Mobile Acetylene Trailer Accidents: Fire During Unloading in Dallas, Texas, July 25, 2007; Fire During Unloading in The Woodlands, Texas August 7, 2007; and Overturn and Fire in East New Orleans, Louisiana, October 20, 2007
Special Investigation Report

Mobile Acetylene Trailer Accidents:
Fire During Unloading in Dallas, Texas, July 25, 2007;
Fire During Unloading in The Woodlands, Texas, August 7, 2007; and
Overturn and Fire in East New Orleans, Louisiana, October 20, 2007
Abstract: The National Transportation Safety Board investigated three accidents that involved highway vehicles transporting bulk quantities of acetylene gas that occurred in 2007 and reviewed reports of a 2008 overturn accident of another vehicle. The vehicles, called mobile acetylene trailers, carried up to 225 cylinders that were connected by a manifold system and filled with acetylene. Two of the accidents occurred as the vehicles overturned on public highways, and two of the accidents occurred while the vehicles were being prepared for unloading. In the two overturn accidents, cylinders were ejected from the trailers and damaged, releasing acetylene, which ignited. In one unloading accident, the fire on the initial trailer spread to cylinders on an adjacent trailer; in the other, the fire also spread to nearby buildings and vehicles. The failures of the cylinders on these trailers and the resultant damage raised concerns about the accident protection provided by these vehicles, the adequacy of the minimum safety standards and procedures applicable to unloading these vehicles, and the adequacy of fire suppression systems at loading and unloading facilities.

The safety issues discussed in this report are adequacy of mobile acetylene trailer design for protecting cylinders during transport, effectiveness and safety of unloading procedures for mobile acetylene trailers, and adequacy of fire suppression systems at mobile acetylene trailer loading and unloading facilities.

As a result of this special investigation, the Safety Board makes safety recommendations to the Pipeline and Hazardous Materials Safety Administration and the Compressed Gas Association.
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## Acronyms and Abbreviations

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Executive Summary

The National Transportation Safety Board investigated three accidents that involved highway vehicles transporting bulk quantities of acetylene gas that occurred between July 25 and October 20, 2007, and reviewed reports of a 2008 overturn accident of another vehicle. The vehicles, called mobile acetylene trailers, carried up to 225 cylinders that were connected by a manifold system and filled with acetylene. Two of the accidents occurred as the vehicles overturned on public highways, in East New Orleans, Louisiana, on October 20, 2007, and in Lamar, Colorado, on June 9, 2008. Two of the accidents occurred while the vehicles were being prepared for unloading, in Dallas, Texas, on July 25, 2007, and in The Woodlands, Texas, on August 7, 2007. In the two overturn accidents, cylinders were ejected from the trailers and damaged, releasing acetylene, which ignited. In one unloading accident, the fire on the initial trailer spread to cylinders on an adjacent trailer; in the other, the fire spread to cylinders on adjacent trailers and to nearby buildings and vehicles. The failures of the cylinders on these mobile acetylene trailers and the resultant damage raised concerns about the accident protection provided by these vehicles, the adequacy of the minimum safety standards and procedures applicable to unloading these vehicles, and the adequacy of fire suppression systems at loading and unloading facilities. To address these concerns, the Safety Board conducted a special investigation of mobile acetylene trailers.

These trailers, with multiple cylinders and a manifold system for loading and unloading the cylinders, are the only vehicles authorized to transport and deliver bulk quantities of acetylene. Currently, two companies in the United States operate mobile acetylene trailers. Each company has about 200 trailers, thus the total number of these trailers is about 400.

The trailers in the four accidents that the Safety Board investigated and reviewed were operated by Western International Gas & Cylinders, Inc. (Western). In the 10 years before these four accidents, Western mobile acetylene trailers had been involved in additional accidents; the company investigated four of them. The Safety Board reviewed reports of three of these accidents that had some relevance to the accidents in this investigation.

In its investigation, the Safety Board attempted to determine the hazards of the transportation and delivery of acetylene gas in bulk. The investigation looked at the protection of the cylinders during a vehicle overturn and the standards and procedures for handling acetylene during loading and unloading. The following safety issues were identified in this special investigation:

- Adequacy of mobile acetylene trailer design for protecting cylinders during transport
- Effectiveness and safety of unloading procedures for mobile acetylene trailers
- Adequacy of fire suppression systems at mobile acetylene trailer loading and unloading facilities.

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1 A manifold system collects the acetylene gas from multiple cylinders into one pipe or chamber; when the cylinders are filled, the acetylene gas is dispersed from one pipe to multiple cylinders.
As a result of this special investigation, the Safety Board makes recommendations to the Pipeline and Hazardous Materials Safety Administration and the Compressed Gas Association.
Acetylene Gas

Acetylene is a colorless flammable gas that has historically been handled relatively safely at pressures below atmospheric pressure (about 15 pounds per square inch, gauge \( \text{psig} \)). However, at elevated pressures acetylene becomes extremely unstable.\(^3\) With the addition of energy, acetylene undergoes a decomposition reaction in which it breaks down to flammable hydrogen gas and elemental carbon. Carbon generated during this reaction is deposited on piping and other components. The decomposition reaction releases tremendous amounts of energy and may generate temperatures between 5072° and 5252° Fahrenheit (F). A black plume forms when the carbon and hydrogen are expelled from the cylinder. External heating, compression heating, an electrostatic spark, or a shockwave can also cause an acetylene decomposition reaction. With substantial energy input, a decomposition reaction can occur within a cylinder or pressurized system in the absence of air. When combined with air, pressurized acetylene will readily ignite with very little energy input and a lower temperature. Such a reaction can result in deflagration or detonation.\(^4\)

Western has a material safety data sheet for acetylene that states that the flash point\(^5\) for acetylene is 32° F, acetylene has flammable limits\(^6\) between 2.5 percent and 82 percent in air, and it is lighter than air. Acetylene also may decompose explosively at elevated temperatures and pressures. The potential for a decomposition reaction to occur is proportional to the pressure; the higher the pressure, the more likely it is for a reaction to occur.

According to a paper by S. A. Miller and E. Penny,\(^7\) the progression from deflagration to detonation is dependent on the original pressure and the diameter and length of the pipe. Testing showed that an acetylene deflagration in a 1-inch-diameter pipe originally pressurized to 73.5 psig takes 12 feet to reach detonation. However, when the original acetylene pressure is 294 psig, detonation occurs between 2.8 and 3.2 feet. Once detonation occurs, the reaction front travels through open piping at a speed greater than the speed of sound. The acetylene in the cylinders on the vehicles involved in the accidents in East New Orleans, The Woodlands, and Dallas was

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\(^2\) The term \( \text{psig} \) is a unit of pressure relative to the surrounding atmosphere (as in a container).


\(^4\) Deflagration is a very rapid exothermic chemical reaction that is propagated through the unreacted material at a velocity less than the speed of sound. The propagation is achieved by the spread of flame and hot gases into the unreacted material. Detonation is an explosive process in which the extremely rapid chemical reaction is propagated through the unreacted material at supersonic velocity by means of a shockwave. The shockwave is associated with a compressive zone of very high temperature passing through the unreacted material.

\(^5\) The flash point of a chemical is the lowest temperature at which a liquid can form an ignitable mixture in air near the surface of the liquid. The lower the flash point, the easier it is to ignite the material.

\(^6\) The flammable limits of a chemical define the concentration range in which a flammable substance can produce a fire or explosion when an ignition source (such as a spark or open flame) is present. The concentration is generally expressed as percent fuel by volume.

pressurized to about 250 psig. Residue pressure in the cylinders involved in the Lamar, Colorado, accident was less than 15 psig.

According to Samuel A. Miller’s book, *Acetylene: Its Properties, Manufacture and Uses*, testing of acetylene explosions caused by shockwaves in piping showed that for certain pipe lengths, pipe diameters, and acetylene pressures, ignition occurred after the shock wave was reflected from the closed end of a tube. In postaccident discussions, a representative of Praxair, Inc., stated that testing performed by Union Carbide had revealed that a decomposition reaction could occur with the rapid introduction of high-pressure acetylene into a blocked 1-inch-diameter pipe as the shockwave was reflected. Union Carbide found that this pipe must be at least 1 1/4 inch long for the reaction to occur.

**Transporting Acetylene**

Given the extreme reactivity of pressurized acetylene, no bulk or large pressure vessel has been developed that is considered safe for its transportation. Therefore, bulk acetylene is transported on mobile acetylene trailers, of which one often contains more than 200 U.S. Department of Transportation (DOT) specification 8AL cylinders that are manifòled, that is, linked together by a manifold system used for loading and unloading. (These cylinders are approximately 4 feet tall and 1 foot in diameter.) The trailers were designed so that the cylinders are mounted upright, set close together, and braced in groups to control their movement during transportation and to prevent them from falling over. (See figure 1.) The cylinders on these vehicles are not secured to the trailer to prevent their ejection during overturn, nor are they required to be.

Title 49 *Code of Federal Regulations* (CFR) 178.60 contains the DOT specifications for the 8AL cylinders that are designed specifically to contain acetylene gas during transportation. The 8AL cylinders are filled with a porous mass and a liquid solvent. Although acetone typically is the solvent used in individual acetylene cylinders, dimethylformamide is the liquid solvent used in bulk transportation cylinders because it is less volatile and requires less maintenance. These features are designed, in part, to reduce the likelihood that the acetylene will undergo a decomposition reaction within the cylinder. Each cylinder has two fusible plugs in the top that are designed to melt in the event of an internal decomposition reaction or when exposed to external heat and thus relieve pressure in the container. Venting pressure through the fusible plug openings reduces the likelihood of a cylinder overpressure failure. However, exposing an acetylene cylinder to excessive heat or energy can overwhelm the ability of the fusible plugs to vent sufficient gas, and a cylinder failure can occur.

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9 According to the Compressed Gas Association, Union Carbide Corporation originally designed and tested mobile acetylene trailers. In 1992, Union Carbide Corporation’s Industrial Gas Division formed an independent company that is now called Praxair, Inc.
Figure 1 shows cylinders on a mobile acetylene trailer. The valve opening on each cylinder is connected by spiral tubing, called a pigtail, to the manifold that delivers or receives the acetylene gas to or from the cylinder. Attached to the manifold, on the back of the trailer, is a cargo transfer fitting, which is not visible in this photograph. This fitting is the connection between the trailer and the piping from the plant. The tubing and manifold piping are designed to contain the energy of an accidental decomposition reaction. A manual block valve (block valve) controls the flow of acetylene to and from the cargo transfer fitting. The piping includes an air-actuated valve that shuts off the flow if a trailer pulls away accidentally before it is disconnected. A needle valve on the manifold is used to reduce pressure on the manifold after cargo transfer and leak testing. Pressure gauges are mounted on the trailer: one on the manifold and one on the trailer piping between the block valve and the connection to the plant piping. According to Western, filling the cylinders through the manifold connection takes about 12 hours.

During transportation of the cylinders, each cylinder valve must be closed and the pressure in the manifold and pigtails is reduced. Because pressurized acetylene’s potential for ignition increases dramatically when it is combined with air, some positive acetylene pressure must be maintained in the manifold and pigtails at all times to prevent the introduction of air.

Although the trailer has strong outer railings and the manifold is mounted above the top of the cylinders, neither the railings nor the manifold protects the cylinder valves in case of a trailer overturn. The four accident mobile acetylene trailers had no rollover protection for the valves, nor were they required to.
Western’s Acetylene Unloading Procedures

Western had standard operating procedures for connecting mobile acetylene trailers to piping at customer sites. The procedures that were used at the sites of the two unloading accidents—the Hughes Christensen (The Woodlands) and Southwest (Dallas) unloading sites—are shown in figure 3.

Operating a mobile acetylene trailer encompasses two jobs: driving the trailer and performing the tasks involved in loading and unloading the acetylene cylinders carried on the trailer. Although one person can both drive the trailer and load/unload the trailer, mobile acetylene trailers are often operated by a team of two people, called “driver/operators,” with one driving the trailer and one or both performing the tasks of loading/unloading. In this report, the driver/operators will be identified as “operators.” Each operator is required to carry a copy of the standard operating procedures and to follow the procedures step by step when preparing a trailer for unloading.

Western’s standard operating procedures require that after connecting the trailer to the plant piping (step 9), the manual block valve on the trailer be opened (step 10) before the trailer manifold is fully pressurized (step 12). Performing these operations out of sequence—opening the block valve after pressurizing the manifold allows highly pressurized acetylene to enter a blocked section of piping that contains residual air, which is dangerous because (1) a blocked pipe potentially can cause a reflected shockwave that can initiate a decomposition reaction and (2) pressurized acetylene that mixes with air inside piping can ignite easily with little energy input. Western’s procedure of slowly opening the block valve when the pressure in the manifold is at 50 psig (step 10) allows lower pressure acetylene to mix safely with air in that portion of the
piping. This minimizes the potential for an accidental decomposition reaction to occur within the piping by reducing the pressure shockwave and by slowly mixing the acetylene and residual air.

Figure 3. Western unloading procedures. (Pressurizing manifold in step 2 is for leak test. Opening cylinder valves in step 12 is pressurizing manifold for unloading.)
Accident Narratives

The accidents included in this special investigation are two trailer overturns that occurred in East New Orleans, Louisiana, on October 20, 2007, and in Lamar, Colorado, on June 9, 2008, and two accidents that occurred before the acetylene was unloaded, in Dallas, Texas, on July 25, 2007, and in The Woodlands, Texas, on August 7, 2007. Also included in this report are three previous accidents (in 2001 and 2005) involving Western mobile acetylene trailers at loading/unloading sites in which cylinders were damaged, releasing acetylene, which ignited, or the acetylene decomposed, resulting in fire.

Overturin Accidents

East New Orleans, Louisiana

About 5:00 a.m. central daylight time\(^\text{10}\) on October 20, 2007, an eastbound Western tractor and mobile acetylene trailer carrying 220 manifolded DOT 8AL specification cylinders (450 standard cubic feet\(^\text{11}\) capacity each) filled with acetylene gas overturned on Interstate Highway 10 in East New Orleans, Louisiana. As a result of the overturn, the cylinders were thrown from the trailer, and acetylene gas from 145 of the 220 cylinders was released and ignited. The overturn and resulting fire destroyed the tractor, the mobile acetylene trailer, and many of the cylinders. (See figure 4.) Six other vehicles were damaged when they struck or were struck by the accident debris. There were no fatalities; the operator sustained minor injuries from the accident. Property damage to the vehicle totaled $200,000.

Just after midnight on October 20, the operator had picked up a load of acetylene from the BASF Corporation plant in Geismar, Louisiana, and was to take the load to the Western facility in Slidell, Louisiana. He had been off duty since 3:00 p.m. October 17. The capacity of all the cylinders was about 100,000 standard cubic feet of acetylene. The operator told the police that he had fallen asleep while driving and hit a bridge rail.

Of the 145 cylinders that released acetylene, 88 were so severely damaged that they were discarded. Of the remaining 57 cylinders that released acetylene, 32 had their valves broken off, and all 57 had evidence of heat exposure and melted fusible plugs. Significant damage to these cylinders included burst heads, a bulging and burst sidewall near the top head weld, extreme localized bulging of the heads and sidewalls, and denting. (See figure 5.)

\(^{10}\) Except where otherwise noted, all times in this report are central daylight time.

\(^{11}\) A standard cubic foot is the volume of a gas at a pressure of 14.7 psi (atmospheric pressure) and 60° F.
Figure 4. East New Orleans accident vehicle and cylinders.

Figure 5. East New Orleans cylinder showing burst near head.
Lamar, Colorado

About 12:15 p.m. mountain daylight time on June 9, 2008, a southbound Western tractor and mobile acetylene trailer carrying 225 DOT 8AL specification cylinders (450 standard cubic feet capacity each) containing acetylene gas residue overturned on Highway 287 about 6.5 miles south of Lamar, Colorado. As a result of the overturn, about half of the cylinders were thrown from the trailer, and acetylene gas from 86 of the 225 cylinders was released and ignited. (See figure 6.) The overturn damaged the tractor and the trailer. There was some fire damage on the trailer. There were no injuries from the accident. Property damage to the tractor and trailer totaled about $200,000.

Figure 6. Lamar accident vehicle.

The trailer had been unloaded at a Western facility in Pueblo, Colorado, and was en route to Louisiana to be refilled. There was still a residue of acetylene in each cylinder. The valves of all the cylinders were closed during transportation. Before this trip, the operator had been off duty since June 6, 2008. The Colorado accident report indicated that the vehicle skidded for 106 feet, went off the right side of the roadway, and traveled an additional 250 feet before striking a delineator pole. The vehicle was then steered to the left onto the roadway, where it rolled over completely. The vehicle came to rest perpendicular to and completely across the two-lane road. At least half of the cylinders were thrown from the vehicle, and the remainder fell over. The valves were broken off of 52 cylinders, and acetylene was released and ignited. The fire caused

12 The Safety Board did not investigate this accident.
fusible plugs on other cylinders to melt, which released acetylene that also ignited. About 86 cylinders were damaged by the fire. The tractor and trailer had extensive collision damage; the trailer had some fire damage.

**Unloading Preparation Accidents**

*The Woodlands, Texas*

About 2:55 p.m. on August 7, 2007, acetylene gas ignited on a Western mobile acetylene trailer containing 62 manifolded DOT 8AL specification cylinders (420 standard cubic feet capacity each) resulting in a fire on that trailer and an adjacent trailer at the Hughes Christensen plant in The Woodlands, Texas. (See figure 7.) The fire occurred as the operators were preparing the trailer to be unloaded. There were no injuries or fatalities. Property damage to the two trailers totaled $40,200.

![Figure 7. Security camera photograph of acetylene gas fire in The Woodlands, Texas.](image-url)

The trailer had been filled and shipped from the Western plant in Bellville, Texas. The total capacity of the cylinders on the trailer was about 26,040 standard cubic feet of acetylene. A trainee operator was to make his first delivery of a mobile acetylene trailer. An operator trainer accompanied the trainee. The operator trainer had made a few trips in which connections were made to facility piping; however, he usually delivered truckloads of filled and palletized cylinders to customer sites. He had made two earlier trips to The Woodlands, the latest in June 2007. The team said that they had followed the written standard operating procedures when they prepared the trailer and connected it at the Hughes Christensen site. Tape from a security camera showed a person on the trailer moving back and forth along the length; the person appeared to be opening the cylinder valves and pressurizing the manifold. When the accident occurred, the two operators
were standing on the ground at the back of the trailer near the trailer’s block valve and attachment to the plant’s discharge arm, but the focus of the camera was not adequate to show what they were doing. During postaccident interviews, both operators said that they had believed that they had completed the connection procedures and had pressurized the manifold. They told interviewers that after they had reviewed Western’s standard operating procedures manual, however, they realized that they had not opened the block valve before pressurizing the manifold as Western’s procedures required. Just after the accident, the trainee operator told a Hughes Christensen employee that the trailer had jumped as they opened the block valve. Shortly after that, the security camera recorded a black plume coming from one of the cylinders on the trailer. (See figure 8.) A similar reaction occurred on other cylinders on the trailer until the released gases ignited. Heat from the fire on the accident trailer caused the release of unreacted acetylene gas on an adjacent trailer.

![Figure 8. Security camera photograph of black plume coming from a cylinder on trailer in The Woodlands, Texas.](image)

The postaccident examination of the trailer being prepared for unloading revealed that the trailer and manifold piping had some fire damage at and above the level of the top of the acetylene cylinders. There was little damage to the trailer below that level. The cylinders’ fusible plugs were all melted, with some evidence of fusible material remaining on the top of some of the cylinders. At least three cylinders in one cluster had visible bulging on their sidewalls just below the circumferential head weld. The cylinder valves appeared to be intact; however, the hand wheels had been consumed in the fire. The pigtail also had evidence of heat exposure but appeared to be intact. The connection fitting from the trailer to the plant piping had a large deposit of black powderlike material inside. A large deposit of the same black material was also in the plant discharge arm at the Hughes Christensen plant. There was no deposit of a similar material in the discharge arm for the second trailer.
The only emergency response fire fighting equipment available at the Hughes Christensen acetylene unloading location was fire extinguishers. There was no automated water deluge system to suppress a fire.

**Dallas, Texas**

About 9:50 a.m. on July 25, 2007, acetylene gas ignited on a Western mobile acetylene trailer containing 225 manifoldeed DOT 8AL specification cylinders (450 standard cubic feet capacity each) on the docks at the Southwest Industrial Gases (Southwest) facility in Dallas, Texas. (See figure 9.) The fire occurred as the operator was preparing the trailer to be unloaded. A video recording made by a Dallas television network did not record the initiation of this accident; however, it showed a gradual progression of the fire and explosions from the trailer on which the operator was working to adjacent trailers, to Southwest’s building, and to vehicles parked in front, one of which contained acetylene-filled cylinders for delivery. The fire and explosions destroyed the Southwest facility and many vehicles, damaged several nearby buildings, and caused the failure of hundreds of acetylene-filled cylinders from three other Western acetylene trailers, the delivery truck, and the facility’s docks and storage. (See figure 10.) The operator sustained back injuries, and the plant manager and general manager were severely burned during the accident. There were no fatalities. Property damages have not been fully assessed, but Southwest estimated losses of more than $5 million.

![Acetylene gas fire at Southwest facility in Dallas.](image)

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13 The three other trailers were attached to the plant piping and in use at the time of the accident.
The accident trailer was filled and shipped from the BASF Corporation plant in Geismar, Louisiana. The capacity of the cylinders was approximately 100,000 standard cubic feet of acetylene. The operator typically worked in a two-person team that drove, loaded, and unloaded mobile acetylene trailers. The accident occurred during the operator’s third delivery to Southwest, which was his first solo delivery to that location. He had made five solo deliveries to other facilities. The operator said that he had followed Western’s standard operating procedures when he prepared the trailer for unloading at the Southwest facility. He said that after cycling the facility’s discharge arm valve, leaving it closed (step 11 of Western’s unloading procedures), he checked the pressure gauges on the manifold and both read 0 psig, which he did not identify as a problem. Step 4 of Western’s unloading procedures requires that 50 psig of acetylene pressure remain in the manifold, and discussions with Western management revealed that at the completion of step 11 there should still have been slightly less than 50 psig pressure in the manifold.

The operator said that he had climbed on the bed of the trailer and had begun opening the cylinder valves, beginning with the cylinders at the rear of the trailer on the right side of the vehicle, when he heard a “boom” and felt a pressure surge that threw him back against the support rail for the cylinders on the side of the trailer. He said that he saw black smoke and
flames coming from the top of a cylinder toward the front of the trailer. He then ran from the trailer down the dock and around the building.

A Southwest employee on the facility dock about 8 or 9 feet away from the back of the accident trailer said that about 5 minutes after he saw the operator climb on the trailer he saw black smoke over a 5-foot-high partial wall. He stated that he saw fire coming from one of the two rear cylinders on the right side of the trailer. He said he then heard a loud noise, not an explosion, which he described as pressure being released through an open valve. Then he grabbed a fire extinguisher, ran into the break room, and shouted, “Fire!” He ran out the door toward the trailer as the operator passed him going in the opposite direction. He was not able to use the fire extinguisher because, when he ran onto the dock, a cylinder exploded. He said that before he evacuated he saw the plant manager and general manager using a fire hose on the fire.

The plant manager and the plant general manager heard a loud pressure release noise and ran to the dock. The plant manager said that he saw a gray haze over the trailer, indicating a gas leak. He could not tell where the leak was coming from. The general manager said he saw “a mirage of gas, like you see on a hot day on the highway mixed with black eyelashes” over the accident trailer. He noted that the gas was coming from the back of that trailer.

Both managers then helped operate the fire hose, and both saw cylinder explosions, were knocked down, and received second and/or third degree burns while they were operating the hose. Another employee turned on a permanently mounted water monitor and began spraying water onto the trailer. However, because supplying water to the monitor reduced the water pressure in the fire hose, the water monitor was shut off. The hose was not effective in suppressing the fire, which was extinguished about 9 hours later by the Dallas Fire Department. (See figure 11.) The only fire-fighting equipment available at the Dallas plant included fire extinguishers, one fire hose, and the manually operated water monitor on the roof. There was no automated water deluge system.

Postaccident examination of the accident site revealed that the discharge arm to the accident trailer had broken from the plant’s piping and the trailer connection. The discharge arm valve was found in the closed position. No acetylene cylinders were found on the accident trailer. The three other Western mobile acetylene trailers that were attached to Southwest’s unloading apparatus were destroyed, although some cylinders remained on two of these trailers. More than 1,000 cylinders from the trailers and from plant inventory were recovered from an area with a radius of about 1/4 mile. (See figure 12.) Although the cylinders from the Western trailers could be differentiated from Southwest’s cylinders, Western’s records did not identify the cylinders that were mounted on each trailer, so no detailed examinations were performed on the cylinders. A sampling of cylinders of the same size and construction as those from the trailers were visually examined. Damage ranged from a melted fusible plug to a longitudinal tear running the length of the cylinder. In some cases, the top or bottom cylinder head had torn off.
Figure 11. Final phase of fire suppression at Southwest facility in Dallas.

Figure 12. Dallas cylinder damage.
An examination of postaccident photographs of Southwest’s equipment revealed significant problems with Southwest’s acetylene compressors. These problems included plugged or missing pressure safety relief devices, pressure safety relief devices with vent piping that did not exit the building, crankcase oil level devices that did not have sight glasses, and an automated emergency shutdown device with a shutdown indicator set to about 420 psig, or 20 psig higher than allowed by the National Fire Prevention Association (NFPA) standards. Also, the flash arrestor tower\(^\text{14}\) between the trailer and the plant lacked about 3 feet of its maximum capacity of 13 feet of pall rings or Raschig rings,\(^\text{15}\) thus about 10 feet of the rings remained in the flash arrestor. The Western representatives were concerned that a flame front from a failure within the plant may have passed through the flash arrestor and involved the trailers.

Earlier Western Accidents

Western investigated four earlier accidents that involved its mobile acetylene trailers in the last 10 years; three had some relevance to the four accidents discussed above.

On April 10, 2001, a mobile acetylene trailer containing 227 manifolded cylinders caught fire at Western’s plant in Bellville, Texas. The fire destroyed a tractor and two other bulk acetylene trailers. A fourth trailer had minor damage resulting from a tire fire. There were no serious injuries. Western’s investigation determined that the fire initiated on the ball of a ball valve on the trailer’s manifold system. Western determined that stainless steel shavings had been left inside the manifold piping during the construction of the trailer. When high-pressure acetylene was introduced into the piping, these shavings were entrained in the flow and ignited the acetylene as they struck the ball of the valve.

The damage resulting from this accident was increased by the force of the reaction, causing the failure of several of the pigtails on the manifold, which allowed the fire to escape the system. Flames from the broken pigtails touched the sides of adjacent cylinders, causing one or more of them to rupture. This was followed by the rupture and ejection of most of the remaining cylinders on the trailer. The investigation also determined that at least one cylinder valve was open and that the acetylene from this cylinder provided additional fuel to the reaction. The fire on the initial trailer caused the melting of fusible plugs on cylinders on two adjacent acetylene trailers. This released additional acetylene that also ignited. None of the cylinders on the other trailers failed catastrophically.

As a result of this fire, plantwide water deluge systems were installed in many of Western’s facilities. Also, concrete block firewalls were constructed in the trailer gas area at Bellville. Valves were removed from the manifolds on all of Western’s trailers, and the system was flushed with high-pressure nitrogen to remove any shavings or other material. The ball

\(^{14}\) A flash arrestor tower is located on a mobile acetylene trailer between the manifold and the plant piping and is designed to stop a decomposition reaction both from occurring and from continuing through the piping if such a reaction was not stopped.

\(^{15}\) Pall rings, or Raschig rings, are types of packing in the shape of a short piece of pipe. These are placed into a flash arrestor tower, and because they have a lot of surface area they absorb and dissipate heat from an acetylene reaction.
valves were retrofitted with flash arrestors to slow the actuation of the valve, and “Y” strainers were installed in the manifolds to prevent material in a manifold from reaching the valve.

On June 21, 2001, at Dow Olefin’s Seadrift, Texas, plant, a detonation occurred in facility piping at a control valve while a mobile acetylene trailer was being prepared for loading. Both the trailer piping beyond the block valve on the trailer and the plant discharge arm beyond the discharge arm valve were open to the atmosphere before the trailer was connected. Therefore, after the trailer was attached to the plant piping, the piping contained residual air. The explosion self-extinguished, and the operator was not seriously injured. Western’s investigation of this accident determined that air had been trapped between two valves as the fill arm was connected to the trailer. Then, as high-pressure acetylene was introduced into the section of piping containing air, the heat of compression caused the acetylene to ignite. Contributing to the accident was a leakage in a facility control valve on the fill line that raised the internal pressure on that line.

As a result of this accident, Western’s procedures were changed to require the pressure in the facility fill line to be reduced after disconnecting a trailer and to require the fill arm to be purged with nitrogen after it is connected to a trailer. Also, alarms were installed to detect leaking facility control valves.

On June 8, 2005, a decomposition reaction occurred in the manifold system on a mobile acetylene trailer at Western’s Bellville plant that caused the fusible plugs of five cylinders to melt, releasing the products of decomposition. The materials released did not ignite before the deluge system was manually activated, controlling the incident. The incident started when a mobile acetylene trailer, with the cylinder valves open and the manifold fully pressurized, was moved into another bay and the block valve was opened, which initiated an acetylene decomposition reaction.

Western’s investigation determined that the accident was caused by a failure to follow Western’s procedures that require that all cylinder valves be closed and the manifold pressure be reduced. The quick activation of the water deluge system and workers closing other cylinder valves on the trailer under the protection of the water deluge limited the consequences of the accident. After the accident, Western implemented measures to ensure that its standard operating procedures are followed for all trailers.
Other Information

Regulations and Standards

Federal Regulations

Title 49 CFR Subchapter C, Hazardous Materials Regulations, regulates acetylene as a Division 2.1 flammable gas. “Acetylene, dissolved” is the proper shipping name for the material, and it is assigned United Nations identification number UN1001. Section 173.303 of the Hazardous Materials Regulations authorizes acetylene for transportation only in DOT specification 8 or 8AL cylinders or in United Nations cylinders conforming to ISO 3807-2. Transportation of acetylene in bulk packagings, such as cargo tanks, portable tanks, or rail tank cars, is prohibited.

Section 173.301(g) states that cylinders containing acetylene and other regulated gases can be manifolded during transportation. However, the manifolded cylinders must conform to the following conditions: (1) manifolded branch lines must be sufficiently flexible to prevent damage to the valves; (2) the cylinders must be supported and held together as a unit by structurally adequate means; (3) each cylinder must be equipped with an individual shutoff valve that is tightly closed in transit and an individual pressure relief device that discharges upward; and (4) the valves and pressure relief devices must be protected from damage by framing, a cabinet, or other method.

Section 177.834(h) states that except for cargo tanks and portable tanks, the discharge or emptying of a package’s contents before the package is removed from the motor vehicle is prohibited. However, as a direct result of the Dallas and The Woodlands accidents, the Pipeline and Hazardous Materials Safety Administration (PHMSA) issued a safety advisory in September 2007 that stated that this prohibition does not apply in all circumstances. For example, PHMSA said that it has interpreted the prohibition in section 177.834(h) as not applying to tube trailers, which are DOT specification 3AX, 3AAX, and 3T cylinders securely mounted (horizontally) to a transport vehicle, because removing them from the motor vehicle before discharging their contents is not practicable. PHMSA added that it has long applied the same standard to discharge operations involving manifolded acetylene cylinders that are securely mounted to a motor vehicle.

In addition, PHMSA stated the following:

… because of acetylene’s volatility and instability, we have determined that the safety risks associated with removing individual acetylene cylinders from a manifolded system that conforms to [the Hazardous Materials Regulations] requirements and industry standards are far greater than the safety risks associated with discharging cylinder contents while the manifolded cylinders are securely mounted on the vehicle.
**Industry Standards**

The Compressed Gas Association’s (CGA’s) publication G-1.6, *Recommended Practices for Mobile Acetylene Trailer Systems*, provides safe practices for the design, construction, and operation of mobile acetylene trailer systems. The publication also provides recommended safe practices for auxiliary equipment used in conjunction with mobile acetylene trailers, including piping, regulators, flash arrestors, and meters. The relevant areas addressed by the publication are the following:

In section 4, “Design and construction”

- Piping must: … be braced and supported ….
- Leads between cylinders and manifolds must be sufficiently long and flexible to minimize strain on valves and leads.
- Manifolds must be equipped with a shut-off valve, pressure gauge, and vent.
- Vents and pressure relief devices must be directed upwards above the acetylene piping.
- Cylinders must: conform to the Hazardous Materials Regulations; be vertical, supported, and secured; have valves that are capable of being closed in the event of an emergency; … and be arranged in aisles to allow access.

In section 5, “Operation”

- Valves must be closed during transportation.
- Acetylene pressure must be maintained in leads and manifolds during delivery and return shipments.
- During any manual valve operations, or when the trailer is being connected or disconnected, a trained person must be in attendance.

In section 7, “General provisions”

- Charging and discharging stations for mobile acetylene trailers must be provided with conspicuously located and easily accessible fire hoses or fixed spray systems and dry chemical fire extinguishers. Nozzles on fire hoses should be of the type that adjusts from full stream to a fog pattern.

The CGA publication G-1.2, *Acetylene Metering and Piping*, also provides recommended practices for use with acetylene trailers and in acetylene processing facilities. Section 14.2.1.3, “Design,” specifically addresses the construction and maintenance of flash arrestors:
NFPA 70[^16] recommends 6.5 feet (2 meters) packed height in a wetted tower in low pressure service, though successful tests were made with a packed height of 40 inches (102 centimeters). The code further recommends that the packed height be doubled for dry-packed arrestors. The packing should be examined at intervals no longer than 1 year for conditions of settling, corrosion, and plugging.

**Postaccident Activities**

Since the accidents, Western has made a number of changes to its procedures and equipment to address problems identified during the investigations. The company has improved its procedures for preparing trailers for unloading at customer sites, provided additional equipment for trailer and cylinder safety, reviewed its customers’ facilities to insure their safe operation, and installed water deluge systems at customer facilities. These measures are described below.

Western operators preparing their trailers for unloading at facilities without computer-generated instructions are now required to call the Western headquarters control room operator five times throughout the process to verify that critical steps are performed in the proper sequence. During each of the five calls, the control room operator verifies that the current step has been performed before allowing the operator to proceed to the next step in the sequence.

The additional safety equipment Western is installing includes flash arrestors on every mobile acetylene trailer line between the manifold and the trailer loading and unloading attachments to stop the propagation of an acetylene flame front and decomposition reaction between the trailer and the plant. Also, valve protection caps will be installed on all cylinders mounted on mobile acetylene trailers.

Regarding the safety of its customers’ facilities, Western has performed enhanced surveys at all customer facilities to ensure they are compliant with all applicable codes, regulations, and industry practices. Western’s management has stated that automated water deluge systems have prevented escaping acetylene from igniting and would have prevented the property damage and injuries that occurred in these accidents had such systems been in place. Since these accidents, Western has completed installation of water deluge systems at every customer’s unloading site and will require them to be installed at future customer sites.

[^16]: NFPA 70 does not address packed height in flash arrestors, and the NFPA has found no reference for this section.
Analysis

Transporting acetylene cylinders poses risks because of the inherent reactivity of the gas. Additional risk is incurred when the cylinders are moved at speed on roads because the risk of a motor vehicle accident is added. Although the causes of the highway accidents addressed in this report include a driver falling asleep, that cause and others such as driver error are not included in this analysis. Rather, we have documented and analyzed the results of mobile acetylene trailer accidents in an attempt to identify ways to reduce the risk of fire.

When a mobile acetylene trailer is not on the road but is loading or unloading, the reactivity of acetylene gas requires that specific procedures be followed to ensure safety. In these accidents, the operators carried standard procedures lists that they were supposed to follow; nevertheless, steps were performed out of order or incorrectly. Therefore, we looked at the loading/unloading processes in their entirety, focusing on ways to guide and assist operators as they perform their complex tasks.

Overturn Accidents

In the East New Orleans, Louisiana, accident in which the tractor and mobile acetylene trailer overturned, the cylinders mounted on the trailer were thrown from the vehicle. The postaccident examination of the cylinders recovered from the scene revealed that 32 of the cylinders recovered had their valves broken off during the accident, releasing acetylene that ignited. Similarly, in the Lamar, Colorado, accident, about half of the 225 cylinders were thrown from the trailer. The postaccident examination of the cylinders recovered from the scene revealed that 86 of the cylinders had their valves broken off during the accident, resulting in the release and ignition of the residual acetylene. An examination of these cylinders showed that the fire from the cylinders with broken valves caused the fusible plugs of other cylinders to melt, releasing additional acetylene that ignited. Possible ignition sources include the generation of a static charge in the rapidly escaping acetylene and solvent and a spark caused by the steel cylinders striking concrete, rocks or stones, or the road surface.

The Safety Board concludes that the fires in the East New Orleans, Louisiana, and Lamar, Colorado, accidents occurred as a result of the ejection of unsecured cylinders during the rollovers of the mobile acetylene trailers, resulting in damage to many of the cylinder valves and the release of acetylene, which then ignited.

These two accidents demonstrate the high likelihood of an acetylene release and fire when cylinder valves are damaged in rollover accidents. With the extreme flammability of acetylene, undamaged cylinders in proximity to burning cylinders are likely to become involved in a fire. In overturn accidents in which a mobile acetylene trailer rolls onto its side, unprotected or unrestrained cylinders may be ejected from the trailer, as occurred in these two accidents. Ejection of cylinders from a trailer in an accident significantly increases the likelihood of damage to the cylinder valves. In the event that cylinders remain secured to the trailer in an
overturn, their valves can be damaged by guard rails and other roadside objects and even contact with the road surface. With the extreme flammability and reactivity of acetylene, undamaged cylinders close to burning acetylene cylinders are also very likely to become involved in a fire.

The cylinders in these two accidents were not adequately secured to the trailers to prevent their ejection during overturn. Current DOT regulations for manifolded cylinder systems on trailers, such as mobile acetylene trailers, require only that each cylinder be equipped with an individual shutoff valve that is tightly closed in transit and that the valves and pressure relief devices be protected from damage by framing, a cabinet, or other method. Current Federal regulations do not set sufficient standards for the level of protection that must be provided. To reduce the risks of transporting acetylene, cylinders must remain secured to the trailer during a rollover accident, and the cylinder valves must be protected from impact and damage.

Therefore, the Safety Board concludes that the requirements in the Hazardous Materials Regulations covering mobile acetylene trailers do not sufficiently address (1) the protection of the cylinders, valves, and fittings on the trailers from impact forces that occur during an overturn accident and (2) the secure mounting of the cylinders to the vehicles. The Safety Board believes that PHMSA should modify 49 Code of Federal Regulations 173.301 to clearly require (1) that cylinders be securely mounted on mobile acetylene trailers and other trailers with manifolded cylinders to reduce the likelihood of cylinders being ejected during an accident and (2) that the cylinder valves, piping, and fittings be protected from multidirectional impact forces that are likely to occur during highway accidents, including rollovers.

Unloading Accidents

The two unloading accidents occurred when the mobile acetylene trailers were connected to piping at loading/unloading plants while the operators were preparing the trailers to be unloaded.

The Woodlands, Texas

The accident in The Woodlands, Texas, was described in detail by witnesses and recorded by a security camera at the plant. According to the statements of the operators and the video recording, the team had completed connecting their trailer to the plant’s discharge arm and had pressurized the trailer manifold by opening all of the cylinders on the trailer. At that point, the team realized that they had not opened the trailer’s block valve. They then opened the valve. According to the team’s initial statement to emergency responders, when they opened the block valve they heard a loud noise and felt the trailer shake. As noted previously, opening the block valve allows highly pressurized acetylene to enter a blocked section of piping that contains residual air, which is dangerous because (1) a blocked pipe potentially can cause a reflected shockwave that can initiate a decomposition reaction and (2) pressurized acetylene that mixes with air inside piping can ignite easily with little energy input. The black plume rising from the top of a cylinder seen in the security camera video is an indication that an acetylene decomposition reaction had occurred on the trailer. With this evidence of the decomposition
reaction, the black powder found in the fitting between the trailer and the plant piping and in the plant discharge arm was determined to be carbon, which is a byproduct of a decomposition reaction. The Safety Board concludes that the ignition of the acetylene in the accident in The Woodlands, Texas, likely occurred because of the operators’ failure to follow Western’s standard operating procedures, which resulted in the introduction of high-pressure acetylene into closed piping that contained air, which in turn initiated an acetylene decomposition reaction.

Dallas, Texas

The video recording of the Dallas, Texas, accident did not record the initiation of the accident, and the operator and other witnesses made contradictory observations about the initiation of the accident. In addition, representatives of Western expressed concern that a flame front caused by a failure within the plant’s compressor system may have passed through the poorly maintained flash arrestor and started the fire on the accident trailer. Several varying scenarios of the initiation of the accident were considered and discounted during the investigation.

The first scenario was the catastrophic failure of a cylinder. The operator said that he heard an explosion and was thrown back by it and then he saw a black plume coming from one of the closed cylinders; such a plume is an effect of the venting of carbon, which is a byproduct of an acetylene decomposition reaction. An explosion of sufficient force to throw an adult requires a large pressure surge, and an acetylene cylinder failing catastrophically was the only source on the trailer that was capable of such a surge. However, the operator was not burned, and neither he nor the nearby witness observed a fireball or explosive damage to the trailer during the initial stage of the accident, which could be expected in the event of catastrophic failure of an acetylene cylinder. Further, the witness did not hear an explosion despite being only about 9 feet from the trailer. In addition, there were no known conditions that could have caused a catastrophic cylinder failure; the cylinders on the trailer had been filled more than 10 hours before the accident, and the closed cylinders had not been handled since the trailer was backed into the unloading area. Therefore, it is unlikely that a catastrophic cylinder failure caused this accident.

The second scenario was a fire originating in the plant’s compressor system that resulted in a flame front passing through the plant’s piping, through the flash arrestor, and into the accident trailer. All the witnesses stated that the first events occurred on the accident trailer: the first black plume was observed coming from the trailer, the trailer was surrounded by vapor, and the video recordings showed the trailer fully engulfed in fire before the fire progressed to the three adjacent trailers. Given the extreme reactivity of acetylene and the explosive propagation of a decomposition reaction through open piping, the three other trailers that had valves open to the plant piping likely would have been affected immediately had the fire originated in the plant rather than at the accident trailer. More important, the plant’s discharge arm valve, between the plant piping and the accident trailer, was closed, so there was no channel through which the flame front could enter the trailer. Therefore, it is unlikely that a fire that originated in the plant passed into the accident trailer and caused the accident.
The most likely scenario was the initiation of an acetylene decomposition reaction on the accident trailer. This is supported by witness observations of a black plume over the trailer and the operator’s postaccident statement that the trailer’s pressure gauges indicated that the pressure in the manifold was 0 psig after the operator had cycled the valve on the plant’s discharge arm, leaving it closed. Because Western’s standard operating procedures mandate that 50 psig of pressure be maintained in the manifold between the completion of the leak test and the opening of the discharge arm valve, a pressure reading of 0 psig indicate that the unloading procedures had not been performed correctly. The lack of positive pressure in the manifold likely allowed some air to enter the manifold. In addition, had there been 0 psig acetylene pressure in the manifold when the operator connected the trailer to the plant’s discharge arm, the procedures used to mix acetylene and the air in the connection fittings at low pressure would have been ineffective and air could have remained in that area. As the operator began opening the cylinder valves and introduced pressurized acetylene into the manifold, the pressure surge likely hit the closed discharge arm valve and was reflected, generating heat that was sufficient to ignite the acetylene-air mixture in the manifold. The air was quickly consumed, and a decomposition reaction propagated through the manifold and into the trailer’s cylinders through their open valves. The heat from the reaction inside the cylinders melted the cylinders’ fusible plugs and released black plumes. Finally, when the released products of decomposition (hydrogen gas and carbon) ignited, the fire heated nearby cylinders, causing their fusible plugs to melt, releasing acetylene gas that then ignited, and fire engulfed the accident trailer. The fire then spread by radiant heat to the three adjacent trailers. Had the manifold pressure been maintained at 50 psig, as required by Western’s standard operating procedures, air could not have entered the manifold piping to lower the ignition temperature of the acetylene, and the air between the block valve on the trailer and the plant discharge arm valve would have mixed safely with the acetylene entering from the manifold.

Therefore, the Safety Board concludes that the ignition of the acetylene in the Dallas, Texas, accident likely occurred as a result of the operator’s failure to follow Western’s standard operating procedures, which resulted in the reduction of the pressure in the manifold to 0 psig, allowing air to enter the manifold and initiating a decomposition reaction when pressurized acetylene was subsequently introduced into the manifold.

Because the Dallas and The Woodlands accidents likely were initiated by the failure of operators to correctly perform Western’s detailed unloading procedures, the Safety Board evaluated Western’s unloading requirements. Each trailer operator carried a detailed standard operating procedures manual for reference and guidance during loading and unloading. However, in both these accidents, the operators did not perform the unloading procedures correctly or in the proper sequence, which resulted in the acetylene decomposition reactions. In The Woodlands, when the operators realized that they had not performed a required step, they performed the skipped step after they realized their omission. In Dallas, the operator did not recognize that the lack of pressure in the trailer manifold, at a step in the process in which some pressure should be maintained in the manifold, indicated that the unloading procedures had not been performed correctly.
Federal regulations and CGA guidance concerning mobile acetylene trailers focus on design and are silent concerning trailer unloading procedures other than the recommendation that a trained person be in attendance during manual valve operations and when a trailer is being connected or disconnected.

The accidents in Dallas and The Woodlands demonstrate the catastrophic results that can occur when the unloading procedures are not followed exactly. Despite the detailed written unloading procedures Western developed and implemented, the procedures were not sufficient to safeguard against the initiation of a decomposition reaction within the manifold piping and cylinders when simple human errors occurred, as they will from time to time. The complexity of the unloading procedures and the extreme instability of acetylene together created situations having little or no room for human error. The Safety Board, therefore, concludes that because of the instability of acetylene, the current acetylene unloading procedures by themselves are not adequate to ensure safety. The Safety Board believes that PHMSA should require fail-safe equipment that ensures that operators of mobile acetylene trailers can perform unloading procedures only correctly and in sequence.

Fire Suppression at Unloading Sites

There was no automated water deluge system at either The Woodlands or Dallas. Western installed automated water deluge systems at many of its facilities after the April 10, 2001, mobile acetylene trailer fire at its Bellville, Texas, facility. According to Western, the effectiveness of such systems at controlling the spread of fire to other cylinders on the same trailer and from one trailer to the next was proven at the June 8, 2005, decomposition reaction that also occurred at Bellville. The actuation of the water deluge system limited the spread of the fire to other cylinders on the same trailer. In the Dallas accident, attempts to extinguish the fire using a fire hose were ineffective. Had the unloading facilities at The Woodlands and Dallas had automated water deluge systems, the fires also may have been controlled and the spread of fire between the cylinders and to the nearby mobile acetylene trailers may have been reduced or eliminated. After these accidents, Western completed installation of water deluge systems at all Western-owned and customer unloading sites, including The Woodlands. However, the CGA standards require only conspicuously located and easily accessible fire hoses or fixed spray systems and dry chemical fire extinguishers. Automated water deluge systems, which appear to be effective on acetylene cylinder fires, are not required by the CGA standards. Therefore, the Safety Board believes that the CGA should revise the recommended practices in CGA standard G-1.6, section 7, General Provisions, to require automated water deluge systems at all mobile acetylene trailer loading and unloading locations to control the spread of fire to other cylinders on a trailer and to nearby mobile acetylene trailers.
Conclusions

Findings

1. The fires in the East New Orleans, Louisiana, and Lamar, Colorado, accidents occurred as a result of the ejection of unsecured cylinders during the rollovers of the mobile acetylene trailers, resulting in damage to many of the cylinder valves and the release of acetylene, which then ignited.

2. The requirements in the Hazardous Materials Regulations covering mobile acetylene trailers do not sufficiently address (1) the protection of the cylinders, valves, and fittings on the trailers from impact forces that occur during an overturn accident and (2) the secure mounting of the cylinders to the vehicles.

3. The ignition of the acetylene in the accident in The Woodlands, Texas, likely occurred because of the operators’ failure to follow Western International Gas & Cylinders, Inc.’s, standard operating procedures, which resulted in the introduction of high-pressure acetylene into closed piping that contained air, which in turn initiated an acetylene decomposition reaction.

4. The ignition of the acetylene in the Dallas, Texas, accident likely occurred because of the operator’s failure to follow Western’s standard operating procedures, which resulted in the reduction of the pressure in the manifold to 0 psig, allowing air to enter the manifold and initiating a decomposition reaction when pressurized acetylene was subsequently introduced into the manifold.

5. Because of the instability of acetylene, the current acetylene unloading procedures by themselves are not adequate to ensure safety.
Recommendations

As a result of its investigation of the mobile acetylene trailer accidents in East New Orleans, Louisiana, on October 20, 2007; in Dallas, Texas, on July 25, 2007; and in The Woodlands, Texas, on August 7, 2007, the National Transportation Safety Board makes the following safety recommendations:

To the Pipeline and Hazardous Materials Safety Administration:

Modify 49 Code of Federal Regulations 173.301 to clearly require (1) that cylinders be securely mounted on mobile acetylene trailers and other trailers with manifolded cylinders to reduce the likelihood of cylinders being ejected during an accident and (2) that the cylinder valves, piping, and fittings be protected from multidirectional impact forces that are likely to occur during highway accidents, including rollovers. (H-09-01)

Require fail-safe equipment that ensures that operators of mobile acetylene trailers can perform unloading procedures only correctly and in sequence. (H-09-02)

To the Compressed Gas Association:

Revise the recommended practices in Compressed Gas Association standard G-1.6, section 7, General Provisions, to require automated water deluge systems at all mobile acetylene trailer loading and unloading locations to control the spread of fire to other cylinders on a trailer and to nearby mobile acetylene trailers. (H-09-03)

BY THE NATIONAL TRANSPORTATION SAFETY BOARD

MARK V. ROSENKER  
Acting Chairman

ROBERT L. SUMWALT  
Member

DEBORAH A. P. HERSMAN  
Member

STEVEN R. CHEALANDER  
Member

KATHRYN O’LEARY HIGGINS  
Member

Adopted: January 13, 2009

Kathryn O’Leary Higgins, Member, filed the following concurring statement on January 9, 2009.
Board Member Statement

Member Kathryn O’Leary Higgins, concurring:

I concur in this special investigation report on mobile acetylene trailer accidents and am pleased that our hazardous materials investigators looked at several accidents and proposed recommendations to the Pipeline and Hazardous Materials Safety Administration to improve the handling and securing of acetylene tanks. But I write this statement because I am concerned that we do not address the reasons that two of these accidents occurred.

Two of the four operators overturned their vehicles. I have reviewed the police reports for the two rollover accidents that are part of the docket for this special investigation report. The report of the rollover accident in East New Orleans, Louisiana indicates driver condition (falling asleep) as the cause of the accident. No drug or alcohol tests were administered. The report for the Lamar, Colorado accident is much less specific, and the driver’s actions are not explained. It indicates that the truck left the road to the right, hit a post, was steered to the left back on to the road and rolled over. Nothing was said in the report about the driver’s condition.

Based on the limited information in the police reports, it seems that these rollover accidents would not have occurred but for driver error. I believe we should have looked more closely at driver issues, including the experience and training of these drivers and their recent history, as part of our special investigation to try to determine what led to these accidents. Once we identified our interest in these accidents, I believe we should have asked our highway investigators to assist our hazardous materials team so we could answer questions about driver performance and company practice. But without such investigation, we do not know what really caused these accidents and how they might be prevented in the future. There are only two companies that transport acetylene. It should not have been too difficult to take a closer look at their operations as part of this investigation to better understand their practices and policies for their drivers.

The NTSB is a small agency and our resources are limited. We cannot do everything, but if we decide to look more closely at accidents because of the hazardous materials release and subsequent fires, I think we should take the steps necessary to understand what caused the accidents in the first place. I also understand that our limited approach is consistent with other special investigations. Our recommendations, if adopted, will improve how these canisters are mounted, secured and handled – and that will be a solid safety improvement. But our failure to look more closely at driver performance is a missed opportunity to understand what led to two of these accidents and to make recommendations to prevent such accidents in the future.
Appendix A

Investigation

The National Transportation Safety Board was notified of the Dallas, Texas, accident on July 27, 2007; however, the initial information did not indicate that it was a transportation incident. The Chemical Safety Board launched on the accident. When the National Transportation Safety Board received information that vehicle unloading was involved in the accident, a highway investigator from the Dallas regional office was dispatched to the site. On August 1, 2007, a hazardous materials investigator from the Washington, D.C., headquarters was assigned as investigator-in-charge of the National Transportation Safety Board’s investigation and dispatched to the carrier’s headquarters. On August 7, 2007, the Chemical Safety Board notified the National Transportation Safety Board of a second accident involving the unloading of a similar vehicle in The Woodlands, Texas. On August 9, 2007, the hazardous materials investigator from the Washington, D.C., office was dispatched to investigate this accident as well. On October 20, 2007, the National Transportation Safety Board was notified of the overturn of a similar vehicle in East New Orleans, Louisiana. On October 23, 2007, the hazardous materials investigator from Washington, D.C., traveled to New Orleans to begin the investigation of this accident also. One group was established to investigate all three hazardous materials accidents. On January 18, 2008, the Chemical Safety Board announced that it was discontinuing its investigations of the Dallas and The Woodlands, Texas, incidents to avoid duplication of effort.

Participating in the investigations were representatives of the Pipeline and Hazardous Materials Safety Administration and Western International Gas & Cylinders, Inc.

No depositions were taken, and there was no public hearing.