



# Failure to Learn

## the BP Texas City Refinery disaster

Andrew Hopkins

# Failure To Learn The Bp Texas City Refinery Disaster

**United States. Congress. Senate.  
Committee on Health, Education,  
Labor, and Pensions. Subcommittee  
on Employment and Workplace Safety**

## **Failure To Learn The Bp Texas City Refinery Disaster:**

*Failure to Learn The BP Texas City Refinery disaster* Andrew Hopkins, 2015      **Failure to Learn - Mandarin Version**  
FutureMedia, Andrew Hopkins, 2015-03-01 World renowned safety culture expert Professor Andrew Hopkins discusses the causes of a major explosion that occurred at the BP Texas City Refinery on 23 March 2005. The explosion killed 15 workers and injured more than 170 others. Failure to Learn also analyses the similarities between this even and the Longford gas plant explosion in Victoria in 1998, the latter of which is featured in his earlier book *Lessons from Longford*. Hopkins poses questions such as: How can companies better design themselves to manage major hazards? Who was blamed for the explosion? What were the real causes? Why had the lessons not been learnt from earlier incidents at Longford and elsewhere? Hopkins received the 2008 European Process Safety Centre Award for extraordinary contribution to process safety, making this the first time the prize was awarded to someone who is based outside of Europe. Failure to Learn is insightfully written and is an essential reference for all OHS professionals. Other titles by Hopkins available through FutureMedia: Nightmare pipeline failures, Disastrous Decisions, Failure to Learn BP Texas City Refinery Disaster, Learning from High Reliability Organisations, Lessons from Gretley, Mindful Leadership and the Law, Lessons from Longford, the Esso Gas Plant Explosion, Safety Culture and Risk. For more information on FutureMedia products and services visit [www.futuremedia.com.au](http://www.futuremedia.com.au) or [www.processsafety.com.au](http://www.processsafety.com.au).  
*Learning from Failures* Ashraf Labib, 2014-06-19 Learning from Failures provides techniques to explore the root causes of specific disasters and how we can learn from them. It focuses on a number of well known case studies including the sinking of the Titanic, the BP Texas City incident, the Chernobyl disaster, the NASA Space Shuttle Columbia accident, the Bhopal disaster and the Concorde accident. This title is an ideal teaching aid, informed by the author's extensive teaching and practical experience, and including a list of learning outcomes at the beginning of each chapter, detailed derivation and many solved examples for modeling and decision analysis. This book discusses the value in applying different models as mental maps to analyze disasters. The analysis of these case studies helps to demonstrate how subjectivity that relies on opinions of experts can be turned into modeling approaches that can ensure repeatability and consistency of results. The book explains how the lessons learned by studying these individual cases can be applied to a wide range of industries. This work is an ideal resource for undergraduate and postgraduate students and will also be useful for industry professionals who wish to avoid repeating mistakes that resulted in devastating consequences. Explores the root cause of disasters and various preventative measures. Links theory with practice in regard to risk, safety and reliability analyses. Uses analytical techniques originating from reliability analysis of equipment failures, multiple criteria decision making and artificial intelligence domains.

**Understanding the Model Work Health and Safety Act** Barry Noel Sherriff, 2010 This provides a succinct overview of the future changes to work health and safety laws in Australia. This plain English guide explains the reasons behind the harmonisation of the upcoming laws and processes in order to give a clear understanding of the expected changes and their

implications This overview has been designed for OHS professionals who need to be prepared ahead of the 2012 changes and face the challenge of applying this legislation to their business

**Why Not Jail?** Rena Steinzor, 2015 The US Department of Justice is under fire for failing to prosecute banks that caused the 2008 economic meltdown because they are too big to jail Prosecutors have long neglected to hold corporate executives accountable for chronic mistakes that kill and injure workers and customers This book the first of its kind analyzes five industrial catastrophes that have killed or sickened consumers and workers or caused irrevocable harm to the environment From the Texas City refinery explosion to the Upper Big Branch mine collapse the root causes of these preventable disasters include crimes of commission and omission Although federal prosecutors have made a start on holding low level managers liable far more aggressive prosecution is appropriate as a matter of law policy and justice Written in accessible and jargon free language this book recommends innovative interpretations of existing laws to elevate the prosecution of white collar crime at the federal and state levels

*Sources of Behavioral Variance in Process Safety* Timothy D. Ludwig, 2019-12-18 Process safety management seeks to establish a multi level system to assess document maintain and inspect equipment and work practices integral in controlling highly toxic and or reactive materials In a highly engineered environment any variance can set off a chain of events that increases the probability of a process safety incident as violent as an explosion Human behavior is often the biggest source of this variance but it can also be the biggest asset for process safety management Process industries are looking to understand sources of behavioral variance and build better processes based on sound behavioral science Because of this clear link between behavior and process safety performance the behavior science community has been challenged to research the behavioral root causes leading to variation that threaten process safety create and evaluate behavioral interventions to mitigate this variation and identify the system factors that would influence the behaviors necessary to promote process safety This book seeks to translate behavior analysis into practical systems that can help reduce human suffering from catastrophic process safety events All of the chapters in this book were originally published in the Journal of Organizational Behavior Management

**Lees' Loss Prevention in the Process Industries** Frank Lees, 2012-11-05 Safety in the process industries is critical for those who work with chemicals and hazardous substances or processes The field of loss prevention is and continues to be of supreme importance to countless companies municipalities and governments around the world and Lees is a detailed reference to defending against hazards Recognized as the standard work for chemical and process engineering safety professionals it provides the most complete collection of information on the theory practice design elements equipment regulations and laws covering the field of process safety An entire library of alternative books and cross referencing systems would be needed to replace or improve upon it but everything of importance to safety professionals engineers and managers can be found in this all encompassing three volume reference instead The process safety encyclopedia trusted worldwide for over 30 years Now available in print and online to aid searchability and portability Over 3 600 print pages cover the full

scope of process safety and loss prevention compiling theory practice standards legislation case studies and lessons learned in one resource as opposed to multiple sources      *Safety and Reliability: Methodology and Applications* Tomasz Nowakowski,Marek Mlynczak,Anna Jodejko-Pietruczuk,Sylvia Werbinska-Wojciechowska,2014-09-01 Within the last fifty years the performance requirements for technical objects and systems were supplemented with customer expectations quality abilities to prevent the loss of the object properties in operation time reliability and maintainability protection against the effects of undesirable events safety and security and the ability to      **The Unfavorable Result in Plastic Surgery** Mimis N. Cohen,Seth R. Thaller,2018-03-21 Highly Commended by the BMA Medical Book Awards for Surgery The Unfavorable Result in Plastic Surgery has been lauded as a classic text in plastic surgery described by reviewers as an unforgettable masterpiece an invaluable companion text and a vast resource Mimis Cohen co authored the widely acclaimed third edition with the late Robert Goldwyn Along with his esteemed coeditors and a cadre of prominent plastic surgeons Dr Cohen has produced an illuminating fourth edition Embracing the book s original philosophy Mistakes are often the best teachers the updated text and videos are remarkable in their candor yielding a vast number of lessons typically not shared in the literature In the first three sections top experts discuss topics connected with plastic surgery complications including patient dissatisfaction psychological aspects of cosmetic plastic surgery legal safety issues the management of scars redo surgery infections and wound management Sections four through nine detail the treatment of specific procedural complications challenges secondary surgery and avoidance of suboptimal outcomes Experts in their respective subspecialties discuss alternative approaches and considerations in aesthetic plastic surgery breast surgery pediatric craniofacial surgery reconstructive plastic surgery for head neck body lower extremity hand upper extremity and burns Key Highlights Concise easy to cross reference text evidence based clinical pearls and case presentations provide in depth understanding on the prevention recognition and management of unfavorable results Preoperative intraoperative and postoperative surgical complications and risks Updated in full color with more than 3 200 illustrations including a bespoke outstanding artwork program More than 100 technical video clips posted in the Thieme MediaCenter deliver additional educational insights The Unfavorable Result in Plastic Surgery Avoidance and Management Fourth Edition is an essential reference for all plastic aesthetic and reconstructive surgeons and residents It expands on the masterful legacy of the original and is certain to become a go to indispensable source of learning for future generations of plastic surgeons      *Evaluating the Effectiveness of Offshore Safety and Environmental Management Systems* United States. Committee on the Effectiveness of Safety and Environmental Management Systems for Outer Continental Shelf Oil and Gas Operations,2012 This report recommends that the Bureau of Safety and Environmental Enforcement BSEE take a holistic approach to evaluating the effectiveness offshore oil and the Safety and Environmental Management Systems SEMS programs of gas industry operators According to the report this approach should at a minimum include inspections audits by the operator and BSEE key performance indicators

and a whistleblower program SEMS is a safety management system SMS aimed at shifting from a completely prescriptive regulatory approach to one that is proactive risk based and goal oriented in an attempt to improve safety and reduce the likelihood that events similar to the April 2010 Macondo incident will reoccur According to the committee that produced the report it is not possible for a regulator to create a culture of safety in an organization by inspection or audit that culture needs to come from within the organization To be successful the tenets of SEMS must be fully acknowledged and accepted by workers motivated from the top and supported throughout the organization and must drive worker actions The report also notes that BSEE can encourage and aid industry in development of a culture of safety by the way it measures and enforces SEMS The committee believes BSEE should seize this opportunity to make a step change in safety culture by adopting a goal based holistic approach to evaluating the effectiveness of SEMS programs In recommending a holistic approach to evaluating the effectiveness of SEMS programs the report explores in detail the role of SEMS in helping to develop a culture of safety highlights the pros and cons of various methods of assessing the effectiveness of a SEMS program and investigates existing approaches for assessing the SMS programs of various U S and international regulatory agencies whose safety mandates are similar to that of BSEE

Production Over Protections United States. Congress. Senate. Committee on Health, Education, Labor, and Pensions. Subcommittee on Employment and Workplace Safety, 2012

*Deep Water: The Gulf Oil Disaster and the Future of Offshore Drilling: Report to the President, January 2011* United States. National Commission on the BP Deepwater Horizon Oil Spill and Offshore Drilling, 2011-01-11

The explosion that tore through the Deepwater Horizon drilling rig last April 20 as the rig's crew completed drilling the exploratory Macondo well deep under the waters of the Gulf of Mexico began a human economic and environmental disaster Eleven crew members died and others were seriously injured as fire engulfed and ultimately destroyed the rig And although the nation would not know the full scope of the disaster for weeks the first of more than four million barrels of oil began gushing uncontrolled into the Gulf threatening livelihoods precious habitats and even a unique way of life A treasured American landscape already battered and degraded from years of mismanagement faced yet another blow as the oil spread and washed ashore Five years after Hurricane Katrina the nation was again transfixed seemingly helpless as this new tragedy unfolded in the Gulf The costs from this one industrial accident are not yet fully counted but it is already clear that the impacts on the region's natural systems and people were enormous and that economic losses total tens of billions of dollars

Page vi of online resource *The Chemical Engineer*, 2009

The Times Index, 2007 Indexes the Times and its supplements

**Daily Labor Report**, 2006-04

**INVESTIGATION REPORT: Refinery Explosion and Fire**, 2007 On March 23 2005 at 1 20 p m the BP Texas City Refinery suffered one of the worst industrial disasters in recent U S history Explosions and fires killed 15 people and injured another 180 alarmed the community and resulted in financial losses exceeding 1.5 billion The incident occurred during the startup of an isomerization ISOM unit when a raffinate splitter tower was overfilled pressure relief devices opened resulting in a flammable liquid geyser

from a blowdown stack that was not equipped with a flare The release of flammables led to an explosion and fire All of the fatalities occurred in or near office trailers located close to the blowdown drum A shelter in place order was issued that required 43 000 people to remain indoors Houses were damaged as far away as three quarters of a mile from the refinery

Investigation Report U.s. Chemical Safety and Hazard Investigation Board,2014-07-14 On March 23 2005 at 1 20 p m the BP Texas City Refinery suffered one of the worst industrial disasters in recent U S history Explosions and fires killed 15 people and injured another 180 alarmed the community and resulted in financial losses exceeding 1 5 billion The incident occurred during the startup of an isomerization<sup>1</sup> ISOM unit when a raffinate splitter tower<sup>2</sup> was overfilled pressure relief devices opened resulting in a flammable liquid geyser from a blowdown stack that was not equipped with a flare The release of flammables led to an explosion and fire All of the fatalities occurred in or near office trailers located close to the blowdown drum A shelter in place order was issued that required 43 000 people to remain indoors Houses were damaged as far away as three quarters of a mile from the refinery Anatomy of a Disaster ,2007 **Incidents That Define Process Safety** CCPS (Center for Chemical Process Safety),2013-07-01 Incidents That Define Process Safety describes approximately fifty incidents that have had a significant impact on the chemical and refining industries approaches to modern process safety Events are described in detail so readers get a fundamental understanding of the root causes the consequences the lessons learned and actions that can prevent a recurrence There are exhaustive investigative reports about these events allowing you to apply the resulting safety principles to their current operations *Refinery Explosion and Fire (15 Killed, 180 Injured)* ,2007

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