the loading station; Intention was to remove 4 already loaded wagons while the remaining 4 were loading
- Shunter attaches the engine to wagon 8, clears hand brake and wheel block and climbs back in Engine driver
- Shunter did not check the connection between wagon 4 and 5, assuming it was removed
  - Based on misunderstood communication via radio and handsignals with 2 loading area operators
- Engine started to pull the wagons but feel severe resistance. After about 3m they stopped to look for the cause.
- Due to the movement, 2 loading arms (wagons 2 and 4) break-off (gas and liquid arms), 2 other loading arms were severely damaged but not leaking
- A big gas cloud was formed and drifted to the VCM-storage and production area (12h33)
- Loading area operator who saw everything happening from the control room at the loading area was too shocked to press the emergency stop button

### Location





## Damage





Loading arms gas and liquid phase severely damaged but not

leaking



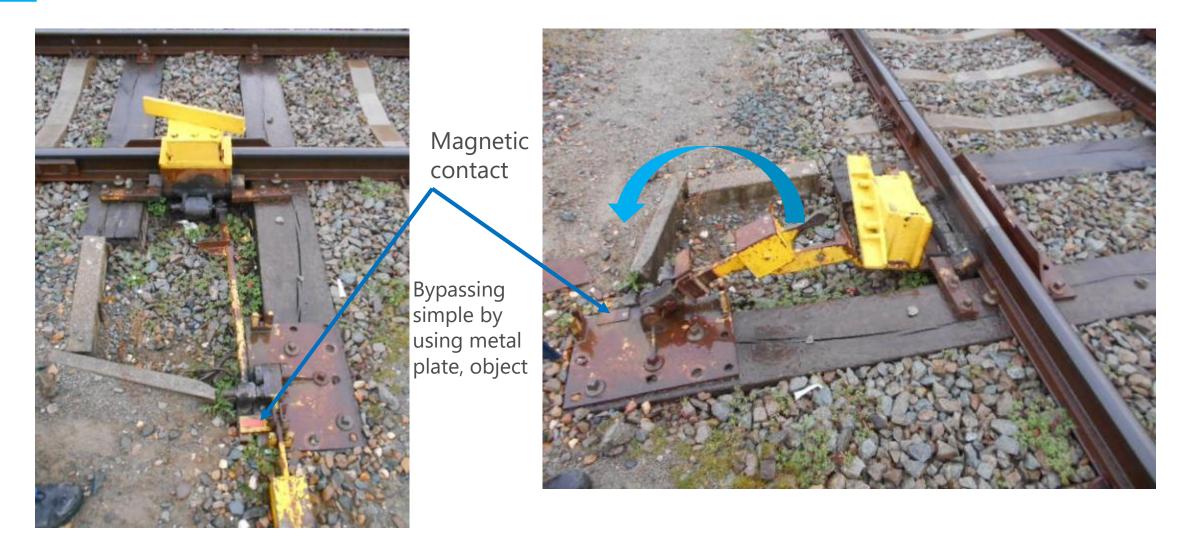
Loading arm DN80 (liquid phase)

### Why:

- Direct Cause:
  - Movement of the rail wagons by engine caused rupture of the loading arms
- Indirect Causes:
  - Conscious bypass of the derailing device by engine driver (team-leader) and shunter to access the loading area (Ex-zone) while loading 4 wagons.
    - Was done twice on the day of the incident, safety device was bypassed since early morning
    - The same way of working was used by other members of the loading team in previous days
  - Normal engine (locomotive) was in maintenance, therefore use of (light) spare engine.
    - Spare engine only able to pull 4 loaded wagons instead of 8
  - No check by engine driver and shunter whether the train was disconnected from the other 4 wagons.
  - Team wanted to be ahead of time and to facilitate the work of the upcoming shift!
  - Team-lead actively joined the unsafe way of working:
    - He did not stop his team-members
    - He was not addressing their unsafe behavior
    - He did not remove the bypass of the derailing device

## Derailing device - safety





Engines





Heavy normal engine. In maintenance on the day of the incident. Able to pull 8 loaded RCT!



Light spare engine. Used during the incident. Only able to pull 4 loaded RCT instead of 8. Able to move 8 empty RCT at once

### Learnings & Actions

- Technical Improvements
  - Installation of VCM-detection at loading area
  - Improving derailing device (making bypassing more difficult)
  - Installing additional emergency stop buttons at loading area
  - Improving rail hook system, also closing valves of loading arms and stopping loading pumps
  - Install fire water sprinkling on every loading point
- Review of all Safety Critical Bypasses in all areas and plants
- Start-up SHE-behavioral program for loading team training, coaching, assessment
- Re-organization of the logistic team!
- Setting up bypassing procedure within logistics department



## Final conclusions and learnings

- Do not accept any deviation of the standards and procedures ("Normalization of Deviation")
- Logistic operations like loading/unloading of railcars need the focus on Safety as process operations!
- Ensure that logistic teams have the same level of education and safety performance as the process operations teams
  - If this is not the case, dedicated programs on safety behaviour are required
  - "Leading by example" is required at all leadership levels!
  - Execute regular audits!
- A clear procedure on bypassing of safety critical devices is required
  - Clearly identify and label the safety critical devices
  - Ensure that all employees know which devices are safety critical
  - Define a Life Saving Rule and/or a Process Safety Fundamental for bypassing:
    - Safety critical devices/interlocks must not be disabled or overridden without authorisation







## Questions?





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