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Congres
Process Safety
December 16, 2025 - Dordrecht

Fiona Macleod
Professor of Process Safety
School of Chemical, Materials and Biological Engineering
University of Sheffield

WHAT UNI? STUDENT CHOICE Awards 2024 **UNIVERSITY OF THE YEAR**

victrex

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EASTMAN

Hovione

bp

JM

龍蟒佰利聯
LOMON BILLIONS

Fiona Macleod

Managing Director Lynemouth Power at EPUKI

England, United Kingdom · Contact info

500+ connections

EP UK Investments Ltd

University of Cambridge

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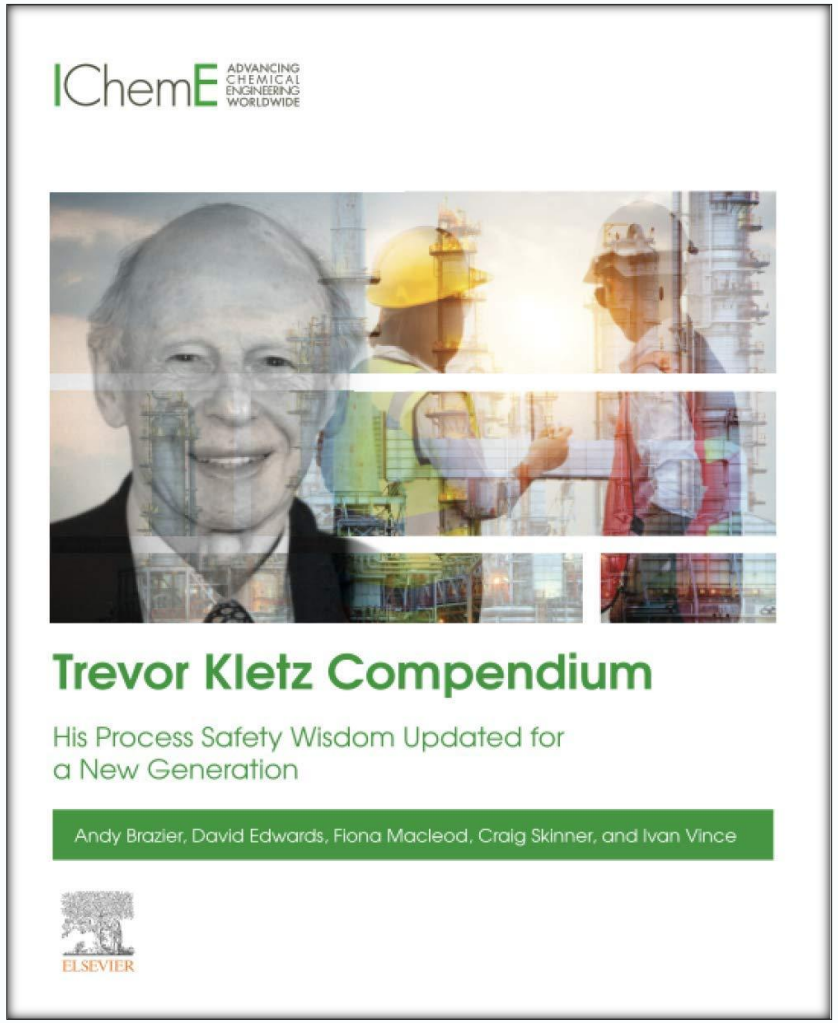
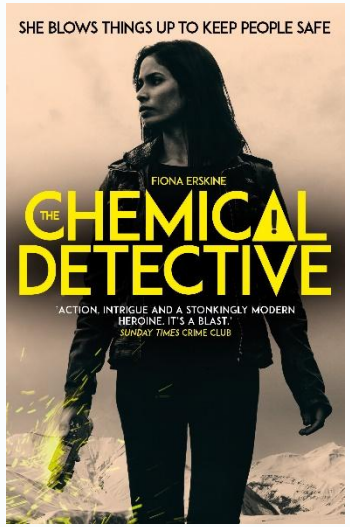
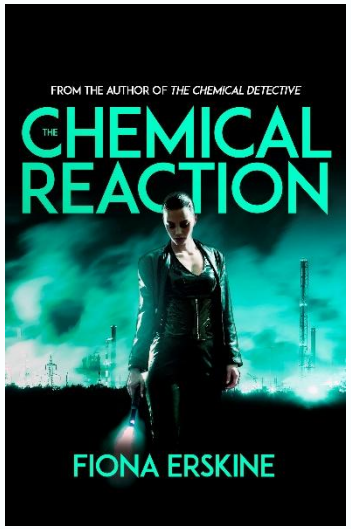
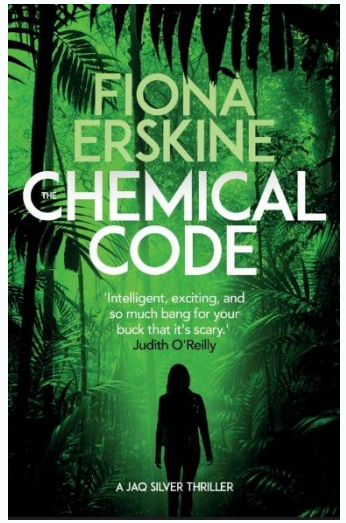
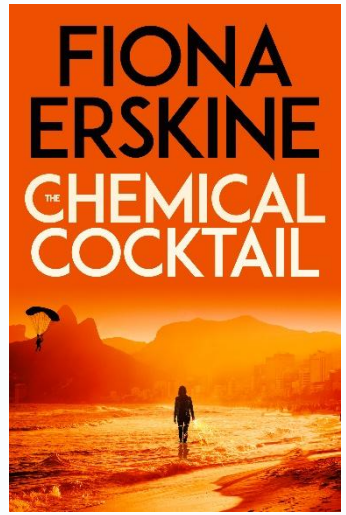
Engineer by day, writer by night

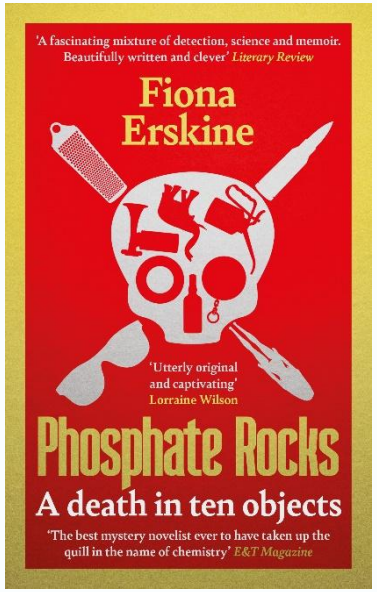


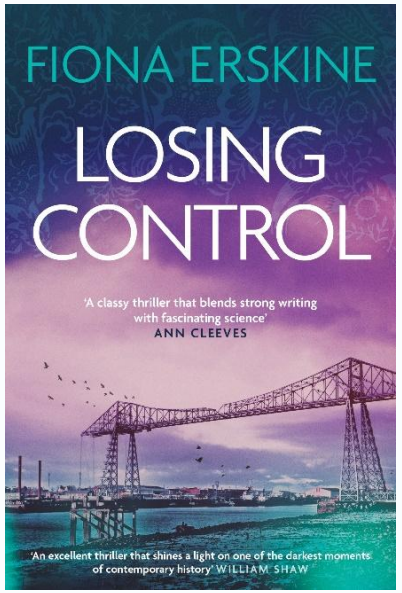












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IChemE Safety Centre

Management of Change (MOC)

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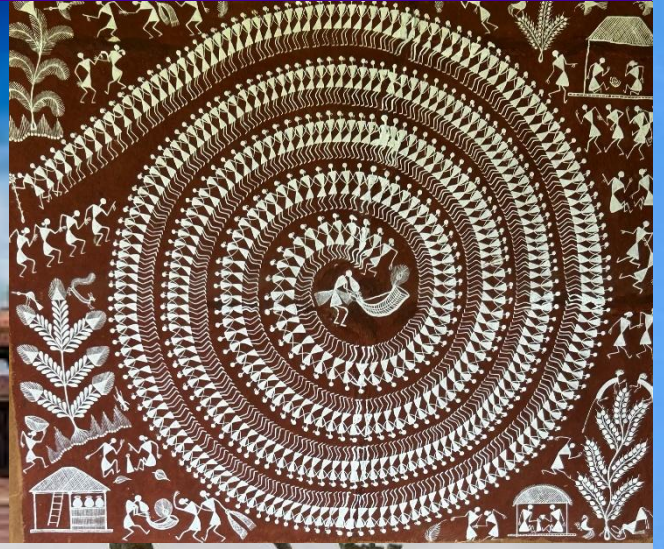
Bhopal 41 Years on

What Have We Learned?

Why Bhopal?

- Why does the Bhopal Gas tragedy still matter ?

- What myths should be debunked
  1. The process design was safe
  2. The local team were incompetent
  3. The accident was caused by an act of sabotage
  4. The high death toll was due to illegal slums
  5. The out of court settlement was fair
  6. The toxic waste has all been safely disposed of
  7. Lessons learned are all about emergency response



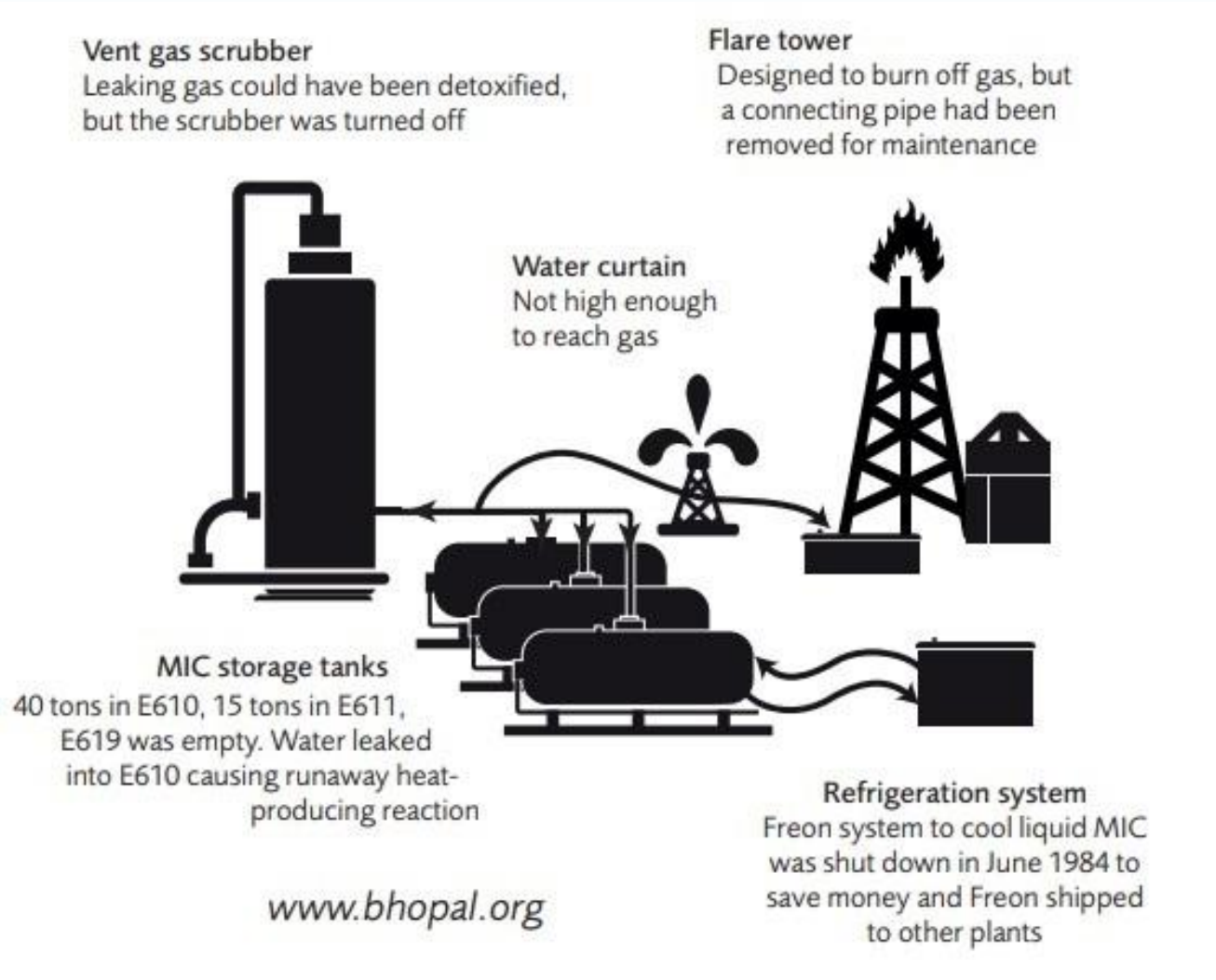
Bhopal, 40 years on

The Tragedy

When?	3 December 1984
Where?	Bhopal, Madhya Pradesh, India
What?	~27 tonnes of toxic gas released
Who?	Thousands killed Hundreds of thousands injured

Failure of emergency response

- Flare
- Scrubber
- Water Curtain
- Spare tank
- Refrigeration
- Community Alarm
- Community Response Plan



Toxic gas release – How did it happen?

How?

Runaway reaction

Methyl Isocyanate (MIC) + H_20 + Fe

Why?

Several theories

The Investigations

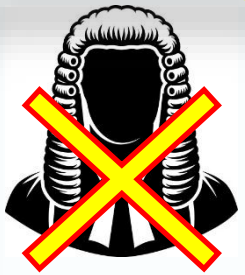
BHOPAL METHYL ISOCYANATE INCIDENT

INVESTIGATION TEAM

REPORT

MARCH, 1985

UNION CARBIDE CORPORATION
DANBURY, CONNECTICUT



Judge NK Singh Inquiry

INVESTIGATION OF LARGE-MAGNITUDE INCIDENTS: BHOPAL AS A CASE STUDY

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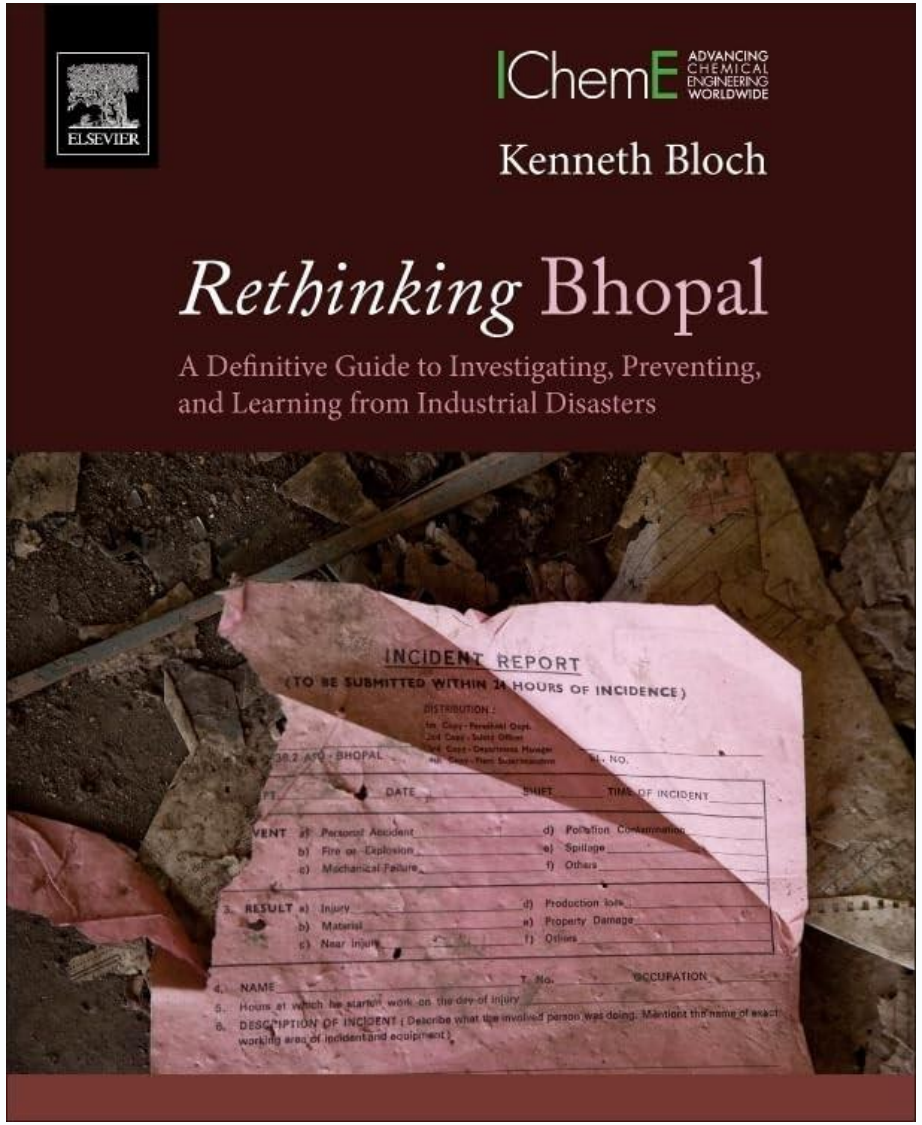
CSIR

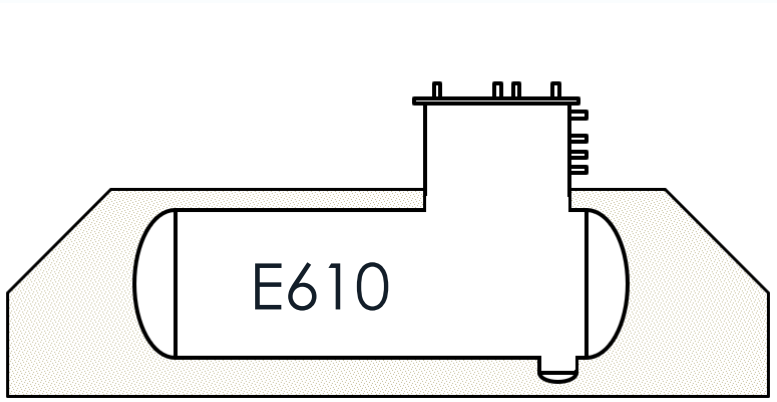
DECEMBER, 1985

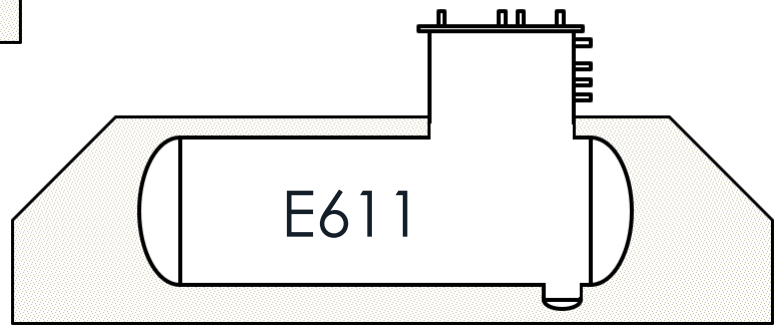


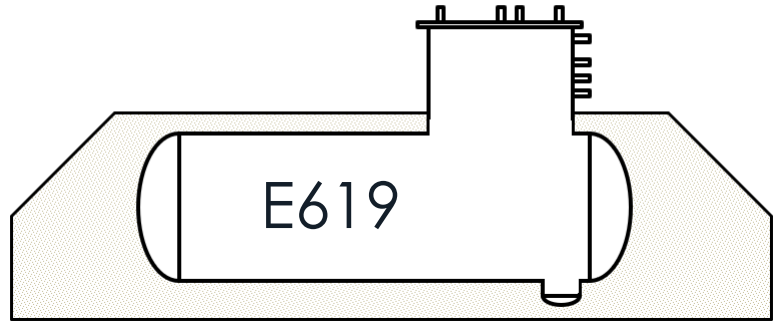
How did water enter the MIC tank?

1. The MIC slow degradation theory
2. The filter washing theory
3. The sabotage theory
4. The nitrogen mix up theory
5. Rethinking Bhopal

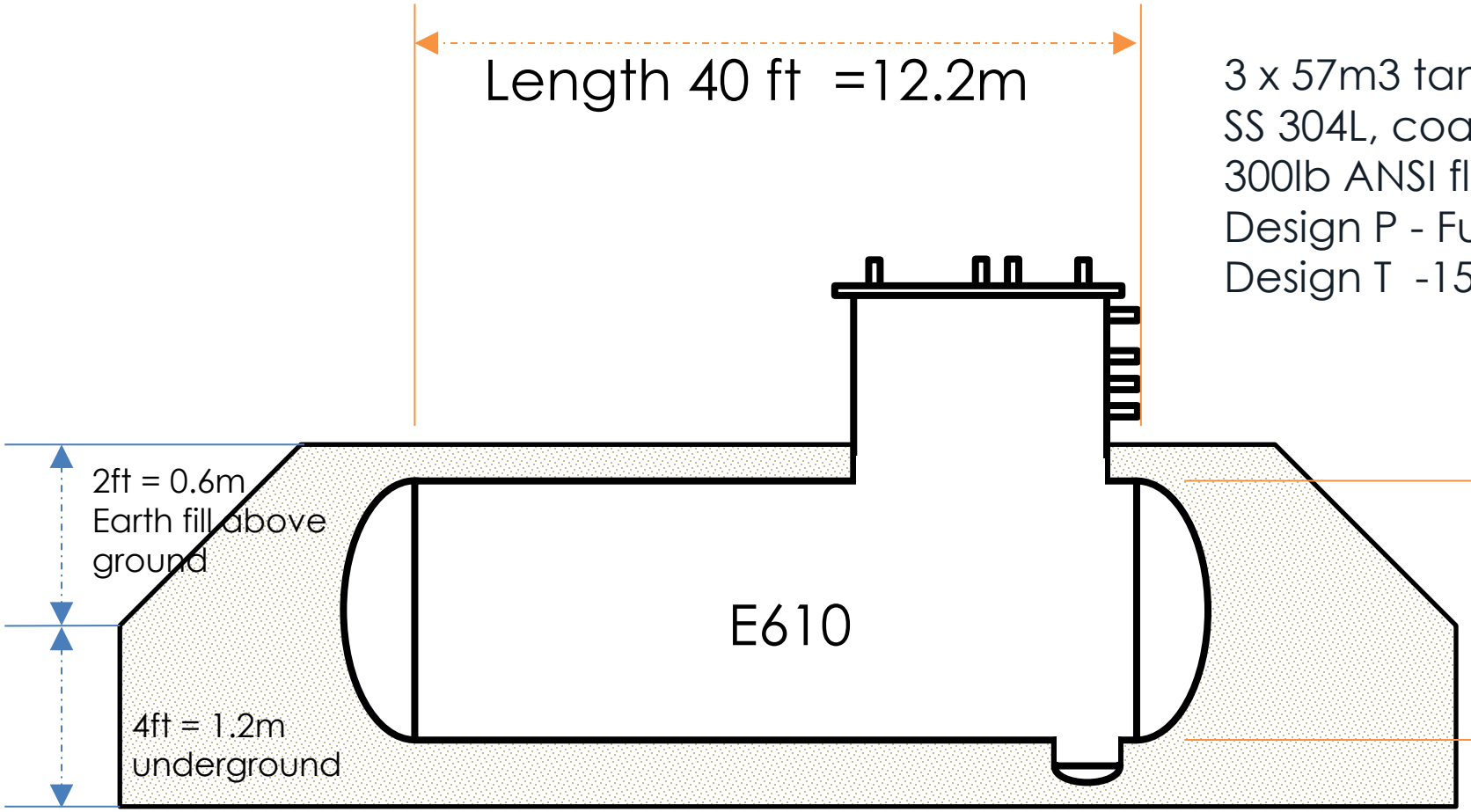
Methyl Isocyanate (MIC) Storage Tanks







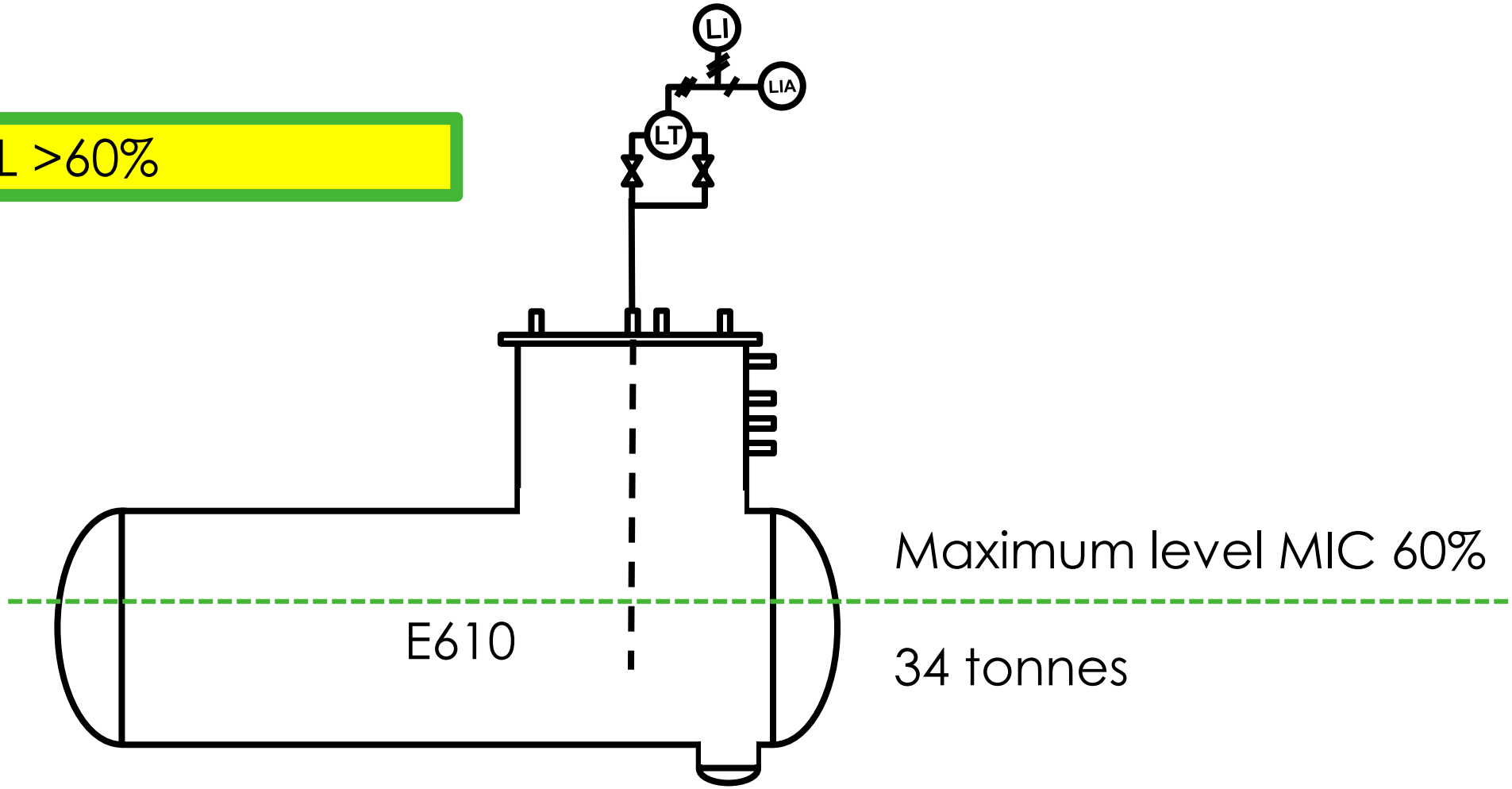
3 x MIC Storage Tanks



3 x 57m3 tanks (15,000 gallons)
SS 304L, coated, cathodic protection
300lb ANSI flanges
Design P - Full vacuum to 40 psig (2.75 barg)
Design T -15° to 121°C

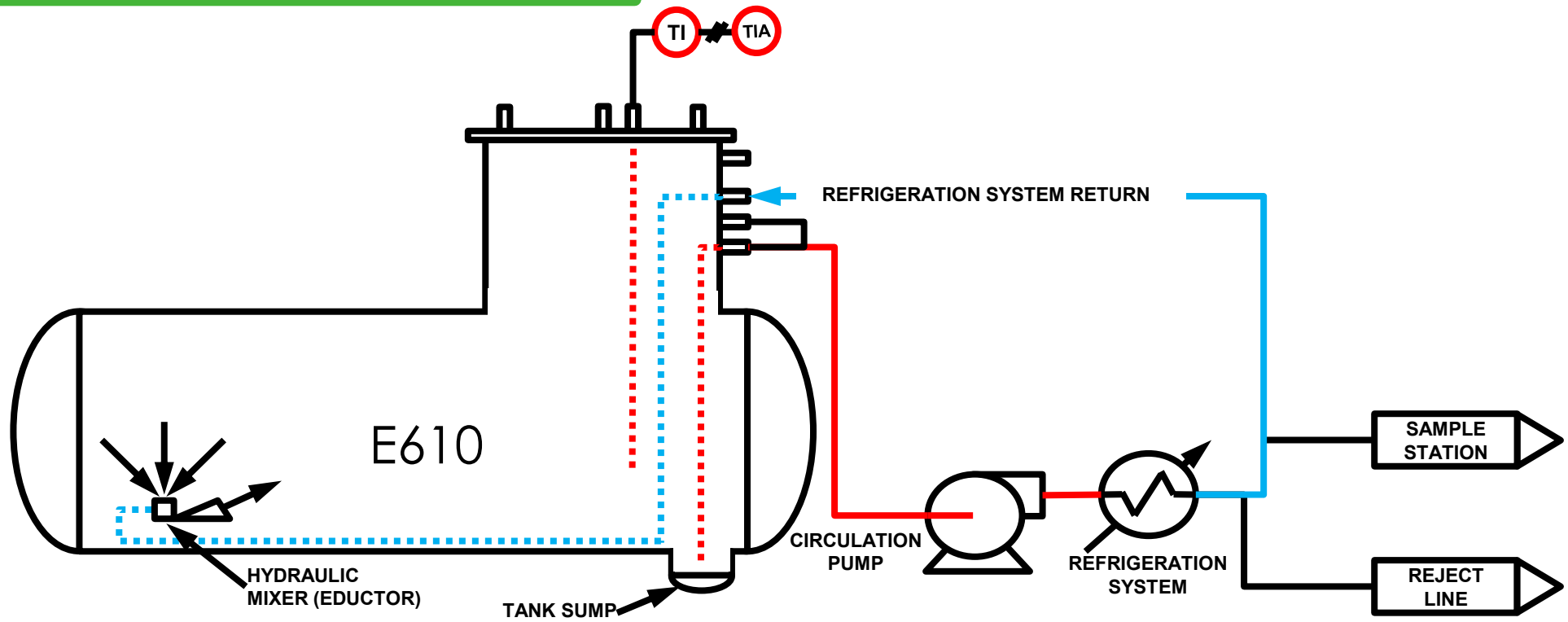
E610 – Level Indication

20% < L >60%

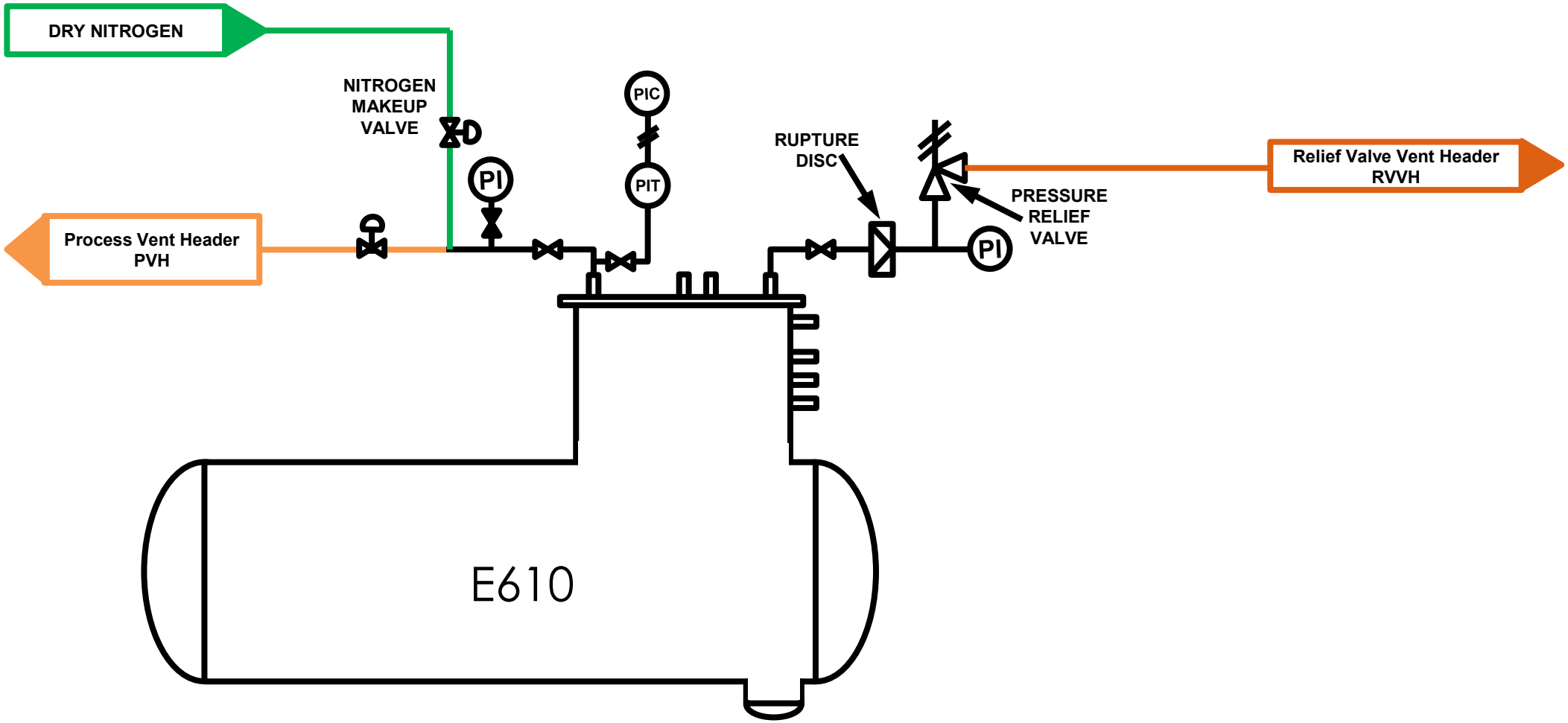


E610 – Temperature Control

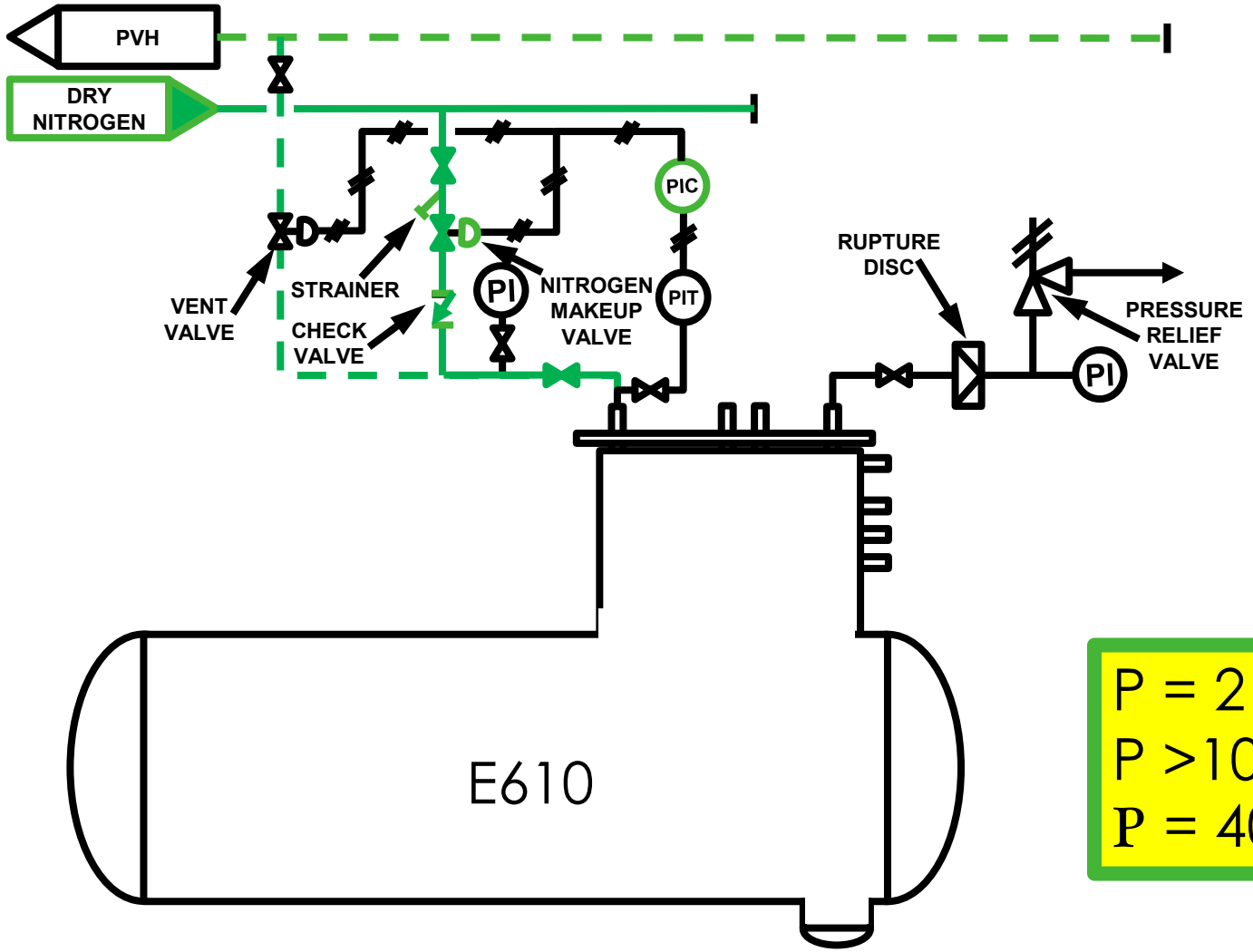
T = 0°C Design Storage T
T >11°C High Temperature Alarm
T = 15°C Maximum allowable T



E610 – Pressure Control

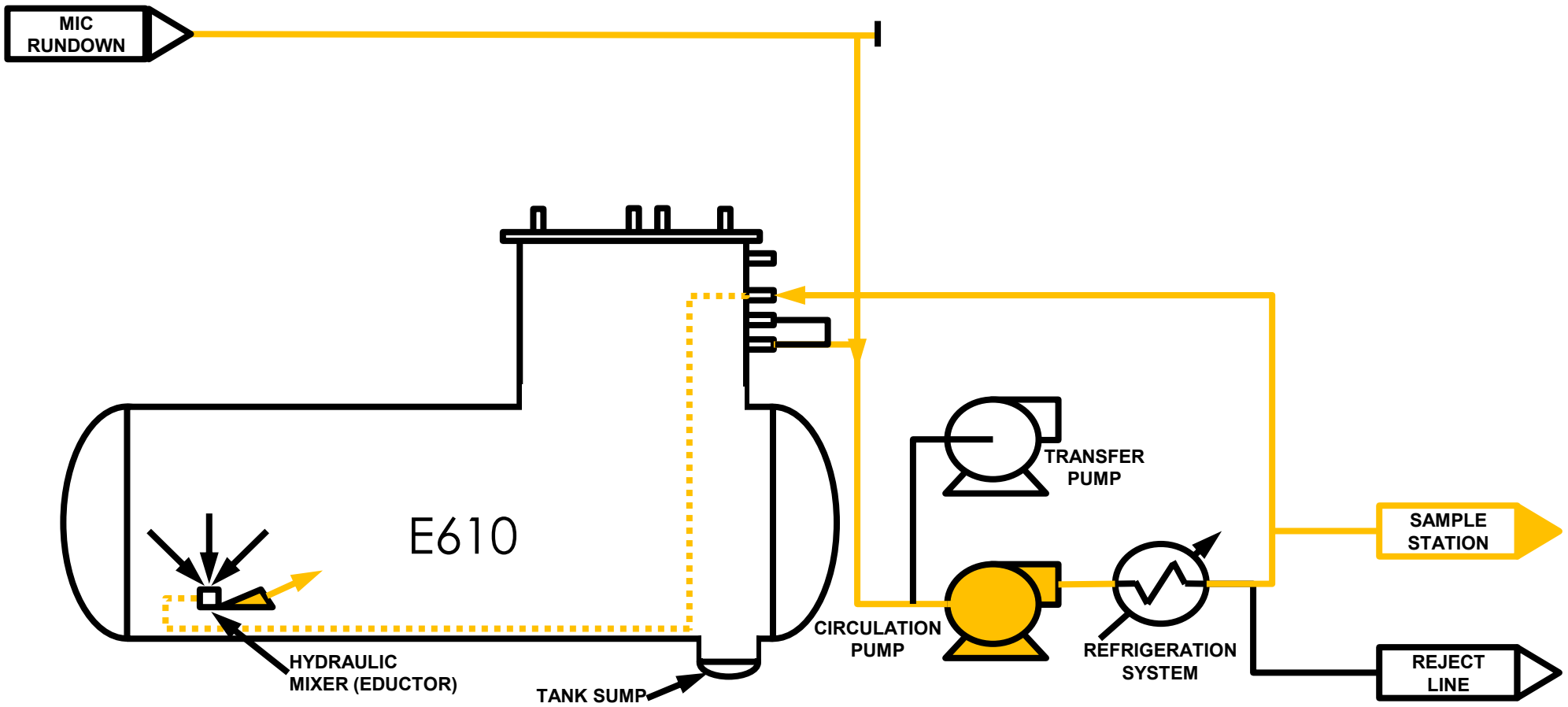


E610 – Pressure Control



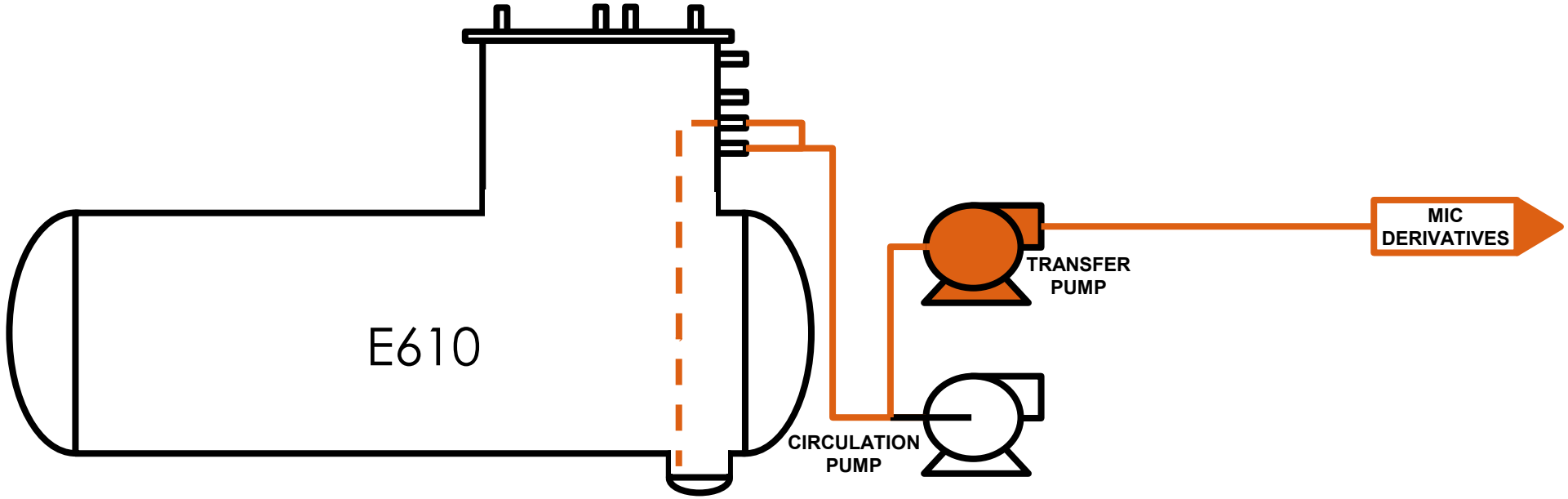
P = 2 psig Design Storage P
P >10 psig Max P (USA)
P = 40 psig Relief BD+PRV

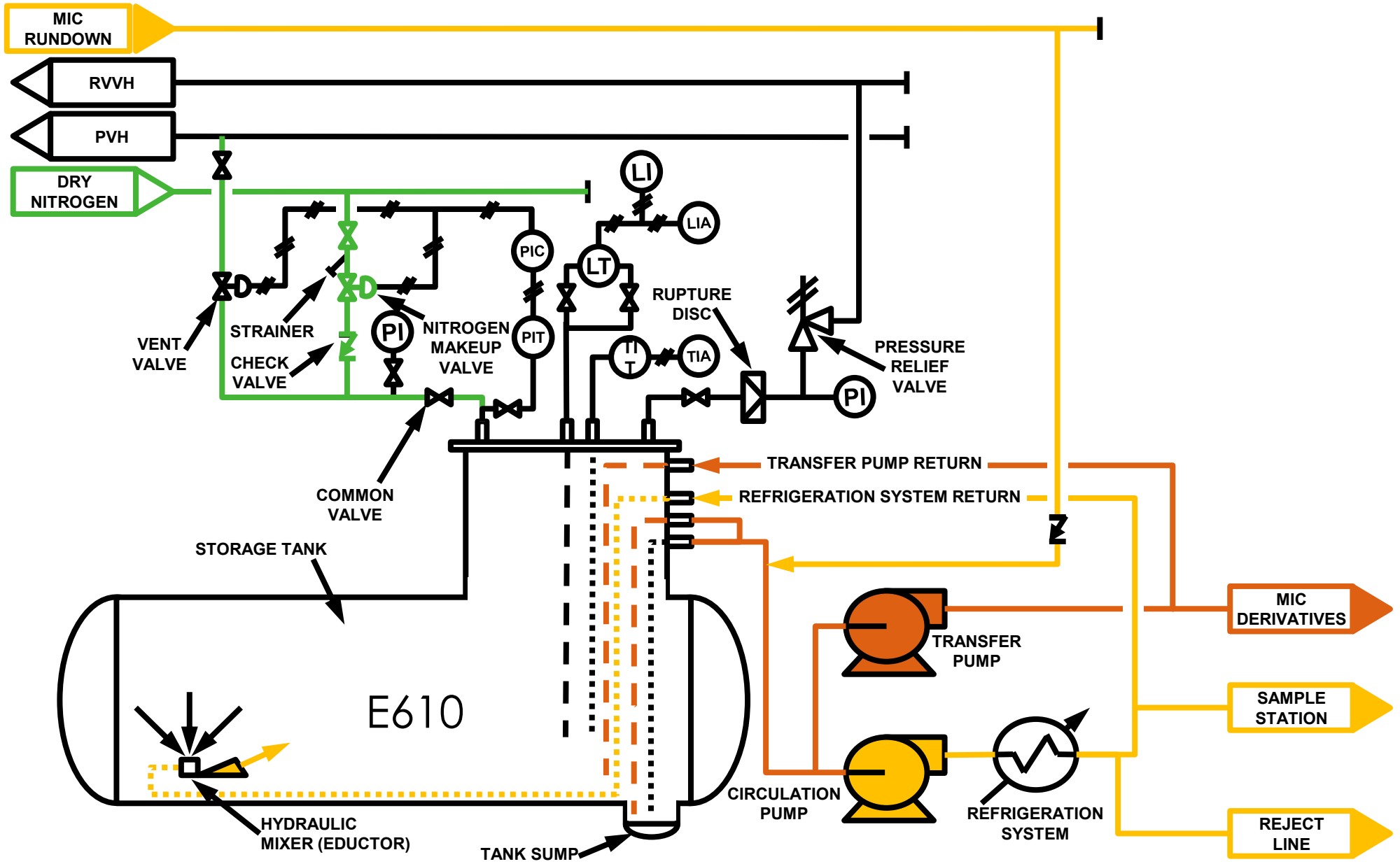
E610 – Quality Control



Kenneth Bloch – Rethinking Bhopal

E610 – Transfer





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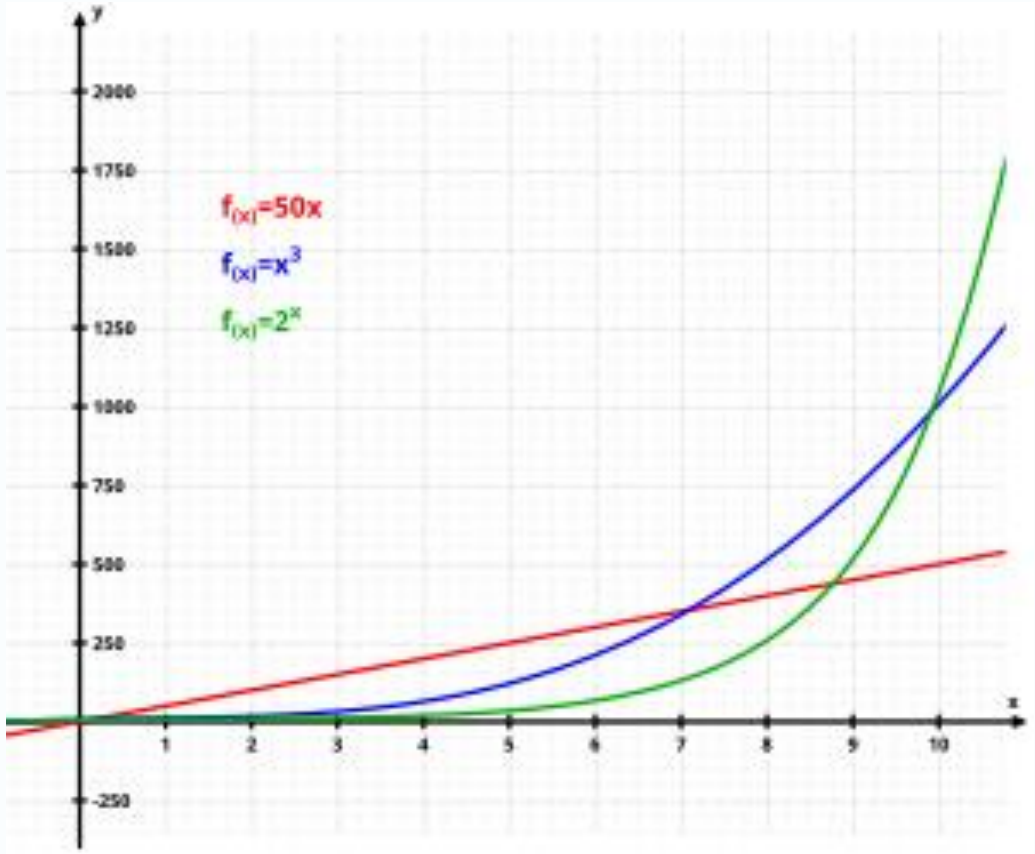
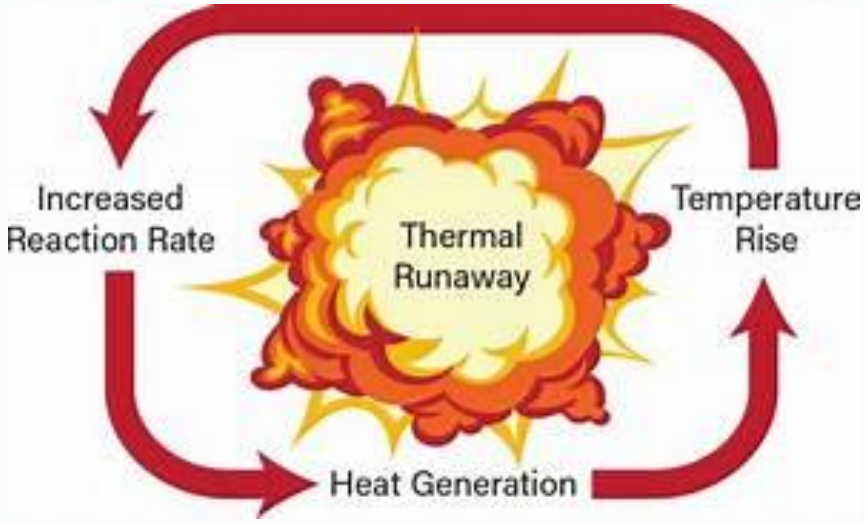
Theory 1 – slow degradation



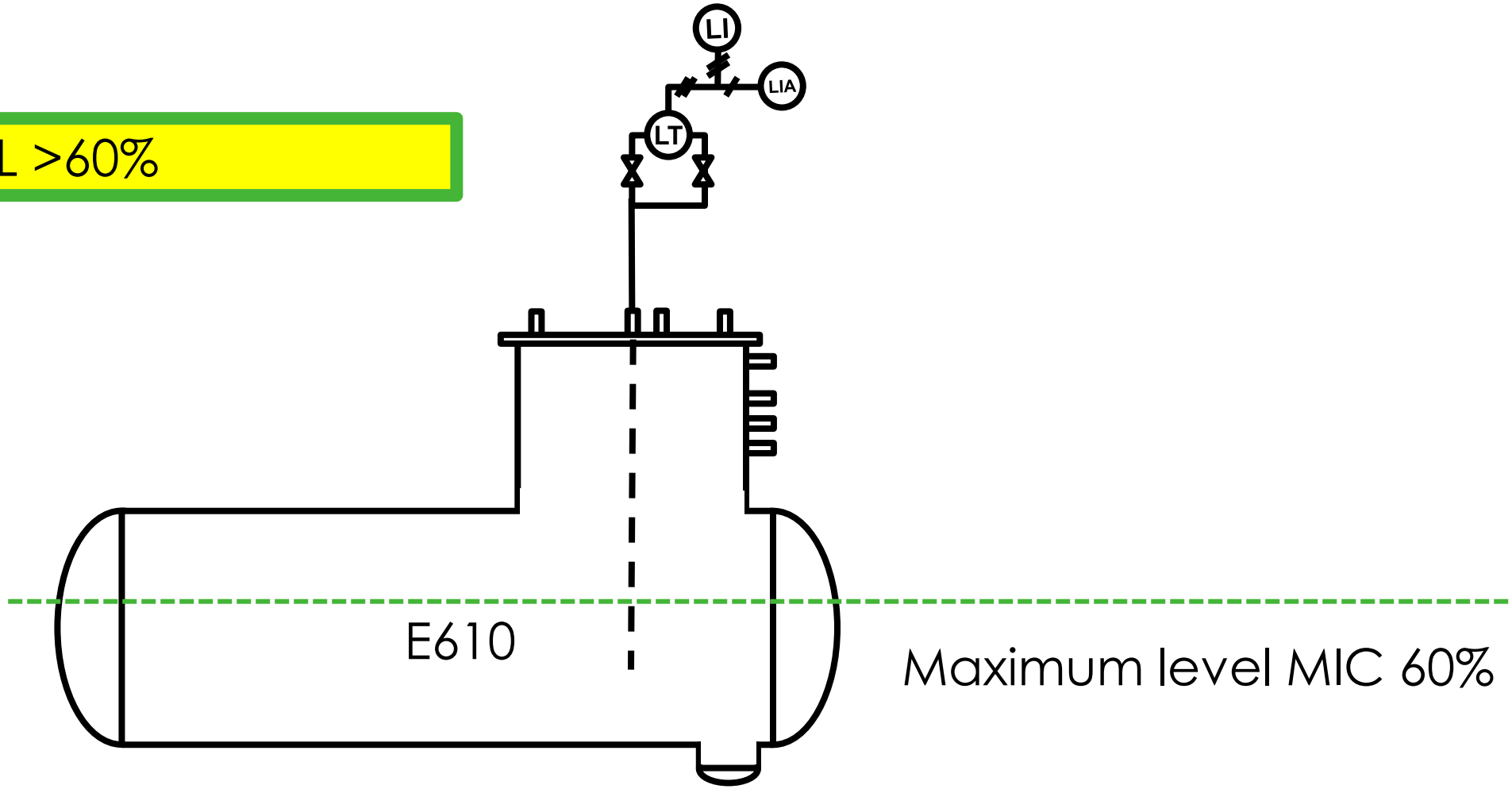


Background

- 27 Day to Permanent Closure
- Loss of experienced staff
- Operational workarounds
- Reduced maintenance
- Compromised safety systems
- Increased inventory

E610 – Level September to December 1984

20% < L >60%

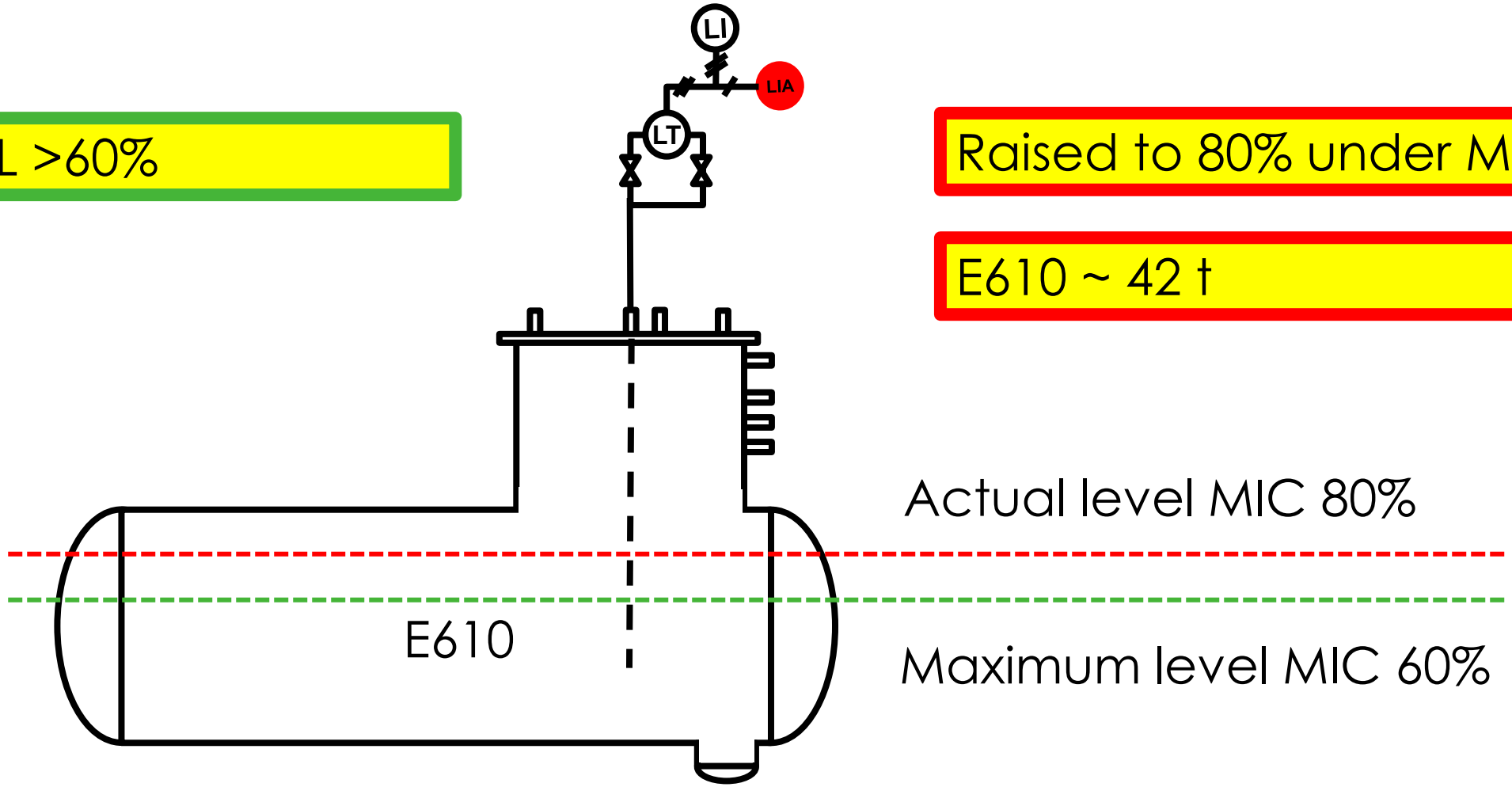


E610 – Level September to December 1984

20% < L >60%

Raised to 80% under MOC

E610 ~ 42 t



31st October 1984

INDIAN EXPRESS

INDIRA GANDHI SHOT DEAD

Attack by security men at 1, Safdarjang Road

One assailant killed, another held

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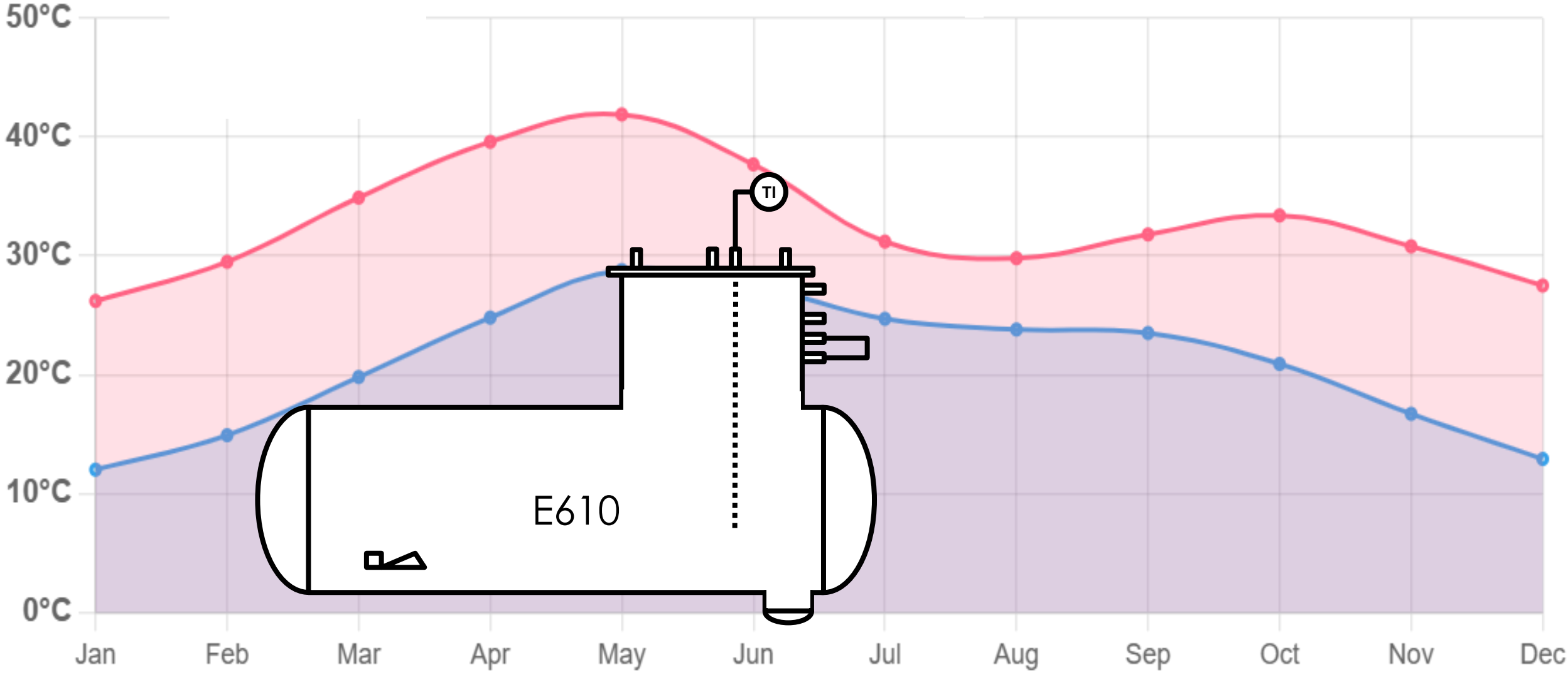
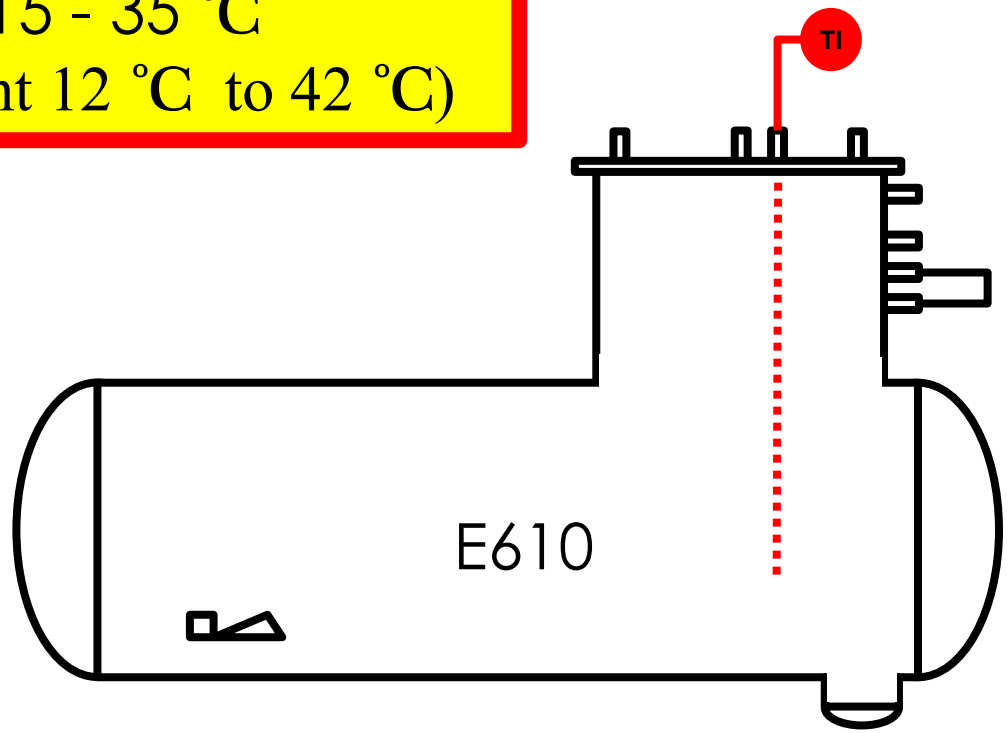
E610 – Temperature 1984



https://weather-and-climate.com/average-monthly-min-max-Temperature,bhopal-madhya-pradesh-in,India

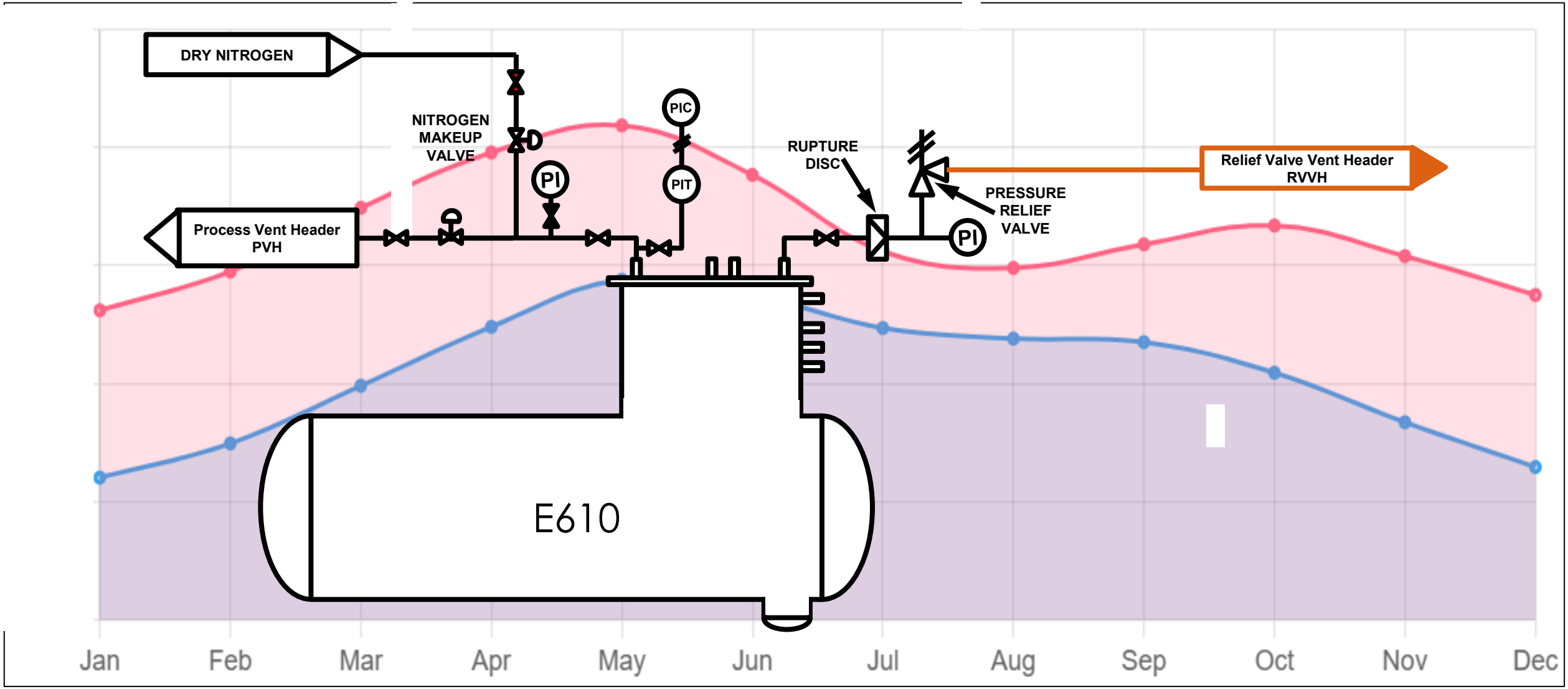
E610 – Temperature 1984

Actual temperature
15 - 35 ℃
(Ambient 12 ℃ to 42 ℃)

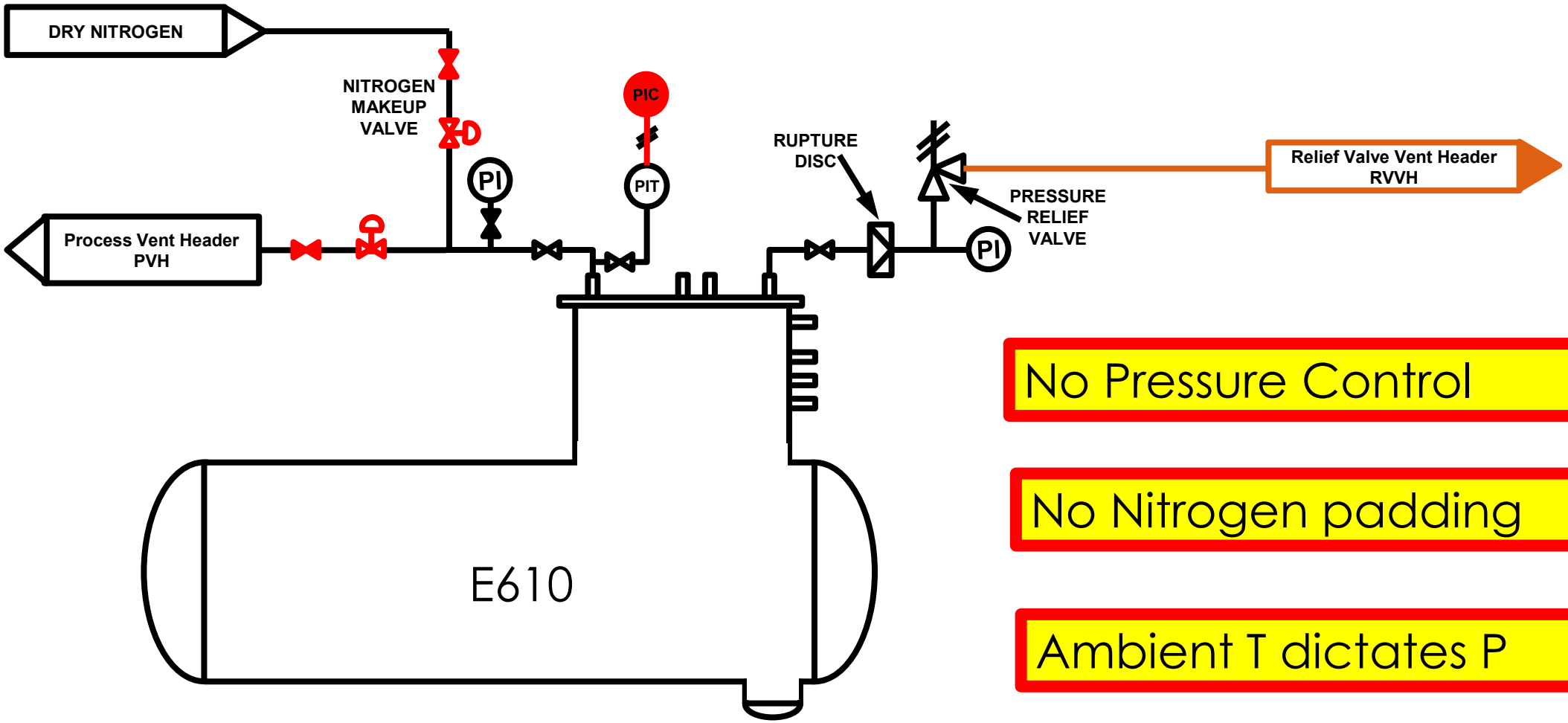


- No refrigeration
- Permanent T alarm
- No Circulation
- No Sampling
- No Reject route

E610 – Pressure 1984



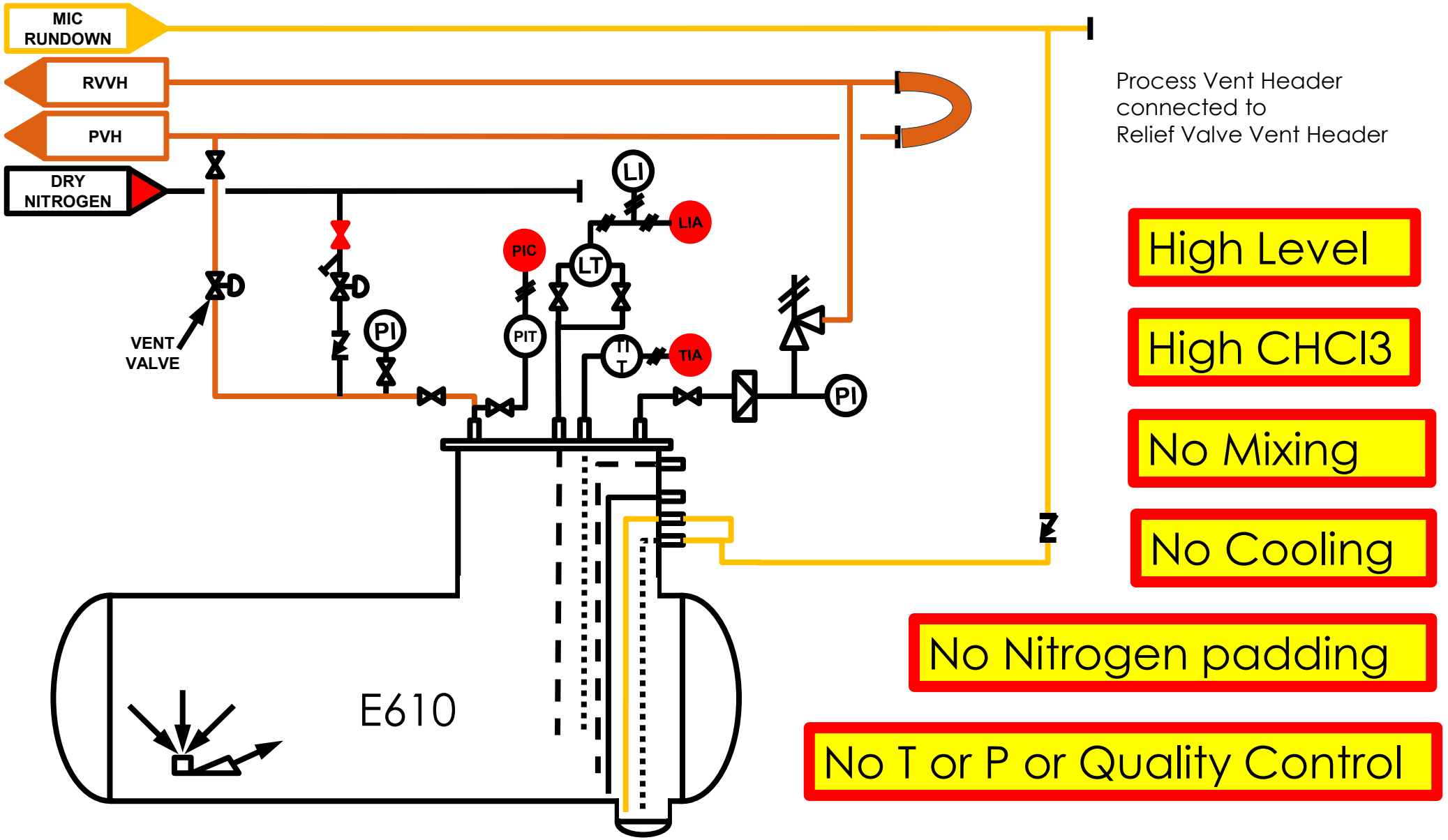
E610 – Pressure 1984



No Pressure Control

No Nitrogen padding

Ambient T dictates P



Process Vent Header
connected to
Relief Valve Vent Header

High Level

High CHCl3

No Mixing

No Cooling

No Nitrogen padding

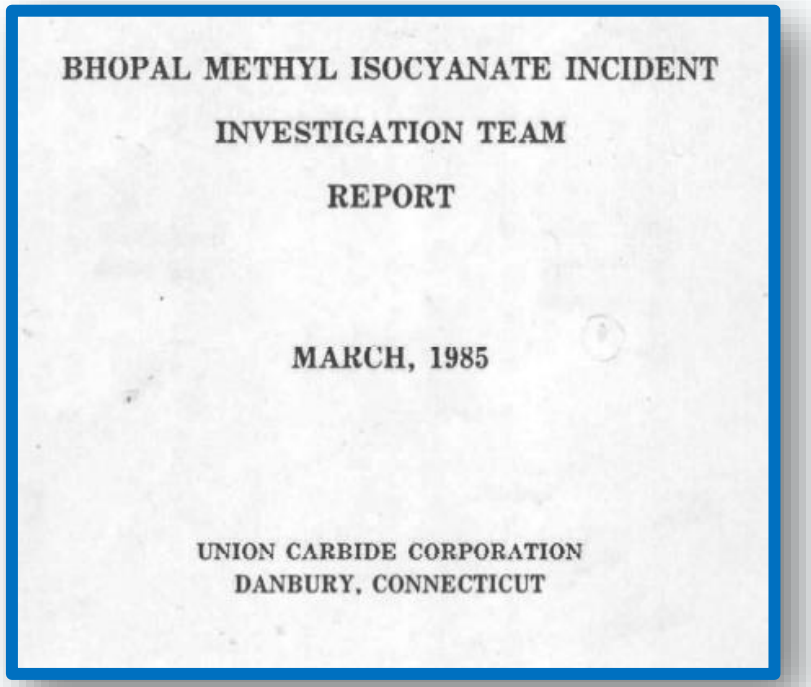
No T or P or Quality Control

Kenneth Bloch – Rethinking Bhopal

Theory 2 – Filter washing

1. The MIC slow degradation theory
2. The filter washing theory

UCC Investigation (March 1985)



BHOPAL METHYL ISOCYANATE INCIDENT

INVESTIGATION TEAM

REPORT

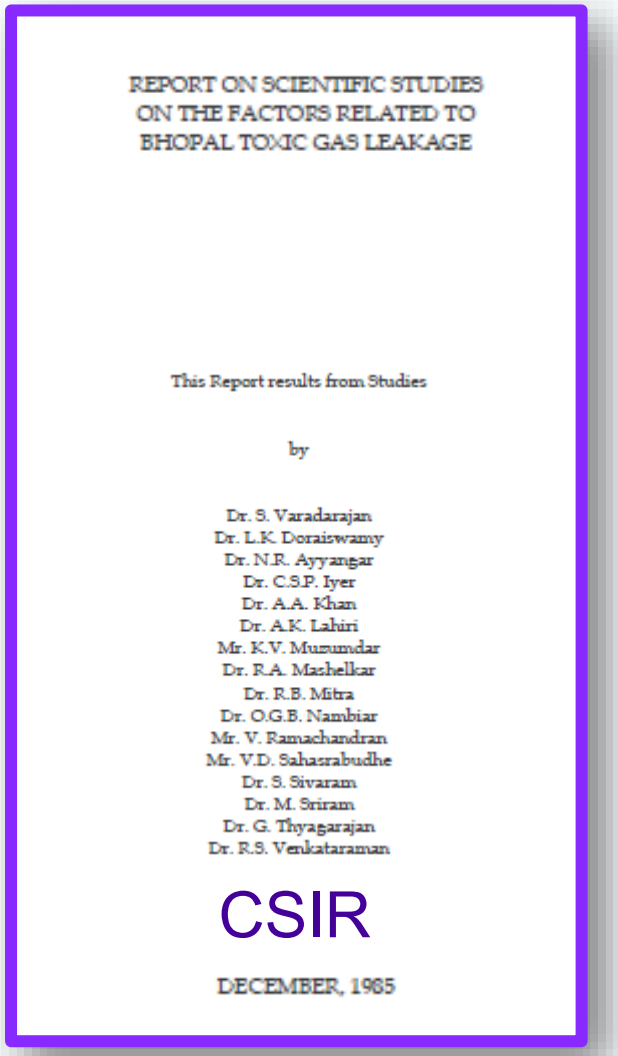
MARCH, 1985

UNION CARBIDE CORPORATION
DANBURY, CONNECTICUT

‘Tank 610 residue (was most likely) produced by the reaction of MIC with (450 – 900 kg) water, higher than normal amounts of chloroform and an iron catalyst’

‘Water could have been introduced inadvertently or deliberately’

CSIR Investigation (December 1985)



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CSIR

DECEMBER, 1985

- Accident conditions inherent and extant
  Bulk storage of a very high hazard intermediate
- Inadequate
  - Design
  - Materials
  - Instrumentation
  - Control
  - Disposal routes
- Tank pressure atmospheric
  Entry contaminants (alkali, metal) from 22nd October 1984
- Water washing MIC pipelines common practice
  500kg water to E610 from filter washing on 2nd December 1984

Theory 2 - Filter washing

Indian Council of Scientific and Industrial Research (CSIR)

During the cleaning of choked filters with water in the Relief Valve Vent Header, such water could have entered the non-pressurised tank and may have carried some metallic contaminants from the carbon steel portions of the header pipelines

Water used to wash filter No

Isolating blank installed

Ramin Abhari – Butterflies of Bhopal

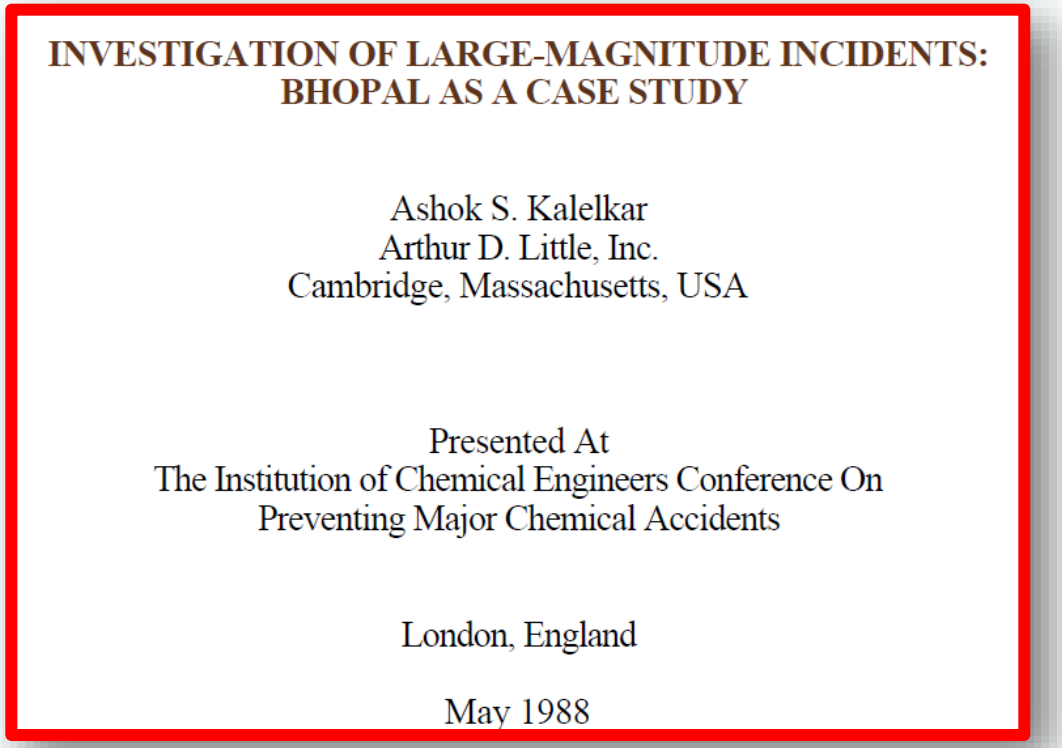
Theory 3 - Sabotage

1. The MIC slow degradation theory
2. The filter washing theory
3. The sabotage theory

AD Little (UCC) 1988

Water-washing of lines in the filter area could not possibly have been the cause of water entry into Tank 610

UCC commissioned report



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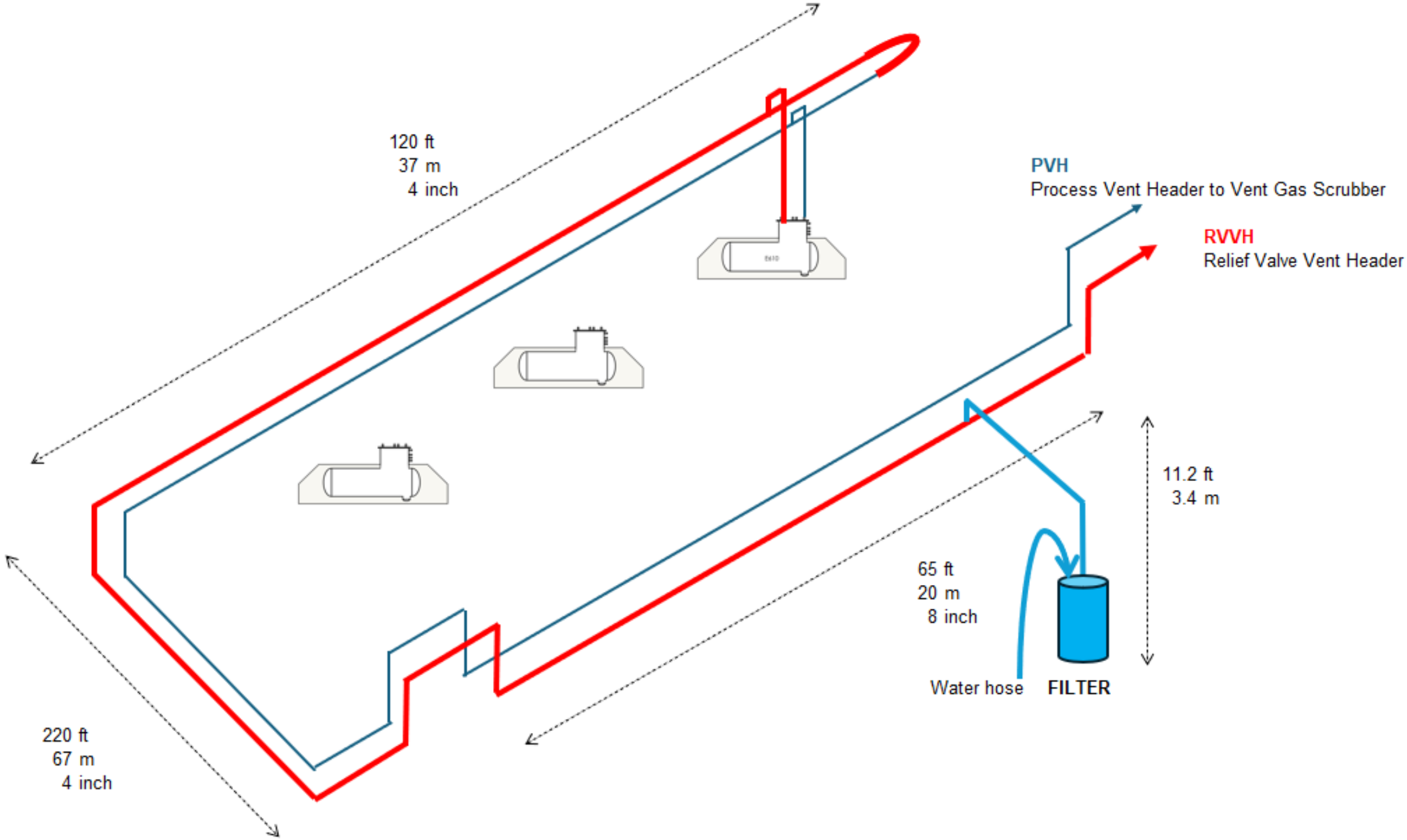
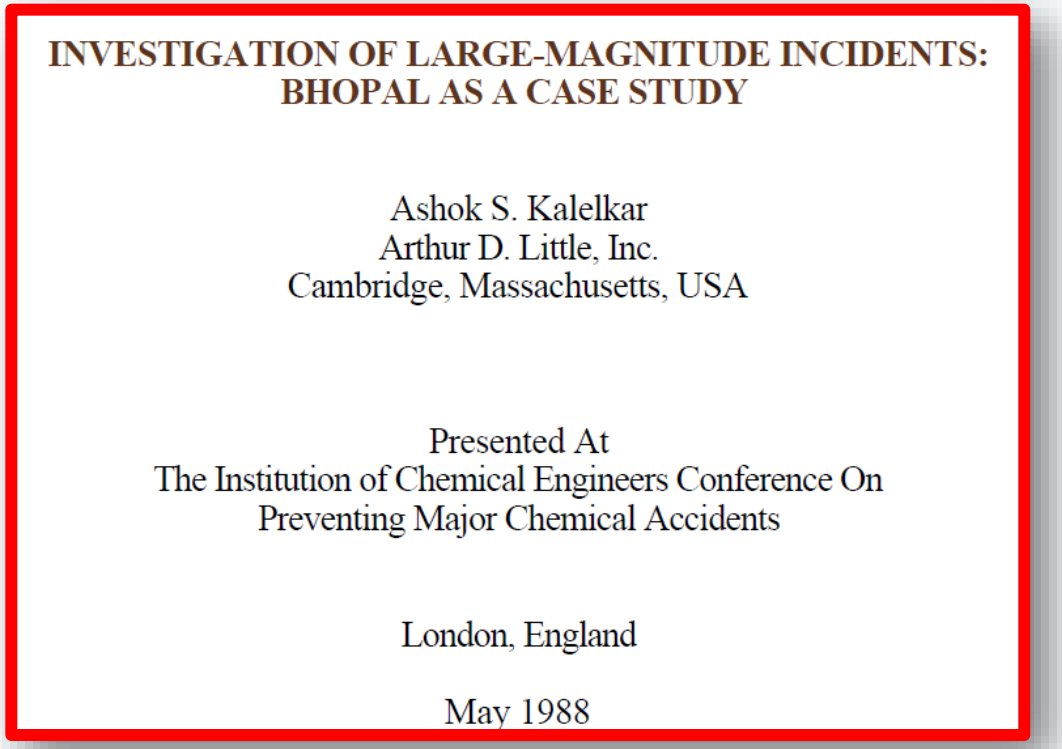

120 ft
37 m
4 inch
PVH
Process Vent Header to Vent Gas Scrubber
RVVH
Relief Valve Vent Header
11.2 ft
3.4 m
65 ft
20 m
8 inch
Water hose
FILTER
220 ft
67 m
4 inch

3. Sabotage theory

A disgruntled operator entered the storage area and hooked up one of the readily available rubber hoses to Tank E610 with the intention of contaminating and spoiling the tank's contents

UCC commissioned report



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Prior accidents

Year	Accidents and Incidents Involving MIC unit	Management Response
1981	One fatality and two serious injuries during removal slip blind	The worker died from his own mistake
1982	25 employees injured due to pump seal leak	3 union leaders, protesting about safety concerns were sacked
1982	18 employees injured due to a piping leak	UCC safety audit found multiple safety deficiencies including ‘potential for release of toxic materials
1983 &1984	Leaks of MIC, Chlorine, Monomethylamine, Phosgene and Carbon Tetrachloride	UCIL action plan claimed that the issues were ‘either corrected or in the process of being corrected.’

Death of Ashraf Khan

- Maintenance worker
- Asked to assist with removal isolation in MIC plant
- Loosened pipe – liquid spurted out
- In panic removed air mask
- Taken to hospital
- Died Christmas Eve 1981
- Investigation - The worker died from his own mistake

3. Sabotage theory

Why sabotage?	No independent investigation Inconsistencies in evidence Industrial Relations (IR) poor Failure to appreciate operational reality
Why were Industrial Relations (IR) poor?	Long history of safety issues Dispute over training
Why stop training?	27 days to factory closure
Why close factory?	Unreliable and uneconomic

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Never ascribe to malice what can be explained by genuine intent – Hanlon's

3. Sabotage

Why claim sabotage?

Strict Liability Doctrine (Indian Penal Code 1860)

Sabotage is one of the few exceptions that overrides legal responsibility for restitution.

Why push for out of court settlement?

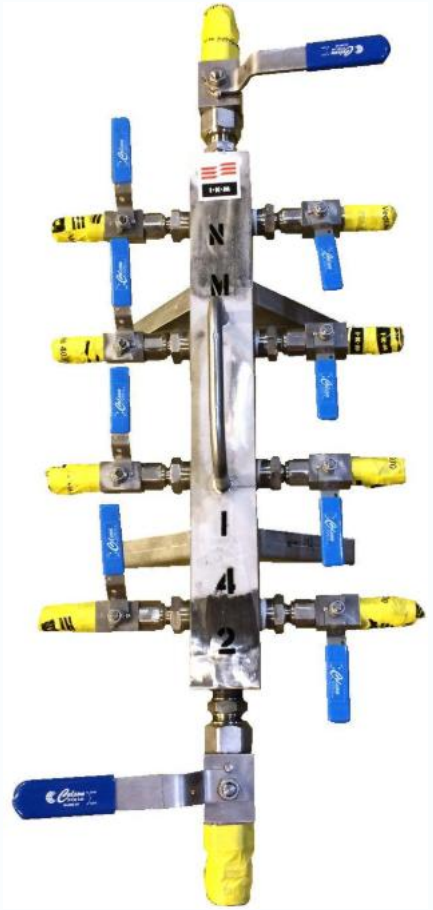
Avoid investigation and sharing facts publicly

https://www.ihrb.org/latest/40-years-later-what-are-the-lessons-from-the-lessons-from-the-bhopal-gas-disaster

Theory 4 – Nitrogen / water hose mix up

1. The MIC slow degradation theory
2. The filter washing theory
3. The sabotage theory
4. The nitrogen mix up theory

4. Nitrogen and water mix up during cleaning



Ramin Abhari – Butterflies of Bhopal

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Theory 5

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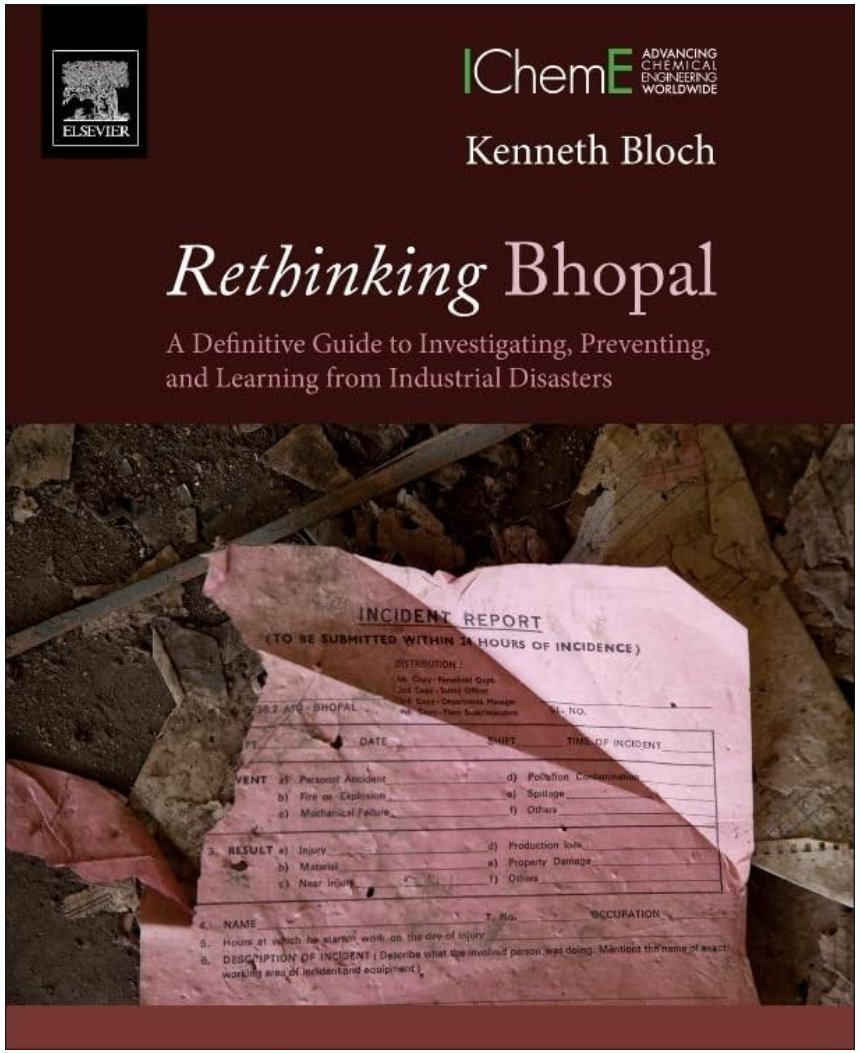
5. Rethinking Bhopal

Rethinking Bhopal



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27 days to closure

- Loss of experienced staff
- Operational workarounds
- Reduced maintenance
- Compromised safety systems
- Increased inventory

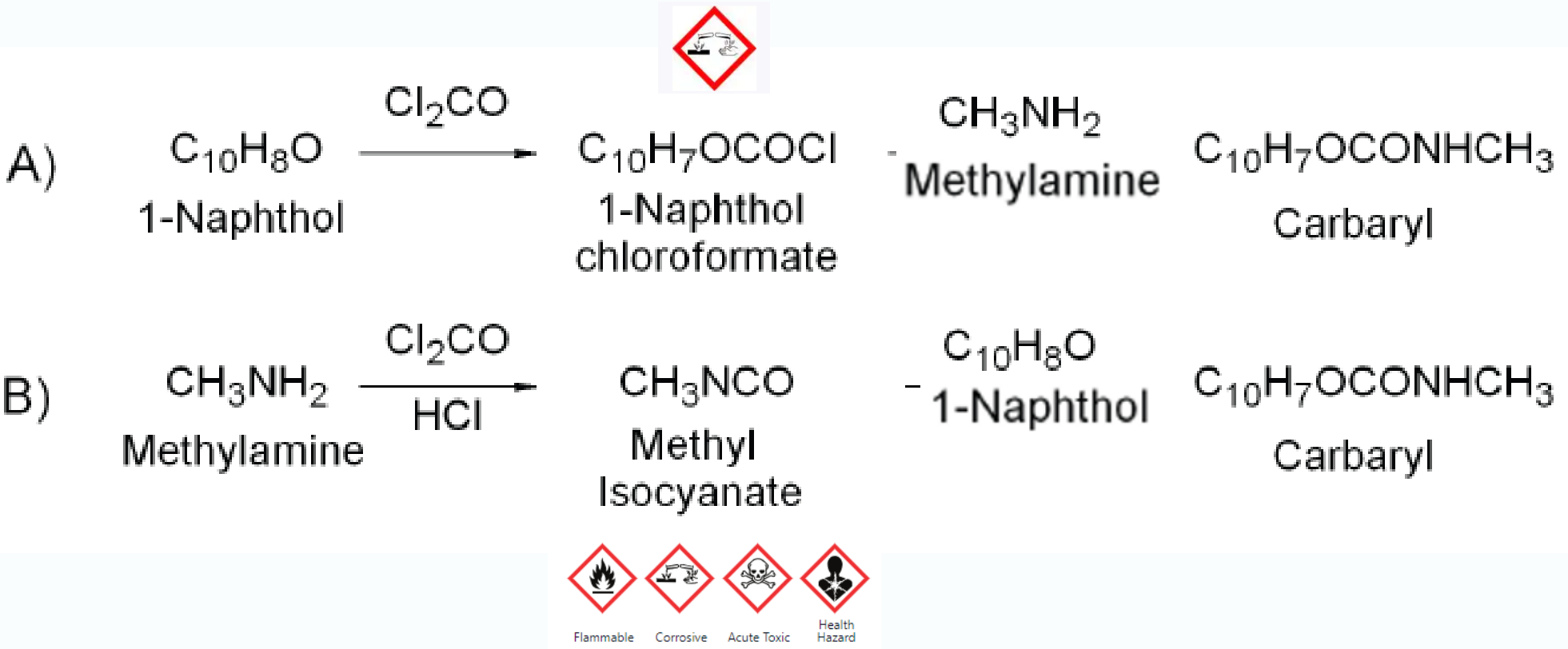
Design decisions

A. Process Hazard Analysis

B. Equipment Selection

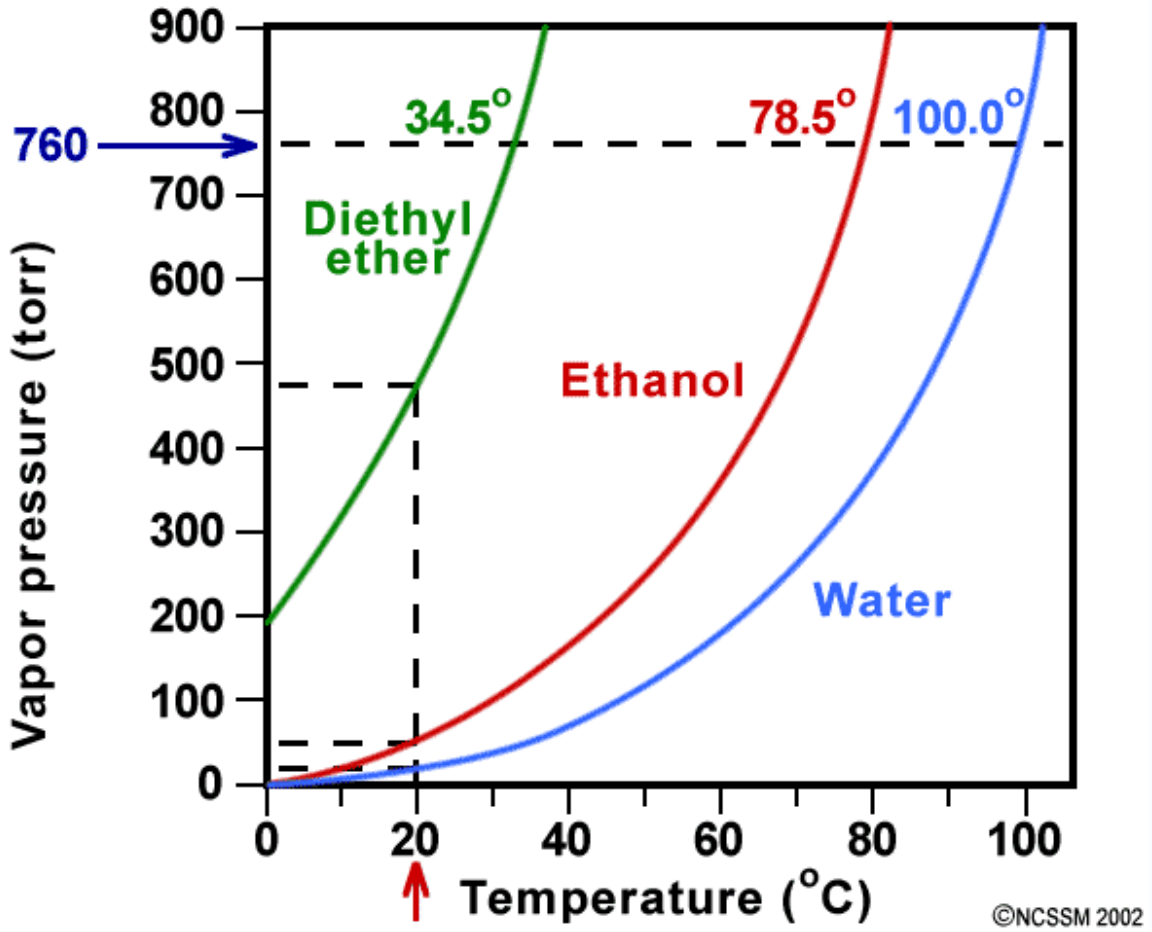
C. Materials of Construction

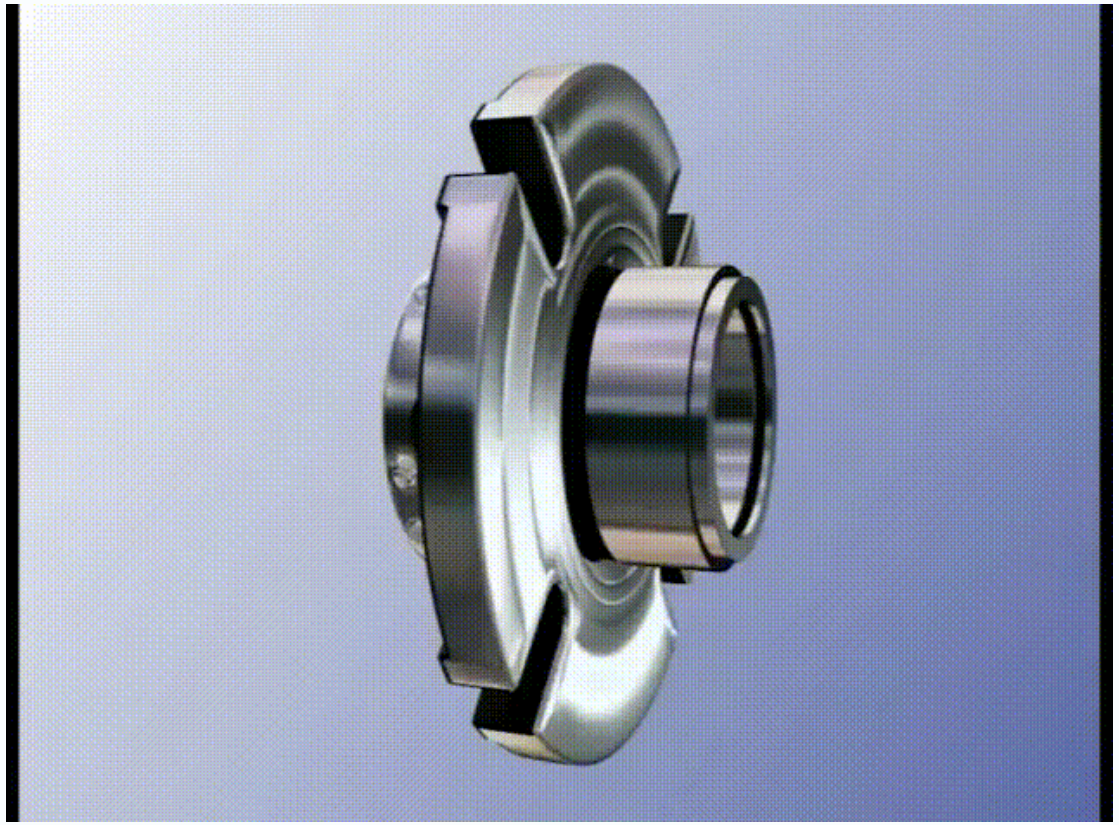
A. Process Hazard Analysis - Change



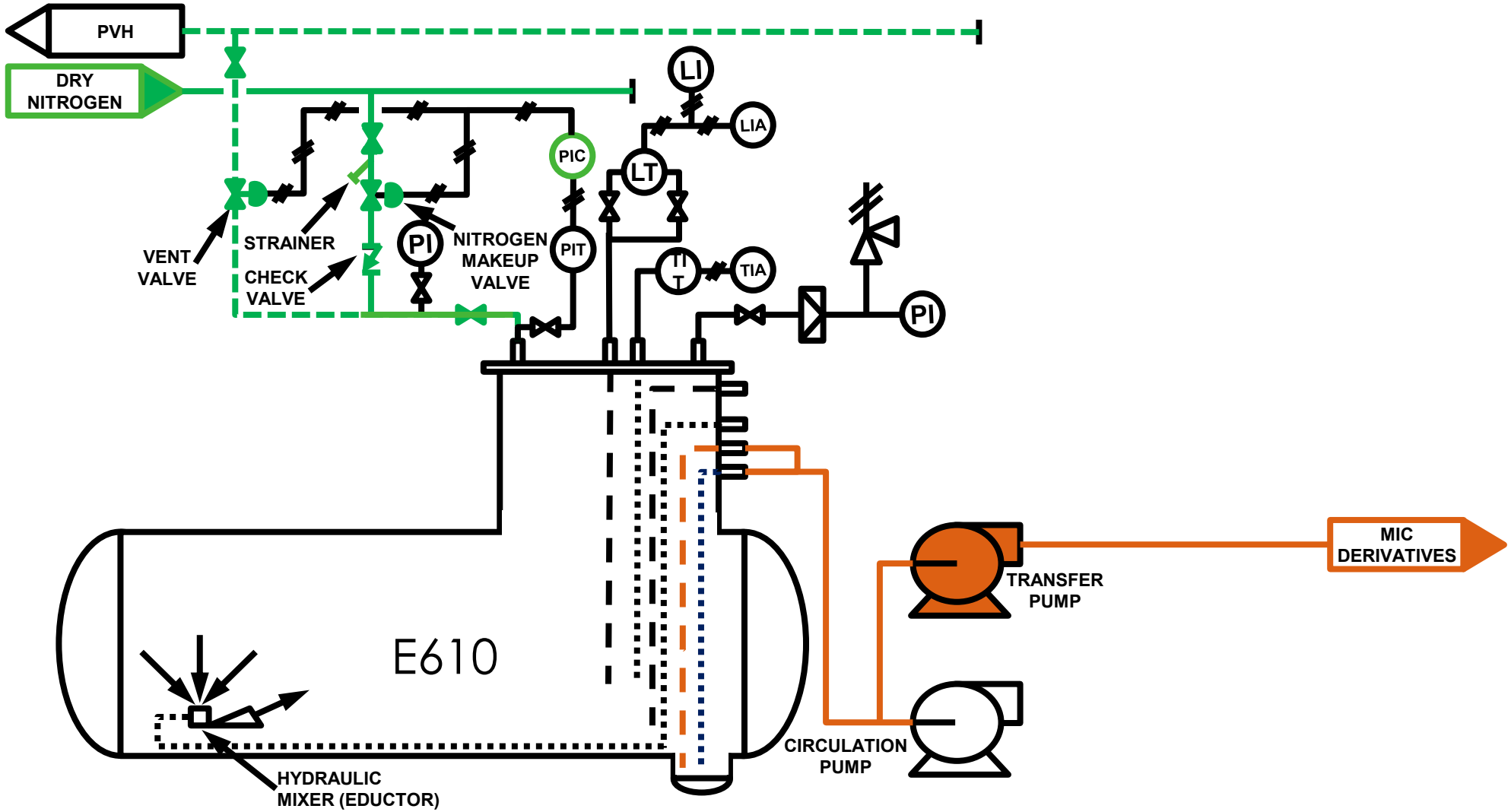
MIC boiling point 35°C, High Volatility, Extremely Flammable, Acutely Toxic

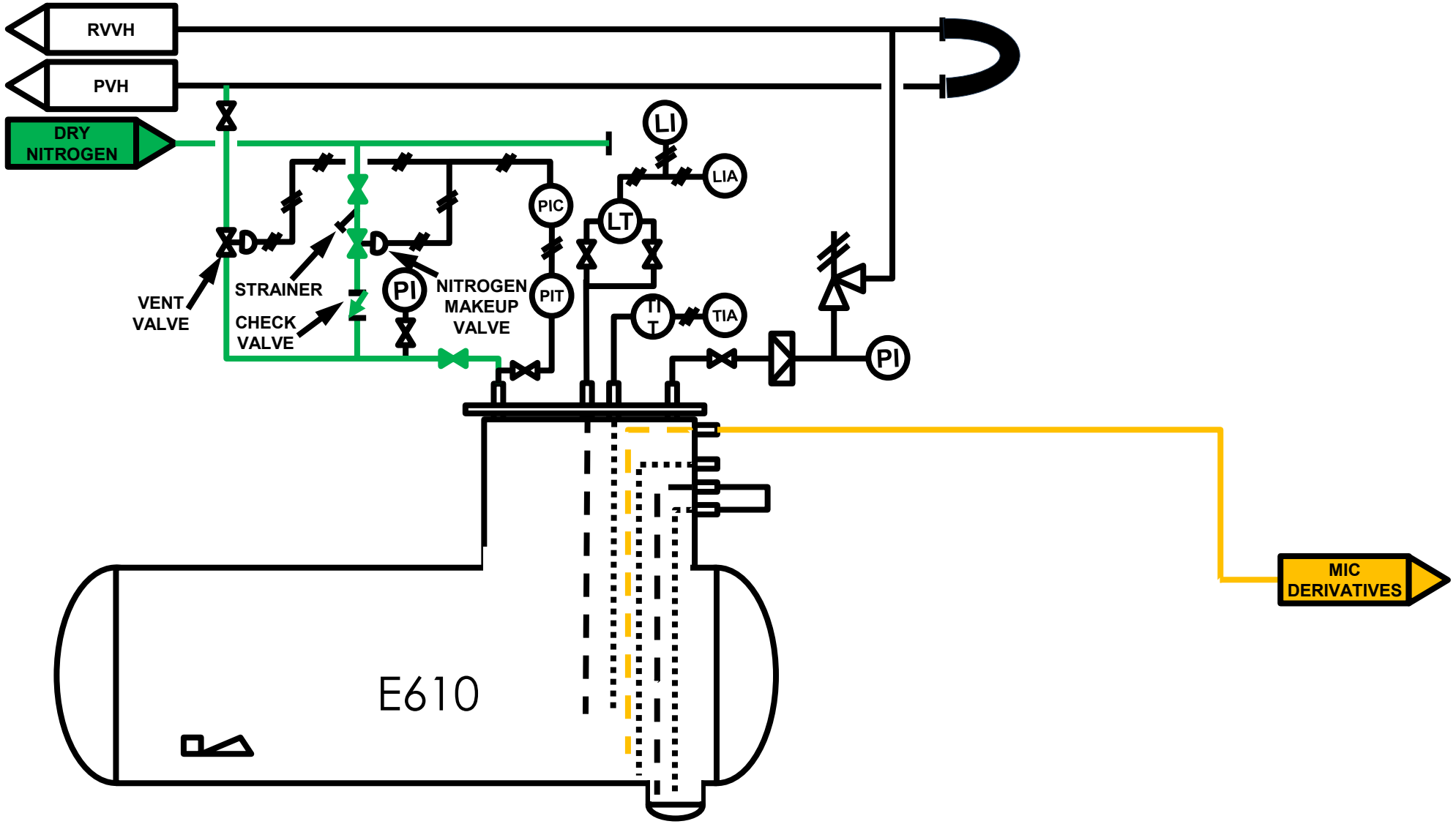
B. Equipment selection – MIC pumps





RODELTA/ AESSEAL®


PVH
DRY NITROGEN
LI
LIA
PIC
LT
VENT VALVE
STRAINER
CHECK VALVE
PI
NITROGEN MAKEUP VALVE
PIT
TI T
TIA
PI
E610
HYDRAULIC MIXER (EDUCTOR)
TRANSFER PUMP
MIC DERIVATIVES
CIRCULATION PUMP


RVVH
PVH
DRY NITROGEN
LI
LIA
PIC
LT
VENT VALVE
STRAINER
CHECK VALVE
PI
NITROGEN MAKEUP VALVE
PIT
TI T
TIA
PI
E610
MIC DERIVATIVES

C. Design Decisions – Materials

Vent header constructed in carbon steel - Dry Nitrogen essential

Transfer pumps unreliable - Nitrogen diverted for MIC pressure transfer

Vent header corrodes - MIC forms solid trimers with iron

Water used to wash away MIC trimers – corrosion gets worse

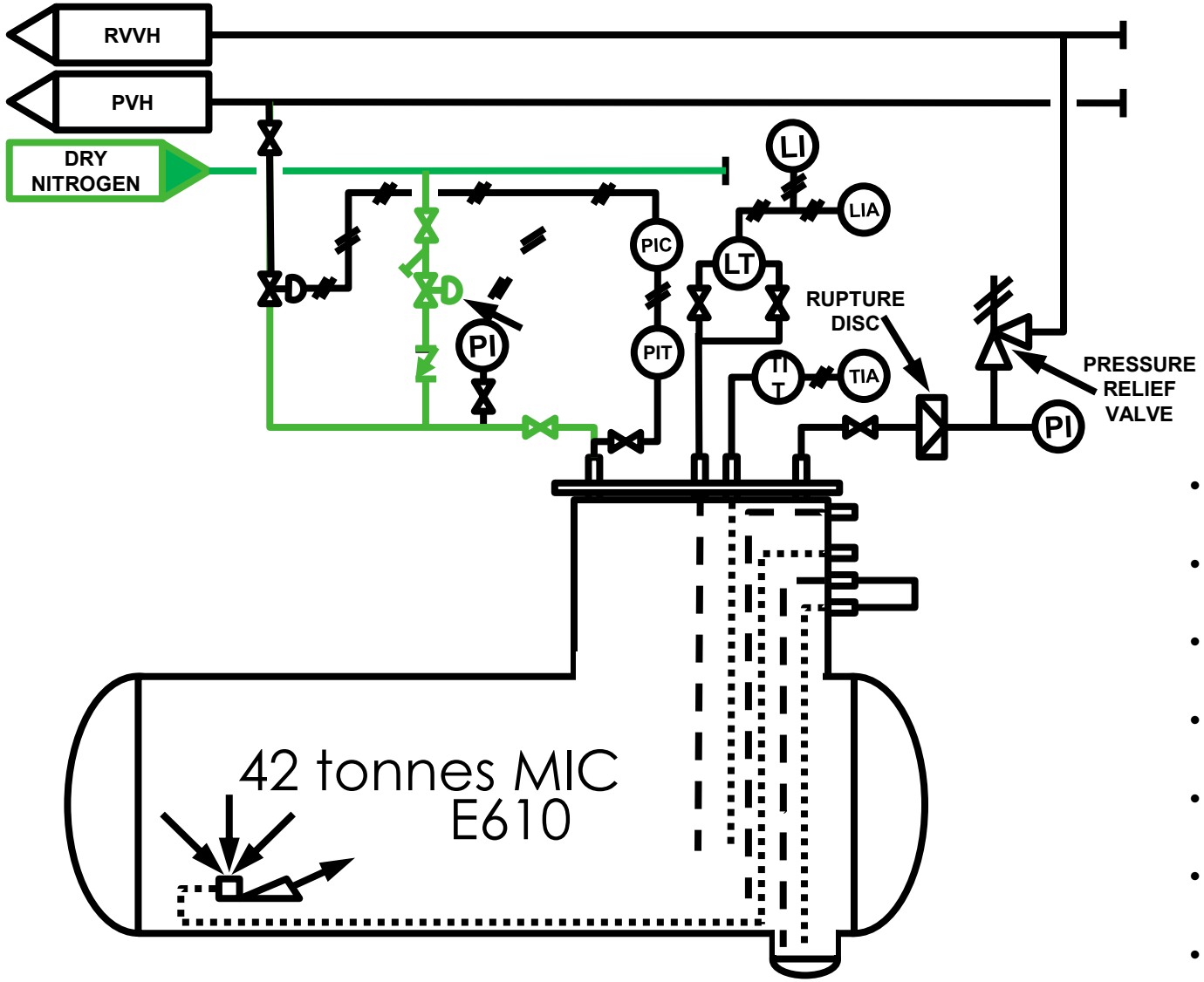
Design decisions

A. Hazards of bulk methyl isocyanate (MIC) underestimated

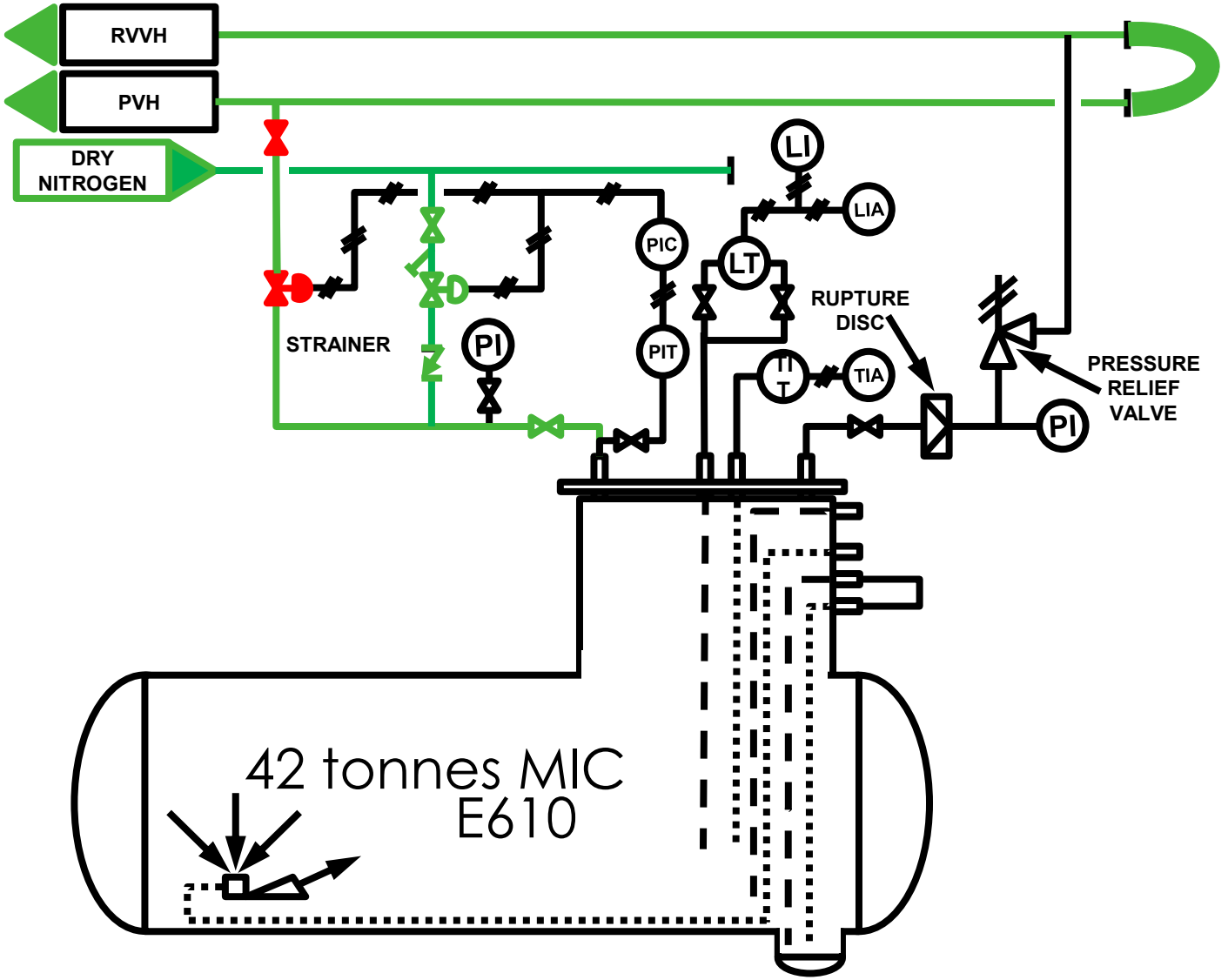
B. Pumps unreliable - Nitrogen diverted to provide MIC pressure transfer

C. Carbon steel rusts and catalyses solid trimer from MIC

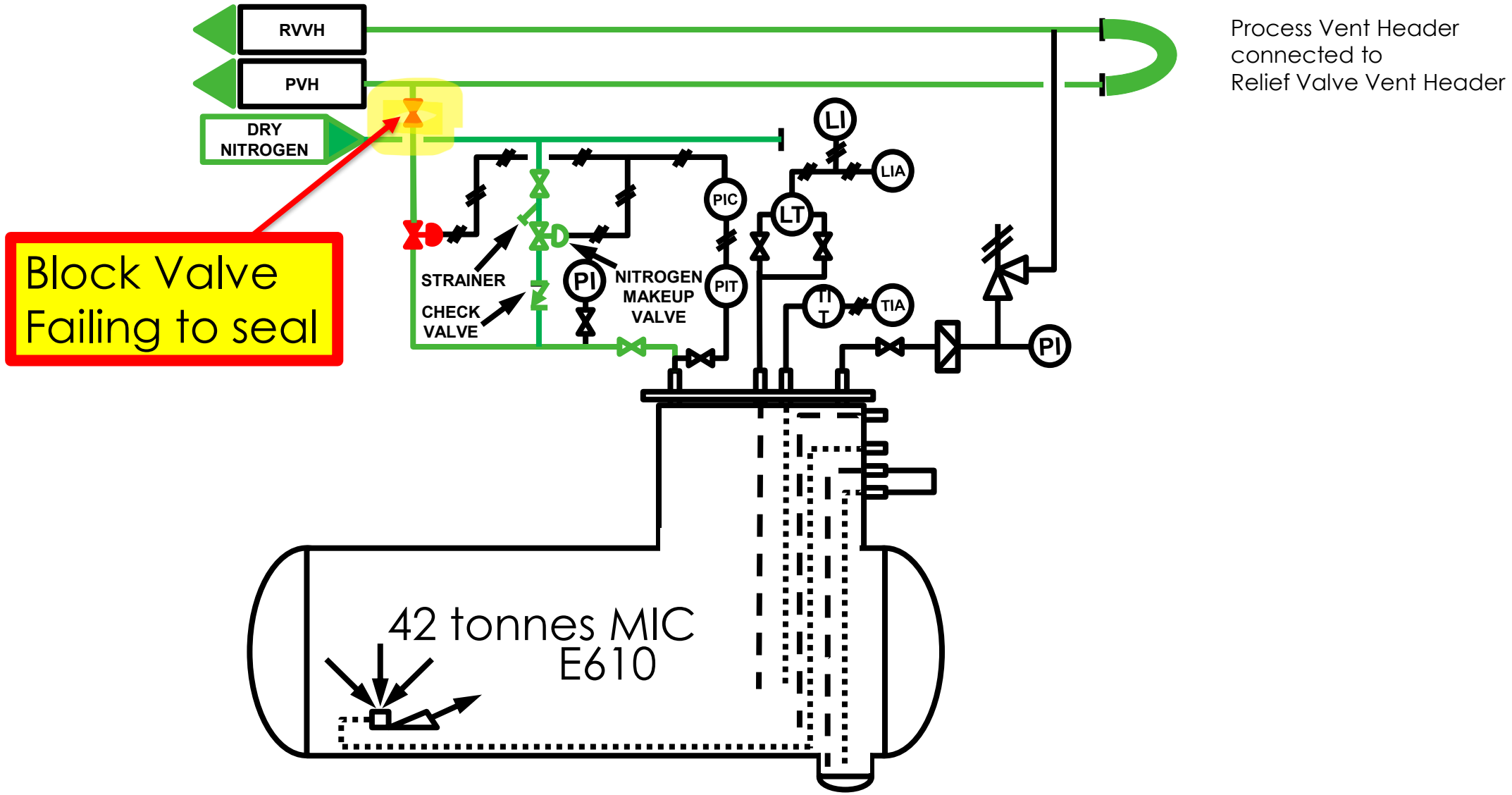
Water used to wash away solid trimer – Water + MIC + rust



- NO TRANSFER PUMP
- NO CIRCULATION PUMP
- NO INTERNAL TANK MIXING
- NO SAMPLING SYSTEM
- NO REJECT ROUTE
- NO REFRIGERATION SYSTEM
- NO MAINTENANCE SUPPORT
- 27 DAYS TO CLOSURE



Process Vent Header
connected to
Relief Valve Vent Header



Process Vent Header
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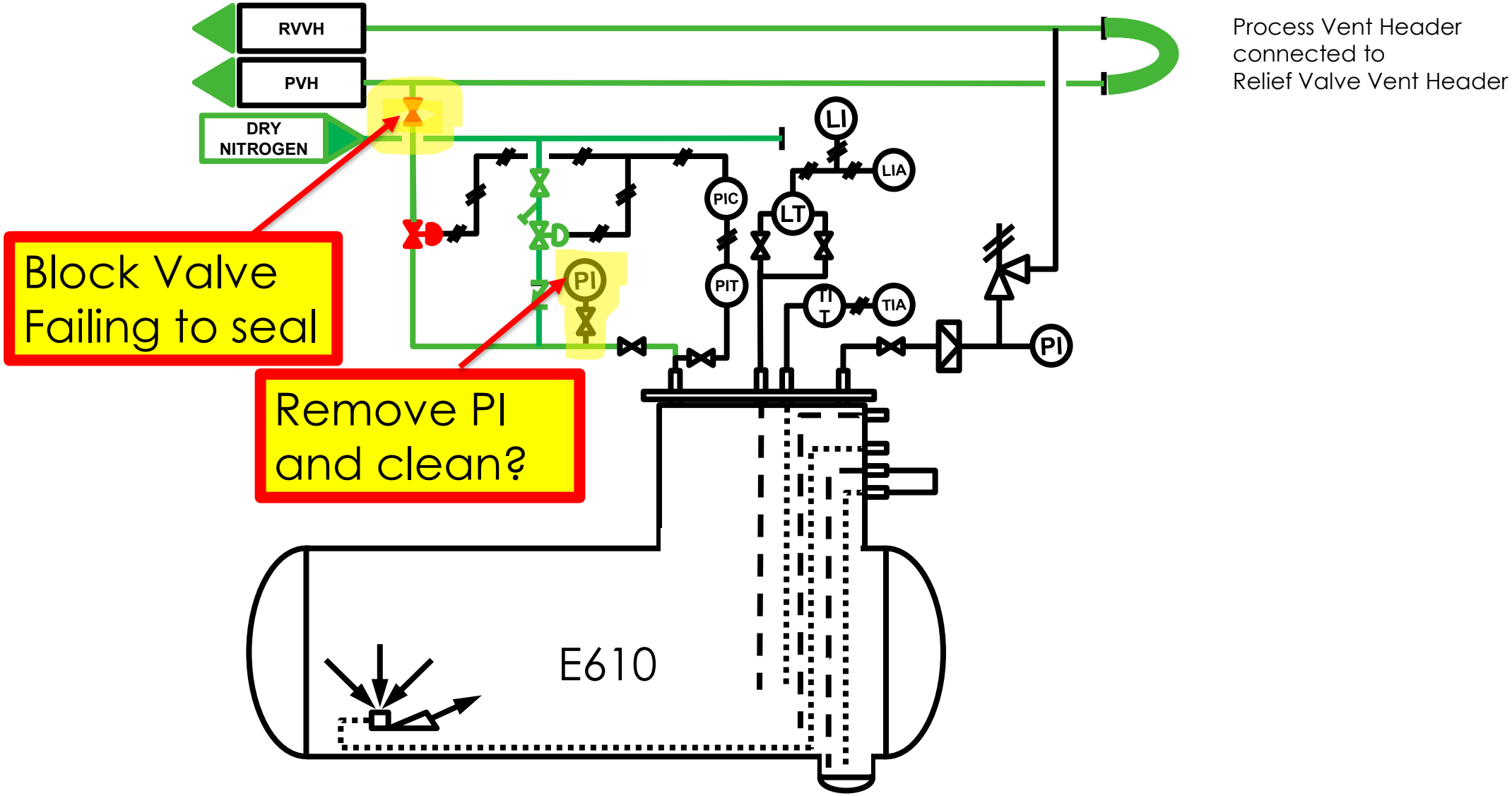
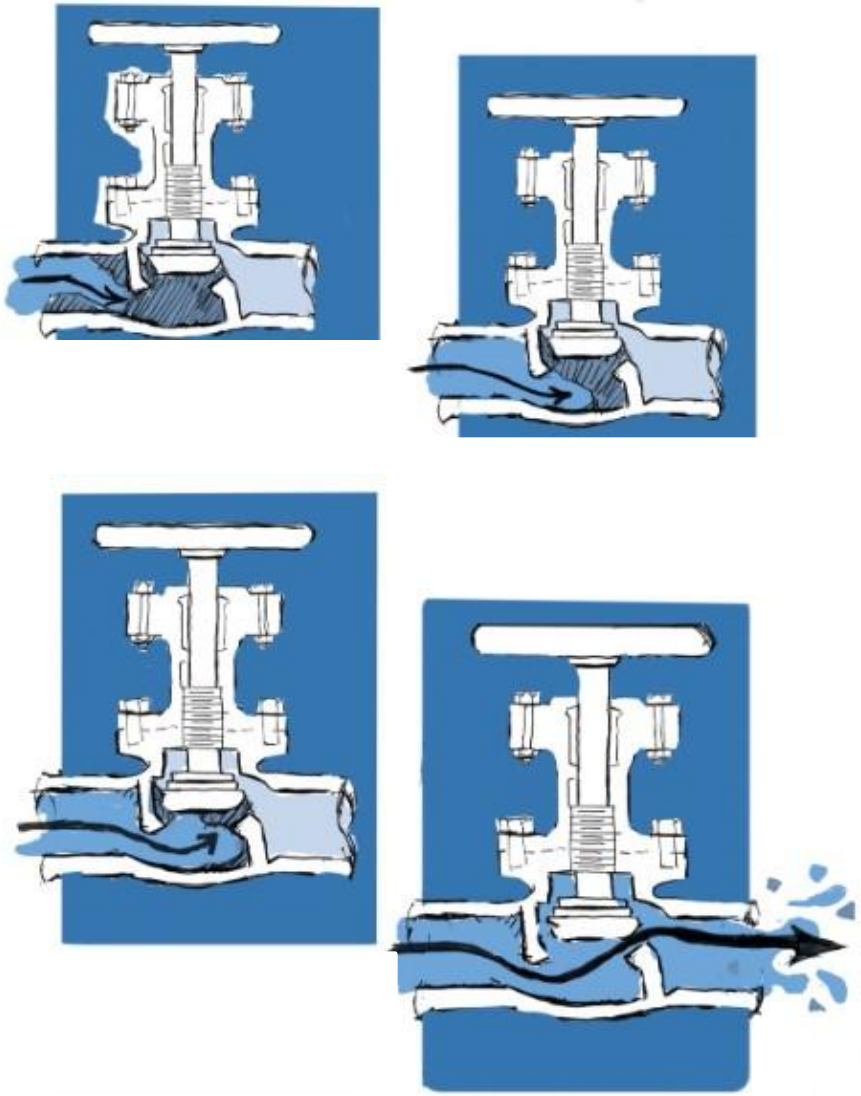
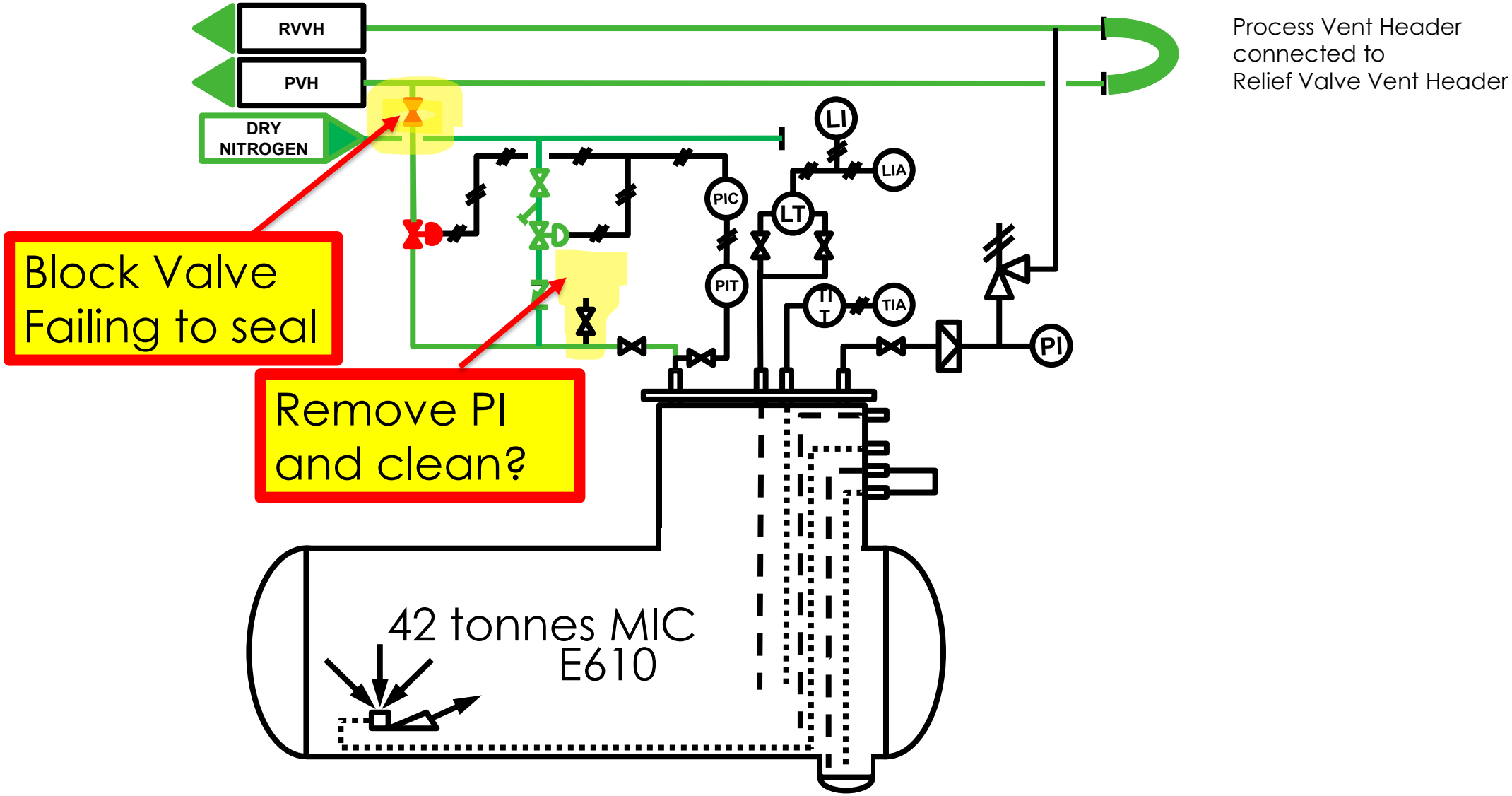
Relief Valve Vent Header



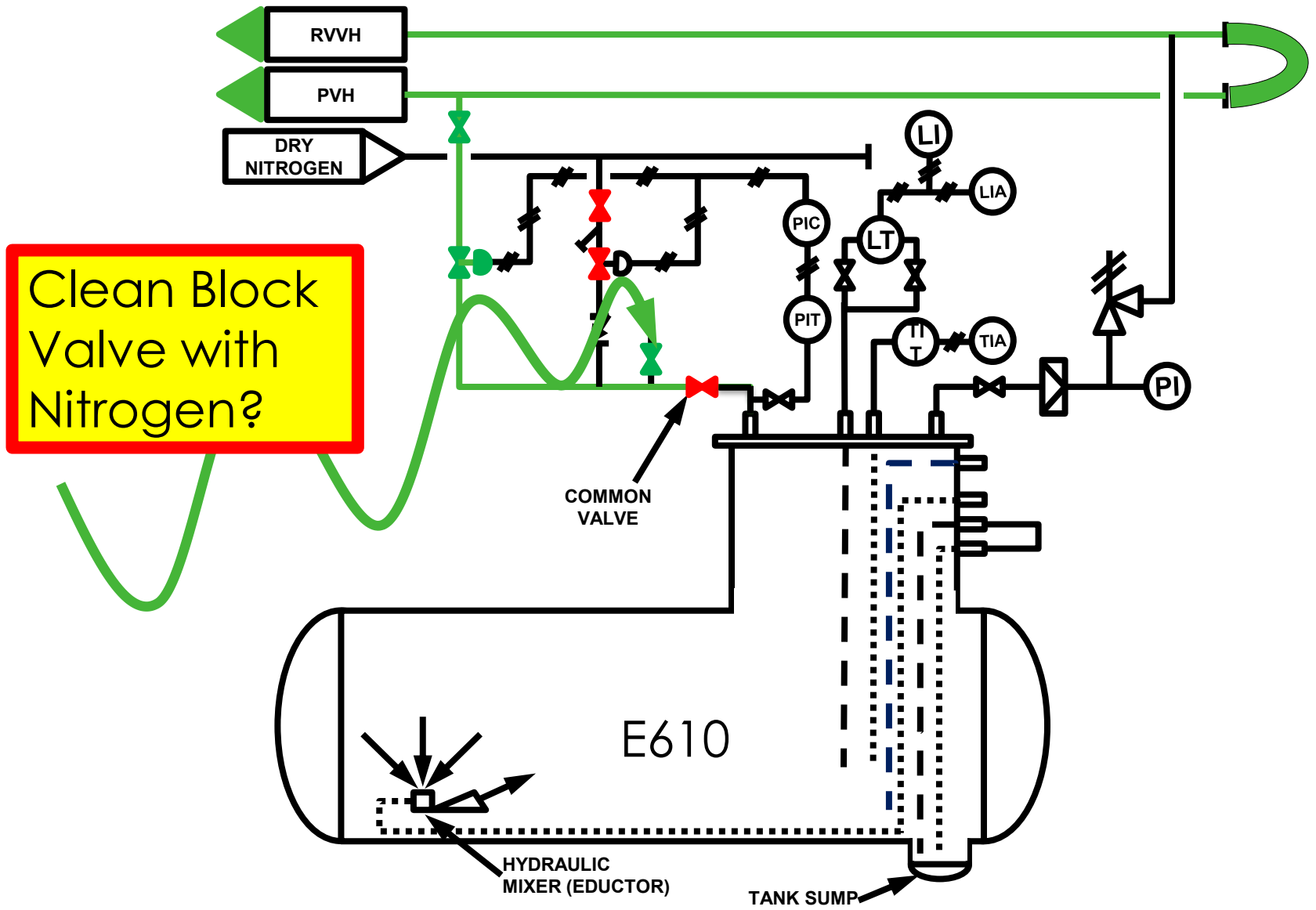
Process Vent Header
connected to
Relief Valve Vent Header


THE MIC TRIMER DEPOSIT IS OBVIOUSLY WORSE THAN USUAL...
UNION CARBIDE
...AND IS KEEPING THIS VENT VALVE FROM CLOSING FOR PRESSURE-TRANSFER. SO WE NEED TO FLUSH IT CLEAR!
WHERE DO YOU SUGGEST CONNECTING THE WATER HOSE FOR THAT?
ISN'T THERE A RISK OF WATER GETTING INSIDE?
PI
WE'LL HAVE TO REPLACE THE PRESSURE GAUGE WITH A WATER HOSE QUICK CONNECT FITTING.
THE ISOLATION VALVE IS CLOSED. WATER'S NOT GONNA GET IN.
E-610
23



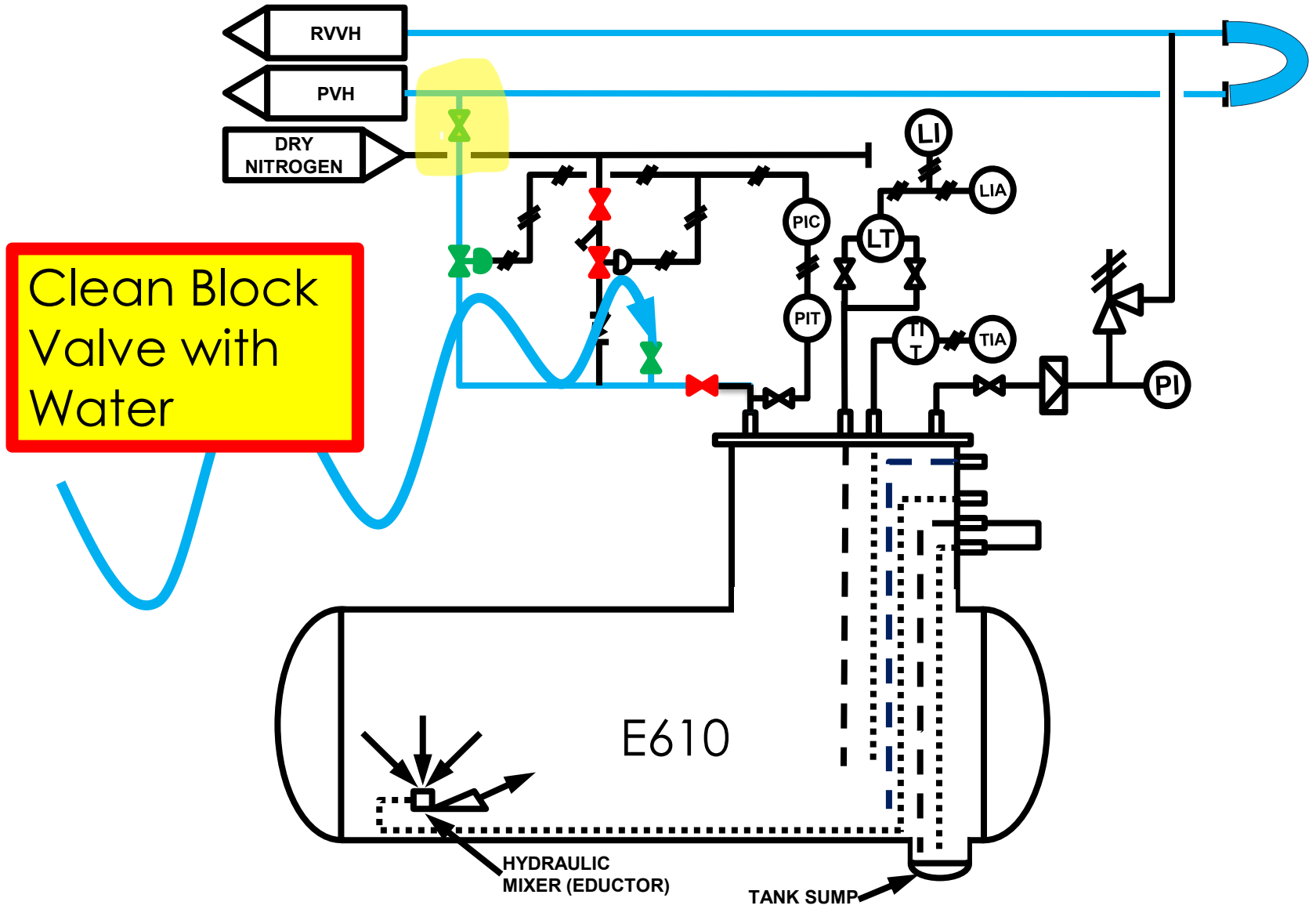


Process Vent Header
connected to
Relief Valve Vent Header

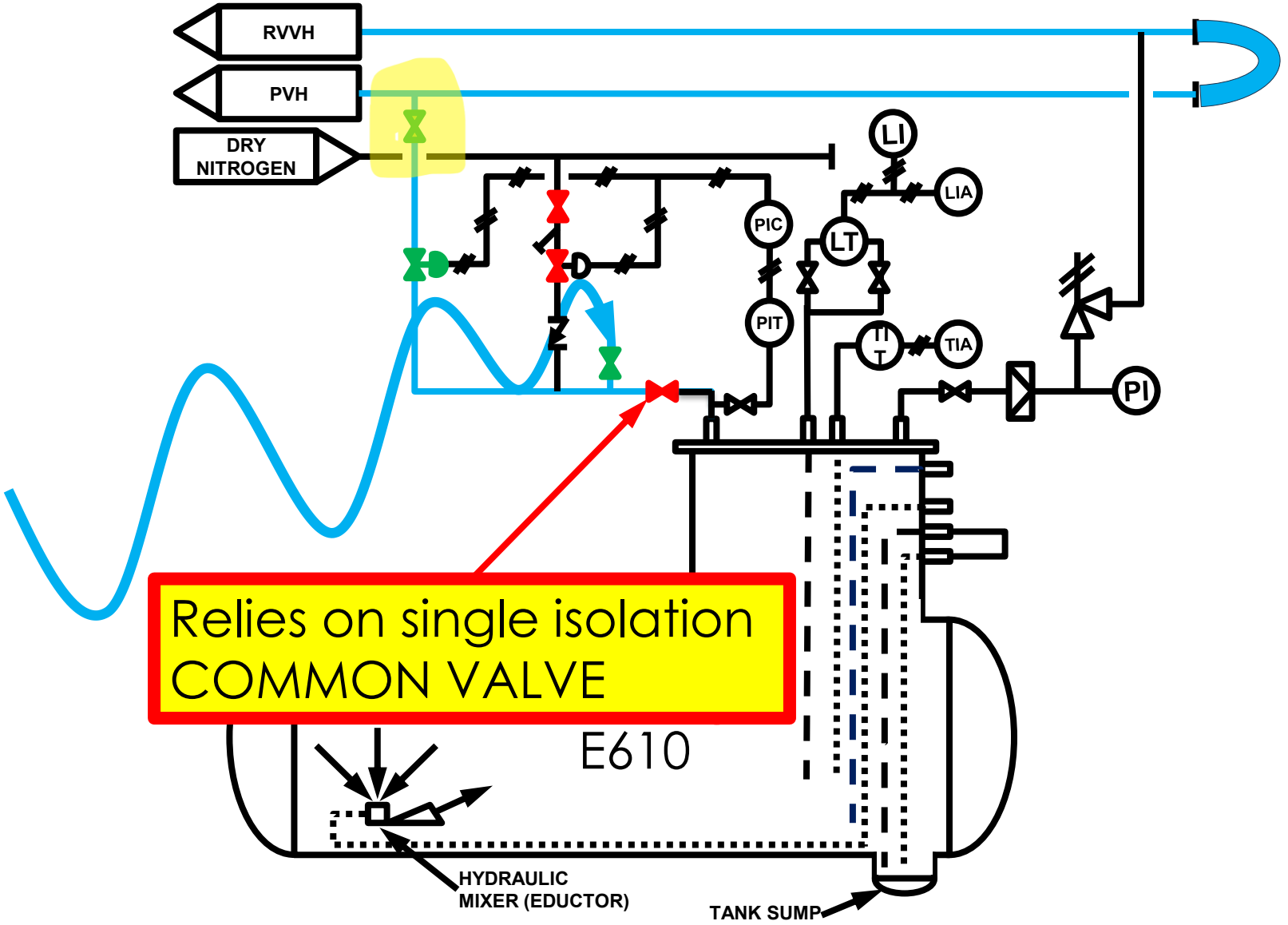


Clean Block Valve with Nitrogen?

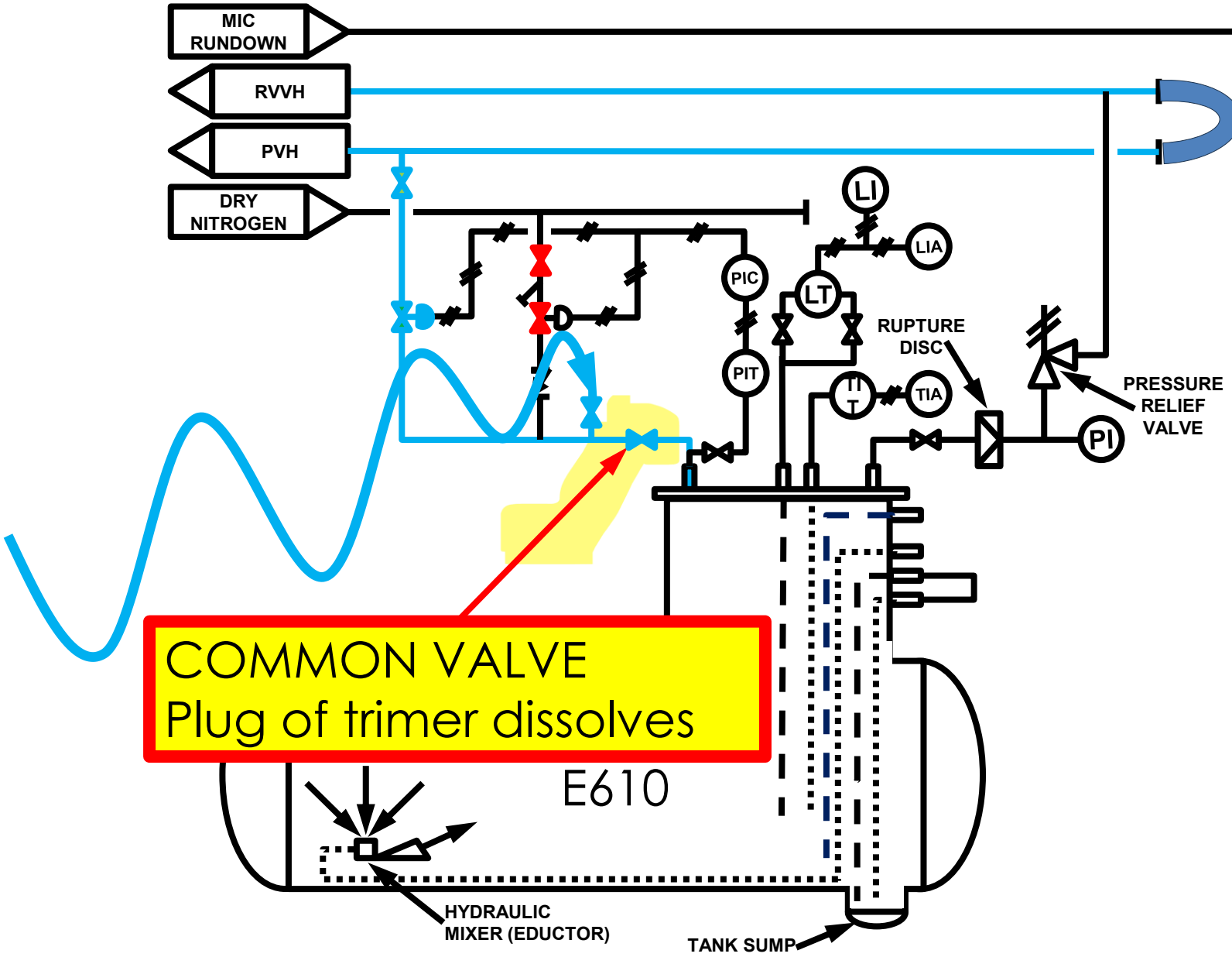
Process Vent Header connected to Relief Valve Vent Header

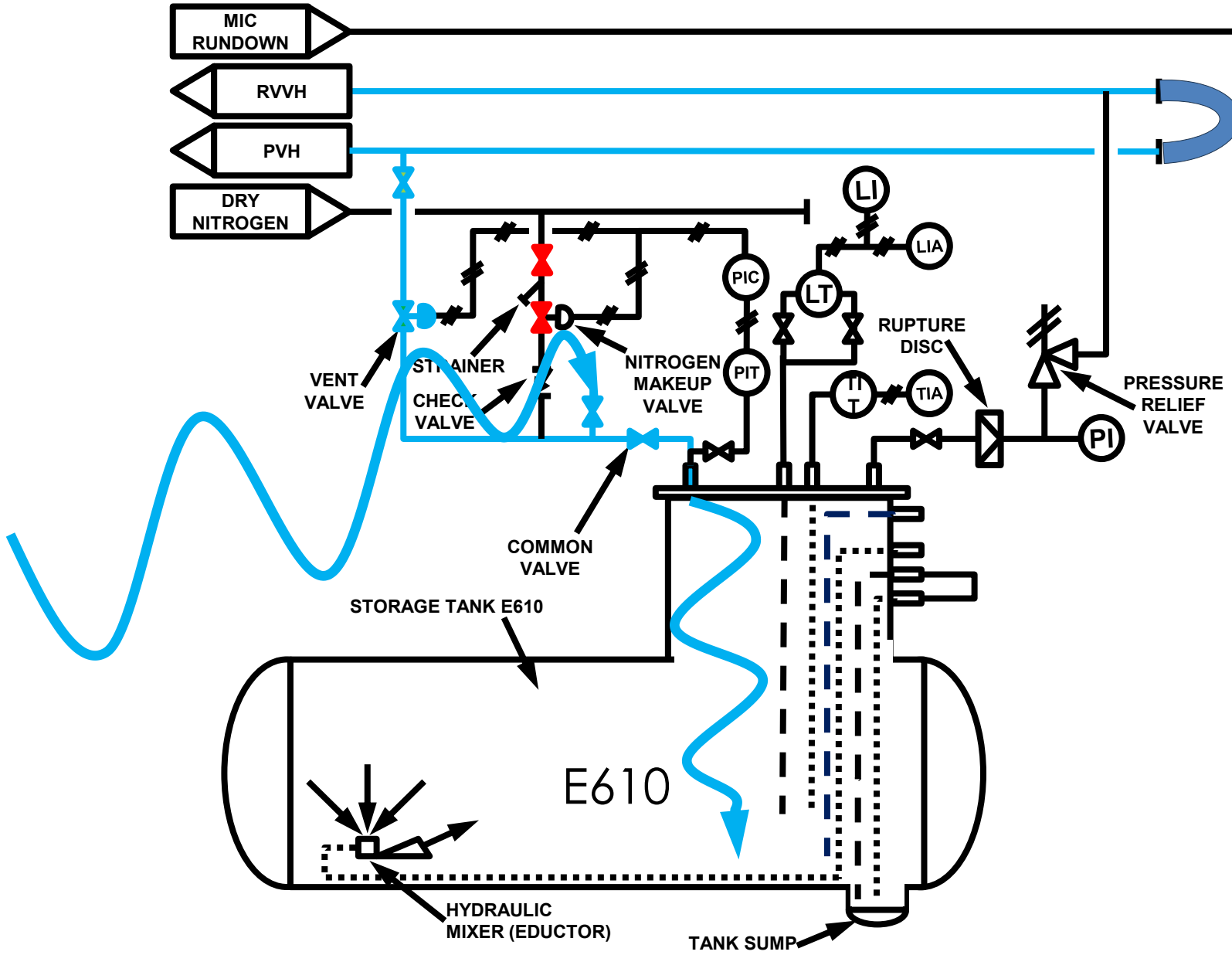


Process Vent Header
connected to
Relief Valve Vent Header



Process Vent Header
connected to
Relief Valve Vent Header


MIC
RUNDOWN
RVVH
PVH
DRY
NITROGEN
LI
LIA
PIC
LT
RUPTURE
DISC
PIT
TI
T
TIA
PRESSURE
RELIEF
VALVE
PI
COMMON VALVE
Plug of trimer dissolves
E610
HYDRAULIC
MIXER (EDUCTOR)
TANK SUMP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CHECK
VALVE
NITROGEN
MAKEUP
VALVE
COMMON
VALVE
STORAGE TANK E610
E610
HYDRAULIC
MIXER (EDUCTOR)
TANK SUMP

The Investigations

BHOPAL METHYL ISOCYANATE INCIDENT

INVESTIGATION TEAM

REPORT

MARCH, 1985

UNION CARBIDE CORPORATION
DANBURY, CONNECTICUT

Judge NK Singh
Inquiry

INVESTIGATION OF LARGE-MAGNITUDE INCIDENTS:
BHOPAL AS A CASE STUDY

Ashok S. Kalelkar
Arthur D. Little, Inc.
Cambridge, Massachusetts, USA

Presented At
The Institution of Chemical Engineers Conference On
Preventing Major Chemical Accidents

London, England

May 1988

REPORT ON SCIENTIFIC STUDIES
ON THE FACTORS RELATED TO
BHOPAL TOXIC GAS LEAKAGE

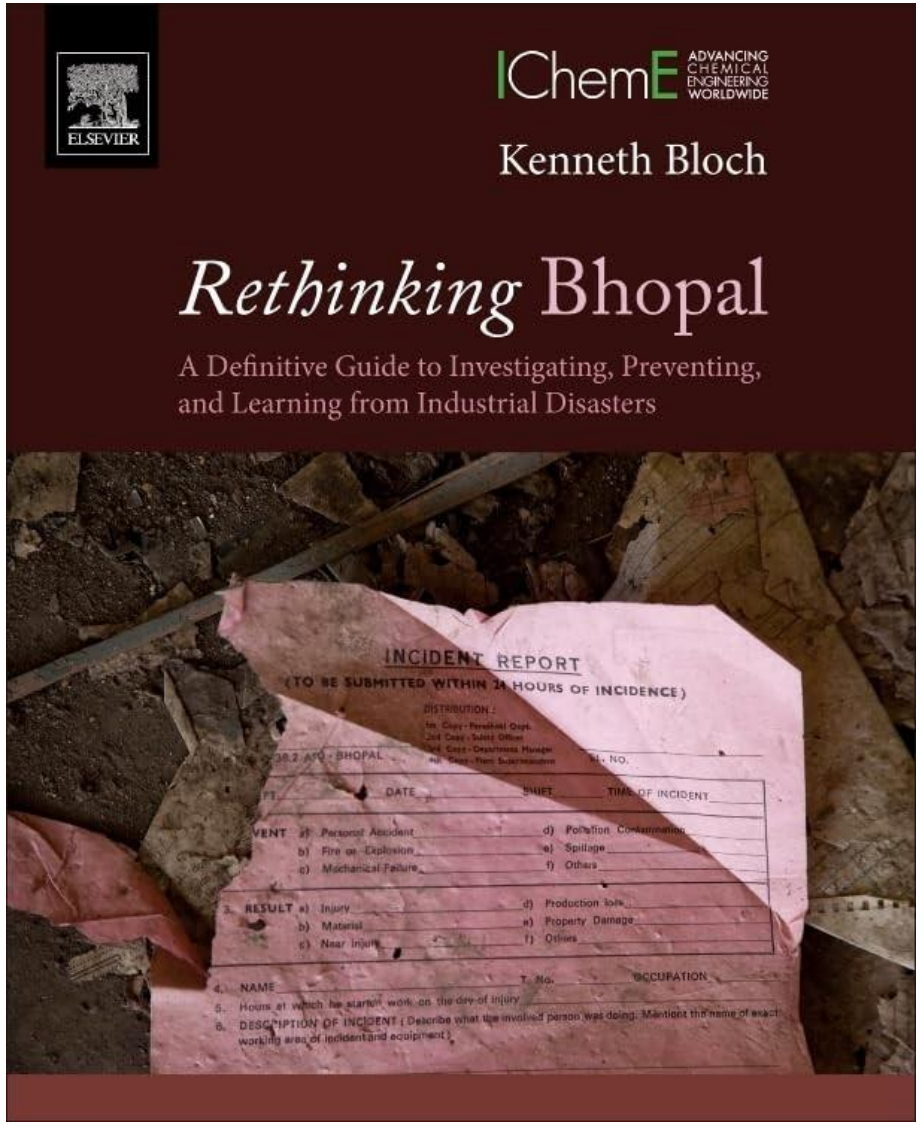
This Report results from Studies

by

Dr. S. Varadarajan
Dr. L.K. Doraiswamy
Dr. N.R. Ayyangar
Dr. C.S.P. Iyer
Dr. A.A. Khan
Dr. A.K. Lahiri
Mr. K.V. Munumdar
Dr. R.A. Mashelkar
Dr. R.B. Mitra
Dr. O.G.B. Nambiar
Mr. V. Ramachandran
Mr. V.D. Sahasrabudhe
Dr. S. Sivaram
Dr. M. Sriram
Dr. G. Thyagarajan
Dr. R.S. Venkataraman

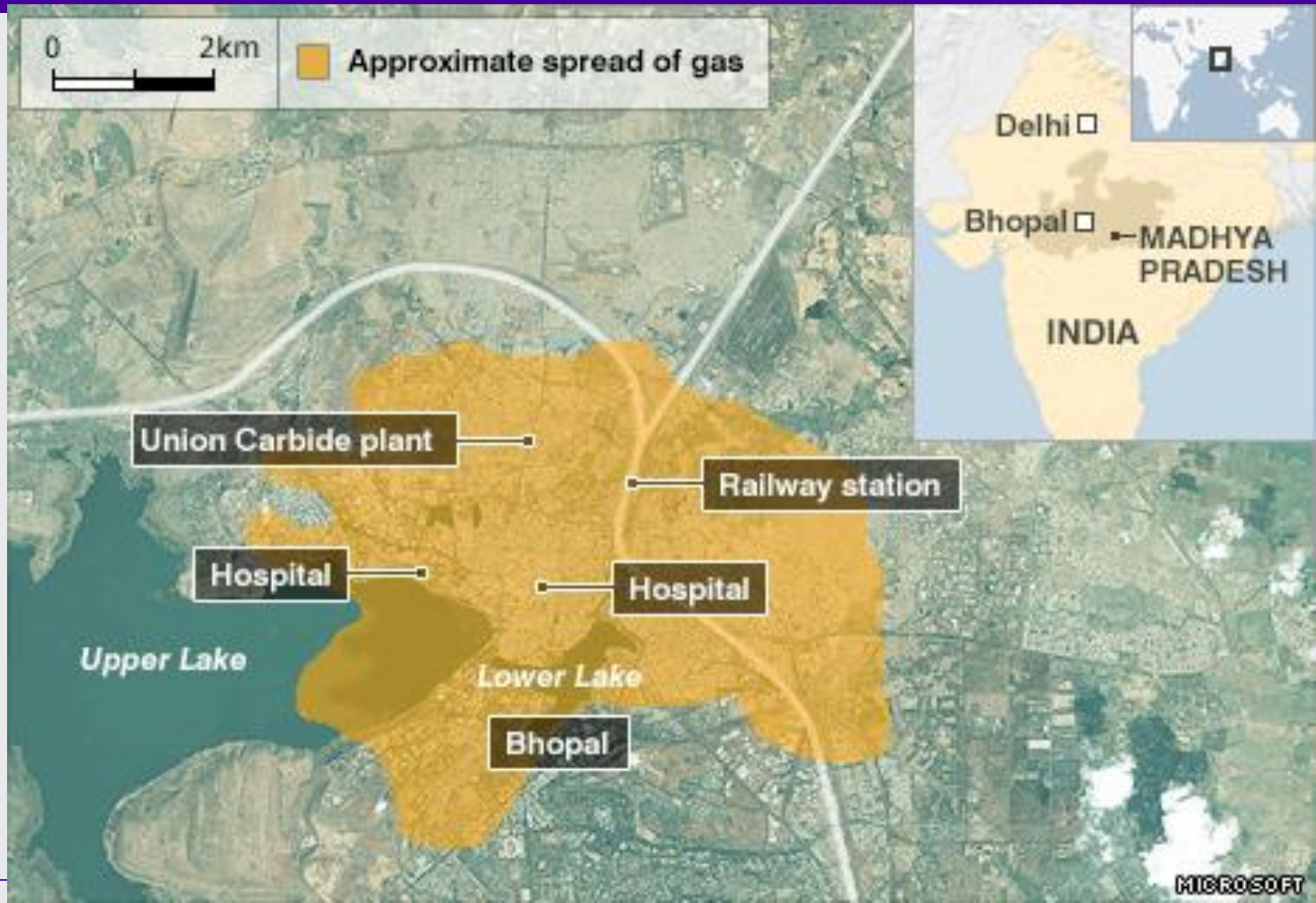
CSIR

DECEMBER, 1985



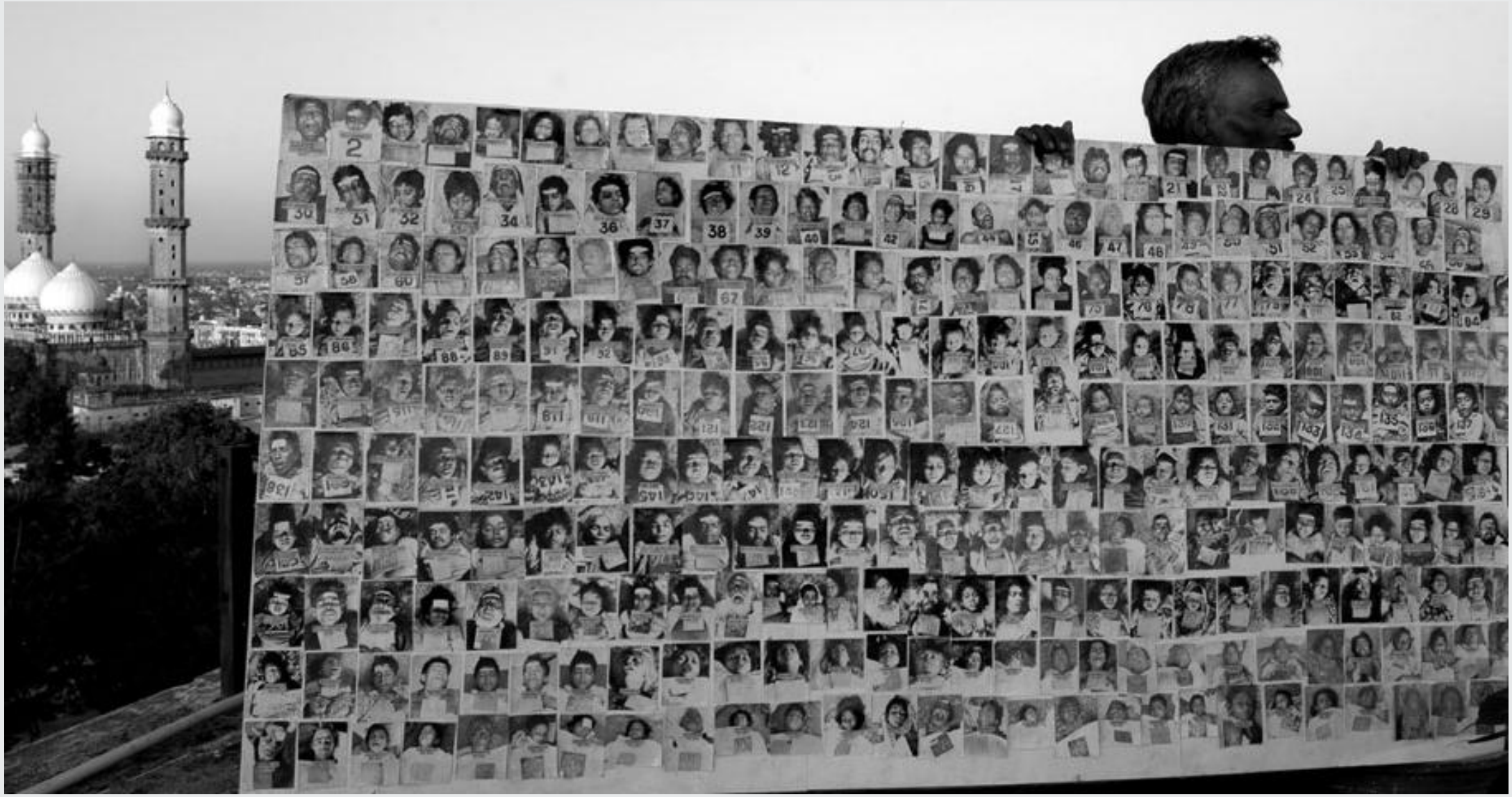
University of Sheffield

The Consequence



University of Sheffield

The Consequence



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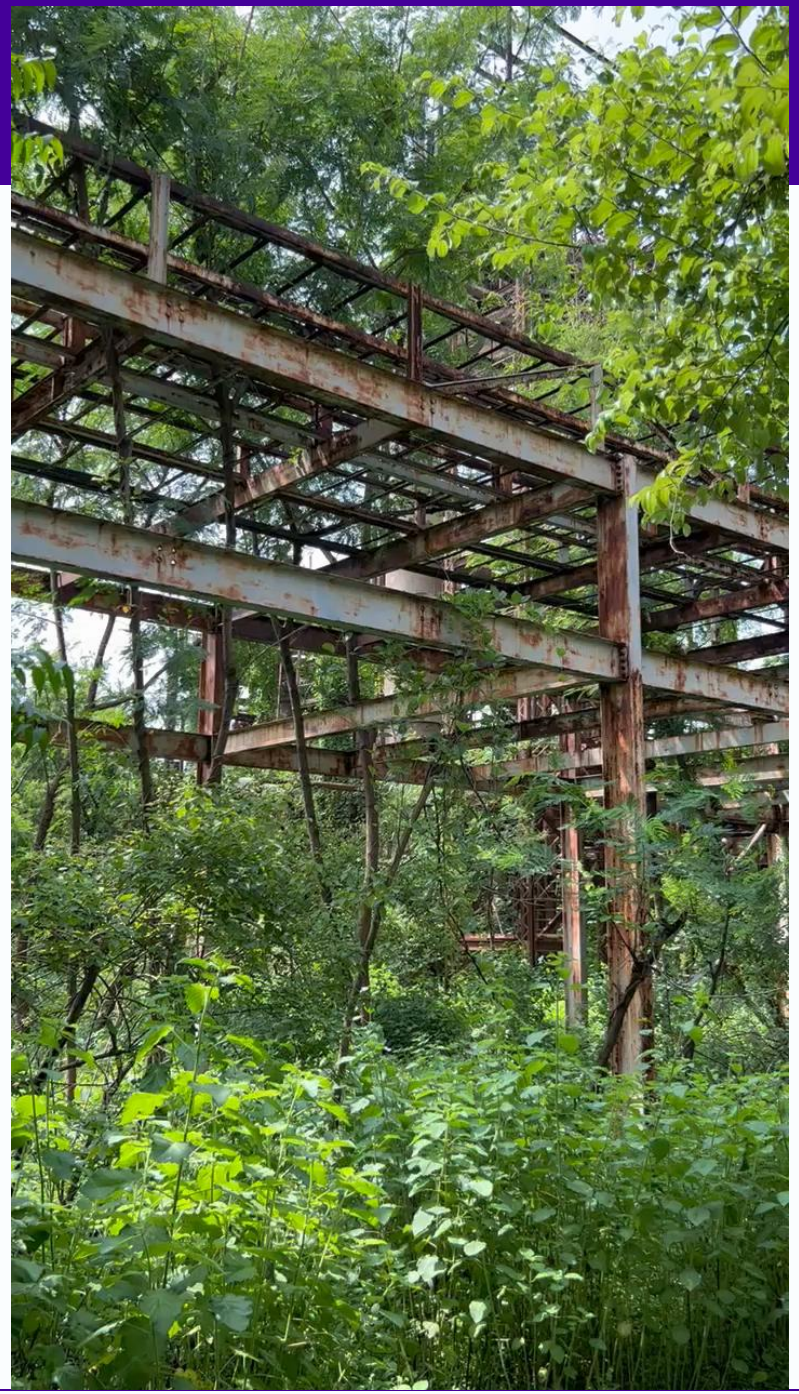
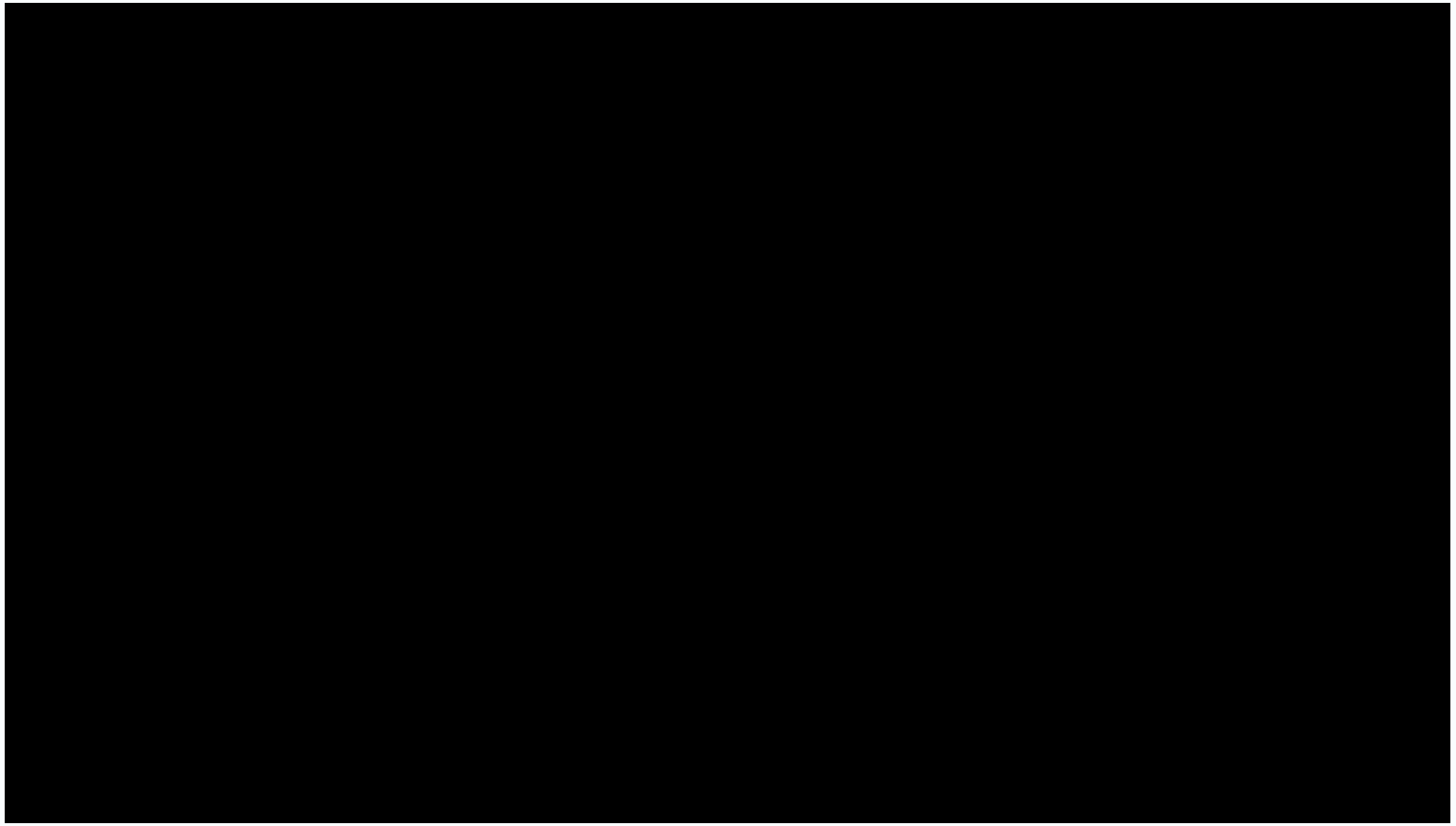


Solar Evaporation Ponds



Why does the Bhopal Gas tragedy still matter?

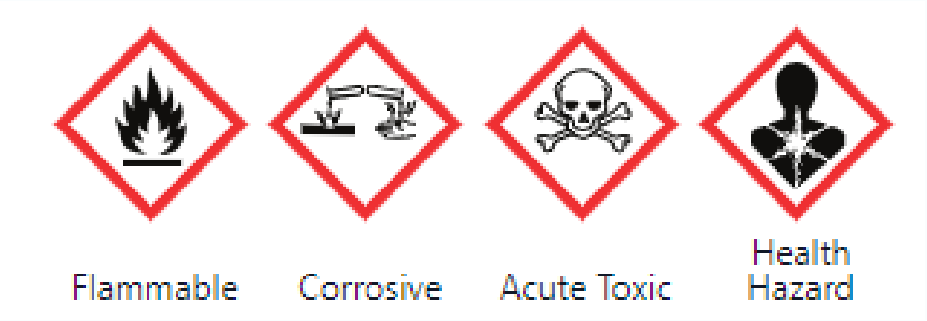
- Galvanised others into action
  - EPSC in Europe
  - CCPS in USA
  - Responsible Care from Canada adopted worldwide
  - OECD Guiding Principles for Chemical Accident Prevention, Preparedness and Response

- Shocking scale of death and injury
- Lack of independent investigation
- Out of court settlement prevented full facts being shared
- The contaminated site has still not been remediated
- The children and grandchildren of the original victims continue to suffer
- Misinformation abounds

Myth 1 Debunked

- ~~The process design was safe~~

- The process was inherently **unsafe**
  - Order of reaction – Highly toxic, volatile and reactive intermediate MIC
  - Storage of unnecessarily high quantities of MIC
  - Equipment selection – unreliable pumps
  - Materials of construction – carbon steel vent piping
  - Management of Change – pressure transfer with nitrogen



Myth 2 Debunked

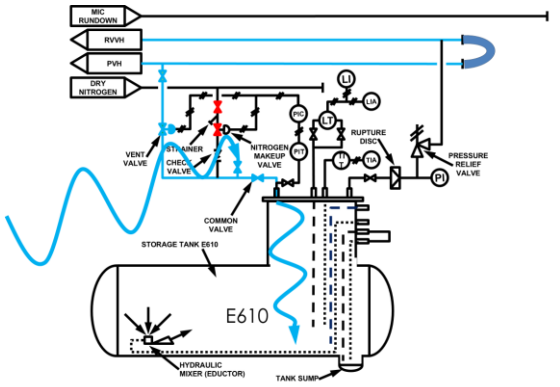
- ~~The local team was incompetent~~

- Well educated and well-trained professionals
- Drift to danger as the plant ran to closure
  - Those who raised safety concerns were forced to leave
  - The hazards of MIC storage after production stopped was underestimated
  - Poorly trained temporary labour brought in
  - The factory was 27 days from closure

Myth 3 Debunked

- ~~The accident was caused by an act of sabotage~~

- Water washing of MIC vent lines was common practice
  - It was required to remove trimer
  - The accident was caused by a misguided attempt to meet closure targets



Kenneth Bloch – Rethinking Bhopal

Myth 4 debunked

- ~~The high death toll was due to illegal slums~~

- The high death toll was due to the release of 27 tonnes of toxic gas over a populous city
  - Nobody died inside the factory
  - The main train station (Bhopal Junction) was built 1884
  - The Taj-ul-Masajid mosque was built from 1870 to 1958
  - Well established residential communities were affected

Myth 5 debunked

- ~~The out of court settlement was fair~~

- The out of court settlement was grossly unfair
  - No punitive element
  - Compensation $470M based on a gross underestimate of
    - number of victims
    - severity of injuries
  - No provision for environmental clean up

Myth 6 debunked

- ~~The toxic waste has all been safely disposed of~~

- 337 tonnes of packaged waste were removed from site
  - Incinerated at Pithampur
  - 900 tonnes of toxic ash with no home

- Millions of tonnes of contaminated soil remain
  - on the former Union Carbide site
  - In external solar evaporation ponds

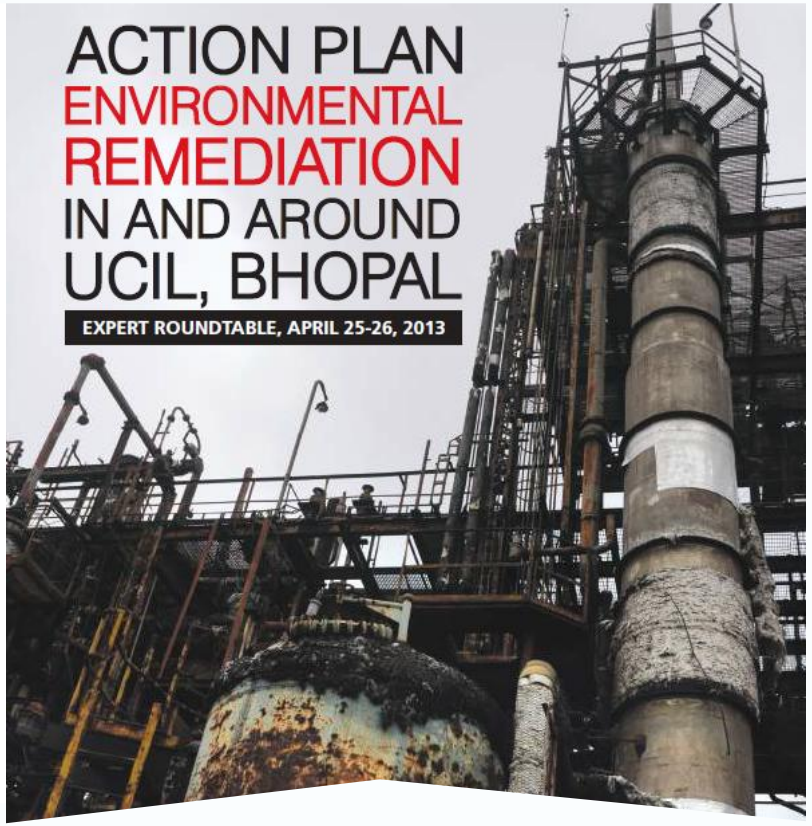
- Sampling has stopped
- The ongoing protests are driven by anger at a terrible injustice

Progress on 2013 plan

Incineration of 337 tonnes of packaged waste has produced 900 tonnes of toxic ash

Summary of Action Plan

IMMEDIATE MEASURES	
SECURING THE SITE AND PREVENTING ANNUAL SURFACE WATER RUNOFF	**THREE MONTHS**
Fencing and guarding of the UCIL site and landfill area within the SEP	Immediate
Stopping construction at the SEP area	Immediate
Measures to be taken to protect annual surface water runoff from the site during monsoon	Three months
EXCAVATION, RECOVERY AND CHARACTERISATION OF WASTE DUMPED AT THE UCIL SITE	**SIX MONTHS**
Clearing vegetation and dewatering the site	One month
Identification and refurbishment of a temporary storage area for excavated waste	Three months
Excavation and recovery of dump materials from already identified and new sites	Three months
Recovery of mercury present in drains, pan filters and soil with the help of local community	Three months
Characterisation and inventorisation of the collected waste for proper treatment and/or disposal	Six months
CHARACTERISATION AND INCINERATION OF THE STORED WASTE AT THE UCIL SITE	**SIX MONTHS**
Trial at the Pithampur incinerator with ten tonnes of similar waste from HIL, Kerala	Three months
Characterisation results of the stored UCIL waste to be made public; if required, further characterisation and inventorisation to be done in parallel with the trials	Three months
Waste with high calorific value and hazardous in nature to be incinerated with continuous stack monitoring; remaining waste to be dealt with suitable decontamination/remediation measures	Six months
MEDIUM- AND LONG-TERM MEASURES	
GROUNDWATER CONTAMINATION ASSESSMENT AND REMEDIATION OUTSIDE THE UCIL SITE	**TWO TO THREE YEARS**
Field investigation and lab analysis of the groundwater	One year
Possibility of hydraulic containment to be explored as an interim measure	Six months to one year
Remediation/containment plan to be developed and implemented	Two to three years
CHARACTERISATION AND REMEDIATION OF WASTE DUMPED IN LANDFILL IN THE SEP AREA	**ONE TO TWO YEARS**
Characterisation of waste and development of a basket of disposal/decontamination/remediation options	One year
Disposal/remediation of the waste and decontamination of the landfill area	One to two years
REMEDIATION OF ENTIRE SEP AREA	**THREE TO FIVE YEARS**
Assessment of the need of geohydrological and contamination analysis based on previous reports	Three months
If required, SEP to be studied for waste characterisation and source of groundwater contamination	One year



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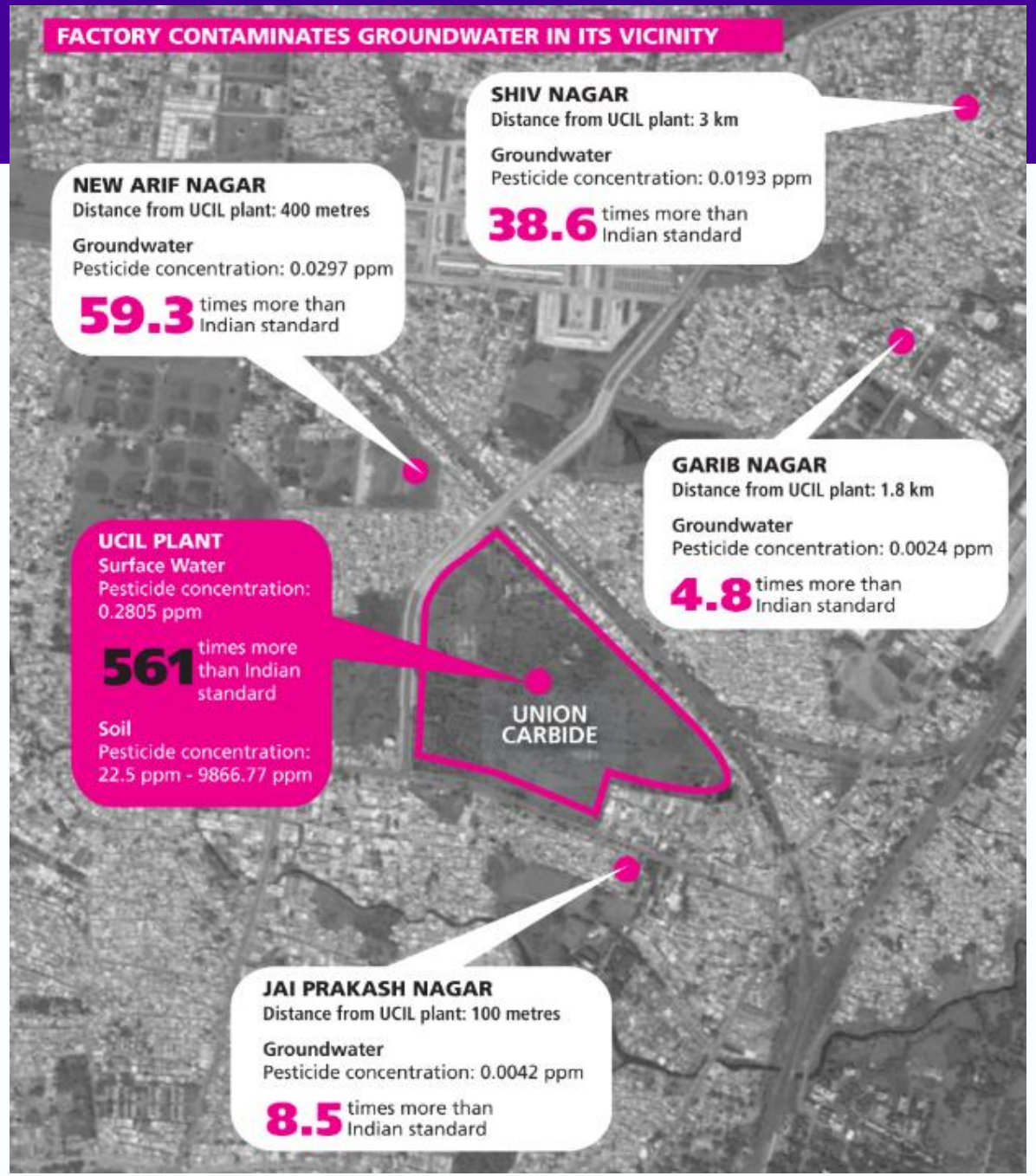
Ongoing Tragedy

Maximum concentration of key contaminants found in soil	(ppm)
Organic	
Hexachlorocyclohexane (HCH)	99,700
Carbaryl (naphthyl methylcarbamate)	51,003
Alpha napthol	9,914
Aldicarb (carbamate pesticide)	7,876
Chlorinated benzenes	2,049
Heavy metals	
Mercury	128,000
Chromium	1,065
Lead	408



Myth 7 Debunked

- ~~Lessons learned are all about emergency response~~

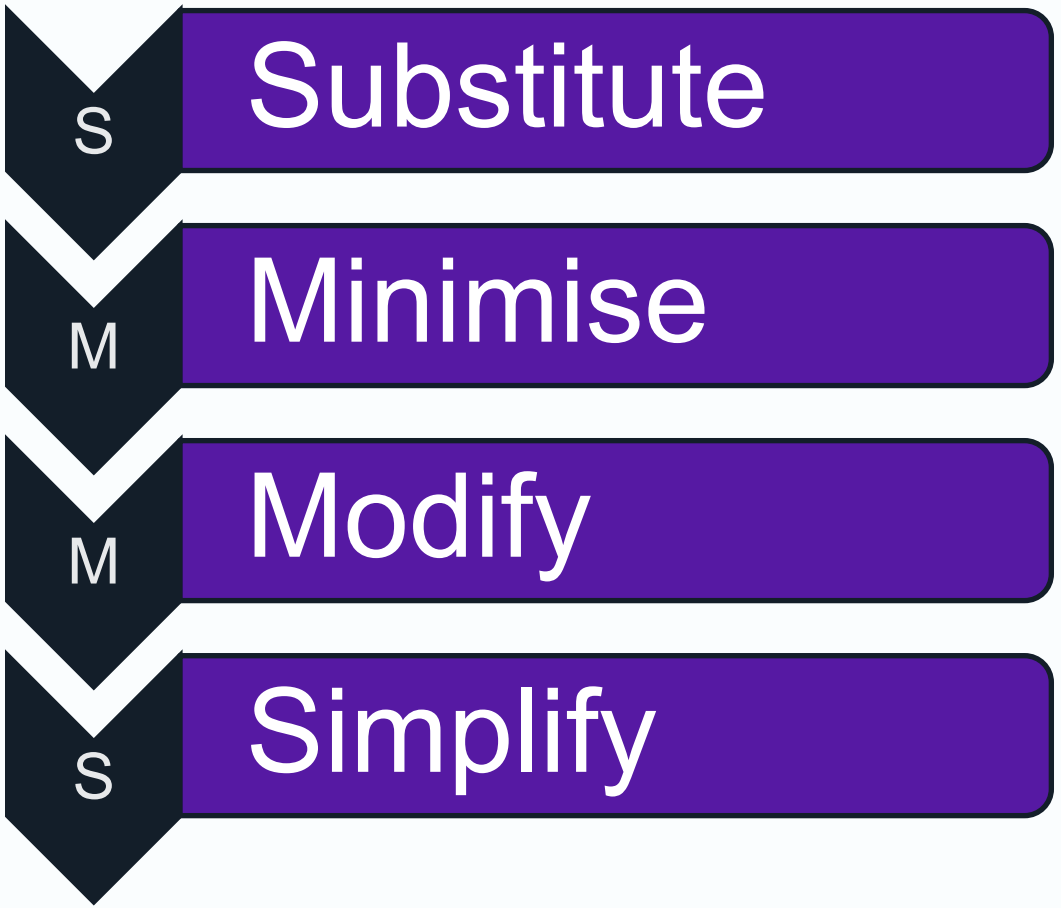
- Lessons learned
  - Respect inherent safety by design
  - Respect your workforce
  - Respect Management of change
  - Emergency response is the last line of defence

OECD Guiding Principles for Chemical Accident Prevention, Preparedness and Response

Prevent	Prepare	Respond	Follow-up
avoid loss of containment	plan for emergency	respond to emergency	investigate & clean up

Design for Inherent Safety

- What you don't have
  can't leak
- People who aren't there
  can't be hurt
- Better to remove a hazard
  than keep it under control



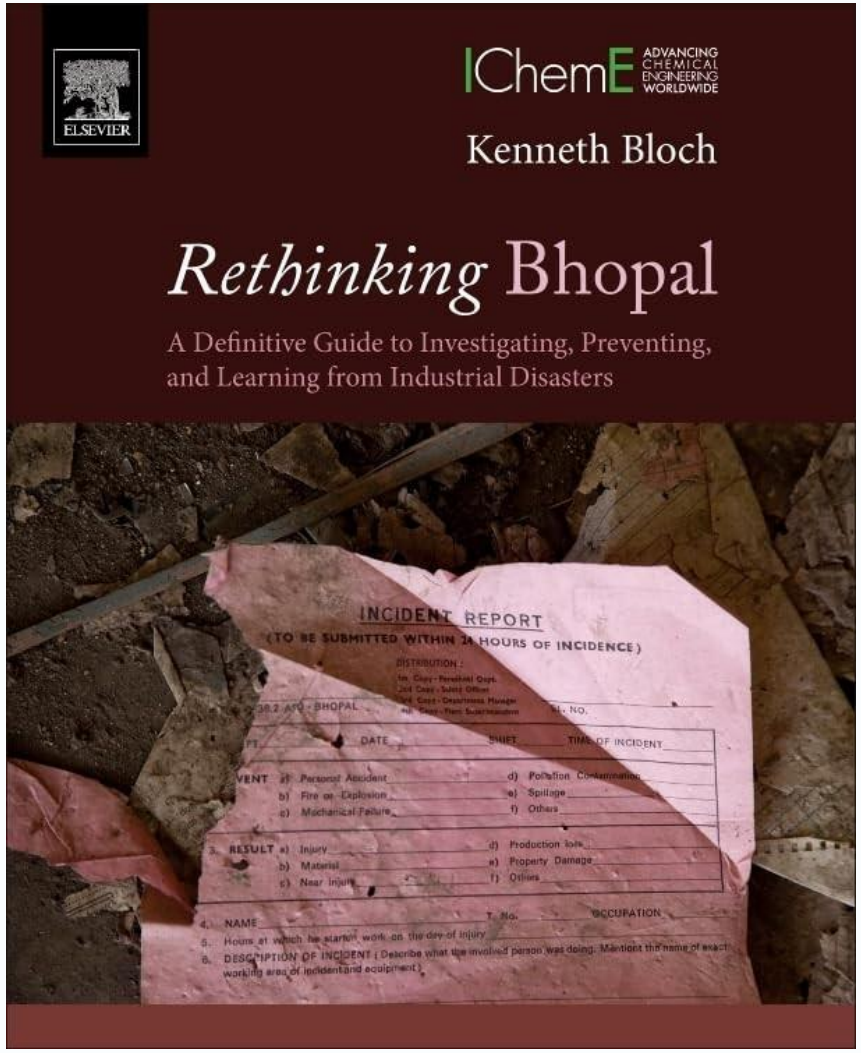
Trevor Kletz

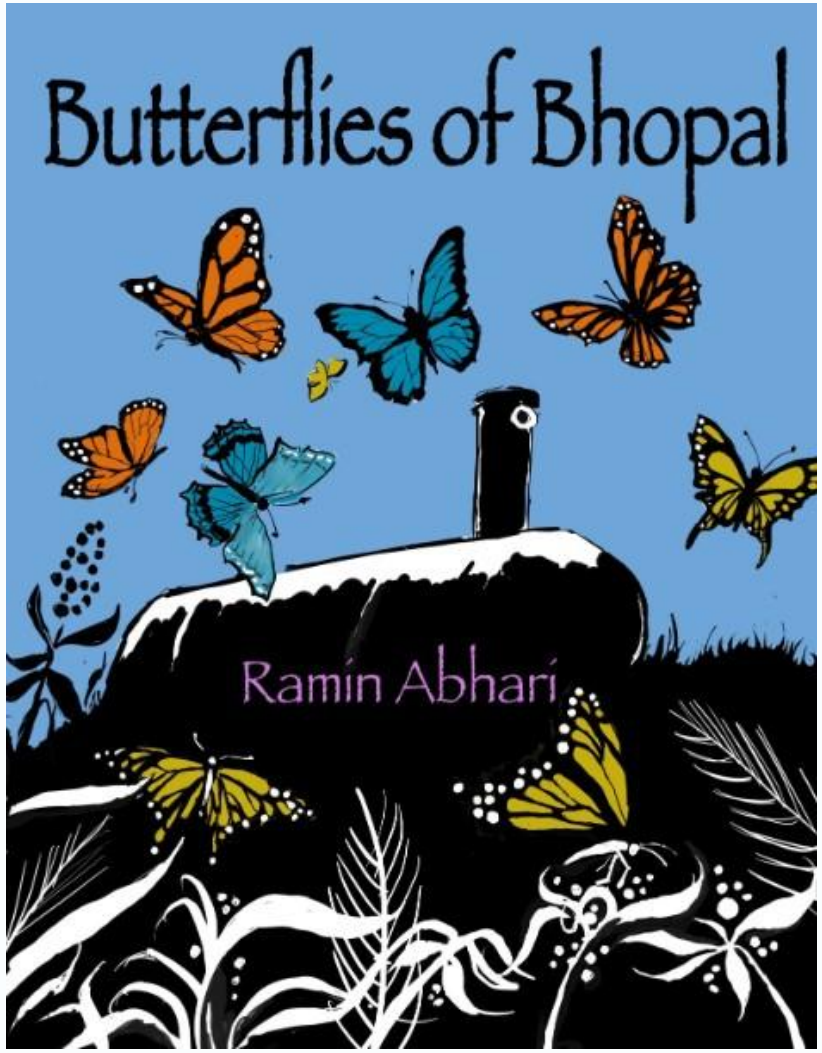
- Every accident is due to human error:
- someone, usually a manager, has to decide what to do;
- someone, usually a designer, has to decide how to do it;
- someone, usually an operator, has to do it.
- All of them can make errors but the operator is at the end of the chain and often gets all the blame.
- We should consider the people who have opportunities to prevent accidents by changing **objectives** and **methods** as well as those who actually carry out operations

What have we learned ?

- Understand your Hazards
- Design for Inherent Safety
- Investigate when things go wrong
- Listen to what your people say
- Closure is complex
- Identify and retain key people
- Safety Critical Equipment MUST remain operational

With thanks to Kenneth Bloch and Ramin Abhari





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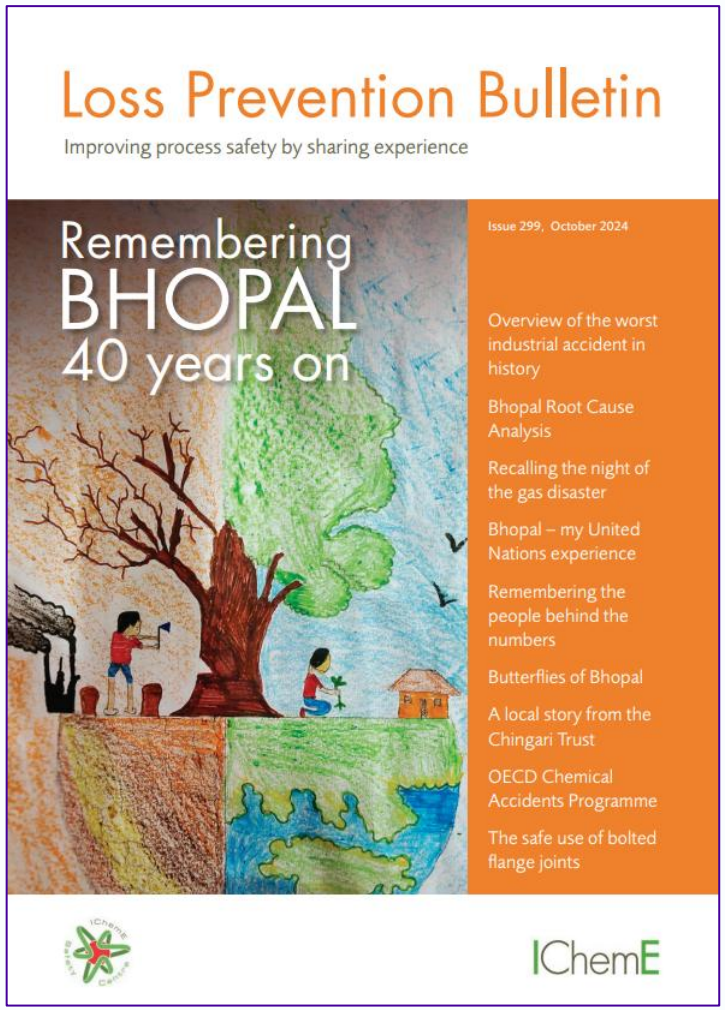
IChemE Loss Prevention Bulletin – Free Downloads



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Chemical, Materials and Biological Engineering

Process Safety and Loss Prevention

WHAT UNI? STUDENT CHOICE Awards 2024 UNIVERSITY OF THE YEAR