

# **TECHNICAL REPORT**

## **SAFETY ASSESSMENT OF PETROLEUM AND GAS PRODUCERS**

By

Bennie G. Vincent and Lawrence M. Krasner  
Factory Mutual Research Corporation

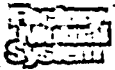
Norwood, Massachusetts 02062

Prepared For

National Institute for Occupational Safety and Health  
5600 Fishers Lane  
Rockville, Maryland 20852

Contract No. 210-77-0033

May 1979



## Factory Mutual Research

1151 Boston-Providence Turnpike  
Norwood, Massachusetts 02062  
Telephone (617) 762-4300  
Telex 92-4415

June 29, 1979

Mr. John A. Gerard  
NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH  
944 Chestnut Ridge Road  
Morgantown, West Virginia 26505

Re: NIOSH Contract No. 210-77-0033  
FMRC J. I. 4A6N8.RG

Dear Mr. Gerard:

The final changes to the technical report "Safety Assessment of Petroleum and Gas Producers", as we discussed in our telecon of 20 June 1979, have been made.

In accordance with the provisions of the referenced contract, we have enclosed five (5) copies and the reproducible master of this report for your use. Five (5) copies have also been sent to the Clearinghouse for Occupational Safety and Health and one (1) copy has been forwarded to Mr. Leo Sanders, Contracting Officer.

A small number of extra copies have been printed and are available for your convenience, if you need them.

Cordially,

  
L. M. Krasner

LMK:bmz

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Approved By:

  
C. Yao, Manager  
Applied Research



**Factory Mutual Research**

1151 Boston-Providence Turnpike  
Norwood, Massachusetts 02062

### ABSTRACT

The purpose of this work effort was to perform a comprehensive assessment of the personnel safety hazards encountered in the petroleum and gas industry. This assessment required: 1) the collection and documentation of historical accident and illness data; 2) an investigation of current regulations, standards and related research; and 3) the development of recommendations for improvement of problem areas or processes.

Federal and state government agencies as well as private safety organizations were contacted in the search for historical accident and illness data. These data included statistical data, estimated casualty figures and documented case histories of previous accidents. All data were computerized and subjected to machine manipulation to aid in analyses.

Safety regulations and standards written for the protection of the man-at-work were researched for their applicability to petroleum industry personnel. In addition, a search of on-going applied research projects was made in order to determine the existence of programs relating to the safety of petroleum and gas producers.

The collected data were analyzed and recommendations designed to ameliorate problems regarding the safety of petroleum and gas producers were made. In addition, recommendations on the collection and reporting of casualty data were also presented.

## ACKNOWLEDGEMENTS

The authors wish to acknowledge contributions by the following Factory Mutual personnel: Mr. David B. Heard for the development and compilation of the Incident Coding Manual; Mr. Donald G. Genoa for the preparation of the COBOL program and the development of computer analysis techniques; Mr. Robert L. Haigis for performing the laborious task of manually scanning reports; and Mr. Louis A. Post for technical editing. Finally, the authors wish to express their thanks to Mr. Earl Shoub of the National Institute for Occupational Safety and Health for his guidance in the completion of this work effort.

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## INTRODUCTION

Since 1970, when national attention was first focused on an impending energy crisis, there has been accelerated growth and expansion in the petroleum and petrochemical industries. During the years between 1970 and 1976 the national demand for crude oil increased by 23-percent. In 1970, demand for crude oil was at 10,909,000 barrels per day (bpd)<sup>(1)</sup>. This figure rose to approximately 13,457,000 bpd by 1976. A 22-percent increase in the number of employees was also experienced during this same period. In 1970 there were approximately 461,000 employees in the oil, gas and petroleum refining industries. Of these, 294,000 were classified as production employees. By 1976 this number had risen to a total of 563,000 employees; 378,000 of whom were listed as production workers.

The bulk of the increase is attributed to expansions in U.S. drilling activity. Well completions jumped from 29,467 in 1970 to 41,455 in 1976. This, in turn, led to an increase in workers at oil and gas extraction sites from 270,000 in 1970 to approximately 360,000 in 1976, a growth of roughly 33-percent.

Petroleum refining operations experienced a somewhat slower growth rate in work force, from 154,000 employees in 1970 to 157,000 in 1976.

Together with the expansion in the petroleum industry was an expected increase in accident and injury cases. This is due possibly to the utilization of new and inexperienced personnel necessary for handling the increased exploration and processing activities.

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(1) Oil and Gas Journal, Jan. 30, 1978



The objective of this study was to assess the current personnel safety hazards associated with the petroleum and petrochemical industries in this country. To accomplish this, a comprehensive survey of the types of accidents occurring in these industries was conducted. An attempt was made to determine causative factors relating to the recorded accidents.

The industries considered are those dealing with the exploration, extraction, processing, and storage of crude oil, natural gas, and liquefied natural gas. Accidents occurring in transit, either by vehicle or pipeline beyond a distribution center, were excluded from this study. Pertinent data from over 1,800 accident reports occurring between 1970 and 1977 were gathered and computerized for analysis. The analyses performed on these data were directed toward defining and evaluating the magnitude and extent of the safety problems existing in the oil and gas industries.

## DATA COLLECTION AND MANIPULATION

### 2.1 EXISTING REGULATIONS AND STANDARDS

Initially an attempt was made to determine the extent of existing petroleum industry safety regulations and standards. While hard regulations aimed specifically at the petroleum industry are scarce, it was discovered that safety guidelines are currently available through several sources. The American Petroleum Institute (API), National Fire Protection Association (NFPA), Occupational Safety and Health Administration (OSHA) and the National Institute for Occupational Safety and Health (NIOSH) are organizations in this country that issue standards and guidelines applicable to the petroleum industry. Sources outside the United States that also issue guidelines are the British Standards Institution (BSI) and the Institute of Petroleum (IP) in Great Britain.

The most comprehensive set of recommended practices issued in this country for the petroleum industry comes from API. Many of these are gleaned from existing regulations for other industries and modified to apply specifically to the petroleum industry. These guidelines are generated by members of API working in conjunction with safety experts from other organizations and petroleum industry personnel.

Specific guidelines for the handling and storage of petroleum products, together with recommended fire fighting techniques, are issued by NFPA in the form of Fire Codes. Like the API, NFPA's Fire Codes are the result of a collective effort of many individuals and organizations. Members of API, fire equipment manufacturers, private and government safety research organizations and petroleum industry personnel combine to write the applicable standards.

For the most part, safety problems in the petroleum industry tend to be of the same type as those encountered in any other industrial occupation. Thus, the standards issued by OSHA in its General Industry Safety and Health Standards<sup>(1)</sup> provide applicable safety guidelines for petroleum industry facilities.

<sup>(1)</sup> General Industry Safety and Health Standards, (29CFR1910), Occupational Safety and Health Administration, Rev. January 1976.

General safety guidelines for the petroleum industry are also provided by NIOSH in its Health and Safety Guide for Bulk Petroleum Plants.

Other sources of petroleum safety regulations and standards are the various insurance companies specializing in these types of risks. These companies issue guidelines applicable only to the areas they insure. Information regarding such guidelines is generally not available to the public.

Sources of regulations and standards outside this country include the Institute of Petroleum in Great Britain which has prepared a series of safe practice codes covering almost every aspect of the petroleum industry. One other organization, the British Standards Institution (BSI) of London has also issued safety guidelines.

Appendix A contains a listing of standards and regulations concerned with the safety of the man-at-work in the petroleum industry.

## 2.2 ON-GOING RESEARCH

FMRC performed a literature search of its available resources in an effort to determine the extent of on-going research into the safety problems of the petroleum industry. To assure completeness, the Smithsonian Science Information Exchange (SSIE) was commissioned by FMRC to conduct a survey of all on-going research projects contained in its data base also. The SSIE collects and indexes over 100,000 research project records annually. Its data base includes input from over 1,300 public and private research organizations covering basic and applied research in all areas of the life, physical, social, behavioral, and engineering sciences.

With the exception of several epidemiological studies, mostly directed at the determination of carcinogens, the searches by SSIE and FMRC yielded little data. Apparently there are few petroleum industry safety studies in progress at this time. A bibliography of projects of possible interest to the petroleum industry is presented in Appendix B.

One project worthy of note is currently being conducted by the Explosion and Energetics section of FMRC's Applied Research Division. This work is a joint effort by FMRC and a large petroleum company and consists of a series of explosion tests in enclosures modeled after those found on off-shore platforms. Hopefully, the end result will be a reduction of the severity of explosions occurring at these facilities by determining explosion venting requirements for process enclosures. However, all test results and information relating to the project are proprietary at this time.

## 2.3 INCIDENTS

### 2.3.1 Sources

Numerous organizations were contacted in the search for data for inclusion in this program; the following responded with population information and/or case histories:

American Petroleum Institute (API);  
Bureau of Labor Statistics (BLS);  
National Fire Protection Association (NFPA);  
U.S. Geological Survey (USGS);  
Occupational Safety and Health Administration (OSHA);  
Departments of Labor from the States of California, Pennsylvania and Oklahoma;  
U.S. Coast Guard (USCG); and  
National Fire Prevention and Control Administration (NFPCA).

Other information was obtained from NFPA publications, Oil and Gas Journal, Factory Mutual Loss Incident data, and various publications and periodicals.

The entire incident data set consists of 1,887 incidents collected from over fifteen sources. However, the bulk of the data set was taken from the American Petroleum Institute (57%), the Occupational Safety and Health Administration (16%) and the U.S. Geological Survey (14%). Most of the recorded incidents occurred between the years 1973 to 1977, with 316 recorded for 1975, 519 for 1976, and 475 events for 1977.

### 2.3.2 Quality

As expected, the most detailed information came from our own Factory Mutual Loss Reports. However, these reports only include 1) those companies which are, in whole or in part, insured as organizations in the Factory Mutual System, and 2) those incidents involving large property losses. Incidents which involved many casualties but little or no property loss would not be included in the FM data base. The FM System does not insure personnel.

Other sources of fairly detailed information were API, NFPA, USGS and the state departments of labor. Recordkeeping practices for those organizations were varied, resulting in differing degrees of completeness of the data. In general, the incident reports received from all sources were sanitized to exclude names of persons, places and organizations. Some of these reports lacked specific dates for low-severity occurrences.

As a rule, data from the API consisted primarily of fire-related phenomena (fire, fire/spill, explosion) taken from that organization's annual Fire Loss Summary. The exceptions to this rule were the fatality incident data which included all fatalities reported to the API. API data prior to 1974 is only marginally complete. Much of the data in the early years of collection by the API does not contain specific dates or causal information, and usually consists of a one or two-line description of the incident. Beginning in 1974 the computerization of incidents resulted in more detailed information by this organization.

Computerized data containing incidents for the years 1971 through 1978 were obtained from the NFPA and the USGS. These data were fairly complete although they represented only narrow areas of interest. The NFPA data provided incidents of fire and explosion occurring in the petroleum industry. The USGS data consisted of fires, explosions and blowouts occurring in the offshore petroleum industry. Such incidents were generally classified as "Major" because their inclusion in the data meant that significant property damage or casualties were incurred.

Computerized data from OSHA provided casualty information. All incidents which met the OSHA criteria for reporting injuries and fatalities for the period between July, 1970 to June, 1976 were included in these data. These data should, therefore, provide a means of comparison with other data sources, particularly with API and BLS, and show the reliability of the fatality statistics. According to OSHA guidelines, an on-site investigation is warranted for any industrial accident which results in at least one fatality or five or

more injuries requiring hospitalization. Therefore, all occupational fatalities in the U.S. should be included in the OSHA data.

The BLS was the major source of statistical data, although some manipulation of the data was warranted since population and casualty figures for production and nonproduction (secretaries, office workers, maintenance employees, etc.) were lumped together. The BLS began the computerization of their data during the last half of 1971. Personnel contacted expressed varying degrees of confidence in the reliability of the data for the 1971 and 1972 reports. As a result, the year 1973 was selected as the starting point for survey of this organization's data. The last year in which there was a complete report was 1975; only partial data exists for 1976.

Information concerning petroleum industry illnesses is very sketchy. With exception of the illness incidence rates provided by BLS and API, such information was not available. The best sources of industrial illness data are the State Workmen's Compensation Commissions. The task of obtaining and reviewing the reports from these agencies was judged to be impractical.

### 2.3.3 Manipulation

To facilitate the handling of incidents and insure the recording of all essential information, a Loss Incident Report form was drawn up. This form consisted of 22 categories of information and the provision for inclusion of remarks on the back of the form if further clarification were warranted. In most cases there was not enough information to fully complete the form, but as a rule information was sufficient to facilitate some manipulation of the data. The form was designed to allow the conversion of this information to computer codes (see Appendix C, Page 1). Various types of information in each of the categories were given alpha or numeric computer codes which would allow the complete computerization of all data. The sheet contains spaces for information such as date, location and time of incident, weather factors, Standard Industrial Classification (SIC) code, operational activity and occupancy in which the incident occurred, type of incident, cause and number of casualties, equipment involved, primary and secondary causes of the incident, responding

emergency equipment, business interruption and damage costs, and the type of petroleum product involved. A copy of the coding manual outlining the method of translation of incident information into computer codes is included in Appendix C.

A Loss Incident Report form for each incident was filled out as completely as possible then forwarded to the FMRC Computer Center. These data were recorded on storage disks in the form of 125 character records with each record representing one incident. Each record consisted of 57 fields of coded information. Since data were taken from various information sources, there was a very high probability of recording an incident more than once. This was especially true for high severity incidents. It was, therefore, necessary to devise a method of partitioning the data set which would isolate duplicate entries.

Three techniques were employed to eliminate duplicate entries from the data. The first technique was employed as the incidents were being added to the data set. The second came after the data set was finalized and required the development of a separate computer program. The third technique consisted of a manual survey of all incidents classified as duplicate entries using the first two techniques.

Each record (incident) is keyed using the first eleven characters of information from the coded Loss Incident Report form. These characters consist of the file transaction code (1-2), date (3-8), state (9-10) and the incident number (11). As records were put onto disk storage, the date and state codes were checked against those records already stored to determine if an incident with identical codes were already on file. If such an incident were present, an incident number beginning with the number 1 was inserted in space 11 of the new record. As other records with identical state and date codes were added, the incident number was incremented by one up to a maximum of nine. If more than ten incidents with the same date and state codes were encountered, duplication was assumed and all were immediately printed out for inspection. Some data from the API caused some difficulties resulting in modifications to this procedure. Over 320 incidents from 1973 were recorded in which neither the month, day of the month, nor state were reported. This left the year in

which the incident occurred as the only identifying key. Since more than 320 incidents occurred in 1973 (with no other keying information), no more than 10 incidents could be added to the data set because the others were identified as duplicate entries. Dummy variables for month, day of the month and state were added to these records to make each one unique.

The second method of determining duplicates was performed after the data set was finalized and involved the comparison of several fields of information on each record. Data fields containing coded information for date of incident, operational activity, occupancy, incident type, and information source were chosen for this comparison. The record of each incident in the data set was scanned and the fields containing the first four of the cited parameters were checked to see if they were identical to those of any other incident record in the data set. It was felt that it would be highly improbable that two incidents of the same type (fire, explosion, personnel injury, etc.) could occur on the same date and involve the same operational process. If the first four parameters of the two incidents were identical, then the last parameter (information source) of each record was checked. If the two incidents were reported by the same information source it was assumed that they were distinct occurrences, since each major information source screens its own data for duplicates. However, if the information sources were different, it was assumed that one of the incidents could be a duplicate and both were printed out for further evaluation.

Finally, an extensive manual survey of all incidents occurring on the same date was conducted. The coded information available on each of these incidents was examined and compared for similarities with others. Those judged to be duplicates were eliminated from the data set. This manual survey yielded less than 20 suspected duplicates in excess of those already screened by computer techniques.

After finalizing the data set, software was developed to perform the necessary analyses. This entailed the development of a COBOL computer language program consisting of over 2,000 statements. This program is capable of partitioning the data set by any one of, or a combination of, up to three data fields. For example, the number of incidents occurring in a given year can be found, or the number of incidents in a given year which were taken from a



specified information source can be isolated. Even further, the number of incidents in a given year, from a specified information source as a function of operational activity can also be determined. Combinations of different data fields were used to partition the data into various configurations needed for an effective analysis. Computer runs of several partitions are presented in Appendix D. All programming was performed on the IBM 370/158 computer.

### III

#### DATA ANALYSIS

##### 3.1 EXTENT OF THE SAFETY PROBLEM

Data analysis began with the comparison of existing statistical data available from the Bureau of Labor Statistics (BLS) and the American Petroleum Institute (API) in order to obtain an assessment of the extent of the problem. Unfortunately, the data from each of these two organizations are collected and presented using different guidelines, making comparison difficult.

The most complete source of statistical data on industrial injuries and illnesses is the BLS; therefore, these data were examined first. The BLS data are presented in categories defined by the Standard Industrial Classification (SIC) manual<sup>(1)</sup>. These data include annual employment figures plus total recordable occupational injury and illness incidence rates for lost workday cases and non-fatal cases without lost workdays. The BLS data are obtained through the use of an annual survey questionnaire (OSHA Form No. 103) sent to over 200,000 sample units throughout the United States. These sample units are selected to constitute a representative cross-section of all industries in the private sector. Completion of the questionnaire and its return to the BLS are mandatory under federal regulations<sup>(2)</sup>.

The two most clearly applicable categories for the oil and gas industry are SIC Major Groups 13 and 29. SIC Major Group 13 covers all operations involving the extraction, production and recovering of crude oil and natural gas. This category includes exploration of well sites, drilling activities and crude oil and gas preparation up to the point at which the product leaves the producing site for refining. Major Group 29 covers all establishments primarily involved in petroleum refining, including the production and manufacture of hydrocarbon liquids (gasoline, kerosene, benzene, jet fuels, etc.), solvents, cutting and lubricating oils, and liquefied petroleum gases.

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(1) Standard Industrial Classification Manual, Office of Management and Budget, 1972.

(2) Code of Federal Regulations, Title 29, Part 1904.20-22.

Unfortunately, the BLS data provide only injury incidence data computed as an average for all workers in a given industry. Those rates include the injury experience of managers, administrators and assorted office and building employees not actively involved in production or manufacturing.

The BLS injury and illness data provide incidence rates in the form of events per 100 full-time employees. These incidence rates are computed using the formula:

$$I = \frac{N_T \times 200,000}{EH} \quad (1)$$

Where

$N_T$  = total number of injuries;

EH = total hours worked by employees during period, usually taken as one calendar year.

The 200,000 represents an hourly base for 100 full-time equivalent workers for one year (40 hours per week x 50 weeks per year x 100 full-time employees).

Using this method, the actual hazards experienced in certain production activities could go undetected if the nonproduction labor force associated with it were sufficiently large. To eliminate the effect of nonproduction personnel, an exercise was developed which computes injury incidence rates for production personnel only.

Essentially, this exercise is based on the assumption that the nonproduction personnel in a given industry are not exposed to any significantly different hazards than are the nonproduction workers in any other industry. In short, the safety hazards encountered by an office manager in a textile manufacturing firm would not be appreciably different than those of an office manager in a plastics factory, financial institution, or business service organization. By eliminating the injuries normally associated with such occupations, together with the percentage of the work force represented by them, a more accurate assessment of the injury experience of a given occupation could be obtained. For this exercise, the office and administrative personnel in the oil and gas industry were likened to those in the business-related category, Miscellaneous Business Services (SIC Code 73).

Those employees classified under Miscellaneous Business Services include maintenance personnel and service employees as well as office workers. This seems to represent a realistic mix of workers for nonproduction personnel in the industries under investigation. The number of injuries associated with the nonproduction and production personnel are computed using the following formula:

$$N_{NP} = \frac{I_{OFFICE} \cdot T_{NP}}{100} \quad (2)$$

where:

$I_{OFFICE}$  = injury incidence of workers in Miscellaneous Business Services.  
(units of injuries per 100 employees)/year;

$T_{NP}$  = average number of nonproduction personnel for the industry in question; and

$$N_P = N_T - N_{NP} \quad (3)$$

where:

$N_P$  = total injuries for production personnel/year;

$N_T$  = total injuries for industry (from BLS data)/year; and

$N_{NP}$  = total injuries for non-production personnel/year.

The adjusted injury incidence rates can be computed using

$$I_{ADJ} = \frac{N_P \times 200,000}{EH_P} \quad (4)$$

where:

$EH_P$  = hours for all production personnel =  $T_P$  (total production personnel)

$\times H_{AVE}$  (average weekly hours for production personnel)  $\times 50$  (weeks per year worked).

With this technique, several industries were selected, in addition to the oil and gas industry categories, for comparison. The Chemical (SIC 28), Textile (SIC 22), Metal (SIC 33) and Lumber (SIC 24) industries were chosen as representative industrial areas whose injury incidence rates bracket those representing the petroleum industry.

The adjusted injury incidence rates are presented in Table I under columns labeled  $I_{adj}$ . As expected, the adjusted rates were significantly higher in all instances. Using the injury incidence rates of Miscellaneous Business Services non-production personnel, increases ranged from 16% in 1976 to 28% in 1972 for Major Group 13 (Oil and Gas Extraction). Major Group 29 (Petroleum Refining) yielded increases from 14% in 1973 to 27% in 1975 when these rates were adjusted. The textile industry (SIC Code 22) proved to be least affected by the adjustment, recording increases of less than 5 %. This allowed three categories, Petroleum & Refining, Chemical, and Textiles to be judged as having roughly the same hazard potential to their workers. However, the adjusted rates for the petroleum refining industry are not significantly higher than are the average injury incidence rates for the total private sector.

The figures for the oil and gas extraction industry present a slightly different picture. The injury incidence rates for this industry both before and after adjustment are higher than the averages for the total private sector.

The inference to be drawn from the BLS data is that, while safety problems do exist for both Petroleum Industry categories, the more serious of these is encountered during the exploration and extraction phases.

TABLE I  
INJURY INCIDENCE COMPARISON\*

Year	SIC Code	Employees (Thousands)		Total Injuries (Thousands)		Injury Incidence Per 100 Empl.		IADJ All Injuries Per 100 Empl. <sup>2</sup> (Adjusted)		IADJ Lost Workday Injuries/100 Empl. <sup>2</sup> (Adjusted)	
		All	Pro-duction	Avg. Weekly. Hours	Lost Workday	All	Lost Workday	Non-Production	Pro-duction	Non-Production	Pro-duction
1976 Total Private Sector (Total non-government labor force)						NA	NA	4.6		1.8	
Oil & Gas Extr.	13	360	247	42.8	44.1 <sup>1</sup>	12.8	5.9		14.9		
Pet Refining	29	203	131	40.0	15.1	7.6	3.1		9.0		
Chemical	28	1034	589	40.0	78.0	7.5	2.9		9.8		
Textiles	22	966	844	40.0	94	10.3	2.7		10.5		
Metals	33	1190	933	40.0	183	16.0	6.1		18.3		
Lumber	24	606	508	40.0	146.9	21.7	9.6		28.0		
1975 Total Private Sector (Total non-government labor force)						8.8	3.2	4.9			
Oil & Gas Extr.	13	335.7	231	42.3	45.8 <sup>1</sup>	13.8	6.1		16.6		7.6
Pet Refining	29	197.4	125	39.4	16.8	8.5	3.0		10.8		3.5
Chemical	28	1013	570	39.4	74.7	7.5	2.6		9.4		3.0
Textiles	22	902	782	39.4	82.4	10.0	2.4		9.9		2.3
Metals	33	1180	919	39.4	184.1	16.4	5.9		18.9		6.9
Lumber	24	557	464	39.4	101.8	20.7	8.5		21.3		8.96
1974 Total Private Sector (Total non-government labor force)						10.0	3.4	5.2		1.8	
Oil & Gas Extr.	13	304.5	206	42.4	35.2 <sup>1</sup>	11.8	5.4		13.8		6.6
Pet Refining	29	198.6	126	40.0	17.3	8.9	2.9		10.7		3.5
Chemical	28	1056.6	616	40.0	89.2	8.5	2.6		10.8		3.2
Textiles	22	988.1	875	40.0	102.8	10.8	2.5		11.1		2.4
Metals	33	1335.5	1067	40.0	250.2	19.0	6.6		22.1		7.7
Lumber	24	626.2	539	40.0	130.4	21.8	8.9		23.4		9.6
1973 Total Private Sector (Total non-government labor force)						10.6	NA	5.4		1.8	
Oil & Gas Extr.	13	274.3	182	42.5	34.4 <sup>1</sup>	12.6	5.7		15.2		7.2
Pet Refining	29	193.4	122	40.7	16.9	9.2	1.8		10.5		2.8
Chemical	28	1035.5	603	40.7	89.4	8.8	2.7		10.8		3.2
Textiles	22	1030.5	905	40.7	116.5	11.4	2.5		11.9		2.6
Metals	33	1320.9	1062	40.7	264.3	20.2	6.2		23.2		7.0
Lumber	24	639.7	551	40.7	146.0	23.6	9.1		25.2		9.7
1972 Total Private Sector (Total non-government labor force)						10.5	NA	5.5		2.2	
Oil & Gas Extr.	13	261.9	174	40.6	33.3	12.6	5.5		16.1		7.1
Pet Refining	29	189.6	117	40.7	18.0	9.7	2.5		11.8		2.5
Chemical	28	1002.2	581	40.7	91.5	9.1	2.6		11.6		2.9
Textiles	22	991.0	871	40.7	111.9	11.3	2.7		11.9		2.7
Metals	33	1234.8	984	40.7	249.7	20.4	5.5		23.6		6.2
Lumber	24	612	527	40.7	149.1	24.9	9.1		26.9		9.8

\* Incidence rates computed as events per 100 full-time employees.

1) Computed from Incidence Rates.

Statistical data from the American Petroleum Institute (API) were examined next. The differences in collecting and presenting data by the API make it difficult to compare with data from BLS. Using the API system of reporting, a company could report its injury and illness statistics using several SIC codes. For example, injuries occurring while two employees were engaged in distinct work activities for the same company could be reported using two different SIC codes. The BLS system requires the use of one SIC code by a company at a given site. This is usually determined by the primary work activity at this location.

In the petroleum industry numerous contracting organizations engage in various specialty operations such as exploration, drilling, work-over/maintenance and fire fighting. Under the reporting systems utilized by API and BLS, casualties incurred by a contractor, while performing operations for a given company, would not be reported by that company, even though the incident occurred on its property. The reporting of such casualties would be the sole responsibility of the contractor. Consequently, if a contractor failed to file a report, the event would go undocumented. Since contracting firms specialize in some of the more hazardous petroleum industry operations, it is highly desirable that their injury and accident experience be fully documented. It is expected that this will have a more significant impact upon API statistical data than upon BLS data. If such firms are not API members, then these data will be lost. Theoretically, the BLS includes representation from the entire private sector, so the contribution from petroleum industry contracting organizations should be included in its data.

The API made some minor modifications in presenting its data beginning in 1973 and culminating with its 1974 Annual Summary. Data prior to 1974 are not as detailed as those presented in the years since that time. Table II presents a breakdown of pertinent statistical data available from the American Petroleum Institute. As is the case with the BLS, the API data indicate that the major problem is in extraction and not in refining.

Efforts were made to obtain petroleum industry casualty statistics from the National Safety Council (NSC). The NSC is a nongovernmental public service organization which collects and compiles safety statistics for the purpose of accident prevention. The bulk of its data comes from voluntary reports submitted by its members. However, differences in reporting and compilation

TABLE II  
AMERICAN PETROLEUM INSTITUTE  
INJURY AND ILLNESS DATA<sup>(1)</sup>

Year	SIC Code	Number of Employees	Average Weekly Hours	Total Injuries		Injury Incidence <sup>(2)</sup>		Total Illnesses
				All	Lost Workday	All	Lost Workday	
1976 <sup>(3)</sup>		417,713	40.7	19,301	6,644	4.68	1.91	577
Exploration & Production	1311	60,866	40.8	2,591	894	4.28	1.44	62
Gas Process.	1321	7,084	41	288	75	3.98	1.1	1
Drilling	1381	2,486	40	608	210	24.47	8.77	0
Refining	2911	79,781	40.7	5,030	926	6.58	2.32	307
1975		424,904	40.8	20,673	6,132	4.9	1.74	567
Exploration & Production	1311	54,598	41.3	2,460	732	4.44	1.35	36
Gas Process.	1321	5,927	41.5	299	67	4.87	1.17	1
Drilling	1381	1,918	42.2	515	196	25.45	9.65	0
Refining	2911	81,698	40.2	5,594	912	7.2	2.25	321
1974		406,427	41	20,324	6,226	5.0	1.62	513
Exploration & Production	1311	51,430	41.5	2,418	713	4.62	1.36	48
Gas Process.	1321	5,808	42.1	311	73	5.11	1.19	1
Drilling	1381	1,506	46.8	487	179	27.66	10.2	1
Refining	2911	81,292	40.6	5,212	1,031	6.63	1.66	262

(1) Occupational injuries and illnesses recordable under OSHA record keeping requirements. Recordable cases include:

- 1) Occupational fatalities regardless of the length of time between injury and death, or the length of the illness; or
- 2) Occupational illnesses; or
- 3) Occupational injuries which result in one or more of the following: loss of consciousness, restriction of work or motion, transfer to another job, or medical treatment (other than first aid)

(2) Computed as  $I = \frac{N_T \times 200,000}{EH}$

I = incidence rate

N<sub>T</sub> = total number of injuries

EH = total hours worked by employees during period, usually taken as one calendar year.

The 200,000 represents an hourly base for 100 full-time equivalent workers for one year (40 hours pr week x 50 weeks per year x 100 full-time employees).

(3) All API respondents



procedures made the comparison of its data with that from the API and BLS difficult. In addition, the NSC ceased to compile current injury incidence rates for the petroleum industry after 1973. It was slated to resume its reporting of petroleum industry accident data after a revision of its compilation procedures in 1977.

Fatality data from OSHA, API and BLS were also obtained. This was done in order to provide some indication of the degree of coverage of the petroleum industry by each of these organizations. As can be seen in Table III, significant differences do exist.

TABLE III  
FATALITY STATISTICS<sup>1</sup>

Organization	1974	1975	1976
OSHA	69	82	95
API	70	50	41
BLS*	210	200	160

\* Estimates projected from injury incidence rates and rounded to the nearest ten.

<sup>1</sup> Totals are the sum of deaths for major SIC groups 1300 and 2900.

### 3.2 REVIEW OF CASE HISTORY DATA

In order to obtain causative information on accidents and injuries in the oil and gas industry, it was necessary to collect and review case histories of previous accidents. A number of these are presented in Appendix E.

A review of such data revealed that the amount of causative information contained in an accident report varied directly with the severity of the incident. Incidents which received national media coverage contained the most detailed information.

Incidents were selected to illustrate an operation or area in which a problem seemed to exist. The incidents were grouped in one of three categories according to the general operational area in which the incident occurred:

- 1) Exploration and extraction - onshore, offshore;
- 2) Processing - petroleum, gas, petrochemicals;
- 3) Storage - petroleum, gas, petrochemicals.

#### 3.2.1 Extraction Sites

The most widely recognized occurrence which is likely to produce casualties at an extraction site is the blowout. A blowout is an uncontrollable flow of fluids from a wellhead or wellbore due to the unbalanced high pressure in the reservoir. Many blowouts seem to occur during workovers, i.e., routine maintenance and repair operations performed during temporary production interruptions. One reason for the relatively high incidence of blowouts during workovers is that safety equipment is often removed during these operations. Most wells are equipped with "choke valves", whose purpose is to shut off the flow of fluid in case of a sudden increase in pressure from the reservoir. These types of devices are removed during workovers to allow equipment to move freely in the wellbore.

A blowout is a hazardous event under any circumstances but, if ignition of the petroleum or gas occurs, the results can be disastrous. Wells can burn for weeks or months before being extinguished. In these cases, the casualty list can include fire fighters as well as petroleum workers.

While blowouts are the most publicized events in oil and gas operations, the majority of accidents occurring at extraction sites, both onshore and offshore are similar to those in other activities.

Workers on site include welders, electricians, carpenters, pipe fitters, millwrights, heavy equipment operators, and laborers. Consequently, significant hazards exist apart from those associated with fires and explosions. Because of this, it is very difficult to categorize these incidents. Most injuries are not the result of a catastrophic incident. Instead they are usually the result of falls, lifting heavy objects and contact with high voltage or hot surfaces by one individual.

### 3.2.2 Processing Facilities

Problem areas in processing include operations involving furnaces or heated reactor vessels, pumps and piping. There are many variations in types of equipment utilized in the processing of oil, gas and petrochemicals and there are no readily identifiable problems because of the general lack of specific detail in the incident reports. The difficulty arises when the product escapes containment.

Of the types of equipment involved in accidents, furnaces and pumps are most frequently singled out as malfunctioning units. The large volume of petroleum products handled by this equipment makes any malfunction a serious one.

The number and proximity of personnel to the defective equipment are the primary factors contributing to the number of casualties.

Repairs on process and storage equipment during shutdown are significant contributors to accident and injury rates and deserve special mention. Flammable liquids and gases remain in vessels and can be ignited during repairs or maintenance operations.

### 3.2.3 Storage Areas

Tank farms and storage areas for large quantities of petroleum and petrochemicals represent a slightly different hazard than those encountered in other operational areas. Usually, no significant numbers of personnel are assigned to these locations so that the risks to operators is reduced. However, once material has spilled or been ignited, the prime candidates for casualties are the emergency response units such as the plant emergency organization, municipal fire fighters and rescue squads. Very often, in the cases of fires and explosions, they are dealing with an unpredictable phenomenon.

Tanks may release burning liquids or vapors, or have fires surround them for hours without incident, but then, under seemingly identical circumstances, these tanks will rupture violently. There have been cases where this occurred and resulted in multiple fatalities and injuries.

### 3.3 ANALYSIS OF THE DATA SET

The data set was partitioned in numerous ways in order to provide for analyses. Printouts of the various partitions run for these analyses are presented in Appendix D.

The American Petroleum Institute was the largest single source of incident detail and, therefore, influenced greatly the conclusions drawn from analysis of the data. Approximately 48% of the API incidents were fire events. An additional 32% were fires with a spill mentioned somewhere in the scenario. Equipment failure was cited as the primary cause for 62% of the mishaps. Process malfunction, the second largest category, was responsible for 12% of the incidents. The API reported a total of 147 injuries and 239 fatalities (production personnel only) over the years 1973 through 1977. The totals reported by API for the entire industry (production plus non-production personnel) are, of course, significantly higher. Of the reported incidents only 7% involved an injury and only 6% resulted in a fatality. A comparison of fatalities to injuries leads to the conclusion that "serious" incidents, i.e., those involving major property damages or loss of life, are more likely to be included in API data than high-frequency but low-severity occurrences.

Data from reports by the Occupational Safety and Health Administration accounted for 16% of the incidents. The OSHA incidents were all subject to the OSHA reporting guidelines. This is reflected in the breakdown of the data. Approximately 77% of the OSHA incidents were personnel accident cases. Only 11% were fire cases. The most frequently listed cause for all incidents was "other" which accounted for 41% to the incidents. Another 16% were listed with "unknown" as the primary cause. This is not necessarily a reflection of the completeness of the OSHA reports, rather it reflects the vagueness of the automated summaries which were used in reviewing the data. The OSHA incidents covered the years from 1974 through July, 1977. There were a total of 302 incidents involving 128 injuries and 292 fatalities. As in the API data the ratio between fatalities and injuries shows that OSHA is primarily interested in the serious mishaps.

The U.S. Geological Survey (USGS) provided the offshore incidents, roughly 85% of which were fires. The primary causes of these incidents were grouped under several different categories (see Appendix C). Equipment failure and "unknown" causes each accounted for 28% of the events. Another 14% were caused by process malfunction and 12.5% were attributed to personnel error. The 263 incidents reported by the USGS involved 191 injuries and 51 fatalities. These incidents occurred between the years 1970 to 1977.

Any conclusions drawn will be somewhat biased because of a nonrepresentative data base. The bulk of the data obtained were fire incidents (See Figure 1).

A graph showing the severity of recorded incidents by operational activity (See Figure 2) provides an excellent illustration of the lack of a significant spread between injuries and fatalities for each of the operational areas. This indicates that a large percentage of the high-frequency, low-severity accidents were not included in the data base.

An inspection of the BLS injury and fatality data presented in Table I shows injury counts of 52,000 to 62,000 per year for the years 1974 through 1976 for the petroleum industry (SIC Codes 13 and 29). The fatality counts during the same period were estimated by BLS to be between 160 and 210 for the same SIC major categories (Table III). On the other hand, figures from the API (Table II) show injury counts of about 28,000 per year with fatalities averaging about 55 per year.

Certain injuries likely to occur in most other manufacturing areas are also likely to occur in the gas and oil industries. Petroleum industry casualty data should include trips/falls, strains and overexertions which are the most frequently listed causes of industrial injuries. Unfortunately, only a few of these types of injuries are included in the data base. Burns represented the single most frequently listed cause of trauma for the incidents in the collected data. However, the burns accounted for just over 5% of total injuries. Over 92% of the injuries were listed as either unknown or unspecified.

An effort was made to determine the primary fuel involved in the collected incidents. Gases (unspecified) were reported in 7% of the incidents. Finished gasoline involved approximately 5%. Oil (unspecified) was identified in

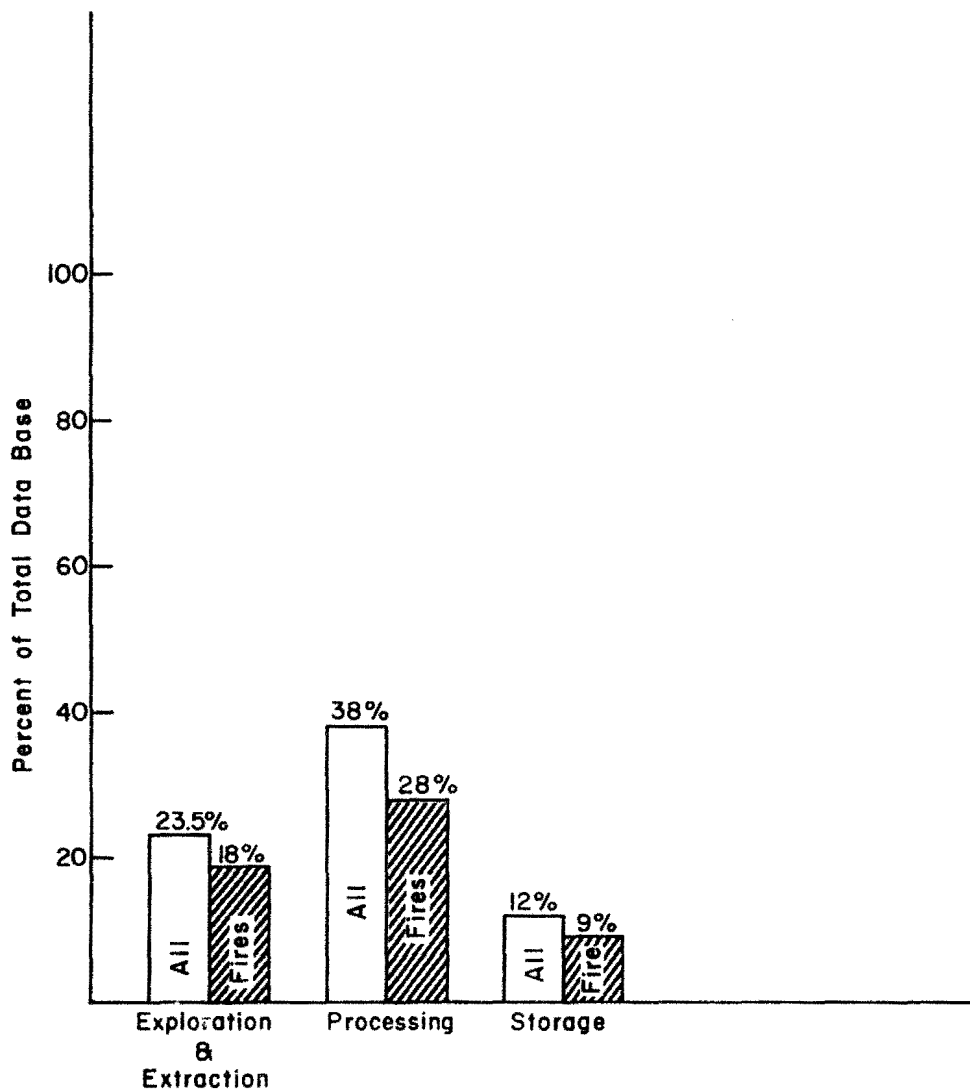


FIGURE 1 DISTRIBUTION OF INCIDENTS BY OCCUPATIONAL AREA

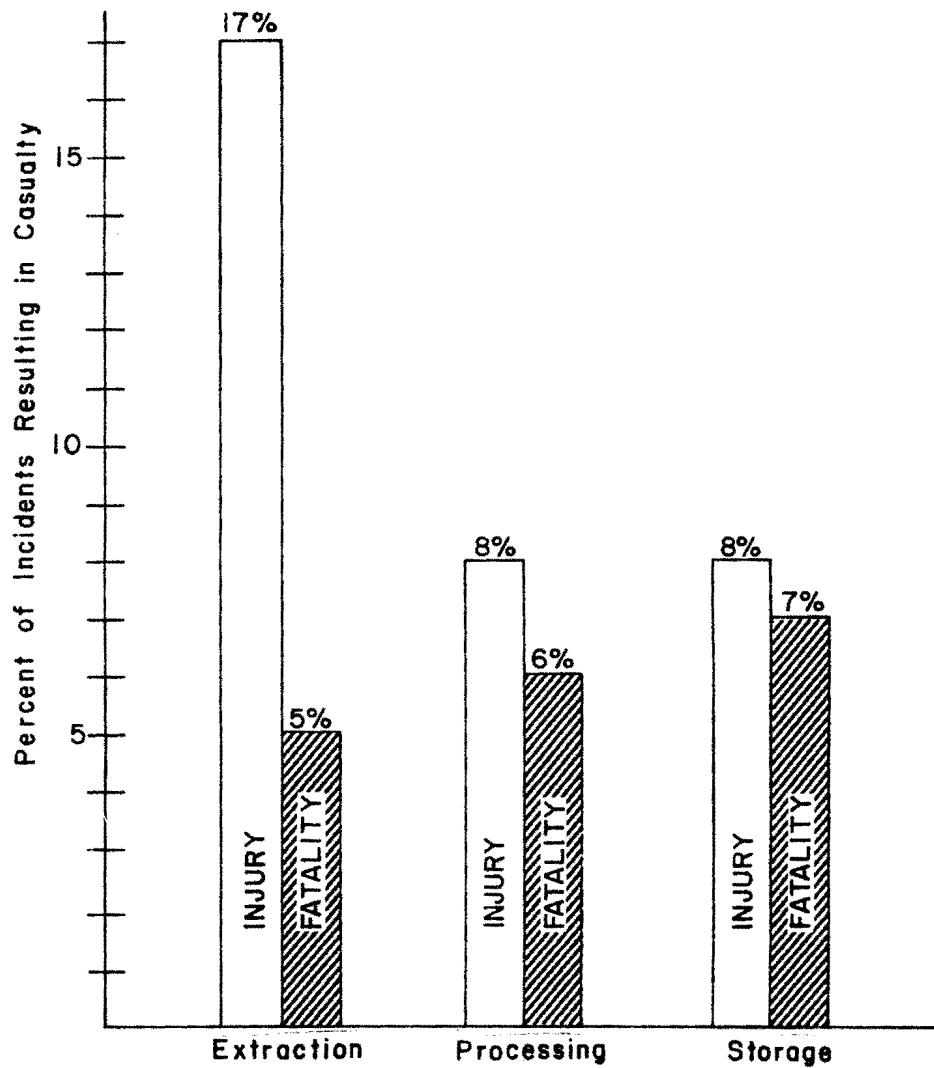


FIGURE 2 DISTRIBUTION OF CASUALTIES BY OCCUPATIONAL AREA



4% of the cases and naphtha was named in 2%. Approximately 17% of the incidents involved no petroleum product at all. The bulk of the data reported unknown or unspecified petroleum products.

To assist the analysis of the data set, the incidents were divided into three categories according to the operational area in which the incident took place: 1) Exploraton and Extraction, 2) Processing, and 3) Storage. A breakdown of the casualty statistics is given in Table IV.

### 3.3.1 Exploration and Extraction

Incidents clearly defined as having occurred during exploration activities represented less than 1/2% of the data set (8 incidents). Six of these were either a fire or an explosion. Data on this operational area comes primarily from the API. The BLS combines exploration data with its extraction category, making it impossible to separate the two.

Approximately 23% (442 incidents) of the data set were incidents occurring at extraction sites. This figure includes the operational activities separately listed as 1) Development, 2) Field Production, and 3) Extraction<sup>(1)</sup>. Over 347 of these incidents were fires (See Figure 1). The most frequently listed causes were equipment failure and process malfunctions.

According to our data base, nearly 17% (75) of all extraction site incidents resulted in at least one injury. Of these incidents, offshore operations were responsible for 65 injury-causing events and only 10 were attributed to onshore extraction sites. A total of 197 injuries occurred at extraction sites. The bulk of these injuries were reported by offshore platforms with 171 cases. The remaining 16 were reported by onshore facilities. Four high-severity mishaps<sup>(2)</sup> combined for a total of 74 of the 197 injuries reported. All four of these occurred on off-shore platforms.

Just under 5% (21) of the extraction site incidents involved at least one fatality. A total of 89 fatalities were reported as occurring at extraction sites, representing slightly more than 12% of the 726 fatalities in the data base. Sixty-one of these were reported by offshore platforms. Three high-severity incidents<sup>(2)</sup> produced 42 of the documented fatalities. Off-shore platforms reported two of these high-severity incidents which claimed 32 lives.

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(1) See Appendix C, page 6.

(2) Ten or more casualties.

TABLE IV  
DISTRIBUTION OF INCIDENTS AND CASUALTY STATISTICS

<u>Operational Area</u>	<u>Number of Incidents</u>	<u>Percentage<sup>1</sup> (%) of Data Base</u>	<u>High Severity Occurrences<sup>2</sup></u>			
			<u>Involving Injuries</u>		<u>Involving Fatalities</u>	
			<u>Incidents</u>	<u>Count</u>	<u>Incidents</u>	<u>Count</u>
Exploration and Extraction	450	25%	4	74	3	42
Processing	716	38%	4	63	9	116
Storage	138	12%	3	42	1	40

<sup>1</sup> Incidents in which the operational area was unknown or unspecified accounted for approximately 25% (470).

<sup>2</sup> Ten or more casualties.

### 3.3.2 Processing

Nearly 38% of the incidents in the data base occurred during processing. A total of 716 incidents were recorded either during processing or during the transfer of the material to and from processing sites (excluding transportation accidents). Approximately 8% of the recorded incidents involved an injury. Four of these were high-severity mishaps accounting for a total of 63 injuries. Six percent of the recorded incidents caused at least one fatality. There were nine high-severity occurrences resulting in a total of 116 deaths. Interestingly, the injury and fatality totals were each 198. Processing accounted for over 29% of the total injuries and approximately 27% of the total fatalities.

Approximately 45% of all incidents collected for this category were classified as fires; another 28% were spills involving fires. The most frequently listed cause of the fire incidents was equipment failure (45%). Nearly 25% of those incidents which reported equipment failure named furnaces (11%) and pumps (14%) as the malfunctioning units. Piping, hoses and fittings malfunctioned in an additional 6% of the reported incidents and faulty tanks accounted for approximately 4%.

### 3.3.3 Storage

Slightly over 12% (138) of all incidents collected occurred in storage areas. The largest percentage were fires (62 %) and fire/spill events (14 %). The most frequently listed causes of these incidents were equipment failure (42%) and personnel error (10%). Storage tanks failed in almost 40% of the incidents. Vaporizers failed in 12% of the documented cases.

Less than 8% of the incidents occurring in storage areas involved an injury; a total of 68, of which 42 came as results of three separate high-severity incidents. Approximately 7% of the total incidents involved a fatality; 58 being reported as occurring in storage areas. Forty of these occurred in one incident. These casualty figure for storage areas represent 20% of the total injuries and 8% of the total fatalities documented in the data set.

## CONCLUSIONS

During the conduct of this project the major work effort was directed toward the review and collection of existing petroleum industry safety and health data. Conclusions relating to this effort are presented first.

A review of existing safety regulations and standards show that the API issues the most comprehensive set of standards and recommended practices in this country. Outside the United States, the Institute of Petroleum in Great Britain provides a fairly complete set of Safe Practice codes. Insurance companies provide guidelines to their insureds in the petroleum industry, but these are usually proprietary.

On-going research projects which undertake the study of accidents and injuries in the petroleum industry are virtually nonexistent.

The bulk of the recorded data came from the API, OSHA, and USGS. The largest percentage of these data were fire-related incidents (fire, fire/spill and explosions).

The most detailed incidents tended to be the low-frequency, high-severity occurrences. Even these were sanitized to exclude names of persons, places, and organizations. There was very little documentation of high-frequency, low-severity incidents.

Statistical data from the BLS, even when adjusted to exclude non-production personnel, and from the API show that injury incidence rates for refining (SIC 2911) are not significantly different from averages computed for the entire private sector.

At present there is no system for determining any correlation of reported petroleum industry occupational illnesses with any inherent job hazard. Even more significant is the fact that there is no one comprehensive data source from which petroleum industry injury and illness data can be secured.

Analysis of the data set revealed several trends of interest. It must be reiterated that these conclusions are drawn from a data set biased in favor of 1) low-frequency, high-severity incidents, 2) fire events, and 3) injuries, instead of a realistic mix of injuries and illnesses.

From an inspection of the data, there appears to be a significant injury problem in the area of extraction (See Figure 2). According to the collected

data, 17% of the extraction site incidents result in at least one injury. Data on extraction sites available from the BLS and API also give indication of safety problems at extraction sites.

Incidents in processing areas represented the largest block of data in the set. Nearly three-quarters of these were fire-related. The most significant information obtained from the analysis of processing incidents was the identification of furnaces and pumps as potential hazards; this was substantiated by a review of case histories.

Storage areas present the least hazard to petroleum industry personnel due, in part, to minimal exposure in these areas. The most frequently listed (42% of the total) cause of incidents was equipment failure. However, the potential for major catastrophe is increased in these areas due to the high concentration of flammable and explosive products.

Causal information shows that the primary cause of all incidents was equipment failure which was responsible for over 43% of the total. Process malfunctions were the second leading cause with approximately 10% of the total. Personnel error was attributed to over 9% of the recorded incidents.

With the possible exception of the extraction area casualty figures, it is difficult to draw conclusions using the available injury and fatality data.

The differences in fatality rates shown in Figure 2 are not significant enough to indicate a trend. However, early in this program an attempt was made to correlate the number of deaths reported by each agency to that agency's degree of coverage of the petroleum industry. As can be determined from Table III, there are significant differences in the numbers of fatalities reported by OSHA, API and BLS.

Of the three organizations, only OSHA has mandatory reporting requirements. A work-related fatality must be reported to an OSHA office within 48 hours of such an occurrence. However, there have been questions regarding industry strict compliance with these regulations in the past.<sup>(1)</sup>

The API gathers its data from voluntary reports submitted by its members on a yearly basis. API provided the best causal information and claims to represent 90 to 95% of the petroleum industry. However, the injury and fatality counts given by API were consistently lower than those of other sources.

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(1) "National Safety Council and BLS Procedures For Estimating Work Accident Fatalities", Statement to Senate Subcommittee on Labor, July 22, 1974.

The differences in reporting and presenting data by this organization explain the discrepancies and these are mentioned in Section III.

The fatality counts given by the BLS are significantly higher than those of the other two organizations for a given year. The fatality figures are also the result of an estimation procedure similar to the one used to determine injury incidence rates.

RECOMMENDATIONS

Although a credible number of incidents were documented and analyzed during the conduct of this research effort, a significant discovery was that this number represented only a small biased percentage of the total accident and injury cases. Consequently, most of the recommendations deal with the issue of acquiring the data needed for an effective analysis of the injury and illness situation in the petroleum industry. With this in mind the following recommendations are offered:

1. Analysis of the data collected for this study reveals that the mechanical problem of furnaces and pumps is significant enough to warrant further attention. In order to define the extent of hazards associated with the use of this equipment, a study of the various types of furnaces and pumps used in the petroleum and gas producing industry should be conducted. Topics to be addressed are: 1) the failure rates of furnaces and pumps versus the failure rate of other types of equipment used in oil and gas producing operations; and 2) the identification (type, manufacturer, etc.) of the malfunctioning equipment in an attempt to identify problem makes or models. At present the best available data have identified this equipment in generic terms only and no data exist which will provide a profile of operating equipment used in the petroleum and gas producing industry.
2. Since most of the historical accident data were lacking in the details necessary to determine causal factors, a reporting system which collects and updates accident cause information on, at least, an annual basis should be instituted. This is particularly applicable to the high-frequency, low-severity accidents occurring in the petroleum and gas industry.
3. At present there is very little information regarding petroleum industry illnesses. A system should be developed which will provide for the reporting and compilation of petroleum industry illness data.

4. Currently, the bulk of injury and illness data appear to be collected and presented by Standard Industrial Classification (SIC) codes or by operational area. The collection of these data within other variables should be investigated; for example, collection of injury and illness data by occupation, type of trauma, or type of incident would simplify the task of determining where the more serious problems occur.
5. The data collection system should be continued as begun in this project with the most detailed and recent data available, including the use of newspapers and journals. The task of reviewing historical accidents is complicated by the lack of detail in all but the most severe cases. Documenting recent accidents on a continuous basis would, at least, partially remedy this problem. As better reporting systems are developed and initiated, the data collection system used for this project would be capable of incorporating the new and more detailed information.
6. For particular areas of interest where more immediate answers are needed, an extensive survey should be conducted using a combination of questionnaire and on-site visits. Specific questionnaires should be sent to petroleum and gas producers, local and state agencies for the purpose of collecting new data and clarifying data already collected. Follow-up on-site visits could be used whenever warranted. During the conduct of this study, it was found that, while some organizations possessed relevant data on file, they were unable to provide this information due to the absence of the necessary manpower on their part and the time constraints imposed by the contract on ours.





APPENDIX A

EXISTING SAFETY REGULATIONS AND STANDARDS FOR THE  
PETROLEUM INDUSTRY

## NATIONAL FIRE PROTECTION ASSOCIATION

### STANDARDS

54	National Fuel Gas Code
58	Liquefied Petroleum Gases, Storage and Handling
59A	Liquefied Natural Gas, Storage and Handling
70	National Electric Code
704	The Fire Hazards of Materials
30	Flammable and Combustible Liquids Code
78	Lightning Protection Code

### RECOMMENDED PRACTICES

329	Underground Leakage of Flammable and Combustible Liquids
325M	Properties of Flammable Liquids, Gases, Solids
77	Static Electricity
497	Electrical Installations in Chemical Plants

## OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

Part 1910, Title 29 of the Code of Federal Regulations

### BRITISH STANDARDS INSTITUTION

CP3013: 1974, Code of Practice For Fire Precautions In Chemical Plants, July 1974.

## AMERICAN PETROLEUM INSTITUTE

### STANDARDS

- 12B Specification for Bolten Production Tanks, 11th Edition, May 1958.
- 12D Specification for Large Welded Production Tanks, 7th Edition, Aug. 1957.
- 12F Specification for Small Welded Production Tanks, 6th Edition, Mar. 1968.
- 526 Flanged Steel Safety Relief Valves, 2nd Edition, Nov. 1969.
- 607 Fire Test for Soft-Seated Ball Valves, 1st Edition, Sept. 1977. (Tentative)
- 620 Recommended Rules for Design and Construction of Large, Welded, Low-Pressure Storage Tanks, 5th Edition, July 1973. Supplement No. 2 to 5th Edition, Dec. 1974. Replaced by 6th Edition, Aug. 4, 1977.
- 650 Welded Steel Tanks for Oil Storage, 5th Edition, July 1973. Supplement No. 1, 5th Edition, Oct. 1973. Supplement No. 2, 5th Edition, Aug. 1974. Replaced by 6th Edition, Aug. 4, 1977.
- 1104 Standard for Welding Pipe Lines and Related Facilities, 12th Edition, December 1971. (Met. Lab. has 5 copies)
- 2000 Venting Atmospheric and Low-Pressure Storage Tanks (Refrigerated) 2nd Edition, Dec. 1973.
- 2023 Guide for Safe Storage and Handling of Heated Petroleum-Derived Asphalt Products and Crude Oil Residue, March 1977.

### RECOMMENDED PRACTICES

- 500A Classification of Areas for Electrical Installations in Petroleum Refineries, 3rd Edition, April 1966.
- 510 Inspection, rating and repair of pressure vessels in petroleum refinery service, July 1975 (3rd Edition).
- 520 Design and Installation of Pressure-Relieving Systems in Refineries, Part I--Design, Dec. 1976. Part II--Installation, Jan. 1963.
- 521 Guide for Pressure Relief and Depressuring Systems, Sept. 1969.
- 2003 Protection Against Ignitions Arising Out of Static, Lightning, and Spray Currents, Sept. 1967.

## STANDARDS

- 2015                    Cleaning Petroleum Storage Tanks, 2nd Edition, Nov. 1976.
- 2021                    Guides for Fighting Fires In and Around Petroleum Storage  
                         Tanks. First Draft, May 1974.
- 2510                    Design and Construction of LP-Gas Installations at Marine  
                         and Pipeline Terminals, Natural Gas Processing Plants,  
                         Refineries, and Tank Farms, 3rd Edition, May 1970.

INSTITUTE OF PETROLEUM

CODES OF SAFE PRACTICE IN THE PETROLEUM  
INDUSTRY

PART

- |    |  |
|----|--|
| 1  | <u>Electrical Safety Code</u>                        |
| 2  | <u>Marketing Safety Code</u>                         |
| 3  | <u>Refining Safety Code</u>                          |
| 4  | <u>Drilling and Production</u>                       |
| 6  | <u>Petroleum Pipelines</u>                           |
| 8  | <u>Drilling and Production in Marine Areas</u>       |
| 9  | <u>Liquefied Petroleum Gas</u>                       |
| 10 | <u>Storage and Piped Distribution of Heating Oil</u> |

European Petroleum Organizations

Part 1: Operations

European Code of Safe Practice in the Storage and  
Handling of Petroleum Products



APPENDIX B

ON-GOING RESEARCH INTO INJURY AND ILLNESS PROBLEMS IN THE  
PETROLEUM INDUSTRY

Underscoring indicates items of special interest.



0102039 SSIE VOL: CMA 905 1  
 REPORT OF CHARACTERIZATION OF ORGANIC EMISSIONS FROM  
 PETROCHEMICAL SOURCES  
 INVESTIGATORS: BARNES HM  
 PERFORMING ORG: U.S. ENVIRON. PROTECTION AGCY., ENVIRON.  
 SCIENCES RES. LAB., DURHAM, NORTH CAROLINA, 27711  
 SPONSORING ORG: U.S. Environmental Protection Agency, Office  
 of Research & Development, Environmental Sciences Research  
 Lab., Research Triangle Park, North Carolina, 27711  
 MONITOR: Nader US  
 CONTRACT/GRANT NO.: G712B-B0-14  
 1/76 TO 9/78 FY: 78 FUNDS: \$20,000

The objective of this task is to quantitatively and  
 qualitatively determine the gaseous organic emissions from  
 various petrochemical sources, principally those involving  
 chemical processing.

Initial investigations involve studies at stationary sources  
 emitting halocarbon compounds. The two sources examined thus  
 far include a solvent degreaser using trichloroethylene and  
 one using methylene chloride. Sequential samples are  
 collected both at the point emission sources and at downwind  
 fence-line locations and analyzed for halocarbons using GC/MS  
 techniques.

Currently, a preliminary report on hydrocarbon  
 characterization data available in the literature as well as a  
 discussion of ongoing programs within EPA, was issued in  
 9/76. A halocarbon emissions measurement report will be  
 issued in 7/77.

#### DESCRIPTORS:

Nonresearch & Selected Topics, 2.Literature Search  
 Substances, 3.Trichloroethylene  
 Organic Compounds, 2.Aliphatic Compounds, 3.Halides,  
 4.Chloride, 5.Methylene Chloride  
 Chemical Kinetics & Mechanisms, 2.Reaction Media, 3.Gaseous  
 Chemical Engineering, 2.Petroleum Research, 3.Refining  
 Processes, 4.Refining Process -other, 5.Petroleum Chemicals:  
 2.Safety, 3.Occupational Safety  
 Chemistry - Specialized Fields, 2.Chemistry -major Fields,  
 3.Chemical Engineering  
 Air Pollution, 2.Sources of Air Pollution, 3.Industrial  
 Sources, 4.Chemical Industry, 2.Types of Pollutants, 3.Gases,  
 3.Organic Compounds, 3.Stack Emission - Flue Products  
 Applications of Materials, 2.Lubricants and Fluids,  
 3.Greases  
 Surface Cleaning, Finishing, 2.Chemical Cleaning  
 Chemical Processing, 2.Chemical Processing -general

0000726 SSIE NO.: CMA 0957 I

## EVALUATION OF LINER MATERIALS EXPOSED TO HAZARDOUS AND TOXIC SLUDGES

INVESTIGATORS: HAYO HE: GOLUEKE CG: WHITE RM  
 PERFORMING ORG: MATRECON INCORPORATED, 2811 ADELINE ST., OAKLAND, CALIFORNIA, 94608

SPONSORING ORG: U.S. Environmental Protection Agency, Office of Research & Development, Municipal Environmental Research Lab., 26 W. St. Clair St., Cincinnati, Ohio, 45268

MONITOR: Landreth RE

CONTRACT/GRANT NO.: 68-03-2173; C618A-7005

2/75 TO 11/78 FY: 78 FUNDS: \$74.00

OBJECTIVE: To determine the effective lives of twelve pond liner materials exposed to a variety of nonradioactive industrial hazardous wastes.

APPROACH: To expose specimens of liners sealed at the bottom of individual test cells to six different hazardous wastes to determine seepage through liners and changes in physical properties over twenty-four months.

CURRENT PLANS: To seal six polymeric liners and six admix and soil liners in cells for exposure to six different sludges containing hazardous waste streams. The six polymeric liners will include polyvinyl chloride, butyl rubber, chlorosulfonated polyethylene, chlorinated polyethylene, ethylene propylene rubber and neoprene. The soil and admix liner materials will include a bentonite clay seal, an emulsified asphalt seal, a soil cement, an hydraulic asphalt concrete, a compacted fine grain soil and a sixth liner to be selected. The hazardous wastes will include a strong acid, a strong base, a pesticide, an oil refinery tank bottom waste containing scale, lead wastes from gasoline tanks and a cyclic hydrocarbon sludge. Seepage through the liners will be assessed over twenty-four months and exposed liner specimens will be demounted at intervals and then physical properties determined for comparison with original properties.

## DESCRIPTORS:

Pesticides, 2.General Classifications, 3.Pesticides -non-specific  
 Substances, 2.Toxic Substances, 3.Toxic Substances -non-specific, 3.Bentonite  
 Soil Mechanics, 2.Soil Types, 3.Soil Cement  
 Organic Compounds, 2.Aliphatic Compounds, 3.Halides,  
 4.Chloride, 5.Chlorides -other, 2.Poisons, Toxic Compounds,  
 3.Pesticides  
 Organic Sulfur Compounds, 2.Sulfonic Acids and Derivatives,  
 3.Sulfonates  
 Polymer Chemistry, 2.Organic Polymers, 3.Chloropolymers,  
 3.Polyethylene, 3.Polypropylene, 3.Polyvinyl Chloride,  
 3.Organic Polymer -other, 2.Polymer Type -other  
 Chemical Energy Conversion, 2.Fuels, 3.Hydrocarbon Fuels,  
 4.Gasoline  
 Chemical Engineering, 2.Safety, 3.Hazardous Materials  
 Waste Water Treatment/Disposal, 2.Source of Wastes,  
 3.Industrial Wastes, 4.Chemical Manufacturing Wastes.

1.Petroleum Wastes, 2.Sludge Treatment & Disposal, 3.Sludge Disposal, 4.Sludge Disposal -other, 3.Sludge -other  
 Chemical & Physical Properties, 2.Physical & Chemical Properties, 3.Phys. & Chem. Properties -gen.  
 Chemistry - Specialized Fields, 2.Chemistry -related Fields,  
 3.Environmental Chemistry  
 Energy Research, 2.Energy Cross Refer., 3.Fuel Storage  
 Physical Properties- Materials, 2.Physical Properties -general  
 Applications of Materials, 2.Sealants, Seals  
 Miscellaneous Materials, 2.Asphalt Concrete, 2.Bituminous Materials  
 Elastomers, 2.Neoprene, 2.Rubber -synthetic  
 Elements & Inorganic Compounds, 2.Acids - Inorganic, 3.Acid -inorganic Non-specific, 2.B Sub-group, 3.Lead, 4.Lead, 2.Bases, 3.Bases -other

0297525 SSIE NO.: WX 696 I

## OCCUPATIONAL MALIGNANCIES AMONG PETROCHEMICAL WORKERS OF ALBERTA

INVESTIGATORS: GRACE MG: FINCHAM S : EGEDAH L R  
 PERFORMING ORG: W.W. CROSS CANCER INSTITUTE, BIostat ANALYS & CANC REGISTRY, 11560 UNIVERSITY AVE. T6G 1Z2, EDMONTON, ALBERTA, CANADA

SPONSORING ORG: Supporting Organization Not Reported, Country not reported

CONTRACT/GRANT NO.: D-1ARC-78-64

0/77 TO 0/79 FY: 78 FUNDS: NA

A study is being designed to demonstrate possible relationships between occupational exposure to carcinogenic substances and cancer incidence and mortality in Alberta. Retrospective data will be collected on approximately 1,000 members of the Oil, Chemical and Atomic Workers Union, and on an unexposed control group similar in size and other characteristics. Sources of data will be union and employers records, vital statistics, the Provincial Cancer Registry and Patient Index System. Persons with occupational radiation exposure are excluded from the study.

## DESCRIPTORS:

Public Health, 2.Epidemiology of Disease, 3.Environmental Health, 4.Occupational Hazards  
 Cancer, 2.Carcinogenesis, 3.Environmental Carcinogenesis,  
 2.Cancer Epidemiology  
 Test Animals, Human, 2.Homo Sapiens - Modern

CR17630 SSIE NO.: CY 589

ANALYSIS, SCREENING, AND EVALUATION OF CONTROL TECHNOLOGY FOR WASTEWATER GENERATED IN SHALE OIL DEVELOPMENT

INVESTIGATORS: DANSON GW; MERCER BW  
PERFORMING ORG: SATELLE MEMORIAL INSTITUTE, WATER & LAND RESOURCES, P.O. BOX 999, RICHLAND, WASHINGTON, 99352

SPONSORING ORG: U.S. Energy Research & Development Admin., Div. of Environmental Control Technology, Washington, District of Columbia

CONTRACT/GRANT NO.: EY-76-C-06-1830

10/76 TO 9/77 FY: 77 FUNDS: NA

The program is designed to identify the capabilities of current technology to produce environmentally acceptable discharges from shale oil development wastewaters.. wastewaters related to shale oil development will differ significantly from those of the petroleum industry.. Should improper or inadequate treatment technology be employed, shale oil development may threaten then quality of ground and surface waters with high dissolved solids levels, oxygen demand, and toxic trace materials.. Experimental data will be generated utilizing bench and pilot-scale facilities to prepare mine and in situ retort waters for surface discharge, groundwater recharge, or land spreading.. Work will focus on wastewaters from the Wyoming and Colorado tracts..

RESULTS: A critical evaluation of wastewater treatment needs has been written identifying the areas of concern and some of the likely technologies which can be applied..

#### DESCRIPTORS:

Substances, 2.Toxic Substances, 3.Toxic Substances -nonspecific

Chemical Engineering, 2.Petroleum Research, 3.Shale Oil; 2.Process Development, 3.Bench Scale

Waste Water Treatment/Disposal, 2.Source of Wastes, 3.Industrial Wastes, 4.Petroleum Wastes; 2.Characteristics of Waste Water, 3.Biological Oxygen Demand, 3.Total Dissolved Solids; 2.Waste Water Treatment, 3.Waste Treatment -general; 2.Waste Water Disposal, 3.Artificial Recharge, 3.Land; 2.Sewage System- Treatment Plant, 3.Sewage Treatment Plants, 4.Effluent Standards, 4.Pilot Plants

Chemistry - Specialized Fields, 2.Chemistry -related Fields, 3.Petroleum Chemistry

Energy Research, 2.Fossil Fuels and Sources, 3.Oil Shale; 2.Environmental Aspects

Economic Geology, 2.Deposits - Non-metallic, 3.Oil Shale Water Resources, 2.Environment - Locale Parameter, 3.Industries, 4.Mineral Processing Industry, 4.Mining Industry; 2.Types of Water, 3.Groundwater, 3.Surface Water; 2.Water Quality, 3.Pollution Sources, 4.Mining Activities; 2.Water Supply, 3.Recharge -water, 4.Artificial Recharge

Geographic Locations, 2.North America, 3.Colorado, 3.Wyoming

#### STUDIES OF OCCUPATIONAL CANCER

INVESTIGATORS: DECOUFLE P ; DECOUFLE P ; BLAIR AE; THOMAS TL ; GRAUMAN DJ; MASON TJ

PERFORMING ORG: U.S. DEPT. OF HLTH. ED. & WEL., NATL. CANCER INSTITUTE, FIELD STUDIES & STATISTICS SEC, BETHESDA, MARYLAND, 20-014

SPONSORING ORG: U.S. Dept. of Health Education & Welfare, Public Health Service, National Inst. of Health, National Cancer Inst., 9000 Rockville Pike, Bethesda, Maryland, 20014

CONTRACT/GRANT NO.: Z01-CP-04480-01-EEB

10/76 TO 9/77 FY: 77 FUNDS: NA

This project concerns identification of unusual patterns of cancer within specific occupational groups that may be indicative of exposure to hazards in the work environment.. Study groups are selected for a variety of reasons including 1) known or potential exposure to established or suspect carcinogenic substances, 2) prior case reports and case-control studies suggesting an unusual cancer experience for the group, 3) availability of existing sources of data for defining a population-at-risk.. Data sources include employment and death records maintained by companies, membership and death listings maintained by labor unions and professional organizations, and state licensing records.. Studies underway include cohort mortality studies of persons employed in dry cleaning establishments, men employed in different work areas of large manufacturing plant (machinists, foundry workers, welders, platers), and persons exposed to benzene and other chemicals in a single chemical production plant.. Proportionate mortality studies are being conducted for workers in the petrochemical industry and pharmaceutical and biological manufacturing, chromate painters and leather workers..

BIBLIOGRAPHIC REFERENCE: Decoufle, P., Lloyd, J.W., and Salvin, L.G.: Causes of Deaths Among Construction Machinery Operators., J. Occup. Med. 19: 123-128, 1977.,

#### DESCRIPTORS:

Public Health, 2.Epidemiology of Disease, 3.Environmental Health, 4.Occupational Hazards; 3.Statistical Studies, 4.Morbidity, 4.Mortality; 2.Preventive Medicine, 3.Case Finding

Cancer, 2.Carcinogenesis, 3.Environmental Carcinogenesis; 2.Cancer Epidemiology

Pharmacology, 2.Drug Groups, 3.Carcinogens Occupations, Populations, 2.Occupations - Other Specific, 3.Factory Workers

Substances, 2.Elements & Inorganic Anions, 3.Transition Metals, 4.Chromium, 5.Chromate; 3.Benzene

Test Animals, Human, 2.Homo Sapiens - Modern

010979 SSIE NO.: ZXC 130 B

# U.S. CANCER MORTALITY SURVEY

INVESTIGATORS: MASON TJ; MASON TJ; MASON TJ; FRAUMENI JF;  
HOOVER RN; BLOT WJ; STEPHENSON BL; RAMSBOTTOM RI  
PERFORMING ORG: U.S. DEPT. OF HLTH. ED. & WEL., NATL. CANCER  
INSTITUTE, ENVIRONMENTAL STUDIES SECTION, BETHESDA, MARYLAND, 200-  
14

SPONSORING ORG: U.S. Dept. of Health Education &  
Welfare, Public Health Service, National Inst. of  
Health, National Cancer Inst., 9000 Rockville Pike, Bethesda, Mar-  
land, 20014

CONTRACT/GRANT NO.: Z01-CP-04378-03-EEB

10/76 TO 9/77 FY: 77- FUNDS: NA

The objective of this study is to examine the cancer mortality experience in the United States relative to cancer etiology.. Special emphasis is placed upon the selection of areas in the U.S. for intensive stud .. Publications from this area of interest have facilitated the design of ongoing analytical investigations to test specific etiologic hypotheses.. Included among these are studies of lung cancer in coastal Georgia, bladder cancer in New Jersey, colon cancer in rural Nebraska, and liver cancer in southeast Texas.. An analysis of cancer mortality among nonwhites revealed striking similarities in geographic patterns for cancers of the breast, colon, rectum, and esophagus.. Site-specific analyses for cancers of the esophagus, buccal cavity and pharynx, and large bowel revealed associations with ethnicity and industry.. Industry-specific studies revealed elevated nasal cancer rates in counties with large numbers employed in the furniture industry, and elevated rates for cancers of the lung, nasal cavity and sinuses, and skin in counties where the petroleum industry is most heavily concentrated.. We are continuing to expand our data sets, both of reported deaths and measures of exposure..

BIBLIOGRAPHIC REFERENCES: Mason, T.J., McKay, F.W., Hoover, R., Blot, W.J., Fraumeni, J.F., Jr.: Atlas of Cancer Mortality Among U.S. Nonwhites: 1950-1969, DHEW Publication No. (NIH) 76-1204, 1976, 142 pp.. Mason, T.J.: Comment on Reserve Mining: Statistical Evaluation of Carcinogens in the Environment.. 4:13-17, 1976.

## DESCRIPTORS:

Public Health, 2.Epidemiology of Disease, 3.Environmental Health, 4.Geographic Factors:, 3.Statistical Studies, 4.Mortality

Medicine/Phys.- General Topics, 2.Etiology  
Cancer, 2.Carcinogenesis, 3.Environmental Carcinogenesis:,  
2.Cancer Epidemiology

Cancer - Body Sites, 2.Digestive System Cancer, 3.Esophageal Cancer, 3.Intestinal Cancer, 3.Liver & Biliary System Cancer, 3.Oral Cancer:, 2.Respiratory System Cancer, 3.Lung Cancer:, 2.Urogenital System Cancer, 3.Bladder Cancer  
Digestive System, 2.Pharynx, 2.Esophagus, 3.Esophagus -general:, 2.Intestine, 3.Structures, 4.Large Intestine, 5.Colon, 5.Rectum, 5.Large Intestine -nonspecific:, 2.Liver,

3.Liver -general  
Respiratory System, 2.Diseases and Conditions, 3.Respiratory Disease -general  
Urogenital System, 2.Struct Abnorm Func Ot Than Kid,  
3.Urinary Bladder, 4.Urinary Bladder -general  
Biometric Parameters, 2.Sex As A Parameter, 3.Sex Comparisons & Differences  
Ethnic and Social Parameters, 2.Social Class, 3.Social Class -nonspecific:, 2.Ethnic Parameters -ns,  
Regional Parameters, 2.County, 2.Rural Areas  
Substances, 3.Petroleum  
Test Animals, Human, 2.Homo Sapiens - Modern  
Social Sciences, 2.Demography, 3.Demography -other:,  
2.Occupation, 3.Occupation -general  
Economics, 2.Welfare Economics  
Air Pollution, 2.Sources of Air Pollution, 3.Industrial Sources, 4.Industrial Sources -general  
Geographic Locations, 2.North America, 3.Maine, 3.Nebraska:,  
2.Regional United States, 3.New England  
Elements & Inorganic Compounds, 2.Metalloids, 3.Arsenic,  
4.Arsenic

0209288 SSIE NO.: ZMA 1113

TOXICITY TO MARINE ORGANISMS OF PETROCHEMICALS & ENERGY  
RELATED ORGANIC SOLVENTS DERIVED FROM OFF-SHORE ACTIVITIES &  
OCEAN DUMPING (ABBREV)

INVESTIGATORS: RICHARDS NL; SCHIMMEL S; TAGATZ S  
PERFORMING ORG: U.S. ENVIRON. PROTECTION AGCY., GULF BREEZE  
ENVIRON. RES. LAB., GULF BREEZE, FLORIDA, 32561

SPONSORING ORG: U.S. Environmental Protection Agency, Office  
of Research & Development, Environmental Research Lab., Sabine  
Island, Gulf Breeze, Florida, 32561

CONTRACT/GRANT NO.: Q625A-2-2

10/76 TO 9/77 FY: 77 FUNDS: \$20,000

Offshore petroleum extraction may affect marine organisms  
and ecosystems in the Gulf of Mexico and other areas  
undergoing intensified petroleum exploitation, extraction, and  
transportation activities. The research objective is to assess  
the effects of these emissions on marine organisms and  
communities. Bioassays on single species and communities will  
be continued on selected components of drilling muds. Work  
will be initiated on whole drilling muds and other pollutants  
emitted from extraction activities such as cutting and  
non-mobilized petroleum hydrocarbons.

## DESCRIPTORS:

Reference Codes, 2. Marine Biology, 3. Marine Animals  
Tests and Methods, 2. Other, 3. Bioassays  
Substances, 3. Petroleum  
Energy Research, 2. Fossil Fuels and Sources, 3. Petroleum;  
2. Environmental Aspects  
Economic Geology, 2. Deposits - Non-metallic, 3. Oil -  
Petroleum  
Water Resources, 2. Water Quality, 3. Pollution Effects,  
4. Biological, 5. Biology -general, 3. Water Quality -general  
Oceanography, 2. Marine Pollution, 3. Ocean Dumping,  
3. Petroleum Wastes - Spillage  
Environments, 2. Environmental Factors-geologic, 3. Environmen-  
tal Impact  
Geographic Locations, 2. Oceans, 3. Atlantic Ocean Areas,  
4. Gulf of Mexico

0208548 SSIE NO.: WX B29

HISTORICAL DATA BASE FOR ONE COMPANY IN THE PETROLEUM  
INDUSTRY

INVESTIGATORS: ALDERSON MR; CARTER JT; COOMBS EJ  
PERFORMING ORG: INST. OF CANCER RESEARCH, DIVISION OF  
EPIDEMIOLOGY, CLIFTON AVE. SM2 5PX, SUTTON, ENGLAND, UNITED  
KINGDOM

SPONSORING ORG: Supporting Organization Not Reported, Country  
not reported

CONTRACT/GRANT NO.: D-IARC-77-557

10/76 TO 9/77 FY: 77 FUNDS: NA

This project will set up a comprehensive file to examine

future queries about the influence of work in a particular  
process upon mortality from specific diseases., Specific job  
histories will be obtained for all individuals who have worked  
at two large refineries for more than one year since these  
refineries were established. A comprehensive job history will  
be abstracted and the file will accumulate at the same time  
data on the plants and processes at each of the refineries  
including designation of the major variation in the raw  
materials, intermediaries, and products from each process.  
Individuals leaving the industry will be traced and the  
intention is to provide death details for all individuals who  
have died.. This file of data will be primarily used as a  
computer-based retrieval system to check specific queries  
about health-risks from various processes.. The primary  
approach will be to relate observed mortality to expected  
mortality taking into account age, sex, calendar period, and  
location in the country..

## DESCRIPTORS:

Methodology & Instrumentation, 3. Computer Methods -general,  
4. Computers in Medicine  
Nonresearch & Selected Topics, 2. Information Centers &  
Services, 3. Archives  
Public Health, 2. Epidemiology of Disease, 3. Environmental  
Health, 4. Occupational Hazards, 3. Statistical Studies,  
4. Morbidity, 2. Health Status of Populations  
Cancer, 2. Cancer Epidemiology  
Substances, 3. Petroleum  
Test Animals, Human, 2. Homo Sapiens - Modern

0209295 SSIE NO.: WX 301 1  
 INSTITUTE OF PETROLEUM EPIDEMIOLOGICAL SURVEY  
 INVESTIGATORS: ALDERSON MR  
 PERFORMING ORG: INST. OF CANCER RESEARCH, DIVISION OF  
 EPIDEMIOLOGY, CLIFTON AVE. SM2 5PX, SUTTON, ENGLAND, UNITED  
 KINGDOM  
 SPONSORING ORG: Supporting Organization Not Reported, Country  
 not reported  
 CONTRACT/GRANT NO.: D-IARC-77-556  
 10/76 TO 9/77 FY: 77 FUNDS: NA

The aim is to monitor background data in order to quantify the overall level of morbidity and mortality and examine the variation from disease in relation to broad categories of work or "environment". Some twenty companies in the oil industry have agreed to fund an epidemiological study through the Institute of Petroleum. Present plans are to collect data from eight refineries (three Shell, three BP, one Esso, and one Mobil); details are required about men who have been employed for at least a year from 1950 to 1975, including those who have left the industry, retired, or died. The analysis will examine mortality rates by cause (taking age, location, and type of work into account). Comparisons will be made between men doing different work within refineries, and with the mortality data for men in other industries in the same region as each refinery and in the country as a whole. Such a study can quantify the general mortality (and thus indirectly the overall level of health in the industry). Examination of material on individual diseases may identify specific issues that warrant detailed study.

#### DESCRIPTORS:

Public Health, 2. Epidemiology of Disease, 3. Environmental Health, 4. Occupational Hazards, 3. Statistical Studies, 4. Morbidity, 4. Mortality  
 Cancer, 2. Carcinogenesis, 3. Chemical Carcinogenesis, 3. Environmental Carcinogenesis, 2. Cancer Epidemiology  
 Pharmacology, 2. Drug Groups, 3. Carcinogens  
 Substances, 3. Petroleum  
 Test Animals, Human, 2. Homo Sapiens - Modern  
 Chemical Engineering, 2. Petroleum Research, 3. Refining Processes, 4. Refining Process - other, 2. Safety, 3. Occupational Safety

The project objectives are to quantify emissions to the environment from petroleum refineries. The discharge concentrations are compared to estimated risk levels in the environment. Emissions data are confirmed within known limits of error by the most appropriate means available. Actual field sampling is a major part of this program. The discharge levels are compared to estimate measures of risk by extrapolation from known adverse effects levels. Interested parties in Government as well as industry are invited to participate in the program to insure the results will be of use to all parties.

Outputs will be reports of emissions data useful for standards setting, offset calculations and estimates of risk from exposure to toxic materials emitted from petroleum refineries.

#### DESCRIPTORS:

Air Pollution, 2. Sources of Air Pollution, 3. Industrial Sources, 4. Petroleum Industry, 2. Detection & Measurement, 3. Air Pollution Sampling, 2. Air Quality Standards  
 Water Resources, 2. Environment - Local Parameter, 3. Industries, 4. Petroleum Industry, 2. Techniques and Instrumentation, 3. Water Sampling, 2. Water Quality, 3. Water Quality - general, 3. Pollution Sources, 4. Industrial Wastes, 4. Petroleum Wastes - Spillage, 3. Water Quality Control, 4. Water Standards & Baselines  
 Environments, 2. Environmental Factors - geologic, 3. Environmental Impact  
 Techniques and Instrumentation, 2. Field Studies, 2. Sampling

0205498 SSIE NO.: GMA 418B  
 ASSESSMENT OF ENVIRONMENTAL EMISSIONS FROM GIL REFINING  
 INVESTIGATORS: MESICH F; ROSEBROOK D  
 PERFORMING ORG: RADIAN CORPORATION, 8500 SHOUL CREEK  
 BLVD., AUSTIN, TEXAS, 78766  
 SPONSORING ORG: U.S. Environmental Protection Agency, Office  
 of Research & Development, Industrial Environmental Research  
 Lab., Research Triangle Park, North Carolina, 27711  
 CONTRACT/GRANT NO.: 68-02-2147; F604B-5  
 10/76 TO 9/77 FY: 77 FUNDS: \$577,600



APPENDIX C  
CODING MANUAL  
FOR  
LOSS INCIDENTS REPORTS



# LOSS INCIDENT REPORT

NIOSH Contract No. 210-77-0033 FM Serial No. 4A8N8.RG

FILE TRANSACTION CODE  
(A-Add, C-Change, D-Delete)

DATE		STATE		INCIDENT NO.			
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INFORMATION SOURCES		ADDITIONAL SOURCES		PRECIP.			
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ADDRESS (LOCATION OF INCIDENT)				SIC			
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OPERATIONAL ACTIVITY		OCCUPANCY					
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INCIDENT TYPE							
<div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">35</div>							
OPERATING PERS.		OTHER PLANT PERS.		OTHER PERSONS			
INJURIES FATAL.		INJURIES FATAL.		INJURIES FATAL.			
<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">36</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">37</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">38</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">39</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">40</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">41</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">42</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">43</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">44</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">45</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">46</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">47</div> </div>			
INJURY		UNSPECIFIED		TOTAL			
<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">48</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">49</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">50</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">51</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">52</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">53</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">54</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">55</div> </div>			
FATALITIES		NO. CAUSE		NO. CAUSE			
<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">56</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">57</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">58</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">59</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">60</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">61</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">62</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">63</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">64</div> </div>			
EQUIPMENT INVOLVED		OTHER EQUIPMENT (IF ANY)					
<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">74</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">75</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">76</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">77</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">78</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">79</div> </div>			
INCIDENT CAUSE		PRIMARY					
		SECONDARY					
EMERGENCY EQUIPMENT		OTHER EMERGENCY EQUIPMENT		OTHER EMERGENCY EQUIPMENT			
<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">86</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">87</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">88</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">89</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">90</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">91</div> </div>			
BUSINESS INTERRUPTION (DAYS)		DOLLAR COST					
<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">92</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">93</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">94</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">95</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">96</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">97</div> </div>					
GROUP OF PETROLEUM PRODUCTS		MATERIAL NO.					
<div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">98</div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">99</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">100</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">101</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">102</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">103</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">104</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">105</div> </div>					
CAS NO.		SEE REMARKS					
<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">106</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">107</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">108</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">109</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">110</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">111</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">112</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">113</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">114</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">115</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">116</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">117</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">118</div> </div>			
<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">119</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">120</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">121</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">122</div> </div>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">123</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">124</div> </div>			

LOSS INCIDENT REPORT  
NIOSH CONTRACT NO. 210-77-0033  
FMRC Serial No. 4A6N8.RG

Data Entry No.

1                    Register Number - Hard Coded

2                    File Transaction Code    A - Add, C - Change; D - Delete

Date of Incident

3 - 8                This is the date on which the incident occurred. This data element is in the major (leftmost) portion of the key to the incident.

Its format is:

YY MM DD

where YY stands for year

MM    "        "    month

DD    "        "    day

State Code

9 - 10              This is an alphabetic code for state as given by the National Bureau of Standards (NBS) publication FIPS PUB 5-1.

<u>Name</u>	<u>Abbrev.</u>	<u>Name</u>	<u>Abbrev.</u>	<u>Name</u>	<u>Abbrev.</u>
Alabama	AL	Kentucky	KY	North Dakota	ND
Alaska	AK	Louisiana	LA	Ohio	OH
Arizona	AZ	Maine	ME	Oklahoma	OK
Arkansas	AR	Maryland	MD	Oregon	OR
California	CA	Massachusetts	MA	Pennsylvania	PA
Colorado	CO	Michigan	MI	Rhode Island	RI
Connecticut	CT	Minnesota	MN	South Carolina	SC
Delaware	DE	Mississippi	MS	South Dakota	SD
Dist. of Col.	DC	Missouri	MO	Tennessee	TN
Florida	FL	Montana	MT	Texas	TX
Georgia	GA	Nebraska	NE	Utah	UT
Hawaii	HI	Nevada	NV	Vermont	VT
Idaho	ID	New Hampshire	NH	Virginia	VA
Illinois	IL	New Jersey	NJ	Washington	WA
Indiana	IN	New Mexico	NM	West Virginia	WV
Iowa	IA	New York	NY	Wisconsin	WI
Kansas	KS	North Carolina	NC	Wyoming	WY

Incident Sequence Number

11                    This is a one-digit numeric data element used to ensure uniqueness in the incident key. It will be zero except when more than one incident has occurred on the same date in the same state. The second incident on the same day in the same state will be coded 1. The third will be 2, ad infinitum. It is the rightmost part of the key to incident.

---

City Code

12 - 15              This is a four-digit numeric code for city from the IBM Standard "Codes for Cities and Towns of 2500 or More".

---

Time of Day

16 -19              This data shows the time of day when the incident occurred.

The format is:

Hours - 2 numerics representing 24-hour clock  
Minutes - 2 numerics

---

Weather

20                    This element shows three elements of weather (wind, precipitation, temperature) in a three-digit code.

The first digit represents wind. The Codes are:

0 Not Applicable	3 21-30 mph	6 50-60 mph
1 0-10 mph	4 31-40 mph	7 61-75 mph
2 11-20 mph	5 41-50 mph	8 Hurricane
		9 Unknown

---

21                    The second digit represents precipitation. Codes are:

0	Not Applicable
1	Rain
2	Fog
3	Snow
4	Hail
5	None
9	Unknown

---

22                    The third digit represents temperature range. Codes are:

0	Not Applicable
1	Below Freezing
2	32 - 75°F (0 - 23.9°C)
3	76°F - 90°F (23.9°C - 32.22°C)
4	91°F - 100°F (32.78°C - 37.78°C)
5	Over 100 ( 37.78°C)
9	Unknown

---

# Information Sources

23

This is a code to reflect the source of the report. The code is hierarchical with the first character representing:

<u>Type of Source</u>	<u>Code</u>
Federal Government Agency	A
State Governmental Agency	B
Local Governmental Agency	C
International Governmental Agency	D
Private Sector-Business	E
Private Sector-Educational	F
Private Sector-News Publication	G
Personal Contact	H
Other	Z

There are three source fields available. The second and third digits are assigned to Name of Reporting Source Code which is assigned in ascending sequence from 01 to 98. The code 99 is reserved for unknown.

The codes presently assigned are:

23.24.25	A01 U.S. Dept. of Transportation	A06 U.S. Dept. of Labor
	A02 U.S. Coast Guard	A07 ERDA
	A03 U.S. EPA	A08 U.S. Geological Survey
	A04 Office of Pipeline Safety	A09 U.S. Dept. of Commerce
	A05 OSHA	A10 NFPCA (Nat'l Fire Prot. Control Admin.

B01 Mass. Dept. of Nat'l Resources	B05 Ohio EPA
B02 Maryland Water Quality Control	B06 N.J. Fisheries Com. Lab.
B03 N.J. EPA	B07 N.Y. DEC
B04 Conn. DEP	B08 Dept. of Labor

C01 Public Fire Dept.	C02 Public Police Dept.
-----------------------	-------------------------

E01 Factory Mutual	E04 Oil & Petroleum Co.
E02 Avon	E05 Insurance Company
E03 American Petroleum Institute	(other than FM)

G01 Newspaper	G04 Fire Journal
G02 NFPA Publication	G05 Fire Command
G03 Magazine Article	G06 Chemical Engineering

Incident Type

A Fire	J Fire & Spill	S Toxic Fumes & Spill
B Explosion	K Fire & Pollution	T Machinery Breakdown
C Smoke	L Explosion & Smoke	U Unknown
D Toxic Fumes	M Explosion & Toxic Fumes	V Marine Incident
E Spill	N Explosion & Spill	W Multiple (See Remarks)
F Pollution	O Other	X Well Blow-out
G Fire & Explosion	P Explosion & Pollution	Y Collision
H Fire & Smoke	Q Smoke & Toxic Fumes	Z Employee Accident
I Fire & Toxic Fumes	R Toxic Fumes & Pollution	

36 - 51

Injuries/Fatalities of Operations PersonnelOther Plant Personnel, Other Persons & Unspecified Persons

These two data elements are numeric in representation. The number is entered directly; i.e., if 20 others were injured or killed, a 20 is entered in the element field. The single digit numbers are entered with a zero preceding them, e.g., eight is 08. The number of injuries/fatalities is entered for Operating Personnel, other Plant Personnel, Other Persons, and for Unspecified Persons.

Note: Reports that indicate injuries and/or fatalities but do not specify the number should be coded 99. Since 99 can also indicate a definite number of injuries or fatalities in excess of 98, a note of clarification in "Remarks" is necessary.

52 - 53

Total Injuries

Enter the sum of the injuries listed in boxes 36, 37; 40, 41; 44, 45; 48, 49

54 - 55

Total Fatalities

Enter the sum of the fatalities listed in boxes 38, 39; 42, 43; 46, 47; 50, 51

SIC - Standard Industrial Code

29-30-31-32	13 00	Major Group - Crude Petroleum and Natural Gas
	1311	Crude Petroleum and Natural Gas
	1321	Natural Gas Liquids
	1381	Drilling Oil and Gas Wells
	1382	Oil and Gas Field Exploration Service
	1389	Oil and Gas Field Services, Not Elsewhere Classified
	29 00	Major Group - Petroleum Refining and Related Industries
	2911	Petroleum Refining
	2951	Paving Mixtures and Blocks
	2952	Asphalt Felts and Coatings
	2992	Lubricating Oils and Greases
	2999	Products of Petroleum and Coal, Not Elsewhere Classified

### Operational Activity

33	1. Exploration	4. Transfer	7. Extraction
	2. Development	5. Plant Processing	8. Other
	3. Field Production	6. Storage	9. Unknown

## 34 Occupancy

A	Extraction Site (on shore)	H	Engine house	O	Other
B	Off-shore platform	I	Dog house	P	Pumping Station
C	Chemical Plant	J	Petro refin/nat gas	Q	
D	Refinery	K	Processing Mfg. Area	R	Research Facility
E	Light Hydrocarbon Processing Plant	L	Loading Facility	S	Storage (Incls. Bulk plant)
F	By-Products Processing Plant	M	Pipeline	T	Terminal
G	Gas Processing Plant	N	Transport (Overland/Marine)	U	Unknown
				V	Compressor Station

Number of injuries/Fatalities

- (59 - 60) The number of injuries and/or fatalities for each type of  
 (62 - 63) trauma. The code is the actual number involved;  
 (65 - 66) i.e., 8 persons would be coded 08; 23 persons would be  
 (68 - 69) coded 23, 99 or more persons would be coded 99.  
 (71 - 72) The code 99 also indicates that an unspecified number of  
 casualties involving a specified trauma was reported.  
 Clarification of the 99 code in "Remarks" is necessary.
- 

- 58 A one alpha-digit is used to identify the type of trauma  
 (61) responsible for the casualty related to the number of  
 (64) persons involved.  
 (67) Note: There can be more than one trauma causing casualties  
 (70) for each incident.  
 (73) A Amputation, Paralysis, Loss of Body Function or member L Person. Health, Heart Strain, etc.  
 B Bruises and Contusions M Crushing Injury  
 C Cuts, Lacerations & Punctures N Asphyxiation  
 D Occupational Diseases O Other Injury  
 E Eye Injuries n.e.c. P Concussion  
 F Fracture Q Multiple Injuries  
 G Injury by Extreme Temp. R Reported as Explosion  
 H Strains, Sprains, Dislocation, S Chemical Burns  
 Hernias  
 I Inhalation or Absorption T Heat Burns  
 J Electrical Shock U Not Reported or Unknown
-

74-75-76  
(77-78-79)

Three numeric digit code to indicate the type of  
equipment involved in the incident, if any.  
Add code numbers for other equipment alphabetically.

000	No Equip. Involved	194	Controls	365	Extruder
010	Absorber	198	Control Panel	366	Fan Shaft
013	Aeration Facility	200	Cooler	367	Fan Stack
015	Agitator	201	Cooling Pan	368	Fat Fryer
020	Aircraft	203	Cooking Lines	370	Field Equip. & Mach'y.
021	Air Cond. Unit	205	Cover	372	Filling Valve
023	Alkylation Unit	210	Cracker	380	Filter
030	Alumina Tower	220	Crane or Derrick	381	Filter Pot
035	Armature	225	Crystalizer	382	Feeder
040	Autoclave	227	Cylinder	383	Feed Hopper
046	Backhoe	230	Debutanizer	384	Fire Pump Driver
047	Bag	240	Decking	385	Fire Water System
048	Battery	250	Deethanizer	386	Firewall
049	Bay (Service Sta.)	260	Degasser	387	Firebox
050	Boat or Ship	268	Dehydrator Unit	388	Flare Drain
055	Bottle	270	Deisobutanizer	389	Flame Arrestor
061	Blower	273	Delayed Cooking Unit	390	Flasher
064	Board Road	280	Demethanizer	391	Flare Vent Fan Unit
065	Bottoms Lines	281	Demister Pots	392	Flare Header Line
070	Boiler/ Pressure Vessels	287	Disconnecting Switch	399	Flume
075	Boxes (Control)	289	Disposal Tank (salt water)	400	Fluid Reformer
079	Burner	290	Depropanizer	401	Flare Stacks
080	Building	291	Dip Tank	402	Floating Roof
083	Butadiene Unit	292	Dewaxing Unit	405	Fluid Cat. Unit
090	Cables	293	Diverter Inner Sleeve	406	Flume (use 399)
093	Canopy	294	Drain Line	410	Forecolumn
100	Carburetor	295	Drain Plug	420	Fractionator
107	Catalyst	296	Distribution System	424	Fuel Line
110	Centrifuge	297	Drain Valve	429	Fuel System
118	Charger	298	Drain Systems	430	Furnace
120	Chiller	300	Drill	436	Gasifier
130	Christmas Tree	301	Drip Pan	437	Gas Unit
138	Clinker	310	Drilling Rig & Equip.	438	Gasket
140	CO <sub>2</sub> Still	315	Drum	439	Guy Wire
142	Coalescer	317	Dryer	440	Generator
146	Coil Outlet	318	Dumpster	441	Gas Pipe Line
147	Coil	319	Duct	442	Gauge
148	Coker	320	Electric Cable	443	Gun Barrel
150	Column	322	Electrical Equipment	444	Guard House
160	Communications Equipment	330	Elevator	445	Hatch Cover Plate
169	Compactor	337	Emergency Equipment	447	Hangar
170	Compressor	340	Engine	449	Header
175	Cone Roots on Tanks	341	Energized Conductor	450	Heater
178	Container	342	Engine Exhaust	453	Heat Shield
180	Converter	350	Evaporizer	455	Heater Treater
182	Conveyor	360	Exchanger	457	Heat Tape
190	Condenser	362	Exhaust Manifold	458	Heater Treater
		363	Exhaust Stack	460	Hoisting Gear



# EQUIPMENT INVOLVED (Cont'd)

462	Hot Box	620	Prefractionator	797	Storage Drum
470	Hydrogenator	622	Preheater	798	Storage Tank
477	Hydrocracker	624	Pressure Regulator	799	Steam Generator
478	Hydraulic Line	625	Pressaturator	800	Stripper
479	Hydroformer Unit	626	Pressure Line	801	Strainer
489	Hydrotreater	627	Production Equip.	807	Submersible Equip.
481	Hydrofiner	628	Propane Stove	810	Surge Tank
486	Ignition System	629	Pulverizer	811	Sump
487	Inspection Plate	630	Pump	812	Sump Vent
490	Instrumentation	631	Pump Station	815	Supply Line
495	Industrial Vehicle	632	Pump Bank	817	Suppressors
499	Jack Bolt	634	Pump Packing	820	Switchgear
500	Insulation	640	Oil Field Treater	821	Switch Box
501	Jack Screw	645	Rags	830	Tank
502	Light Fixture	646	Radio	832	Thermal Relief System
503	Junction Box	647	R. R. Tank Car	834	Thief Hatch
504	Luct Unit	648	R. R. Equipment	840	Tools-Handheld
505	Lina Log Pig	650	Reactor	841	Tool Box
509	Loading Deck	652	Reabsorber	850	Tower
510	Loading Rack	655	Reboiler	860	Transfer System
511	Loadline of Crane	660	Refiner	861	Transfer Line
520	Laboratory Equip.	670	Reformer	870	Transformer
522	Ladder	671	Reformer Line	872	Trash Bin
524	Lubricator	680	Refrigerator	879	Treater Pot
525	Level Control	700	Regenerator	880	Treater
530	Machine Shop Equip.	707	Relief Valve	881	Treater House
531	Master Panel	710	Riser	882	Tube (Flange)
533	Marine Equipment	714	Roof of Tank	890	Turbine
538	Meter Equipment	715	Sealing Roller	899	Vacuum Bottle
539	Material Handling Equip. Loader	720	Safety Facility/Equip.	900	Valve & Actuator
540	Methanator	722	Scaffold	901	Valve Body Plug
542	Meter House	730	Scrubber	902	Valve Line
548	Mill	735	Service Sta. Equip.	905	Valve Packing
550	Mixer or Agitator	738	Sewer	910	Vaporizer
560	Mobile Vehicle	740	Seal, Packing, Stuffing Box	912	Adhesive Vault
561	Moving Equip.	741	Shaft	915	Vent
569	Mud Line	743	Sign	916	Vent Line
570	Motor	744	Sight Glass	918	Vessels
571	Naptha Rerun Unit	750	Separator and Purifier	919	Vending Machine
572	Overboard Line	754	Slop Oil System	920	Vent Stack
573	Office Equip.	755	Space Heater	921	Vent System
574	Overflow Line	756	Spilling Chain	927	Voltage Line
576	Oxidizer	758	Selenoid Switch	930	Wash Box
580	Piping, Hoses, Nozzles, Fittings	760	Splitter	933	Washing Wells
585	Pit Pilot Light	770	Spray Equip.	940	Waste Disposal System
586	Plastic Cans	780	Stabilizer	941	Waste Recovery Unit
587	Platform	781	Starter Bendix	945	Water Injection
590	Polymer Fish Tower	782	Stack	950	Welding & Cutting Equip.
599	Pole	785	Starter Panel	955	Well
600	Polymerization Vessel	786	Start Upline	956	Well Equipment
606	Portable Pumping Unit	790	Still	958	Window
608	Power Line	792	Steam Line	960	Work-over Rig & Equip.
610	Precooler	794	Steam Regulator	990	Other
619	Precipitator	795	Steam Cleaning Unit	999	Unknown
		796	Steam Ejector		

INCIDENT CAUSE

The first digit represents the procedural cause of the incident which resulted in casualty (casualties).

- |   |                           |                       |
|---|---------------------------|-----------------------|
| 1. Equipment Failure                    | 5. Management or          | 8. Other              |
| 2. Process Malfunction                  | Personnel Fault           | 9. Reported "Unknown" |
| 3. Transfer System, Failure Malfunction | 6. Vandalism or Sabotage  | 0. None Reported      |
| 4. Natural Phenomenon                   | 7. Mobile Equip. Accident |                       |

81-82

(84-85)

DESCRIPTION OF INCIDENT CAUSE

- |   |  |
|---|--|
| 00 None Reported<br>(No further breakdown)                    | 41 Wind, Hurricane, Tornado                      |
| 01 Corrosion  | 42 Lightning                                     |
| 02 Metal Fatigue  | 43 Flood   |
| 03 Inadequate Design  | 44 Rain  |
| 04 Defective Fabrication<br>and/or Installation               | 45 Snow  |
| 05 Overload   | 46 Hail  |
| 06 Over or Under Pressure                                     | 47 Earthquake                                    |
| 07 Faulty Safeguard   | 48 Ambient Temperature                           |
| 08 Inadequate Safeguards                                      | 50 Negligence, Carelessness                      |
| 09 Welding Defect   | 51 Slips and Falls                               |
| 10 Gas Accumulation   | 52 Faulty Maintenance                            |
| 11 Dropped  | 53 Lack of Emergency Planning                    |
| 12 Struck by Mobile Equip.                                    | 54 Lack of Information                           |
| 13 Struck by other object                                     | 55 Housekeeping                                  |
| 14 Power Failure  | 56 Failure to Follow Proper Procedures           |
| 15 Power Surge  | 58 Human Error                                   |
| 16 Short Circuit  | 59 Equip. Left Unattended                        |
| 17 Blow-out   | 61 Vandalism                                     |
| 18 Inadequate, Lack of, Failure<br>of Controls or Instruments | 62 Sabotage                                      |
| 19 Malfunction or Impairment<br>of Equipment                  | 67 Upset condition                               |
| 21 Unwanted Reaction  | 70 Collision                                     |
| 22 Spontaneous Combustion                                     | 71 Failure of Control System                     |
| 23 Foreign Substance in Process                               | 72 Helicopter Accident                           |
| 24 Improper Process Temperatures                              | 73 Fixed Wing Aircraft Accident                  |
| 25 Utility Failure - Electric Power                           | 74 Marine (Boat, Ship, Barge, etc.)<br>Accident  |
| 26 Utility Failure - Steam                                    | 75 Movement when loading or Unloading            |
| 27 Utility Failure - Air                                      | 77 Overturn                                      |
| 28 Utility Failure - Cooling Water                            | 79 Collision and Overturn                        |
| 29 Utility Failure - Inert Gas                                | 80 Erosion                                       |
| 30 Rupture, Puncture  | 81 Inadequate Spacing                            |
| 31 Pump Failure   | 82 Inadequate Drainage                           |
| 32 Loose Fitting(s)   | 83 Improper Waste Disposal                       |
| 33 Structural Failure of Equip.                               | 85 Code Violation                                |
| 34 Faulty Valve   | 86 Sparks or Hot Surfaces                        |
| 35 Container Overfill   | 87 Widespread Flammables at Time of<br>Ignition  |
| 36 Spill  | 88 Inadequate Emergency Training or<br>Equipment |
| 37 Normal Operation   | 90 Electrical                                    |
| 38 Auto ignition  | 92 Inaccessable Location                         |
| 39 Corona Discharge   | 93 Delayed Discovery                             |
| 40 Vibration  | 94 Prime Mover Failure                           |
|   | 96 Personal Health Condition                     |
|   | 98 Other   |
|   | 99 Unknown                                       |

### Emergency Equipment

This element of data describes equipment utilized during after-incident operations. There are three fields for equipment.

The code is a two-digit hierarchical code. The first digit has the following values:

86	0	None	
(88)	1	Construction Equipment	
(90)	2	Firefighting Equipment	
	3	Personnel Safety Equip.	8 Multiple Types of Equip.
	4	Cleanup Contractor's	9. Equipment Unknown

---

The second digit represents a breakdown of the first digit categories as follows:

	10	Construction Equip. General	12	Cranes or Hoisting Equip.
	11	Earth Moving Equip.	18	Other or Multiple Types of Construction Equipment
	13	Jacks, Braces, Wedges, etc.		
86-87	20	Fire Fighting Equip. General	24	Portable Extinguishers
(88-89)	21	Chemical, Foam, CO <sub>2</sub> , etc.	28	Other or Multiple Types of Fire Fighting Equip.
(90-91)	22	Pumpers		
	23	Ladder		
	30	Personnel Safety Equip.	34	Masks & Prot. Clothing
	31	Ambulances		
	32	Protective Clothing	38	Multiple Types of Other Types
	33	Masks		
	40	Cleanup Equip. (Gen'l)	43	Chemical
	41	Dikes, Barriers, Containment	48	Multiple or Other
	42	Recovery, Equip. - Skimmers, etc.		
	80	Other or Multiple Types	83	Constr. & Cleaning Equip.
	81	Constr. & Fire Equip.	84	Fire & Safety Equip.
	82	Constr. & Safety	85	Fire & Cleanup Equip.
			86	Safety & Cleanup Equip.
	90	Equipment Unknown		

---

Business Interruption

No. of days the facility was off-line

Examples:      1 day      001  
                  22 days      022  
                  403 days      403

Cost of Damage

95-96

Cost of Product Loss, Damage and Cleanup is a data representation in two parts of the cost involved, two significant figures and an exponent.

The total cost is rounded up to two significant digits if the third is 5 or more.

The two elements are coded the same using exponent as follows:

	<u>Range of Number</u>	<u>Significant Representation</u>	<u>Exponent</u>
Exponent 97	0-99	01-99	0
	100-990	10-99	1
	1,000-9,900	10-99	2
	10,000-99,000	10-99	3
	100,000-990,000	10-99	4
	1,000,000-9,900,000	10-99	5

To code a cost of 27500, round up to 28,000 then code:

95-96-97

$\begin{array}{c} \underline{2 \quad 8} \quad \underline{3} \\ \nearrow \quad \nwarrow \end{array}$   
 Significant Digits Exponent

A single digit significance should be preceded by a zero.

Group of Petroleum Products

Alpha Digit Representing the Group of Petroleum Products Involved.

A Natural Gas	N Naptha
B Crude Oil	O Other
C Gas Condensate	P Petrochemical Feedstock
D Diesel Oil	Q Coke
E Light Heating Oil	R Residual Fuel Oils
F Gas Oil	S Still Gas
G Finished Gasoline	T Asphalt
H Heavy Fuel Oils	U Unknown
I Liquified Gas	V Reported as Oil
J Jet Fuel	W Waxes
K Kerosene	X None-Not Applicable
L Lubricant	Y Multiple Materials
M Methane	Z Reported as Gas

99-105

Material Number

This code represents the material used in the "Registry of Toxic Effects of Chemical Substances" - Dept. of HEW Public Health Service, Center for Disease Control, National Institute for Occupational Safety and Health, dated June 1976.

This code has two alphabetic characters followed by five numeric digits. When in ascending sort, the material names are arranged alphabetically.

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106-114

Chemical Abstracts Registry Number

This is a number assigned to this compound so that it may be uniquely identified. This number will also permit this incident file to be tied in with other Material Files such as OHM-TADS.

---

115

See Remarks

Notifier to alert the reader to any further information included under "Remarks" for which there is no code in the incident file.

---

116 thru 125    Extra spaces for expansion of the Incident Data Base.

---

Remarks

If additional pertinent information and/or narrative is required, it should be recorded under "Remarks" on the reverse side of the Incident data sheet and will be retrieved manually.

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**APPENDIX D**

**NIOSH COMPUTER PRINTOUTS**

The computer sheets presented in this appendix show how the data were partitioned for analysis. For an example refer to the first page of the print-out. The first line at the top of this page describes the primary partitioning variable. For this particular computer run, the data were partitioned by Occupancy Class, and this page contains all on-shore extraction site incidents. The second line gives the number of on-shore extraction site incidents included in the entire data set and the corresponding percentage. In this case, there were 200 such incidents representing 10.7 percent of the data set. The definitions of secondary variable sets of "x" and "y" are given on the third and fourth lines. For this run, the x-variable set represents the years in which the incidents occurred. It is a 13-element set which includes the years 1967 through 1978 plus "00" for unknown or unspecified year. The y-variable set represents total injuries; these are actual numbers of injuries. However, this set contains only totals for which there are corresponding incidents. For example, if no incident occurred in which there were nine injuries, then 9 would not be a part of this set. The elements of variable sets "x" and "y" are used to construct a grid. There are provisions for three sets of numbers in each slot in the grid. The number in the upper right corner represents the actual number of incidents possessing the corresponding x and y variables. The number located at the left center represents the percentage of the total incidents having the common variable  $x_i$  (an element of the set "x") represented by the uppermost number. Similarly, the number set in the lower right represents the percentage of the total incidents having the common variable  $y_i$  (an element of the set "y").

Using these guidelines, the following information can be extracted from the table. In 1976 there were a total of 49 incidents occurring at on-shore extraction sites. This represented 24.5 percent of the total incidents occurring at these sites. Forty-four of these (90%) resulted in no injury. The total number of incidents occurring at on-shore extraction sites which resulted in no injury was 190. This constituted 95 percent of the total on-shore extraction site incidents. Twenty-three percent of these no-injury incidents occurred in 1976.













	167	168	169	170	171	172	173	174	175	176	177	178	179	180	TOTAL
14															1
15															1
16															1
17															1
18															1
19															1
20															1
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68															1
69															1
70															1

FORM-137A (C.O. 3-201) - FAF-C-01060A

SYSTEMS AND ACCURACY  
OF INCIDENTS INCLUDED, 0.000 + OF ALL INCIDENTS

FORM-137A (C.O. 3-201) - FAF-C-01060A

SYSTEMS AND ACCURACY  
OF INCIDENTS INCLUDED, 0.000 + OF ALL INCIDENTS









STUDIES

[illegible][illegible]





DISPATCHING AND RECEIVING / LOGGING FACILITY  
 13 MONTHS INCLUDING, DASH 1 OF ALL LOGS OF  
 X = YES TO LOGS  
 Y = YES TO LOGS

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	%
1	1	1	1	1	1	1	1	1	1	1	1	1	1	13	100.000
2	1	1	2	1	1	2	1	1	2	1	3	1	1		
3	1	1	1	1	1	1	1	1	1	1	1	1	1		
4	1	1	1	1	1	1	1	1	1	1	1	1	1		
5	1	1	1	1	1	1	1	1	1	1	1	1	1		
6	1	1	1	1	1	1	1	1	1	1	1	1	1		
7	1	1	1	1	1	1	1	1	1	1	1	1	1		
8	1	1	1	1	1	1	1	1	1	1	1	1	1		
9	1	1	1	1	1	1	1	1	1	1	1	1	1		
10	1	1	1	1	1	1	1	1	1	1	1	1	1		
11	1	1	1	1	1	1	1	1	1	1	1	1	1		
12	1	1	1	1	1	1	1	1	1	1	1	1	1		
13	1	1	1	1	1	1	1	1	1	1	1	1	1		
14	1	1	1	1	1	1	1	1	1	1	1	1	1		
15	1	1	1	1	1	1	1	1	1	1	1	1	1		
16	1	1	1	1	1	1	1	1	1	1	1	1	1		
17	1	1	1	1	1	1	1	1	1	1	1	1	1		
18	1	1	1	1	1	1	1	1	1	1	1	1	1		
19	1	1	1	1	1	1	1	1	1	1	1	1	1		
20	1	1	1	1	1	1	1	1	1	1	1	1	1		
21	1	1	1	1	1	1	1	1	1	1	1	1	1		
22	1	1	1	1	1	1	1	1	1	1	1	1	1		
23	1	1	1	1	1	1	1	1	1	1	1	1	1		
24	1	1	1	1	1	1	1	1	1	1	1	1	1		
25	1	1	1	1	1	1	1	1	1	1	1	1	1		
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27	1	1	1	1	1	1	1	1	1	1	1	1	1		
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32	1	1	1	1	1	1	1	1	1	1	1	1	1		
33	1	1	1	1	1	1	1	1	1	1	1	1	1		
34	1	1	1	1	1	1	1	1	1	1	1	1	1		
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36	1	1	1	1	1	1	1	1	1	1	1	1	1		
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41	1	1	1	1	1	1	1	1	1	1	1	1	1		
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45	1	1	1	1	1	1	1	1	1	1	1	1	1		
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48	1	1	1	1	1	1	1	1	1	1	1	1	1		
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51	1	1	1	1	1	1	1	1	1	1	1	1	1		
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76	1	1	1	1	1	1	1	1	1	1	1	1	1		
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98	1	1	1	1	1	1	1	1	1	1	1	1	1		
99	1	1	1	1	1	1	1	1	1	1	1	1	1		
100	1	1	1	1	1	1	1	1	1	1	1	1	1		
TOTAL	1	1	1	1	1	1	1	1	1	1	1	1	1	13	100.000

DISCOUNTING THE OCCUPANCY

7 PERCENT

PERIODS

BE INCLUSIVE PERIODS, LESS 2.00 PER ALL PERIODS

X = NEW OR IMPROVEMENTS  
Y = TOTAL PERIODS

	157	160	169	170	171	172	173	174	175	176	177	178	179	
1														
2							71	1	1	6	7			24
3							129	4	-	155	26			72,000
4							991	991	991	991	321			
5											2			2
6											50			7,000
7											191			
8														
9														
10														
11														
12							71	11	11	21	111			
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93														
94														
95														
96														
97														
98														
99														
100														
TOTAL														3

STATE POLICE LABORATORY  
16 FORT MONROE HIGHWAY, SUITE 101-102  
FARMINGTON, CONNECTICUT 06031

X = VOLTAGE POINTS  
Y = WEIGHT POINTS

	I-7	I-8	I-9	I-10	I-11	I-12	I-13	I-14	I-15	I-16	I-17	I-18	I-19	I-20	I-21	I-22	I-23	I-24	I-25	I-26	I-27	I-28	I-29	I-30	I-31	I-32	I-33	I-34	I-35	I-36	I-37	I-38	I-39	I-40	I-41	I-42	I-43	I-44	I-45	I-46	I-47	I-48	I-49	I-50	I-51	I-52	I-53	I-54	I-55	I-56	I-57	I-58	I-59	I-60	I-61	I-62	I-63	I-64	I-65	I-66	I-67	I-68	I-69	I-70	I-71	I-72	I-73	I-74	I-75	I-76	I-77	I-78	I-79	I-80	I-81	I-82	I-83	I-84	I-85	I-86	I-87	I-88	I-89	I-90	I-91	I-92	I-93	I-94	I-95	I-96	I-97	I-98	I-99	I-100	I-101	I-102	I-103	I-104	I-105	I-106	I-107	I-108	I-109	I-110	I-111	I-112	I-113	I-114	I-115	I-116	I-117	I-118	I-119	I-120	I-121	I-122	I-123	I-124	I-125	I-126	I-127	I-128	I-129	I-130	I-131	I-132	I-133	I-134	I-135	I-136	I-137	I-138	I-139	I-140	I-141	I-142	I-143	I-144	I-145	I-146	I-147	I-148	I-149	I-150	I-151	I-152	I-153	I-154	I-155	I-156	I-157	I-158	I-159	I-160	I-161	I-162	I-163	I-164	I-165	I-166	I-167	I-168	I-169	I-170	I-171	I-172	I-173	I-174	I-175	I-176	I-177	I-178	I-179	I-180	I-181	I-182	I-183	I-184	I-185	I-186	I-187	I-188	I-189	I-190	I-191	I-192	I-193	I-194	I-195	I-196	I-197	I-198	I-199	I-200	I-201	I-202	I-203	I-204	I-205	I-206	I-207	I-208	I-209	I-210	I-211	I-212	I-213	I-214	I-215	I-216	I-217	I-218	I-219	I-220	I-221	I-222	I-223	I-224	I-225	I-226	I-227	I-228	I-229	I-230	I-231	I-232	I-233	I-234	I-235	I-236	I-237	I-238	I-239	I-240	I-241	I-242	I-243	I-244	I-245	I-246	I-247	I-248	I-249	I-250	I-251	I-252	I-253	I-254	I-255	I-256	I-257	I-258	I-259	I-260	I-261	I-262	I-263	I-264	I-265	I-266	I-267	I-268	I-269	I-270	I-271	I-272	I-273	I-274	I-275	I-276	I-277	I-278	I-279	I-280	I-281	I-282	I-283	I-284	I-285	I-286	I-287	I-288	I-289	I-290	I-291	I-292	I-293	I-294	I-295	I-296	I-297	I-298	I-299	I-300	I-301	I-302	I-303	I-304	I-305	I-306	I-307	I-308	I-309	I-310	I-311	I-312	I-313	I-314	I-315	I-316	I-317	I-318	I-319	I-320	I-321	I-322	I-323	I-324	I-325	I-326	I-327	I-328	I-329	I-330	I-331	I-332	I-333	I-334	I-335	I-336	I-337	I-338	I-339	I-340	I-341	I-342	I-343	I-344	I-345	I-346	I-347	I-348	I-349	I-350	I-351	I-352	I-353	I-354	I-355	I-356	I-357	I-358	I-359	I-360	I-361	I-362	I-363	I-364	I-365	I-366	I-367	I-368	I-369	I-370	I-371	I-372	I-373	I-374	I-375	I-376	I-377	I-378	I-379	I-380	I-381	I-382	I-383	I-384	I-385	I-386	I-387	I-388	I-389	I-390	I-391	I-392	I-393	I-394	I-395	I-396	I-397	I-398	I-399	I-400	I-401	I-402	I-403	I-404	I-405	I-406	I-407	I-408	I-409	I-410	I-411	I-412	I-413	I-414	I-415	I-416	I-417	I-418	I-419	I-420	I-421	I-422	I-423	I-424	I-425	I-426	I-427	I-428	I-429	I-430	I-431	I-432	I-433	I-434	I-435	I-436	I-437	I-438	I-439	I-440	I-441	I-442	I-443	I-444	I-445	I-446	I-447	I-448	I-449	I-450	I-451	I-452	I-453	I-454	I-455	I-456	I-457	I-458	I-459	I-460	I-461	I-462	I-463	I-464	I-465	I-466	I-467	I-468	I-469	I-470	I-471	I-472	I-473	I-474	I-475	I-476	I-477	I-478	I-479	I-480	I-481	I-482	I-483	I-484	I-485	I-486	I-487	I-488	I-489	I-490	I-491	I-492	I-493	I-494	I-495	I-496	I-497	I-498	I-499	I-500	I-501	I-502	I-503	I-504	I-505	I-506	I-507	I-508	I-509	I-510	I-511	I-512	I-513	I-514	I-515	I-516	I-517	I-518	I-519	I-520	I-521	I-522	I-523	I-524	I-525	I-526	I-527	I-528	I-529	I-530	I-531	I-532	I-533	I-534	I-535	I-536	I-537	I-538	I-539	I-540	I-541	I-542	I-543	I-544	I-545	I-546	I-547	I-548	I-549	I-550	I-551	I-552	I-553	I-554	I-555	I-556	I-557	I-558	I-559	I-560	I-561	I-562	I-563	I-564	I-565	I-566	I-567	I-568	I-569	I-570	I-571	I-572	I-573	I-574	I-575	I-576	I-577	I-578	I-579	I-580	I-581	I-582	I-583	I-584	I-585	I-586	I-587	I-588	I-589	I-590	I-591	I-592	I-593	I-594	I-595	I-596	I-597	I-598	I-599	I-600	I-601	I-602	I-603	I-604	I-605	I-606	I-607	I-608	I-609	I-610	I-611	I-612	I-613	I-614	I-615	I-616	I-617	I-618	I-619	I-620	I-621	I-622	I-623	I-624	I-625	I-626	I-627	I-628	I-629	I-630	I-631	I-632	I-633	I-634	I-635	I-636	I-637	I-638	I-639	I-640	I-641	I-642	I-643	I-644	I-645	I-646	I-647	I-648	I-649	I-650	I-651	I-652	I-653	I-654	I-655	I-656	I-657	I-658	I-659	I-660	I-661	I-662	I-663	I-664	I-665	I-666	I-667	I-668	I-669	I-670	I-671	I-672	I-673	I-674	I-675	I-676	I-677	I-678	I-679	I-680	I-681	I-682	I-683	I-684	I-685	I-686	I-687	I-688	I-689	I-690	I-691	I-692	I-693	I-694	I-695	I-696	I-697	I-698	I-699	I-700	I-701	I-702	I-703	I-704	I-705	I-706	I-707	I-708	I-709	I-710	I-711	I-712	I-713	I-714	I-715	I-716	I-717	I-718	I-719	I-720	I-721	I-722	I-723	I-724	I-725	I-726	I-727	I-728	I-729	I-730	I-731	I-732	I-733	I-734	I-735	I-736	I-737	I-738	I-739	I-740	I-741	I-742	I-743	I-744	I-745	I-746	I-747	I-748	I-749	I-750	I-751	I-752	I-753	I-754	I-755	I-756	I-757	I-758	I-759	I-760	I-761	I-762	I-763	I-764	I-765	I-766	I-767	I-768	I-769	I-770	I-771	I-772	I-773	I-774	I-775	I-776	I-777	I-778	I-779	I-780	I-781	I-782	I-783	I-784	I-785	I-786	I-787	I-788	I-789	I-790	I-791	I-792	I-793	I-794	I-795	I-796	I-797	I-798	I-799	I-800	I-801	I-802	I-803	I-804	I-805	I-806	I-807	I-808	I-809	I-810	I-811	I-812	I-813	I-814	I-815	I-816	I-817	I-818	I-819	I-820	I-821	I-822	I-823	I-824	I-825	I-826	I-827	I-828	I-829	I-830	I-831	I-832	I-833	I-834	I-835	I-836	I-837	I-838	I-839	I-840	I-841	I-842	I-843	I-844	I-845	I-846	I-847	I-848	I-849	I-850	I-851	I-852	I-853	I-854	I-855	I-856	I-857	I-858	I-859	I-860	I-861	I-862	I-863	I-864	I-865	I-866	I-867	I-868	I-869	I-870	I-871	I-872	I-873	I-874	I-875	I-876	I-877	I-878	I-879	I-880	I-881	I-882	I-883	I-884	I-885	I-886	I-887	I-888	I-889	I-890	I-891	I-892	I-893	I-894	I-895	I-896	I-897	I-898	I-899	I-900	I-901	I-902	I-903	I-904	I-905	I-906	I-907	I-908	I-909	I-910	I-911	I-912	I-913	I-914	I-915	I-916	I-917	I-918	I-919	I-920	I-921	I-922	I-923	I-924	I-925	I-926	I-927	I-928	I-929	I-930	I-931	I-932	I-933	I-934	I-935	I-936	I-937	I-938	I-939	I-940	I-941	I-942	I-943	I-944	I-945	I-946	I-947	I-948	I-949	I-950	I-951	I-952	I-953	I-954	I-955	I-956	I-957	I-958	I-959	I-960	I-961	I-962	I-963	I-964	I-965	I-966	I-967	I-968	I-969	I-970	I-971	I-972	I-973	I-974	I-975	I-976	I-977	I-978	I-979	I-980	I-981	I-982	I-983	I-984	I-985	I-986	I-987	I-988	I-989	I-990	I-991	I-992	I-993	I-994	I-995	I-996	I-997	I-998	I-999	I-1000	I-1001	I-1002	I-1003	I-1004	I-1005	I-1006	I-1007	I-1008	I-1009	I-1010	I-1011	I-1012	I-1013	I-1014	I-1015	I-1016	I-1017	I-1018	I-1019	I-1020	I-1021	I-1022	I-1023	I-1024	I-1025	I-1026	I-1027	I-1028	I-1029	I-1030	I-1031	I-1032	I-1033	I-1034	I-1035	I-1036	I-1037	I-1038	I-1039	I-1040	I-1041	I-1042	I-1043	I-1044	I-1045	I-1046	I-1047	I-1048	I-1049	I-1050	I-1051	I-1052	I-1053	I-1054	I-1055	I-1056	I-1057	I-1058	I-1059	I-1060	I-1061	I-1062	I-1063	I-1064	I-1065	I-1066	I-1067	I-1068	I-1069	I-1070	I-1071	I-1072	I-1073	I-1074	I-1075	I-1076	I-1077	I-1078	I-1079	I-1080	I-1081	I-1082	I-1083	I-1084	I-1085	I-1086	I-1087	I-1088	I-1089	I-1090	I-1091	I-1092	I-1093	I-1094	I-1095	I-1096	I-1097	I-1098	I-1099	I-1100	I-1101	I-1102	I-1103	I-1104	I-1105	I-1106	I-1107	I-1108	I-1109	I-1110	I-1111	I-1112	I-1113	I-1114	I-1115	I-1116	I-1117	I-1118	I-1119	I-1120	I-1121	I-1122	I-1123	I-1124	I-1125	I-1126	I-1127	I-1128	I-1129	I-1130	I-1131	I-1132	I-1133	I-1134	I-1135	I-1136	I-1137	I-1138	I-1139	I-1140	I-1141	I-1142	I-1143	I-1144	I-1145	I-1146	I-1147	I-1148	I-1149	I-1150	I-1151	I-1152	I-1153	I-1154	I-1155	I-1156	I-1157	I-1158	I-1159	I-1160	I-1161	I-1162	I-1163	I-1164	I-1165	I-1166	I-1167	I-1168	I-1169	I-1170	I-1171	I-1172	I-1173	I-1174	I-1175	I-1176	I-1177	I-1178	I-1179	I-1180	I-1181	I-1182	I-1183	I-1184	I-1185	I-1186	I-1187	I-1188	I-1189	I-1190	I-1191	I-1192	I-1193	I-1194	I-1195	I-1196	I-1197	I-1198	I-1199	I-1200	I-1201	I-1202	I-1203	I-1204	I-1205	I-1206	I-1207	I-1208	I-1209	I-1210	I-1211	I-1212	I-1213	I-1214	I-1215	I-1216	I-1217	I-1218	I-1219	I-1220	I-1221	I-1222	I-1223	I-1224	I-1225	I-1226	I-1227	I-1228	I-1229	I-1230	I-1231	I-1232	I-1233	I-1234	I-1235	I-1236	I-1237	I-1238	I-1239	I-1240	I-1241	I-1242	I-1243	I-1244	I-1245	I-1246	I-1247	I-1248	I-1249	I-1250	I-1251	I-1252	I-1253	I-1254	I-1255	I-1256	I-1257	I-1258	I-1259	I-1260	I-1261	I-1262	I-1263	I-1264	I-1265	I-1266	I-1267	I-1268	I-1269	I-1270	I-1271	I-1272	I-1273	I-1274	I-1275	I-1276	I-1277	I-1278	I-1279	I-1280	I-1281	I-1282	I-1283	I-1284	I-1285	I-1286	I-1287	I-1288	I-1289	I-1290	I-1291	I-1292	I-1293	I-1294	I-1295	I-1296	I-1297	I-1298	I-1299	I-1300	I-1301	I-1302	I-1303	I-1304	I-1305	I-1306	I-1307	I-1308	I-1309	I-1310	I-1311	I-1312	I-1313	I-1314	I-1315	I-1316	I-1317	I-1318	I-1319	I-1320	I-1321	I-1322	I-1323	I-1324	I-1325	I-1326	I-1327	I-1328	I-1329	I-1330	I-1331	I-1332	I-1333	I-1334	I-1335	I-1336	I-1337	I-1338	I-1339	I-1340	I-1341	I-1342	I-1343	I-1344	I-1345	I-1346	I-1347	I-1348	I-1349	I-1350	I-1351	I-1352	I-13
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DISTRIBUTION OF INCIDENTS

7. HUMAN STATION

INCIDENTS

31 INCIDENTS INCLUDED, 4.941 & OF ALL INCIDENTS

X = YEAR OF INCIDENTS

Y = TOTAL INCIDENTS

	167	168	169	170	171	172	173	174	175	176	177	178	179	180	TOTAL	1
00	1	1	1	3			1	1	1	3	20	47			94	90.325
	1	1	4			1	1	1	1	3	20	47				
	1	1	4			1	1	1	1	3	20	47				
01											2	2			5	5.275
											2	2				
											2	2				
02											1	2			3	3.246
											1	2				
											1	2				
07											1				1	1.075
											1					
											1					
TOTAL	1	1	2			1	1	1	3	3	51					
9	1.1	1.1	3.2			1.1	1.1	1.1	3.2	3.3	54.8					



# DISCLAIMER FOR ACCURACY

1 INCIDENTS INCLUDED, 0.054 & UP ALL INCIDENTS

# Summary

X = Y(AU) = 14105715  
Y = TOTAL INJURY

Y = TCTC; Inv:R 1:5

	67	68	69	70	71	72	73	74	75	76	77	78	79	TOTAL
00										1				1
									39					100.000
									99					
70151									1					
									134.91					

LISTED BY AGE OCCUPANCY / RESIDENTS  
 1. INCORPORATED INCLUDING 00001 1 OF ALL INCIDENTS  
 X = YEARS OF INCIDENTS  
 Y = TOTAL INCIDENTS

	157	159	160	170	172	173	174	175	176	177	178	179	
1	1	1	1	1	1	1	1	1	1	1	1	1	
2	1	1	1	1	1	1	1	1	1	1	1	1	
3	1	1	1	1	1	1	1	1	1	1	1	1	
4	1	1	1	1	1	1	1	1	1	1	1	1	
5	1	1	1	1	1	1	1	1	1	1	1	1	
6	1	1	1	1	1	1	1	1	1	1	1	1	
7	1	1	1	1	1	1	1	1	1	1	1	1	
8	1	1	1	1	1	1	1	1	1	1	1	1	
9	1	1	1	1	1	1	1	1	1	1	1	1	
10	1	1	1	1	1	1	1	1	1	1	1	1	
11	1	1	1	1	1	1	1	1	1	1	1	1	
12	1	1	1	1	1	1	1	1	1	1	1	1	
13	1	1	1	1	1	1	1	1	1	1	1	1	
14	1	1	1	1	1	1	1	1	1	1	1	1	
15	1	1	1	1	1	1	1	1	1	1	1	1	
16	1	1	1	1	1	1	1	1	1	1	1	1	
17	1	1	1	1	1	1	1	1	1	1	1	1	
18	1	1	1	1	1	1	1	1	1	1	1	1	
19	1	1	1	1	1	1	1	1	1	1	1	1	
20	1	1	1	1	1	1	1	1	1	1	1	1	
21	1	1	1	1	1	1	1	1	1	1	1	1	
22	1	1	1	1	1	1	1	1	1	1	1	1	
23	1	1	1	1	1	1	1	1	1	1	1	1	
24	1	1	1	1	1	1	1	1	1	1	1	1	
25	1	1	1	1	1	1	1	1	1	1	1	1	
26	1	1	1	1	1	1	1	1	1	1	1	1	
27	1	1	1	1	1	1	1	1	1	1	1	1	
28	1	1	1	1	1	1	1	1	1	1	1	1	
29	1	1	1	1	1	1	1	1	1	1	1	1	
30	1	1	1	1	1	1	1	1	1	1	1	1	
31	1	1	1	1	1	1	1	1	1	1	1	1	
32	1	1	1	1	1	1	1	1	1	1	1	1	
33	1	1	1	1	1	1	1	1	1	1	1	1	
34	1	1	1	1	1	1	1	1	1	1	1	1	
35	1	1	1	1	1	1	1	1	1	1	1	1	
36	1	1	1	1	1	1	1	1	1	1	1	1	
37	1	1	1	1	1	1	1	1	1	1	1	1	
38	1	1	1	1	1	1	1	1	1	1	1	1	
39	1	1	1	1	1	1	1	1	1	1	1	1	
40	1	1	1	1	1	1	1	1	1	1	1	1	
41	1	1	1	1	1	1	1	1	1	1	1	1	
42	1	1	1	1	1	1	1	1	1	1	1	1	
43	1	1	1	1	1	1	1	1	1	1	1	1	
44	1	1	1	1	1	1	1	1	1	1	1	1	
45	1	1	1	1	1	1	1	1	1	1	1	1	
46	1	1	1	1	1	1	1	1	1	1	1	1	
47	1	1	1	1	1	1	1	1	1	1	1	1	
48	1	1	1	1	1	1	1	1	1	1	1	1	
49	1	1	1	1	1	1	1	1	1	1	1	1	
50	1	1	1	1	1	1	1	1	1	1	1	1	
51	1	1	1	1	1	1	1	1	1	1	1	1	
52	1	1	1	1	1	1	1	1	1	1	1	1	
53	1	1	1	1	1	1	1	1	1	1	1	1	
54	1	1	1	1	1	1	1	1	1	1	1	1	
55	1	1	1	1	1	1	1	1	1	1	1	1	
56	1	1	1	1	1	1	1	1	1	1	1	1	
57	1	1	1	1	1	1	1	1	1	1	1	1	
58	1	1	1	1	1	1	1	1	1	1	1	1	
59	1	1	1	1	1	1	1	1	1	1	1	1	
60	1	1	1	1	1	1	1	1	1	1	1	1	
61	1	1	1	1	1	1	1	1	1	1	1	1	
62	1	1	1	1	1	1	1	1	1	1	1	1	
63	1	1	1	1	1	1	1	1	1	1	1	1	
64	1	1	1	1	1	1	1	1	1	1	1	1	
65	1	1	1	1	1	1	1	1	1	1	1	1	
66	1	1	1	1	1	1	1	1	1	1	1	1	
67	1	1	1	1	1	1	1	1	1	1	1	1	
68	1	1	1	1	1	1	1	1	1	1	1	1	
69	1	1	1	1	1	1	1	1	1	1	1	1	
70	1	1	1	1	1	1	1	1	1	1	1	1	
71	1	1	1	1	1	1	1	1	1	1	1	1	
72	1	1	1	1	1	1	1	1	1	1	1	1	
73	1	1	1	1	1	1	1	1	1	1	1	1	
74	1	1	1	1	1	1	1	1	1	1	1	1	
75	1	1	1	1	1	1	1	1	1	1	1	1	
76	1	1	1	1	1	1	1	1	1	1	1	1	
77	1	1	1	1	1	1	1	1	1	1	1	1	
78	1	1	1	1	1	1	1	1	1	1	1	1	
79	1	1	1	1	1	1	1	1	1	1	1	1	
80	1	1	1	1	1	1	1	1	1	1	1	1	
81	1	1	1	1	1	1	1	1	1	1	1	1	
82	1	1	1	1	1	1	1	1	1	1	1	1	
83	1	1	1	1	1	1	1	1	1	1	1	1	
84	1	1	1	1	1	1	1	1	1	1	1	1	
85	1	1	1	1	1	1	1	1	1	1	1	1	
86	1	1	1	1	1	1	1	1	1	1	1	1	
87	1	1	1	1	1	1	1	1	1	1	1	1	
88	1	1	1	1	1	1	1	1	1	1	1	1	
89	1	1	1	1	1	1	1	1	1	1	1	1	
90	1	1	1	1	1	1	1	1	1	1	1	1	
91	1	1	1	1	1	1	1	1	1	1	1	1	
92	1	1	1	1	1	1	1	1	1	1	1	1	
93	1	1	1	1	1	1	1	1	1	1	1	1	
94	1	1	1	1	1	1	1	1	1	1	1	1	
95	1	1	1	1	1	1	1	1	1	1	1	1	
96	1	1	1	1	1	1	1	1	1	1	1	1	
97	1	1	1	1	1	1	1	1	1	1	1	1	
98	1	1	1	1	1	1	1	1	1	1	1	1	
99	1	1	1	1	1	1	1	1	1	1	1	1	
100	1	1	1	1	1	1	1	1	1	1	1	1	
TOTAL	1	1	1	1	1	1	1	1	1	1	1	1	1











SECRET  
ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 07-18-2006 BY 60322 UCBAW

# SALE, 30.1.2011

$$x = y^{\frac{1}{2}} \text{ or } \log x = \frac{1}{2} \log y$$
$$Y = Y^* + Y^{\Delta}$$
[illegible]



[illegible]

DISTRICT 1000 OCCUPANCY / 24-HOUR EXTRACTION SITE INCIDENTS  
200 INCIDENTS INCLUDED, 10/1/12 & ON ALL INCIDENTS

$$Y = Y_{\text{TOTAL}} - \text{TOTAL ITIFS}$$
[illegible]

TOTAL NUMBER OF OBSERVATIONS / 250000  
 TOTAL NUMBER OF OBSERVATIONS / 250000  
 TOTAL NUMBER OF OBSERVATIONS / 250000  
 TOTAL NUMBER OF OBSERVATIONS / 250000

	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	1151	1152	1153	1154	1155	1156	1157	1158	1159	1160	1161	1162	1163	1164	1165	1166	1167	1168	1169	1170	1171	1172	1173	1174	1175	1176	1177	1178	1179	1180	1181	1182	1183	1184	1185	1186	1187	1188	1189	1190	1191	1192	1193	1194	1195	1196	1197	1198	1199	1200	1201	1202	1203	1204	1205	1206	1207	1208	1209	1210	1211	1212	1213	1214	1215	1216	1217	1218	1219	1220	1221	1222	1223	1224	1225	1226	1227	1228	1229	1230	1231	1232	1233	1234	1235	1236	1237	1238	1239	1240	1241	1242	1243	1244	1245	1246	1247	1248	1249	1250	1251	1252	1253	1254	1255	1256	1257	1258	1259	1260	1261	1262	1263	1264	1265	1266	1267	1268	1269	1270	1271	1272	1273	1274	1275	1276	1277	1278	1279	1280	1281	1282	1283	1284	1285	1286	1287	1288	1289	1290	1291	1292	1293	1294	1295	1296	1297	1298	1299	1300	1301	1302	1303	1304	1305	1306	1307	1308	1309	1310	1311	1312	1313	1314	1315	1316	1317	1318	1319	1320	1321	1322	1323	1324	1325	1326	1327	1328	1329	1330	1331	1332	13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CUSTOMER FOR OCCUPANCY / CHEMICAL PLANT INCIDENTS  
75 INCIDENTS INCLUDING 40231 OF ALL INCIDENTS

X = YEARS OF INCIDENTS  
Y = TOTAL INCIDENTS

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	Y
1						21	1	41	21	17	22	28		75	54,937
2					2	1	12	3	13	12	17		1		
3					99	99	99	99	77	99	99	99			
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	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	F
10														1	•205
11														1	•205
12														1	•205
13														2	•410
TOTAL															

SYSTEMS IN EPP OCCUPANCY / LIGHT HYDROCARBON PROC PLANT INCIDENTS  
 INCIDENTS INCLUDED, 0.000 % OF ALL INCIDENTS





DISTRIBUTION BY OCCUPANCY / BUILDING CODE

1. OCCUPANCIES INCLUDE: 0.000000 OF ALL OCCUPANCIES

X = VALUE OF OCCUPANCIES

Y = TOTAL OCCUPANCIES

	167	168	169	170	171	172	173	174	175	176	177	178	179	180	1	TOTAL	2
00	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	100.000
TOTAL	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	100.000
0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	100.000



CONFIDENTIAL (U) 5010-108(3)-00101004

DISTRIBUTION BY OCCUPANCY / PERCENT DISTRIBUTION BY INCLUSIONS

X = YEAR OF INCIDENTS  
Y = TOTAL TALLIES

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	%
1															
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100															

DISTRIBUTION BY OCCUPANCY / POSSESSIONS PER AREA / INCIDENTS

X = YEAR OF INCIDENTS  
Y = TOTAL POPULATION

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	%
1	1	1	1	1	1	1	1	1	1	1	1	1	1	12	90.000
2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
3	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
4	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
5	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
6	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
7	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
8	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
9	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
10	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
11	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
12	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
13	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
14	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
15	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
16	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
17	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
18	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
19	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
20	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
21	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
22	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
23	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
24	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
25	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
26	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
27	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
28	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
29	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
30	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
31	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
32	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
33	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
34	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
35	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
36	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
37	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
38	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
39	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
40	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
41	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
42	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
43	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
44	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
45	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
46	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
47	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
48	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
49	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
50	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
51	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
52	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
53	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
54	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
55	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
56	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
57	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
58	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
59	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
60	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
61	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
62	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
63	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
64	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
65	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
66	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
67	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
68	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
69	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
70	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
71	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
72	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
73	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
74	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
75	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
76	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
77	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
78	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
79	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
80	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
81	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
82	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
83	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
84	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
85	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
86	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
87	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
88	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
89	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
90	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
91	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
92	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
93	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
94	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
95	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
96	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
97	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
98	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
99	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
100	1	1	1	1	1	1	1	1	1	1	1	1	1	1	



INCIDENTS

7 010 110

DISTRIBUTION FOR OCCURRENCE

26 INCIDENTS INCLUDING 1,593 & OF ALL INCIDENTS

X = YEAR OF INCIDENTS  
Y = TOTAL CAPACITIES

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	7
00														20	76,923
							135	71		11	6				
							99	99	99	55					
01														7	7,672
								150			150				
								99							
02														1	3,846
03														1	2,110
11														1	3,846
12														1	3,846
TOTAL								71	11	11	6	11			
7								120.71	3.81	3.812	11.2.5				

DISTRIBUTION FOR ACCIDENTS  
 16 INCIDENTS INCLUDED, 0.0007 1.00 ALL INCIDENTS

X = YEAR OF INCIDENTS  
 Y = TOTAL FATALITIES

	167	168	169	170	171	172	173	174	175	176	177	178	179	180	TOTAL	%
00							71				11	71			151	93.750
						147				7	147					
							281				991	991				
00															1	5.250
							11									
							193									
							141									
10-41											11	71				
							150.01				1.5143.81					

INSTRUCTIONS

1. THE FOLLOWING INFORMATION IS FOR YOUR INFORMATION ONLY. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE.

2. THE TOTAL OF THE FOLLOWING IS 100.

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	%
10	1	1	1	1	2	1	1	1	1	3	1	2	1	18	94.757
11	6	1	1	1	17	1	13	1	17	17	11	1	1		
12	1	1	1	1	1	1	1	1	1	1	1	1	1		
13	1	1	1	1	1	1	1	1	1	1	1	1	1		
14	1	1	1	1	1	1	1	1	1	1	1	1	1	1	5.243
15	1	1	1	1	1	1	1	1	1	1	1	1	1		
16	1	1	1	1	1	1	1	1	1	1	1	1	1		
17	1	1	1	1	1	1	1	1	1	1	1	1	1		
18	1	1	1	1	1	1	1	1	1	1	1	1	1		
19	1	1	1	1	1	1	1	1	1	1	1	1	1		
20	1	1	1	1	1	1	1	1	1	1	1	1	1		
21	1	1	1	1	1	1	1	1	1	1	1	1	1		
22	1	1	1	1	1	1	1	1	1	1	1	1	1		
23	1	1	1	1	1	1	1	1	1	1	1	1	1		
24	1	1	1	1	1	1	1	1	1	1	1	1	1		
25	1	1	1	1	1	1	1	1	1	1	1	1	1		
26	1	1	1	1	1	1	1	1	1	1	1	1	1		
27	1	1	1	1	1	1	1	1	1	1	1	1	1		
28	1	1	1	1	1	1	1	1	1	1	1	1	1		
29	1	1	1	1	1	1	1	1	1	1	1	1	1		
30	1	1	1	1	1	1	1	1	1	1	1	1	1		
31	1	1	1	1	1	1	1	1	1	1	1	1	1		
32	1	1	1	1	1	1	1	1	1	1	1	1	1		
33	1	1	1	1	1	1	1	1	1	1	1	1	1		
34	1	1	1	1	1	1	1	1	1	1	1	1	1		
35	1	1	1	1	1	1	1	1	1	1	1	1	1		
36	1	1	1	1	1	1	1	1	1	1	1	1	1		
37	1	1	1	1	1	1	1	1	1	1	1	1	1		
38	1	1	1	1	1	1	1	1	1	1	1	1	1		
39	1	1	1	1	1	1	1	1	1	1	1	1	1		
40	1	1	1	1	1	1	1	1	1	1	1	1	1		
41	1	1	1	1	1	1	1	1	1	1	1	1	1		
42	1	1	1	1	1	1	1	1	1	1	1	1	1		
43	1	1	1	1	1	1	1	1	1	1	1	1	1		
44	1	1	1	1	1	1	1	1	1	1	1	1	1		
45	1	1	1	1	1	1	1	1	1	1	1	1	1		
46	1	1	1	1	1	1	1	1	1	1	1	1	1		
47	1	1	1	1	1	1	1	1	1	1	1	1	1		
48	1	1	1	1	1	1	1	1	1	1	1	1	1		
49	1	1	1	1	1	1	1	1	1	1	1	1	1		
50	1	1	1	1	1	1	1	1	1	1	1	1	1		
51	1	1	1	1	1	1	1	1	1	1	1	1	1		
52	1	1	1	1	1	1	1	1	1	1	1	1	1		
53	1	1	1	1	1	1	1	1	1	1	1	1	1		
54	1	1	1	1	1	1	1	1	1	1	1	1	1		
55	1	1	1	1	1	1	1	1	1	1	1	1	1		
56	1	1	1	1	1	1	1	1	1	1	1	1	1		
57	1	1	1	1	1	1	1	1	1	1	1	1	1		
58	1	1	1	1	1	1	1	1	1	1	1	1	1		
59	1	1	1	1	1	1	1	1	1	1	1	1	1		
60	1	1	1	1	1	1	1	1	1	1	1	1	1		
61	1	1	1	1	1	1	1	1	1	1	1	1	1		
62	1	1	1	1	1	1	1	1	1	1	1	1	1		
63	1	1	1	1	1	1	1	1	1	1	1	1	1		
64	1	1	1	1	1	1	1	1	1	1	1	1	1		
65	1	1	1	1	1	1	1	1	1	1	1	1	1		
66	1	1	1	1	1	1	1	1	1	1	1	1	1		
67	1	1	1	1	1	1	1	1	1	1	1	1	1		
68	1	1	1	1	1	1	1	1	1	1	1	1	1		
69	1	1	1	1	1	1	1	1	1	1	1	1	1		
70	1	1	1	1	1	1	1	1	1	1	1	1	1		
71	1	1	1	1	1	1	1	1	1	1	1	1	1		
72	1	1	1	1	1	1	1	1	1	1	1	1	1		
73	1	1	1	1	1	1	1	1	1	1	1	1	1		
74	1	1	1	1	1	1	1	1	1	1	1	1	1		
75	1	1	1	1	1	1	1	1	1	1	1	1	1		
76	1	1	1	1	1	1	1	1	1	1	1	1	1		
77	1	1	1	1	1	1	1	1	1	1	1	1	1		
78	1	1	1	1	1	1	1	1	1	1	1	1	1		
79	1	1	1	1	1	1	1	1	1	1	1	1	1		
80	1	1	1	1	1	1	1	1	1	1	1	1	1		
81	1	1	1	1	1	1	1	1	1	1	1	1	1		
82	1	1	1	1	1	1	1	1	1	1	1	1	1		
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86	1	1	1	1	1	1	1	1	1	1	1	1	1		
87	1	1	1	1	1	1	1	1	1	1	1	1	1		
88	1	1	1	1	1	1	1	1	1	1	1	1	1		
89	1	1	1	1	1	1	1	1	1	1	1	1	1		
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92	1	1	1	1	1	1	1	1	1	1	1	1	1		
93	1	1	1	1	1	1	1	1	1	1	1	1	1		
94	1	1	1	1	1	1	1	1	1	1	1	1	1		
95	1	1	1	1	1	1	1	1	1	1	1	1	1		
96	1	1	1	1	1	1	1	1	1	1	1	1	1		
97	1	1	1	1	1	1	1	1	1	1	1	1	1		
98	1	1	1	1	1	1	1	1	1	1	1	1	1		
99	1	1	1	1	1	1	1	1	1	1	1	1	1		
100	1	1	1	1	1	1	1	1	1	1	1	1	1		



CONFIDENTIAL - 242-51940A

SAVEDUJIT THAKUR, *Department of Mathematics, University of Calicut, P.O. Box 24, Calicut, Kerala 674 345, India*

SAVED BY THE LORD FROM DEATH

$$X = \text{YEAR OF INCIDENTS}$$

Y = YCT + AYALITIS

[illegible]

CONTINUING FOR ENCLOSURE

ENCLOSURES INCLUDED, 0.05% OF ALL ENCLOSURES

X = YES IN ENCLOSURES

Y = TOTAL ENCLOSURES

ENCLOSURES

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	%
1															
2															
3															
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DISTRIBUTION BY OCCUPANCY / STATUS / INCIDENTS  
 130 INCIDENTS INCLUDING, 7,330, 4 OF ALL INCIDENTS

X = VALUE OF INCIDENTS  
 Y = TOTAL FATALITIES

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	X
00	1	5	7	5	23	9	22	29	22				1	129	93.475
01	1	4	5	4	13	6	17	22	13				1		
02	1	5	9	9	31	31	31	31	42				1		
03	1	1	1	1	1	1	1	1	1				1	4	2.375
04	1	1	1	1	1	1	1	1	1				1		
05	1	1	1	1	1	1	1	1	1				1	2	1.375
06	1	1	1	1	1	1	1	1	1				1	1	0.725
07	1	1	1	1	1	1	1	1	1				1	1	0.707
08	1	1	1	1	1	1	1	1	1				1	1	0.725
TOTAL	11	51	51	71	51	261	91	231	231	24	1	1	1		
X	.71	3.61	5.41	3.61	10.81	5.31	7.12	2.17	.71	.71	.71	.71	.71		

INCIDENTS

7 TERMINAL

DISTRIBUTION FOR OCCUPANCY

13 INCIDENTS INCLUDED, 0.000 % OF ALL INCIDENTS

X = YEAR OF INCIDENTS

Y = TOTAL FATALITIES

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	%
0														11	54.015
1														1	7.672
2														1	7.672



	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	Σ
	1	1	1	1	1	1	1	1	1	1	1	1	1		
TOTAL	1	1	1	1	1	1	1	1	1	1	1	1	1		
	1	1	1	1	1	1	1	1	1	1	1	1	1		
6	.51	.51	.51	3.31	2.71	1.11	2.71	14.31	17.51	131.11	125.11				

SINCE JANUARY 1978, THE ADVANCEMENT OF TECHNOLOGY & INNOVATION BOARD HAS BEEN ADOPTED BY THE SECRETARIAT FOR THE ADMINISTRATION OF THE GOVERNMENT OF INDIA.

2 INCIDENTS INCLUDED, JULY 3 OF ALL INCIDENTS

SINGLE COPY  
X = Y + V OF X

# Y = TOTAL FATALITIES

[illegible]



## SLAUGHTERS

CG1-17-0511 /

# ANALYTICAL CHEMISTRY

231 INCHES INCLUDING, 21.02 OF ALL INCIDENTS

SECTION JK-22A-X

Y = TOTAL FATALITIES

[illegible]

1 - DISTRICT/UNIT FOR OCCUPANCY / ON-SHORE EXTRACTION SITE INCIDENTS  
 200 INCIDENTS INCLUDED, 10-712 & OF ALL INCIDENTS

X = YEAR OF INCIDENTS  
 Y = INFORMATION SOURCE

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	Σ
1-3					2						3	1		6	3,000
				32						15	17				
				59						6	11				
4-6					100	50								2	1,000
					99	99									
7-9							29	3	2	40	73			192	95,000
							25	2	1	124	30				
							99	99	99	64	39				
TOTAL					3	11	63	3	2	99	74				
Σ					1.00	.50	.5133.00	1.50	1.0124.5137.00						

DISTRIBUTION FOR OCCURRENCE  
242 INCIDENTS INCLUDING 12,000 2 OF ALL INCIDENTS

X = YEAR OF INCIDENTS  
Y = INFORMATION SOURCE

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	2
001														218	90,000
002															
003														22	9,000
004															
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STATEMENT OF RECEIPTS AND DISBURSEMENTS FOR THE FISCAL YEAR 1960

STATE OF TEXAS

	167	168	169	170	171	172	173	174	175	176	177	178	TOTAL
RECEIPTS													
1. TAXES													2,532
2. FEES													
3. GIFTS													
4. OTHER													
TOTAL													2,532
DISBURSEMENTS													
1. SALARIES													85,544
2. FRINGE BENEFITS													
3. TRAVEL													
4. TELEPHONE													
5. POSTAGE													
6. SUPPLIES													
7. REPAIRS													
8. DEPRECIATION													
9. OTHER													
TOTAL													85,544
REVENUE													
1. TAXES													7,545
2. FEES													
3. GIFTS													
4. OTHER													
TOTAL													7,545
EXPENDITURES													
1. SALARIES													1,200
2. FRINGE BENEFITS													
3. TRAVEL													
4. TELEPHONE													
5. POSTAGE													
6. SUPPLIES													
7. REPAIRS													
8. DEPRECIATION													
9. OTHER													
TOTAL													1,200
REVENUE													
1. TAXES													3,797
2. FEES													
3. GIFTS													
4. OTHER													
TOTAL													3,797
EXPENDITURES													
1. SALARIES													
2. FRINGE BENEFITS													
3. TRAVEL													
4. TELEPHONE													
5. POSTAGE													
6. SUPPLIES													
7. REPAIRS													
8. DEPRECIATION													
9. OTHER													
TOTAL													





14-00000-0014-000000000000 14-00000-0014-000000000000 14-00000-0014-000000000000

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	167	168	169	170	171	172	173	174	175	176	177	178	179	180	TOTAL	
1															2	3,774
2																
3																
4															4	7,547
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Students

4504-4-1616

1 INCIDENTS INCLUDED, 0.054 PER 1000 PERSONS PER YEAR

# SYNOPSIS

1.  $\text{H}_2\text{O}$  is a polar molecule.

[illegible]





DISTRIBUTION FOR OCCUPANCY

870 LWA/MNH-1130 / INCIDENTS

3 INCIDENTS INCLUDING 0.1018 OF ALL INCIDENTS

СЛУЖБА ЗА ЗАШТИТУ

$$J_{\text{eff}} = \frac{1}{2} \frac{1}{\omega} \frac{d\omega}{dt} = \frac{1}{2} \frac{1}{\omega} \frac{d\omega}{d\theta} \frac{d\theta}{dt}$$

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	Σ
1683															
							11								
						150			30					2	56.607
							391			39					
1682															
					11									1	53.332
					109										
					391										
TOTAL							11								
					155.3		153.31			153.31					

NUMBER OF POLYMERIZATION REACTIONS

PER POLYMERIZATION REACTION

X = NUMBER OF POLYMERIZATION REACTIONS

Y = NUMBER OF POLYMERIZATION REACTIONS

	127	128	129	130	131	132	133	134	135	136	137	138	139	TOTAL	
10.4														2	2.26
10.1	1	1	1	1	1	1	1	1	1	1	1	1	1	16	20.515
	1	1	1	1	1	1	1	1	1	1	1	1	1		
10.3														13	16.807
10.1														1	1.000
10.2														44	50.010
														2	2.56
TOTAL	11	11	11	11	11	11	11	11	11	11	11	11	11		
	1.23	1.23	1.23	1.23	1.23	1.23	1.23	1.23	1.23	1.23	1.23	1.23	1.23		

EMPLOYERS

EMPLOYING FACILITY

LISTED FOR DECLASSIFICATION

12 EMPLOYERS INCLUDED, 0.046 5 OF ALL EMPLOYERS

84 YEARS OF EMPLOYERS

84 INFORMATION SOURCE

	157	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	R
501	1	1	1	1	1	1	1	1	1	1	1	1	1	5	38,462
145	1	1	1	1	1	1	1	1	1	1	1	1	1		
158	1	1	1	1	1	1	1	1	1	1	1	1	1		
503	1	1	1	1	1	1	1	1	1	1	1	1	1	7	53,892
146	1	1	1	1	1	1	1	1	1	1	1	1	1		
159	1	1	1	1	1	1	1	1	1	1	1	1	1		
504	1	1	1	1	1	1	1	1	1	1	1	1	1	1	7,592
147	1	1	1	1	1	1	1	1	1	1	1	1	1		
160	1	1	1	1	1	1	1	1	1	1	1	1	1		
TOTAL	20	20	20	20	20	20	20	20	20	20	20	20	20		
13,44	1	1	1	1	1	1	1	1	1	1	1	1	1		

# INSTRUCTIONS

1. The first column is the sequence number of the observation.

2. The second column is the date of observation.

3. The third column is the time of observation.

4. The fourth column is the location of observation.

	167	168	169	170	171	172	173	174	175	176	177	178	TOTAL	\$
1													25	96.15
2														
3														
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STATION 1143 - 4000d Sample July 94  
 Station 1143 - 4000d Sample July 94  
 Station 1143 - 4000d Sample July 94

16 INCLOSURES REQUIRED, 0.007 : 44 ALL INCLUSIVE

$$X = Y \cdot A^{-1} = Y \cdot I \cdot Y^{-1}$$

Section 1.7.1.2 - 1

[illegible]

2025 RELEASE UNDER E.O. 14176

[illegible]

9 PARTISANS INCLUDE: 1.018 & 95 ALL INCIDENTS

# STANBOLLI és az új magyar irodalom

2. *Chilodactylus* = A

	127	128	129	170	171	172	173	174	175	176	177	178	179	TOTAL	4
1944						41	41	1		11	11			51	26,310
				130	120	99	120		120	120					
				501	99	171		331	331						
1945															
		11		1						11				31	15,790
	129			133					133						
	501			501					331						
1946															
								51	11	21	11	21			
				145			145	33	11	11	11				
							331	331	671	331	331	991			
TOTAL	11			21	11	11	11	11	11	31	31	21		111	57,895
	1,131			110,31	5,031	31,61	5,315	15,811	3,910	51					

INVESTMENT FOR ACCRUALS / BORROWING STATEMENTS / INCOME STATEMENTS

FOR YEAR OF INCURRING  
FOR INVESTMENT STATEMENTS

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	
NO														1	1.075
NO														12	12.902
NO														80	80.022
TOTAL															







DISPOSITIONAL ANALYSIS / STORES  
AND ENCLOSURES INCLUDING, 7-592 FOR ALL INCIDENTS

X = YES  
/ = NO  
/ = UNKNOWN

	167	168	169	170	171	172	173	174	175	176	177	178	179	TOTAL	
605														1	•725
606														19	13.042
607														50	36.222
608														52	37.041
609														1	•725
610														3	2.174
611														9	6.522
612														1	•725



1990

511-121-1

14881

A-100-11

**X**      **Y**      **Z**      **A**      **B**

2011

[illegible]

CROSS-CUTS, 1950-1959, 1960-1969, 1970-1979

LISTED HERE FOR ACCORDANCE WITH THE 1970-1979 CENSUS

X = YEAR OF INCURRING  
Y = LOCATION, 50-60

	197	198	199	190	191	192	193	194	195	196	197	198	199	TOTAL	Y
197															
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# INCIDENTS

## 7 DISPERSED

### DISTRIBUTION BY OCCUPANCY

210 INCIDENTS OCCURRED, 11,299 OF ALL INCIDENTS

X = VEHICLE INCIDENTS

Y = INCIDENTS IN SHELTER

	127	128	129	130	131	132	133	134	135	136	137	138	139	TOTAL	2
100														191	90,952
101														2	9,752
102														10	4,752
103														1	9,752
104														6	2,957
TOTAL	1	1	1	1	1	1	1	1	1	1	1	1	1		
2															



EMPC-HATA AGO, HOTO, -F-100-0810W6A

PAGE 80

Y-4XIS CODES FOR INFORMATION SOURCE

403 US EPA

405 USDA

404 US GEOLOGICAL SURVEY

401 DEPARTMENT OF LABOR

001 PUBLIC FIRE DEPT

701 FACTORY MANUAL

703 AMERICAN PETROLEUM INST

704 OIL COMPANY

705 INSURANCE COMPANY

706

601 NEWSPAPER

602 MEDIA PUBLICATION

603 MEDIA/TV ARTICLE

604 FIRE JOURNAL

605 FIRE COMPANY

606 CHEMICAL ENGINEERING

UNSPECIFIED

\*END OF RECORD\*

## APPENDIX E

### CASE HISTORIES

Contained in this appendix are case histories of incidents which are intended to show problem areas in the categories of 1) Exploration and extraction, 2) Processing, and 3) Storage. All are actual incidents which occurred in the United States in the years 1970 to 1977 inclusive. Data were selected from the American Petroleum Institute, Factory Mutual Loss Data Reports, and the U.S. Geological Survey, the Coast Guard, Oil and Gas Journal, NFPA Publications and various periodicals. Incidents were chosen to illustrate high-severity and high-frequency, usually low-severity, occurrences. Low-severity mishaps are generally less detailed than high-severity accidents. This becomes apparent in the case histories presented. Incidents were chosen to illustrate an operation or area in which a problem seems to exist. While casualties were not incurred in every one of the incidents presented, the hazard potential certainly was present.

### EXTRACTION SITES

The following incidents occurred at extraction sites:

1. November 13, 1970. Offshore platform on the outer continental shelf in the Gulf of Mexico. An explosion in a glycol reboiler on the platform killed three men and injured 13 others. (Humble Oil Refining Co., West Delta Block No. 73. Accidents Connected with Federal Oil and Gas Oper. on the Outer Cont. Shelf. U.S. Geological Survey, July 1977.)
2. December 1, 1970. Offshore platform. Gulf of Mexico. A blowout and gas explosion occurred on this platform during wireline work on well. Four men were killed and 27 were injured. The well burned for 4-1/2 months. (Shell Oil Co., So. Timbalur Bk 26. Accidents Connected with Federal Oil and Gas Operations on the Outer Cont. Shelf. July 1977.)
3. December 7, 1973. Offshore platform, Gulf of Mexico. Oil leaking from a flange on a wet oil line was ignited by welding operations nearby. Two men were killed and five were injured in the resulting fire. (Atlantic-Richfield So. Pass Bk No. 60. Accidents Connected with Federal Oil and Gas Operations on the Outer Cont. Shelf. U. S. Geological Survey, July 1977.)
4. July 27, 1976. The crew of a drilling contractor was putting in a well when they hit a gas pocket approximately 61 m (200 ft) down. The gas ignited and flashed in the wellbore. The drilling rig caught fire, injuring one member of the crew. (San Juan, New Mexico. Kirby Exploration Company. U.S. Geological Survey Case. Contractor was Coleman Brothers Drilling Co.)
5. May 16, 1977. A drilling crew had set a liner and was continuing operations when a pocket of gas was circulated to the surface. Ignition of the gas occurred. Six men received first, second, and third degree burns. (Fremont County, Wyoming, U.S. Geological Survey case. Taken from computerized record of events.)
6. October 25, 1977. A blowout during a workover operation killed three members of a drilling crew. The accident occurred during remedial work on an oil well. Workmen had perforated a new interval and oil was in the hole when they

started to run tubing with a packer. The first joint of pipe was being run into the hole with a nubbing unit when the blowout of oil and gas occurred. (Navy's Elk Hills Field near Bakersfield, California. Employees of Hydraulic Workover, Inc. Oil and Gas J. October 31, 1977, p. 82.)

Less publicized incidents are those involving minimal property losses and few casualties. Consider the following:

1. 1973. Two employees of a California oil well drilling contractor were electrocuted when the crane they were operating contacted an overhead 16 KV line. The mechanic and driller, part of a five-man crew, were guiding a storage tank into position using the rig. The three remaining members of the crew were also injured in this mishap. (California Work Injuries, Dec. 1974, p. 16 Div. of Labor Statistics and Research.)

2. 1973. An oil field roustabout was securing a temporary steam line to be used for oil field thermal recovery. The line ran from a steam valve header to the well head. The line had been warmed up and steam had been in the pipe for approximately 15 min. About 12.2 m (40 ft) from where the roustabout was driving a hold-down stake into the ground, the line suddenly ruptured and the pipe struck the worker's head, killing him. Steam pressure in the line at the time of the accident was estimated to 1379 to 2068 kPa (200 to 300 psi). The wall thickness in the ruptured section had been reduced due to internal wear. The tube had been previously used for oil well tubing. (California Work Injuries. Dec. 1974, p. 15.)

3. 1973. Site of a California natural gas well. A driller was preparing a derrick for drilling. He was on the derrick floor when a steel deck plate gave way and dropped him 5.5 m (18 ft) to the ground. He died of injuries received in the fall. The steel floor plate was a removable section, but was too long to fit properly. One end was resting at an angle on a supporting member of the structure. Apparently the plate slipped when he stepped on it. (California Work Injuries. Dec. 1974, p. 11.)

4. 1974. Accident occurred while a crew was moving a 10 cm (4 in.) rubber hose from drilling rig to a work boat. The crew was picking up the hose from the mudroom with a crane sling hooked to a rope on the end of the hose. The rope sling broke when the employee cut the line that was securing the hose to the outside railing. When the hose fell away from the railing, the slack in the hose either knocked or pulled the employee over the railing. He fell approximately 12 m (40 ft) striking cables, which held the boat to the rig, before he struck water. He died from injuries received in the fall. (Review of Fatal Injuries in the Petroleum Industry for 1974. American Petroleum Industry, May 1975, p. 3.)

5. May, 1976. A gas explosion occurred on the lower deck of this offshore platform. An infrequently operated gas compressor which was used to send excess gas to shore was being placed into service. Gas leaks were detected in the first stage suction flanges. A violent explosion occurred in the adjacent boiler room while the compressor operator and a maintenance man were shutting down the system by closing a suction valve.

Several weeks prior to the incident, several sets of flanges on the compressor were loosened to drain water. These were not retightened before the unit was placed into service. Gas leaked from the flanges as soon as the gas line was opened. This gas accumulated in the adjacent boiler room where it was eventually ignited.

One man was killed and two others injured in the resulting explosion.

6. July 8, 1977. Trans-Alaska pipeline. A maintenance crew was working in a pump room where they removed an oil strainer from a pump. The crew failed to inform the control room that the strainer had been removed. Personnel in the control room restarted the pump and oil under 1620 kPa (235 psi) spurted from the open strainer in a solid stream. It sprayed the entire area before ignition occurred. The pump house exploded killing one and injuring five others.

7. October 8, 1974. A production crew was preparing a heater treater for crude oil. The cleanout plate had been removed and vapors from the tank were sucked into the intake of a running truck. An explosion occurred before

preventative measures could be taken. Two men were severely burned and a third received minor burns. Four 1000-barrel tanks, two 2000-barrel tanks and three heater treaters were consumed by the fire. (Chevron USA, Inc Duchesne, Utah ).

## PROCESSING

Examples of the types of events occurring at processing facilities are as follows:

1. January, 1973. A  $7.6 \text{ m}^3$  (2,000 gal) Pfaudler vessel had been prepared for the atmospheric distillation of hexane. Shortly after the introduction of steam to the vessel the operator noticed fumes issuing from the area around the manhole cover. He attempted to remedy the situation by tightening the manhole cover. A shift foreman came upon the scene and, after assessing the situation, ordered the evacuation of all personnel in the immediate vicinity of the vessel. The steam to the unit was shut off and cooling water was turned on. All personnel left the area and doors to this area were closed. A short time later an explosion occurred.

Piping and piping racks were broken causing the release of hydrocarbons which subsequently ignited. (Case History No. 1898. Manufacturing Chemists Assoc. Vol. 4, 1975, p. 91. Case Histories of Accidents in the Chemical Industry Vol. 4, 1975.)

2. November 29, 1974. This incident occurred in the Isoprene Synthesis Section of a major petrochemical plant. Three employees were in the process of switching from one furnace to another when an expansion joint in the suction line of a pump ruptured. All three employees were deluged with hot, toxic quench liquor. One employee was overcome and could not escape the area. He received fatal injuries. The hydrocarbon process stream, which came from the ruptured line after the quench liquor, created a vapor cloud which ignited, resulting in an explosion and fire. The explosion caused the rupture of piping and process lines in the area, providing more fuel for the fire.

Shutdown procedures were initiated and carried out. Another employee received fatal injuries when he attempted to rescue the employee downed initially by the rupture of the process line.

The Plant Emergency Organization responded, but was virtually ineffective due to the number and magnitudes of the fires started in the area. Approximately 15 min after the first vapor cloud explosion, a second major explosion took place when a  $75.8 \text{ m}^3$  (20,000 gal) isoprene storage tank ruptured.

Approximately 1.5 hr later, a 3.7 m (12 ft) diameter by 3.6 m x 61 m (200 ft) distillation column also failed, adding thousands of gallons of hydrocarbons to the fire.

Inadequate water supplies and the failure of an electric pump circuit hampered fire fighting efforts. (Fire Journal, Sept. 1975, pp. 99-100.)

3. June, 1975. A furnace charge pump malfunctioned and lost suction. Consequently, the oil in the heater tubes began to overheat. The pump was repaired and flow re-established but a weakened tube overpressured and ruptured. The oil spilled into the firebox and ignited. A rapidly-developing fire caused significant damage before it could be extinguished. There were no personnel casualties. (API Fire Loss Summary.)

4. October, 1975. In this natural gas processing plant a leak developed in the inlet gas line to a furnace. The unit was shut down to make repairs utilizing the normal procedure. However, a tube in the shroud section ruptured spraying hot oil over fire tube. Ignition occurred and the resultant fire damaged the heater, heater instrumentation, piping, insulation and auxiliary equipment. (API Fire Loss Summary.)

5. January 3, 1976. A destructive runaway reaction occurred in this petrochemical plant resulting in an explosion and fire.

The explosive reaction took place during normal operation of a large batch hydrogenation reactor used in the production of 3,4-dichloroaniline. The process involves the hydrogenation of 3,4-dichloronitrobenzene (DCNB) under pressure in an agitated autoclave.

The autoclave was first charged with DCNB and a catalyst as a part of the normal procedure. Then the unit was purged with nitrogen to remove air and later purged with hydrogen. The operator applied steam to the autoclave jacket and set the temperature needed for the reaction. After the vessel had been in operation for a short while, the operator noticed that the hydrogenation reaction was proceeding slower than normal. It was then that he observed that the vessel temperature was set at the low end of the allowable range. In an effort to accelerate the reaction to its normal rate, he raised the set point temperature by 10°C. Shortly after doing this he left to attend to



other duties and about 3 min after his departure the incident occurred. The manway cover was blown off and the autoclave was displaced from the support and driven into the floor below. A flash fire followed. Five persons were injured in the blast and ensuing fire. Large fragments of structural concrete were propelled outward to distances up to 100 ft. There were extensive damages to the building and equipment. (E.I. duPont de Nemours and Company, Inc. Deepwater, N.J.; Report by Tong, N. R. et al. 3,4-Dichloroaniline Autoclave Incident.)

6. June 19, 1976. On the day of the accident the plant had been shut down for maintenance work on a vacuum tower heater. The fire tubes of this unit were in the process of being steamed to atmosphere when the #2 tube suddenly unplugged releasing coke, hot oil and steam. Two operators in the vicinity of the release were sprayed with hot oil. The oil vapor flashed when they contacted the flame from a nearby gas burner. Both men were engulfed in fire and received fatal burns. (API Data. Review of Fatal Injuries in the Petroleum Industry for 1976. May 1977, p. 3.)

7. July, 1976. This incident occurred in a petrochemical plant. The furnace involved experienced a burner failure, activating an alarm. The operator responded and attempted to relight the burner with a gas torch. However, he failed to notice that other burners were also out and that a significant amount of natural gas had accumulated in the firebox. The explosion occurred when the torch flame entered the firebox. The operator and another one of the plant personnel were injured. (API Fire Loss Summary.)

The problem of accidents occurring during plant shutdown for maintenance operations has not been investigated enough. Consider the following:

1. June 19, 1970. During repair operations, employees were removing copper tubing from a condensing unit with a high temperature flame torch. In an adjacent area, workmen were steam cleaning equipment when they caused the release of flammable vapors during their operations. This flammable vapor cloud entered the area in which the torch was being used where it ignited and exploded. The ensuing fire caused the five deaths of (four employees and one fire fighter) and fifteen injuries.

Damages were estimated at \$3,000,000. Factors contributing to the extent of damage include the loss of electrical power (for fire pumps) due to the rapid flame spread. (Amalie Oil Co., Sugar Creek, Penn. Fire Journal.)

2. February 10, 1973. This incident involved an explosion and fire in a liquid-free liquefied natural gas tank which was undergoing repairs. Approximately 28 months before the incident, instrument reading gave indication of a leak in the liner of this tank. At that time it presented no significant hazard since the exterior shell of this tank was not damaged. Sixteen months later this unit was placed out of service for repairs and modifications. Safety controls were carried out which included the purging of the tank with nitrogen and the complete ventilation of the unit. Two months later a crew entered the tank and began repair. A large rip was discovered in the liner at the bottom of the tank along with several small punctures. Repairs to the liner had begun when a fire flashed in the tank creating a pressure wave which lifted the tank's concrete roof from the walls, then dropped it back into the tank. The fire spread with such speed and intensity that it was impossible for any of the men in the tank to escape. As a result 40 men perished.

Apparently residual gases trapped between the tank's inner liner and shell contacted an ignition source from the maintenance crew inside the tank. (Fire Journal, May 1974, Vol. 68, No. 3, pp 71-72.)

3. February, 1976. A maintenance crew at a refinery were in the process of cleaning an empty floating roof crude tank with a hydrocarbon solvent when a flash fire occurred. Vapors from the hydrocarbon cleaning solution came into contact with an unknown ignition source and provided an ignition for remnants of crude oil in the tank. Two members of the crew were killed and eight others received injuries. (API Fire Loss Summary.)

4. May, 1976. A 20 cm (8 in.) relief valve line ruptured on a butadiene unit releasing a large quantity of butadiene-butene mixture. A vapor cloud formed and was ignited by process vessels in the area. An explosion and fire followed with the mixture coming from the relief valve behaving like a torch. Adjacent structures, process vessels and instrumentation received considerable damage. (API, Fire Loss Summary.)

5. August 12, 1976. A refinery maintenance crew, subcontracted by the refinery, was in the process of performing routine maintenance and repairs on a 63 m (207 ft) tall benzine unit when an explosion and flash fire occurred. Twelve men were killed and two others injured in the mishap. Ten of the fatalities were employees of the subcontractor; the remaining two were refinery workers. (Tenneco Oil Co., Chalmette, La. Chemical Engineering, August 76, p. 49.)

## STORAGE AREAS

Incidents occurring in storage areas have an extremely high potential for disaster. Consider the following cases:

1. August 17, 1975. This incident involved a fixed roof storage tank which had recently been fitted with an internal floating roof. Steel legs welded to the floating roof prevented it from falling below a certain minimum height.

Just prior to the incident the liquid in the tank had been drawn down below the minimum level needed to support the floating roof. As a result, it rested on its steel legs and, in addition, its relief vent opened to ventilate the flammable vapors between liquid surface and the roof.

On the day of the mishap a tanker moved into position and began pumping a mixture of crude oil and 5-percent naphtha into the tank. The flow rate of petroleum was not monitored, so there was no indication of how much was being added to the tank. The flammable vapors in the space between the floating roof and the liquid surface were being forced through the roof's vent into the space between the fixed and floating roofs during the pumping operations.

As the tank filled, the hydrocarbon vapors trapped between the two roofs were forced out of overflow vents. These vapors flashed when they contacted high-temperature, high-pressure steam lines in a nearby boiler house. An explosion occurred between the two roofs forcing the floating roof down into the liquid. The oil overflowed and ignited. This explosion took place approximately 6 hr after the filling operations had commenced.

Fire fighters from the refinery, as well as those from nearby towns, responded and attempted to control the fire. During the fire-fighting operations, leaking hydrocarbons accumulated on the surface of the water and foam that had gathered in the area. Sixteen hours after the initial explosion this layer of flammable liquid flashed, catching all personnel in the area unaware. Six fire fighters caught in the flare-up or trapped during subsequent rescue operations received fatal injuries. Two others were evacuated from the fire ground and later succumbed. (Gulf Oil Co., South Philadelphia, Pa. Fire Command, January, 1976, p. 21.)

2. June 22, 1976. This incident occurred in the storage area of a butane plant in Angelton, Texas. It is believed that a flexible coupling on a 5 cm (2 in.) line failed, resulting in the release of butane. Shortly thereafter this butane ignited and the flame from this line was impinging on a  $63 \text{ m}^3$  (18,000 gal), approximately 70 percent full, two  $15 \text{ m}^3$  (4,000 gal) tanks and one  $23 \text{ m}^3$  (6,000 gal) tank.

The area was cleared of all employees and personnel as fire-fighting agencies decided not to risk men and equipment fighting an unpredictable fire. Operations to cool adjacent tanks to prevent their rupture were affected.

Fortunately, no injuries or fatalities were incurred. This can be directly attributed to the assessment of the risk by the fire-fighting agencies and the subsequent decision not to fight the fire. (Fire Command. (Angelton Butane Co.) Fire Command, June 1976, p. 24.)

3. December, 1976. An employee was attempting to transfer gasoline between two tanks. The failure of an electrical device designed to detect closed valves in the transfer piping arrangement allowed the pump to work against a closed valve. Eventually, the piping ruptured and there was a backflow of product. The liquid flashed and the employee was caught in the fire area. He received fatal second and third degree burns over 60-percent of his lower body. (API Data Review of Fatal Injuries in the Petroleum Industry for 1976. May, 1977.)

4. September 24, 1977. An electrical storm is credited with having initiated this fire in the storage area of a large refinery. The entire area was experiencing torrential rains and thunderstorm activity in the early morning hours. The incident began at approximately 2:15 a.m. when a single bolt of lightning contacted a 58 m (190 ft) storage tank containing No. 2 diesel fuel. Since the tank was not filled to capacity, the ignition of flammable vapors above the surface of the liquid resulted in an explosion. The force of the blast removed the cone roof covering the tank and it was reported that shock waves were felt 16.1 km (10 miles) away. A section of the roof from this tank struck and ruptured an adjacent 33.5 m (110 ft) diameter tank containing unleaded gasoline.

Flames from the fire were reported to be hundreds of feet high with heavy black smoke hampering fire-fighting operations. It took approximately 44 hr to effect extinguishment. Damages included lost product and three storage tanks and loss was estimated at \$8,000,000. Effective fire-fighting techniques prevented a much larger loss since efforts to cool adjacent tanks, to prevent this involvement were successful. (Fire Command, February 1978, Vol. 45, No. 2, pp 21-23)