

# 55th Canadian Chemical Engineering Conference Process Safety and Loss Management

## Lessons Learned from an Unusual Hydrogen Reformer Furnace Failure

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**Syncrude Canada Limited** 





#### **QUICK FACTS**

- Syncrude Canada Ltd is a joint venture partnership which converts Athabasca Oilsands into a Light Sweet Blend Crude Oil
- The facility is an integrated mining, extraction and upgrading operation supported by a common power utility
- Current capacity is 250,000 barrels/day of final product which is shipped via pipeline to southern markets
- The Upgrading plant is similar to an oil refinery with two separate operating trains each including a crude unit, fluid coker and hydrotreaters







#### **QUICK FACTS**

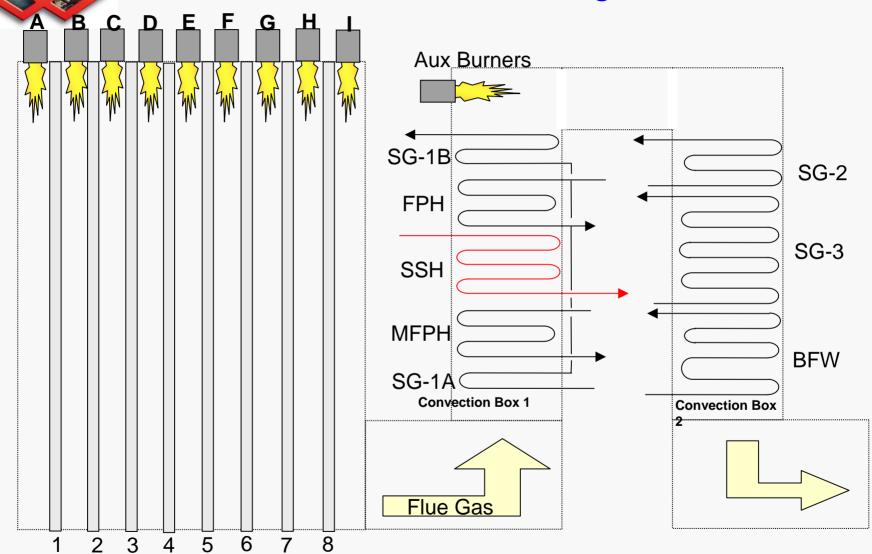
- Within the Upgrading plant 300 MSCFD of hydrogen in three steam/ methane reformers is produced
- The incident occurred in the reformer furnace of unit 3

#### **Furnace Facts**

- Hydrogen output 81 MSCFD built in 1987 and operational in 1988
- The radiant section of the furnace contains eight (8) parallel rows of. Each row contains forty-six (46) tubes for a total of 368 tubes composed of spun cast HP-45 Niobium Modified Alloy with a design wall tube temperature of 935°C.
- Each tube has a 4" ID by 39'10"
- 108 burners arranged in 9 rows

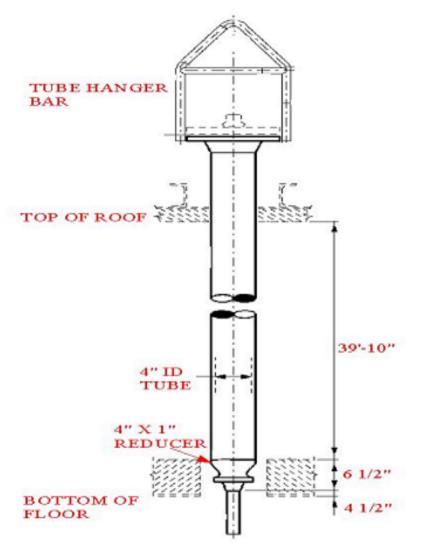


#### General Furnace Arrangement









# **General Tube Arrangement**





### SUMMARY THE INCIDENT

- At 22:39 Sunday January 30, 2005 a rapid sudden high energy pressure impulse occurred within several radiant tubes in the unit 3 reformer furnace
- The furnace was in a startup mode on steam without hydrocarbon feed
- This impulse caused the simultaneous rupture of 5 tubes with sufficient force to eject portions of the tubes out through the roof of the furnace

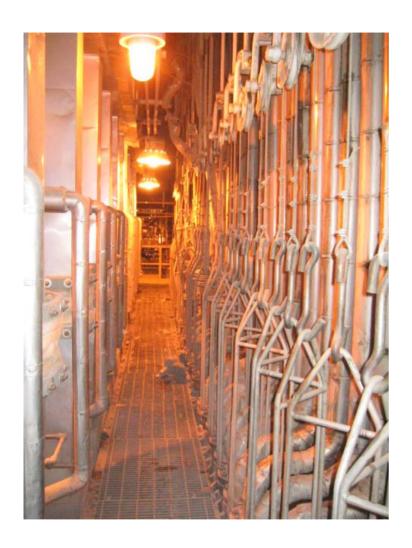




#### **SUMMARY...**

- 41 more tubes were destroyed as a result of impacts by tube segments and the subsequent shock wave
- All of the flue gas tunnels suffered extensive damage
- Fire box sustained impact damage from shrapnel hits
- One Operator sustained serious injuries when he was hit by one of the ejected tube assemblies
- The entire reformer section was condemned necessitating replacement





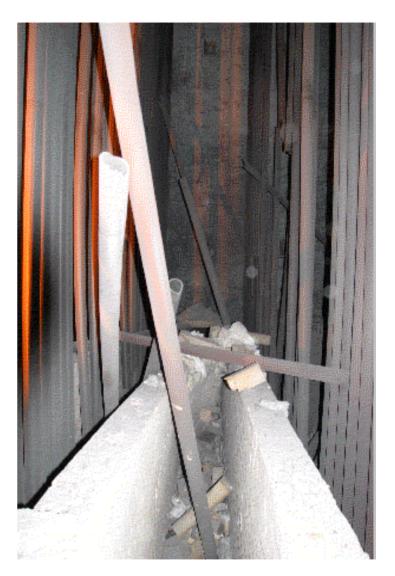
**Pre Incident General Radiant Tube External Arrangement** 



**Post Incident External Damage** 



Tube 161 lifted approximately 16 ft (view looking up)



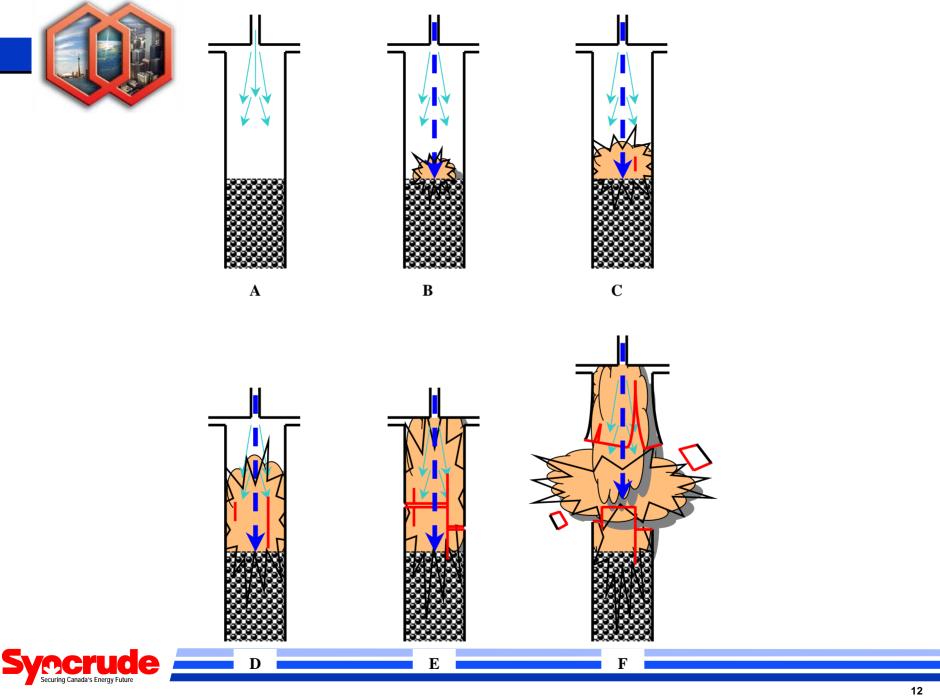
**Internal condition of radiant section** 



## **FAILURE MECHANISM**

- Prior to start-up water was present in the feed system upstream of the radiant tube section
- As the Process Steam flow was ramped up per the startup procedure (increased mass and velocity) it picked up water and carried it into the radiant tubes
- Water introduced into tubes underwent an rapid phase change generating an extreme local pressure impulse and shock wave. The wave initiated longitudinal cracking
  - Entrained water impinged on hot (350°C) catalyst and possibly the pipe wall,"instantly flashing"







#### **ROOT CAUSE**

- Accumulated water was not removed upstream of the radiant section prior to introducing steam
- The Mixed Feed Preheat Coil is the most probable location where water was pooled prior to the event because:
  - Steam could have collapsed into water in the system after shutting down or from passing valves
  - Inlet header is not self draining
  - The outlet header is the low point





#### **LESSONS LEARNED**

#### • Inadequate Safeguards:

 Insufficient size and location of drains to ensure all remnant water is removed

#### • Inadequate Procedure:

- The startup procedure did not account for a startup of a cold furnace with no hold points
- Insufficient information for operators to detect a wet system

#### Lack of MOC

- The startup procedure has two hold points for refractory dry out and new catalyst reduction, during the heat up phase prior to introducing the 600psig startup steam.
- These hold points were not utilized since the neither was required





- Non-essential Personnel
  - At the time of the incident seven people were on the furnace structure
    Only the operations personnel were essential

