U.S. Chemical Safety and Hazard Investigations Board

Business Meeting

October 16, 2017

CSB Headquarters Office - Washington, DC

U.S. CHEMICAL SAFETY BOARD MEMBERS PRESENT:

VANESSA ALLEN SUTHERLAND, CHAIR

MANNY EHRLICH, MEMBER

RICK ENGLER, MEMBER

KRISTEN KULINOWSKI, MEMBER

STAFF PRESENT:

MICHELLE BOUZIANE, ASSISTANT GENERAL COUNSEL

OPERATOR: Welcome to the CSB public business meeting. My name is Richard and I'll be your operator for today's call. At this time, all participants are in a listen only mode. Later, we will conduct a question and answer session. During the question and answer session, if you have a question, please press * and 1 on your touchtone phone. Please note that this conference is being recorded. I'll now turn the call over the Vanessa Allen Sutherland. You may begin.

VANESSA ALLEN SUTHERLAND: Thank you, Richard. Good afternoon, and welcome to everyone in the room and on the phone. This is our second to last business meeting of the Chemical Safety Board or CSB. Today we meet in open session, as required by the Government in the Sunshine Act, to discuss the operations and activities of the agency.

I am Vanessa Allen Sutherland, the Chairperson and CEO of the Board. And today I am joined by Board Members, I'll go down this way, Dr. Kulinowski, Member Ehrlich and Member Engler. Also joining us is Assistant General Counsel Michelle Bouziane and members of our staff.

Before I start, I'd like to make sure that everyone, if you haven't yet, silences your phone and please be aware of the exits. When you came in through our glass doors, for those in the room,

there are two elevator banks. The exits and stairwells are to your left and to your right. So take a moment as well for vibrate.

The CSB is an independent, non-regulatory federal agency who investigates major chemical incidents at fixed facilities. The investigations examine all aspects of chemical incidents, including physical causes related to equipment design as well as inadequacies in regulations, industry standards, and safety management systems. Ultimately, we issue safety recommendations which are designed to prevent similar accidents in the future.

Before we get started, I would like to remind everyone that CSB's latest safety video is now available on our website. You heard us mention that just a few weeks ago at our public meeting. The CSB's feature details…it will feature details on our investigation into the 2016 fire at the ExxonMobil Baton Rouge plant. Please check it out when you have some time.

I will now get started with our formal agenda. We have several items on our agenda today, including an update on investigations, studies, recommendations and deployments, an overview of ongoing Inspector General audits, an organizational update, and a financial update.

During the new business portion of the meeting, the Board Members will discuss two recently calendared recommendations. We

will not be voting on the status of those recommendations today, however. Rather, we are going to publicly deliberate our staff recommendation on responses that the agency has received on those two safety recommendations, which is what we as Board Members should do per the Sunshine Act.

If you are in the room and wish to make a comment at the end of the meeting, please sign up using the yellow sheets at the registration table. It's like a bright neon yellow when you walked in. Or, for those who are on the phone, you may submit any comments by email to meeting@csb.gov to be included in the official record. And that's not just about the new business. You can feel free to type in comments or write down your comments and questions during the meeting on anything that we discuss today.

With that, I would now like to recognize my fellow Board Members for any opening statements or welcome. Dr. Kulinowski?

MEMBER KULINOWSKI: No opening statement. Just welcome everyone and I look forward to what I expect to be a very interesting discussion.

VANESSA ALLEN SUTHERLAND: Okay, thank you. Member Ehrlich?

MEMBER EHRLICH: Yes, I have no opening statement, but I too look forward to what should be a very interesting meeting and I thank you all for taking the time to come.

VANESSA ALLEN SUTHERLAND: And lastly, Member Engler?

MEMBER ENGLER: Ditto.

VANESSA ALLEN SUTHERLAND: So thank you. At this time the Board Members will provide an update on our ongoing investigations. As always, more information about those investigations are available on our website at csb.gov. But again starting with Member Kulinowski, if you could provide your two updates.

MEMBER KULINOWSKI: Sure. I'm going to first provide an update on the Sunoco Logistics Partners incident that occurred on August 12, 2016. Seven workers were injured, including four critically, at Sunoco Logistics Partners terminal facility in Nederland, Texas. The incident involved a flash fire during welding, also referred as hot work. This is one of the issues on our critical drivers list. So it's of great interest to the agency. I look forward to the report.

All field work and interviews have been completed to date and the investigative team is currently preparing a draft report for internal review. Right now, they are addressing first round of comments from the Senior Advisor and the Chair and then after that it will come to the rest of the Board.

Second investigative update is Packaging Corporation of America, another hot work incident, that occurred on February 8,

2017. An atmospheric storage tank exploded at the Packing Corporation of America facility in DeRidder, Louisiana, killing three workers and injuring seven other workers. On the morning of the incident, PCA issued a hot work permit to the fatally injured workers to repair piping near a 100,000-gallon atmospheric storage tank which likely contained an explosive atmosphere.

The status of this investigation is that team has completed its draft report. It is currently undergoing internal review.

VANESSA ALLEN SUTHERLAND: Thank you. Now Member Ehrlich.

MEMBER EHRLICH: Thank you, Madam Chairperson.

The Loy-Lange Box Company investigation examines the April 3, 2017, multi-fatality incident which resulted from a catastrophic steam explosion inside of a pressure vessel, caused when the entire bottom of the vessel separated instantaneously. The vessel was part of a utility steam system used by Loy-Lange Box Company in the production of corrugated box products…board products. Both the main portion of the vessel and the bottom remnant that separated have been recovered. Key areas of focus continue to be the circumstances surrounding the 2012 repair, the cause of the corrosion, and the opportunities that may have existed to detect the progression of corrosion damage over time.

Status. Analysis of raw metallurgical test data is commencing. Development of follow-up interview needs for LLBC night shift stationary engineer. Analysis of repair work still ongoing. Development of interrogatories. Follow-up on various document requests. Identification of key investigatory findings using cause and effect brainstorming tool.

With regard to DuPont LaPorte, Texas, November 15, 2014. On November 15, 2014, nearly 24,000 pounds of methyl mercaptan was released at the DuPont Chemical facility in LaPorte, Texas. The release resulted in the deaths of three operators and a shift supervisor inside an enclosed manufacturing building. Additionally, three other workers were injured from their exposure to methyl mercaptan and at least three more workers experienced methyl mercaptan exposure symptoms.

The CSB investigation team completed its draft report, which is going through internal review.

Thank you.

VANESSA ALLEN SUTHERLAND: Thank you. And Member Engler, if you could provide us with an update on Enterprise Products and MGPI.

MEMBER ENGLER: Thank you.

For Enterprise Products, a flammable gas release with subsequent fire and explosions occurred at the Enterprise Products Pascagoula Gas Plant, in Moss Point, Mississippi on the evening of June 27, 2016. While there were no fatalities or injuries, members of the public in the nearby community evacuated.

Initial metallurgical testing has been completed and results shared with all parties. The next phase of testing will start in November. Additional metallurgical testing will be done that month. And it's anticipated that this testing will be completed before the end of the year. So the investigation, in terms of review of that, of those reports, is ongoing.

For…on October 22, 2016, a chemical release occurred at the MGPI Processing plant in Atchison, Kansas. MGPI Processing produces distilled spirits and specialty wheat proteins and starches. The release occurred when a chemical delivery truck, owned and operated by Harcros Chemicals, was inadvertently connected to a tank containing incompatible materials. The plume generated by the chemical reaction led to a shelter-in-place order for thousands of residents. At least 140 employees and members of the public sought medical attention.

Much of the field work and interviews have been completed. The team is now addressing board comments for the next draft of this

report and is preparing additional steps to conclude the investigation, such as production of a video and additional factual accuracy review.

VANESSA ALLEN SUTHERLAND: Thank you. And I will now provide the last updates which are on the CSB's Arkema, Midland Resource Recovery, and Didion Milling investigations.

First, with regard to Arkema, which occurred on August 29, 2017, rainfall from Hurricane Harvey flooded the Arkema organic peroxide manufacturing facility in Crosby, Texas. As flood waters continued to rise, the facility lost electrical power and the ability to maintain refrigeration for the organic peroxide product containers that required cold storage. Arkema's hurricane ride-out crew relocated these organic peroxide containers from storage buildings to nine refrigerated trailers, but several of these trailers also lost refrigeration due to the rising flood water.

Emergency responders evacuated the hurricane ride-out crew on the 29th of August and established a 1.5-mile evacuation zone. Lacking the ability to maintain refrigeration, the organic peroxide products warmed and some reached their self-accelerating decomposition temperature and burned. One trailer burned on August 31, and two others burned on September 1. Emergency officials initiated controlled burn of the remaining six trailers on

September 3, 2017. The evacuation zone was lifted on the 4th of September, which allow residents to return to their homes.

Our status is the investigation into the loss of refrigeration and the resulting fires is still ongoing. Our CSB Investigators continue to review documents and evidence collected thus far. They've been there for a few weeks now, doing photo documentation and scheduling interviews.

With regard to Midland Resource Recovery, MRR operates a facility in West Virginia that, among other things, decommissions equipment previously used to odorize fuel gas. Two explosions occurred at this facility in a four week period, killing three workers and seriously injuring another worker. The first explosion took place on May 24, killing two employees and seriously injuring the other. On June 20, a second explosion occurred at the facility killing a single worker. Both explosions happened during activities to decommission equipment previously used to odorize fuel gas. The company is cooperating with state and local officials to develop a plan to decommission the remaining odorization units at the facility without causing additional harm to people.

The status of that is we released a factual update on September 22. Currently also available on our website. Our

investigation staff continues its documentation of the facts and analyses following many interviews.

And lastly is the Didion Milling Summary. On May 31 of this year, an explosion at the Didion Milling facility located in Cambria, Wisconsin occurred at approximately 11:00 PM. There were 16 employees working the night shift when the incident occurred. Five employees were killed, and more than a dozen were injured. If this incident had occurred only 12 hours earlier in the day shift, up to 50 people would have been working in the various buildings which were destroyed or damaged in the blast.

Didion Milling processes corn to make a variety of products such as grits, corn meal, and corn flour. Six different buildings on the site comprise the processing, packaging, and office facilities.

The status of that investigation is that we've completed more than 45 interviews, including all the eyewitness interviews from those willing to speak with the CSB from the night of the incident. We have been reviewing almost 3,000 documents, as well as examining the equipment data more than a month leading up to the incident and the night of. Demolition of the mill began last week and should finish sometime this week. I'm not sure exact date but towards the end of the week it's scheduled. And the equipment of interest in

this case will finally be removed which will allow our investigators to begin a more detailed inspections of what has been buried in the rubble. We intend to issue a factual update in the next few weeks so stay tuned for that and we'll have an update at our November public meeting as well.

So, moving on to the status of recommendations generally, the status of where we are collectively. We have a ratio of 79%, which is 639 recommendations closed and 165 open, which is 21% of the total we've issued, the total being 804.

The status of all of our investigations can be…investigations recommendations can be found on our website at csb.gov/recommendations. Plus I'm going to provide a complete summary today and I just heard later today we will be discussing two [inaudible].

Recommendations that have recently been voted on can be found on that same site, under Recent Recommendations Status Update. And each of the status change summaries will describe the rationale for the Board's vote.

With regard to recommendation closures, to date in fiscal year 2017, the CSB has closed 47 recommendations. I'm going to give you a brief breakdown. Three were closed exceeding our recommendations. Six were closed unacceptably. 24 were closed

acceptable, including an acceptable alternative. Five were closed reconsidered or superseded. And eight were closed as no longer applicable.

In fiscal year 2017, the Board voted on the status of 78 recommendations. As I mentioned, later in this meeting, we will talk more specifically about the status change proposals from the Macondo investigation. But before I do…before we get to that, I want to provide organizational and financial updates.

With regard to organizational updates, the staff and board members have reviewed the final status of last year's Action Plan to evaluate our completion of the goals that we set out. Simultaneously, we are finalizing our FY18 Action Plan, which will reflect some priorities that were deferred in the last fiscal year due to our possible elimination and shifting priorities, and some priorities that arose based on ideas or innovation of the staff, as well as our ongoing annual and legal…annual procedural and legal requirements, such as reporting an audit.

Specifically under organizational updates, I'm going to provide just a brief overview of an HR update. Prior to my appointment as the Chair of the CSB, the Office of Personnel Management, or OPM, conducted an evaluation of the CSB in September of 2014, to determine the agency's adherence to merit systems

principles and to assess the effectiveness of the administration of HR's programs and services.

The evaluation concluded in March, 2015, with concerns related to human capital planning, strategic alignment, and a few other issues which this Board has been mindful of and has been working on.

In particular, OPM noted that the agency has not had a human capital plan since 2011 and recommended that the agency update its plan to align its strategic plan, performance, and budget priorities. Additionally, OPM raised concerns about the agency's integrity in hiring and the possibility of veteran's preference violations.

Subsequently, I came on board with the agency in August of 2015. [inaudible] this information, or at least some of it, in bits and pieces, along with the agency's Federal Employee Viewpoint Survey, or FEVS, I decided to have an independent third party perform an organizational assessment. Following the procurement process and selection of that third party, the assessment was conducted from January of 2016 through June of 2016 and revealed major issues with the agency's performance management system, classification of certain positions, and the organizational

structure. This information was communicated to the entire CSB staff in in-person meetings by that consultant.

Once the agency became aware of its organizational issues and had time to dig further into the previous 2014 OPM assessment, we have taken steps to address and correct those issues.

With respect to the classification issue, the assessment pointed out the misclassification of a specific position on our staff and recommended that the agency take steps to correct this issue. An internal review team was assembled to address the issue, meaning a group of employees who were asked to work through the issue by analyzing and reviewing both the current position's description and reviewing the independent third party's work. That review team was tasked with assessing the need for a separate position as opposed to the primary chemical incident investigator position that we have.

Since the review team did not come to a consensus, the agency contacted OPM for an opinion on the classification of this particular position. It's entitled Attorney Advisor (Investigator). In part, OPM responded as follows: "The General Attorney Series DS0905 Standard specifically lists subject matter specialties which may be used in conjunction with official titles. Investigations is not one of those specialties. The duties

described in the Attorney Advisor (Investigations) position description do not appear to meet the series definition of professional legal work or require professional level legal education, knowledge, or degree, in order to perform those studies and appear to be classifiable to another non-professional series."

Ultimately, as the Chairperson of this agency, I have the responsibility and right to determine the agency's organization and apply sound management principles in order to move the agency forward and certainly to be able to rely on the Office of Personnel Management, the federal body looking at this matter, guidance. Therefore, in July of 2017, the agency announced a realignment based on this information and the long outstanding prior investigative or assessment item, and obtained from the OPM an evaluation, including our third-party assessment, to review those internally.

The realignment was rolled out in multiple phases, along with an agency-wide position description review. Some offices within the agency received a simple reporting structure reassignment, while others involved more detailed position management changes.

Last month we shared information in private with employees that are affected by the misclassification of their position, to explain steps that may be taken over the next three months to

rectify the issue. Unfortunately, that information has been publicly shared with individuals inside and outside of the agency. No action has been taken to date or was taken previously, as all are still working to seek alternative ways to address this issue with the expert Office of Personnel Management.

In closing, let me assure everyone that we value each and every employee at the CSB. And we work to retain our staff. As many told me upon my arrival, we had many organizational help issues that long required attention and often through no fault of the staff. Yet we are committed to good operational practices and compliance. We are committed to working with OPM to assist us in resolving some of our issues. And where necessary, the Inspector General. And to present a structurally sound, vibrant agency to the public that is operationally efficient and fiscally responsible. The CSB is a micro-agency and the last thing we want to do or can afford to do is lose employees.

We will continue to update you in a subsequent meeting, as we continue those organizational changes.

So next are our IG updates. As of October 11, 2017, the CSB is currently working with the Office of Inspector General on three audits.

Number one, Semiannual Report to Congress, which are unimplemented recommendations by us. The EPA started their audit on September 20, just a few weeks ago, and requested an updated listing of open recommendations. To date the CSB has only one recommendation open that addresses future office leasing. And that issue will not be [inaudible] until November 2019 for our Denver lease and 2022 for our DC lease.

I don't usually do this in these meetings because we're trying to share information. But I have to say everybody on our staff who helped us get from 37 open IG recommendations when I started to one, which won't be right for another year, in one case and two years…actually three years in another. So thank you very much for that. I really appreciate it.

Next is a Financial Statement Audit. OIG expects to complete this audit by November 2017. We're still on track for that date.

And last is the FISMA Audit. CSB is working with the OIG to provide all requested documentation for information security audit.

And lastly, before we get to our new business is our financial update. The CSB, like the rest of the federal government, we're not unique in that regard, is operating on a continuing resolution that provides sufficient funding to continue our work through December 8th. We are awaiting final action on the FY2018

appropriation. But we continue, as you see, to work with our respective appropriations committee staff to clarify what our funding might be. And we are continuing to operate to complete our Action Plan and Strategic Planning.

So are there any other operational updates, comments, questions, before we move to new business?

MEMBER EHRLICH: Nothing.

VANESSA ALLEN SUTHERLAND: Okay. So under new business, today we will discuss two calendared recommendation status changes by Board Member Engler.

And to clarify, A, why we're not voting and, B, why we're going to have another meeting to vote. Per our adherence to the regulations, we hold quarterly…we've been holding them much more often than quarterly. But we hold quarterly Sunshine Act meetings because it's important for us to tell people what we've been doing, how we're operating. And, as a Board, we don't have the ability to discuss in great detail or deliberate at all, absent doing that in public. There are limited exemptions if [inaudible] personnel matter or highly confidential.

But part of that discussion includes any calendared items. And for those who aren't as familiar with Board and Commissions, part of that process is to assure that the Board deliberates in a

timely manner. Our regulations say that we will consider any calendared item, either at the next public business meeting or within 90 days of it being calendared. Now, this…these items were calendared on the 10th and, by luck, we happen to be having this meeting on the 16th. But we're not going to be voting because we want to be able to hear what each other have to say and to have those who are in the room and on the phone also listen to how we go about discussing our viewpoints and our concerns regarding recommendations, investigations, or any other business, really, that would affect the agency.

So there's no formal vote on these items today. And I will be turning the discussion to Member Engler in a moment to outline for us the calendaring, I guess, rationale. Want to call it that? Okay. Why it's calendared. But I will leave them and then… Are we putting them up on the board? For those in the room, you have a hard copy. We circulated a hard copy of the two recommendations from Macondo that were calendared. They are referred to as R7 and R15. I think we're putting them up on the screen for those who are reviewing. For those who are on the phone, if you will allow me about two seconds so that we can get into the discussion, I'm going to read them.

Both of the recommendations, as I mentioned, are from our investigation, if you're on the Web, trying to find this, 2010-10-I-OS-7 or replace that with 15 for the second recommendation. And those were issued to the Bureau of Safety and Environmental Enforcement, BSEE. That first recommendation, R7 was as follows:

Drawing upon best available global standards and practices, develop guidance addressing the roles and responsibilities of corporate board of directors and executives for effective major accident prevention. Among other topics, this standard shall provide specific guidance on how boards and executives can best communicate major accident safety risks to their stakeholders, as well as corporate level strategies to effectively manage those risks.

Since we issued that recommendation, there has been extensive communication between the staff of the CSB and BSEE. It has become evident through those communications that BSEE does not agree with the recommendation in general. Our recommendations staff strongly believe that BSEE is the most appropriate agency to implement this recommendation to the offshore oil and gas industry. Nevertheless, they have concluded that based on their communications with BSEE that the guidance will not be developed.

Accordingly, the CSB is recommending that it close this recommendation as “Closed, Unacceptable Action.” And further, the staff may develop and issue their own guidance regarding that issue.

The second recommendation, as I mentioned, is R15, which was also issued to BSEE. And that recommendation states:

Issue participation regulations and training requirements for workers and their representatives that include the following:

First, worker-elected safety representatives and safety committees for each staffed offshore facility chosen under procedures overseen by the regulator. These safety representatives will have the authority to interact with employers, such as operators and drillers, and regulators on issues of worker health and safety risks and the development and implementation of the major hazard report documentation.

Second, the elected worker representative has the right to issue an enforceable stop work order if an operation or task is perceived as unsafe. All efforts should be made to resolve the issue at the workplace level, but if the issue remains unresolved, BSEE shall establish mechanisms such that the worker representative has the right and ability to seek regulator intervention to resolve the issue, and the regulator must respond in a timely fashion.

The regulator will host an annual tripartite forum for workplace…workforce representatives, industry management, and the regulator to promote opportunities for interaction by all three entities on safety matters and to advance initiatives for major accident prevention.

And fourth and final, protections for workers participating in safety activities with a specific and effective process that workers can use to seek redress from retaliatory action with the goal to provide a workplace free from fear that encourages discussion and resolution of safety issues and concerns. Protected activities include, but are not limited to, reporting unsafe working conditions, near misses, and situations where stop work authority is used.

Over several months of communicating with BSEE, the recommendations staff concluded that BSEE does that have the proper regulatory authority to institute these recommendations. Therefore the recommendations staff proposed the Board a status change to “Closed, Reconsidered/Superseded”.

The staff circulated these proposals last week and, as I mentioned, Member Engler asked to calendar those for a more full discussion. So with that, I would like to recognize Member Engler at this point to begin our discussion.

MEMBER ENGLER: Thank you, Chair Sutherland. And thank you for…again, for coming to the meeting and for hearing the dialogue. And I will say that I hope you will bear with me. My statement is a little bit longer than usual. If I have the sense that folks are getting restless, I may go much faster. But I do think there are a number of points to make here because this is a very, very serious matter at hand.

First, I'd like to thank the CSB investigations and recommendations staff who produced our four-volume report on the Deepwater Horizons disaster and developed both the safety recommendations and the proposed recommendation status changes that we will discuss today.

I calendared notation item 2018-1 and 2018-2 on October 10th, 2017. I have no objection to this change in status proposed by the CSB's recommendations department of the first notation to close unacceptable action. And pending further discussion today, I anticipate voting to support this status change. I calendared this notation item, however, because it should be considered in concert with 2018-2, the one that's…hopefully you can read on the board here or that…on the screen, or that you have a copy of.

I do not concur with the CSB recommendations staff's status change proposal to close 2010-10-1-OS-15 as "closed,

reconsidered/superseded". Nor do I agree with the Department of Interior's Bureau of Safety and Environmental Enforcement, or BSEE's, reasons to reject CSB's considered and documented rationale for four proposals for enhancing worker participating.

Underlying my view is a principle that safety cannot be achieved without the meaningful engagement of workers. This is not just a personal opinion. According to the Center for Chemical Process Safety of the American Institute of Chemical Engineers, which is funded by its member companies, which, by the way, include BP, those workers, and I quote, "directly involved in operating and maintaining the process are most exposed to the hazards of the process. Moreover, these workers are potentially the most knowledgeable people with respect to the day-to-day details of operating the process and maintaining the equipment and facilities and may be the source for some types of knowledge gained through their unique experience."

As the CSB said in a 2014 document prepared for OSHA, to quote, "The CSB believes that workforce involvement is a key element of improving process safety and accident prevention." And when BSEE itself issued their Safety and Environmental Management Systems Rule Revision in 2013, they demonstrated support for employee engagement with new provisions in their rules for an

employee participation plan, employee stop work authority, and employee incident reporting.

Today, the CSB faces two underlying questions. First, does worker participation really matter for safety? And second, does CSB have an obligation under law or own policies, as well as the will to recommend broad, preventive, regulatory reforms to achieve safety? In this statement, I will focus on seven specific reasons why I oppose the proposed status change to “Closed, reconsidered, superseded” as follows.

First, the CSB recommend…recommendations department does not fully consider the full statutory authority and mandate of CSB to issue reports and studies, including analysis of [inaudible] regulation.

Two, the recommendations department proposal applies an overly narrow understanding of incident causation which is inconsistent with our enabling statue and current CSB policy.

Three, the recommendations department and BSEE have failed to make a convincing case that BSEE does not have statutory authority under the Outer Continental Shelf Lands Act to enforce worker participation.

Four, the recommendations department and BSEE may incorrectly assert that other agencies such as the Department of Homeland

Security and the Department of Labor have primary authority to address these matters and that the recommendations were issued to the wrong recipient.

Five, the recommendations department incorrectly asserts that if this recommendation were implemented, “It would be duplicative and inefficient to the federal regulator, as well as confusing to the federal regulator, the regulated industry, and the public at large.”

Six, BSEE incorrectly asserts that worker safety committees are a characteristic of a “safety case” regime that we do not utilize in the United States.

And seventh, BSEE, with CSB recommendations department concurrence, wrongly rejects the CSB’s proposed enhancements to BSEE’s safety and environmental management system, or SEMS, while asserting that our recommendations are prescriptive rather than performance based. And also implies the prescriptive regulations are generally inappropriate.

I’ll expand on these seven points. First, concerning our statutory authority. According to our enabling statute, the 1999 Clean Air Act Amended, the Board shall in part investigate, determine, and report to the public in writing the facts, conditions, and circumstances and the cause or probable cause of

any accidental release resulting in a fatality, serious injury, or substantial property damage.

But the CSB statutory role does not end with the investigation of specific incidents. In addition, CSB is to, again according to the statute, “Issue periodic reports”, I underlined reports, “to the Congress, federal, state, and local agencies, including the EPA and OSHA concerned with the safety of chemical production, process, handling, storage, and other interested persons, recommending measures to reduce the likelihood or the consequences of accidental releases and proposing corrective steps in the chemical production, process, and handling of storage and safe and free from risk of injury as possible. Moreover, CSB is authorized to conduct research and studies with respect to the potential for accidental releases, whether or not an accidental release has occurred, where there is evidence which indicates the presence of a potential hazard or hazards.”

The CSB’s statutory authority noted above informed the analytic approach of the Macondo investigation. As Volume 4 of the report says, on page 12, “The CSB’s preventive mission as a federal agency is to reduce chemical hazards as broadly as possible through recommendations that will affect national preventive changes.” Volume 4 of the Macondo report is a regulatory gap analysis report

or study that identifies weaknesses in regulation and proposes national preventive changes. It is based on extensive research of how other advanced industrial nations approach offshore safety in the oil industry, as well as an assessment of the deficiencies in the initial excellent start by BSEE.

Two, the recommendations department applies an overly narrow understanding of incident causation which is inconsistent with our enabling statute and CSB policy. To reiterate, the CSB's enabling statute mandates our agency to investigate, determine, and report to the public in writing the facts, conditions, and circumstances, and the cause or probable cause of any accidental release resulting in any fatalities, serious injury, or substantial property damage. The law does not say the CSB should only investigate the specific technical facts that were the immediate cause of the incident. The law directs us to consider the facts, conditions, and circumstances, and the cause or probable cause.

Moreover, the statute's legislative history says, and I quote, "The Board should take on an all-cause theory in discharging its investigatory duties." It is not the single necessary or sufficient cause which is to be the focus of the Board's inquiry, but all circumstances which contributed to the accident and which may effectively be modified to improve safety are circumstances of

concern. Multiple causation is, in fact, the norm and it is expected that the Board will follow many strands of inquiry in response to each accidental release.

Finally, Procedure G of Board Order 40, unanimously approved by the Board on December 7, 2011, takes a broad view of causation, to include factors such as the actions or inactions of the corporation, industry, government, and society, and reflect investigative theory which addresses technical, organizational, and societal causes, including regulatory gaps. The procedure says that the logic tree tool used in CSB investigations should incorporate factors that caused or allowed the incident to occur. Volume 4 of the Macondo reports concludes that greater worker involvement and whistleblower protection could help, to again quote our enable statute, “To reduce the likelihood or the consequence of accidental release.”

Third point, the recommendations department and BSEE have failed to make a convincing case that BSEE does not have statutory authority under the Outer Continental Shelf Lands Act to enhance worker participation. BSEE asserts this lack of authority in part for its unwillingness to adopt the CSB recommendations. Its Safety and Environmental Management Systems Rule, however, clearly does address worker participation. Under these rules, management must

consult with their employees on the development, implementation, and modification of their Safety and Environmental Management Program, develop a written plan of action on how employees will participate in SEMS program development and implementation, and ensure employee access to the SEMS program. Additionally, the rule includes provisions for employees' stop work authority and for employees to report unsafe working conditions.

In correspondence from BSEE to the CSB recommendations department, BSEE says that recommendation 15, the one that we're discussing now, cannot be addressed since it is "likely" that BSEE lacks the statutory authority and that it is "not clear" that BSEE has statutory authority. In contradiction, the BSEE correspondence also states that "The general concept of requiring the operator to maintain safety representatives and safety committees [inaudible] certain responsibility and authority aligned to some extent with certain elements of BSEE's existing regulatory authority."

In my view, BSEE's analysis is unclear, confusing, and likely wrong. BSEE did not provide CSB with a legal opinion that was prepared by the Bureau of Interior Solicitor's Office and that was cited in correspondence to the CSB. For the Board's independent analysis, I requested through the Chair, on October 11, 2017, that CSB's Office of General Counsel prepare for the Board a legal

opinion of BSEE's position concerning their legal authority to implement our recommendations.

Fourth point. The recommendations department and BSEE may incorrectly assert that other agencies such as DHS or the Department of Labor have primary authority to address these matters and that the recommendations were issued to the wrong recipient. Concerning whistleblowers protection, which I'll focus on here, recommendations staff concur with BSEE's analysis regarding their lack of authority with regard to extending whistleblower protections to offshore workers. And currently the Offshore Act provides no such protection.

The Department of Labor's Occupational Safety & Health Administration maintains that OSHA does not have authority to adopt such whistleblower protection. Testifying before Congress in 2010, Dr. David Michaels, the Assistant Secretary for OSHA said, "OSHA has no regulatory or enforcement authority over mobile drilling rigs or production platforms located on the outer continental shelf where the Deepwater Horizon was located." Section 4B1 of the OSH[?] Act preempts OSHA from enforcing its regulations if a working condition is regulated by another agency of the federal government.

Recognizing this lack of protection for offshore workers, the Obama administration supported passage of the Offshore Oil & Gas Whistleblower Protection Act of 2010. In a statement of administration policy, the Obama administration said, “There’s currently no federal law adequately protecting offshore workers who blow the whistle on worker health and safety hazards.”

Further, the Department of Interior’s own Outer Continental Shelf Oversight, so the Department of Interior’s own board, the same agency that BSEE is a part of, says in September 2010 that, “Industry employees have limited whistleblower protections for disclosing safety violations.” They recommended, “Consider working with Congress to establish whistleblower protection specifically for employ…individuals employed in private sector oil and gas companies who disclose safety and environmental violations.”

Perhaps CSB’s whistleblower recommendation should have included the phrase, “Work with Congress to ensure” protection for workers participating in safety activities. And we can come back and discuss that further.

Despite the Interior Department’s oversight board’s 2010 recommendation, and the 2011 report to the President on the Deepwater disaster, which contained a similar proposal to work with Congress to address this gap, BSEE rejected both our concern about

this issue and our recommendation. If today BSEE was concerned about whistleblower protection, they could have communicated to CSB that together we should identify alternative approaches, including working with Congress to enact new law. Ultimately, it depends whether we truly consider whistleblower protection to be essential to a healthy safety culture.

In June, 2013, BSEE issued a Safety Culture Policy Statement. One of its nine tenets was that, “A work environment is maintained where personnel feel free to raise safety and environmental concerns without fear of retaliation, intimidation, harassment, or discrimination.” CSB’s report identified a gap in effective whistleblower protection for offshore workers. The appropriate remedy is not to close out the entire four-part recommendation as “Reconsidered/superseded” but to further engage with BSEE to see if there are opportunities for positive resolution.

Thousands of whistleblowers file complaints as a legal retaliation every year under more than 22 whistleblower protection laws. There is also evidence of retaliation against whistleblowers in the Gulf of Mexico but no effective measures for workers to seek out.

Deepwater Horizon workers had safety concerns prior to the explosion. Jason Anderson, who died when the rig exploded, told

both his wife and daughters that working conditions were not safe on Deepwater Horizon. According to his widow, Shelly's, testimony before the Senate Commerce, Science, and Transportation Committee, Jason was reluctant to talk about these concerns while on the rig and told her, "I can't talk about it now. The walls are too thin." This fear was so strong that Jason reportedly talked to Shelly about his will and getting his affairs in order not long before the explosion.

As former Representative George Miller of California said, in supporting the Offshore Oil and Gas Whistleblower Protection Act a few months after the disaster, "There is no good policy reason for treating onshore and offshore workers differently." This is because a whistleblower may be the only thing standing between a safe work place and a catastrophe.

Fifth, the recommendations department incorrectly asserts that if this recommendation were implemented, it would be duplicative and inefficient to the federal regulator, etc. The CSB recommendations department maintains that the CSB proposal for enhanced work authority duplicates what [inaudible] already adopted in SEMS. A comparison of the BSEE SEMS provision and the CSB recommendation, however, shows that the CSB recommendation contains important enhancements. For example, if an issue is unresolved at

the workplace level, the CSB proposal calls for regulator intervention to resolve the issue. The BSEE SEMS provision says nothing about regulator intervention.

Sixth, BSEE incorrectly asserts that worker safety committees are essentially a characteristic of a safety case regime that we do not utilize in the US. My written statement addresses this issue at greater length, pointing out that 17 states have requirements for safety committees. The US does not have a safety case regime. Safety committees are a well-accepted approach to preventing hazards in a very wide range of workplaces and should be created on every major drilling rig in the Gulf, as our own reports propose.

Lastly, in terms of my point, point, point comments, the BSEE with CSB recommendations department, wrongly rejects the CSB's proposed enhancement to BSEE Safety & Environmental Management Systems Rule, asserting that our recommendations are prescriptive rather than performance based. It also implies that prescriptive regulations are inappropriate. SEMS itself is a hybrid regulatory system that includes both prescriptive and performance-based elements. CSB's recommendations are arguably both as well. For example, the CSB's proposal for worker elected safety representative and safety committees at each staffed facility leaves much to the discretion of BSEE rule making and potentially

the employer, including the composition and size of the committee, the frequency of committee meetings, who chairs the committee, how minutes are taken, etc., etc. Labeling our proposals as merely prescriptive is simply a way to dismiss them without considering their merits.

In conclusion, unfortunately, BSEE has dismissed all four of CSB's recommendations. I don't concur with BSEE's positions and our recommendations department agreements with BSEE's analysis.

On April 20, 2010, 11 workers died and 17 were injured in the Deepwater Horizon. The spill caused enormous environmental contamination and economic damage. We are entrusted by the American people to do all that we can do to prevent such catastrophes. I hope that we will not fall short.

I thus urge my fellow Board Members to vote to disapprove this notation item. And simply voting no should not be the end of the challenge before us. I urge my fellow Board Members to take two steps.

First, to review the Office of General Counsel's forthcoming analysis of BSEE's legal authority to adopt our recommendations. And second, request through the Chair, the recommendations department to arrange a meeting with BSEE leadership. This meeting will allow CSB Board Members to have a direct and hopefully

constructive dialogue about our specific employee participation proposals and perhaps other ways to best engage workers who are on the front lines of safety and environmental protection.

I again thank the staff of both our investigations department for their multi-year effort to produce such an extensive report to try to prevent such catastrophes from happening ever again, as well as the recommendations department for the development of their proposed status change. I look forward to further dialogue about this important issue at our November meeting.

And finally, I thank everybody in the room for their indulgence in listening to me on this long…on this lengthy statement.

VANESSA ALLEN SUTHERLAND: So with that, we as the Board Members, will sort of talk about it and react. I haven't had a chance to digest it yet, just because there's a lot in there and we got it this morning. But I think in November when we actually vote, if there are follow-along conversations that we have that don't get covered today, we can table those. I've asked Michelle to help us take notes for anything we put on [inaudible] or to follow-up on.

But based on the statement that you heard, I'm going to open it up to Dr. Kulinowski and Member Ehrlich for comment. I think

I'm going to paraphrase, but I think the request on the table is to discuss Member Engler's proposal to disapprove the notation items based on the reasons that he just articulated. I know we are still reading it, but I'll open it up for reactions and comments.

MEMBER KULINOWSKI: Okay. First of all, I want to thank Member Engler for the thoughtfulness with which he prepared this very compelling critique of the recommendations department's proposal on Macondo.

Today's discussion of the two recommendations and our ultimate vote from the Deepwater Horizon incident gives the agency opportunity to clarify our role in driving chemical safety in the offshore drilling industry. The blowout remains one of the most catastrophic industrial accidents in US history, as measured by loss of life, injury, and environmental impact. And the CSB's comprehensive four-volume analysis made major contributions to offshore drilling safety by examining the technical, organizational, and regulatory contributors to the incident.

At the time of the incident, the offshore working environment was not well-regulated. In its aftermath, there have been major improvements to safety offshore but are they enough? I also note that this investigation was long and the situation and facts were changing throughout the span of the investigation. So in some

cases, it was maybe an issue of timing with respect to the causation.

So the recommendations that we're discussing today would strengthen the role and responsibility of Boards of Directors and executives in preventing major incidents offshore and strengthen regulations for worker participation in safety activities in a largely non-unionized workplace environment. I agree with our investigators and Member Engler that worker participation and safety activities strengthens the safety culture of an organization and is vitally important in promoting a safer workplace.

But [inaudible] questions before us are, one, whether CSB recommendations must arise exclusively and directly from the facts of an incident or whether our statutory authority permits us some latitude to identify regulatory shortcomings where we see them. And, two, whether these specific recommendations are directed to the appropriate recipient. And for the rest of my response to Member Engler, I'll focus on R15 as he did not find any issues with R2.

So I agree with Member Engler that our enabling statute gives us the authority to conduct studies that enhance chemical safety broadly. The Macondo incident was certainly big enough to warrant a more expansive analysis than one of our case studies would. So

the question remains in my mind. BSEE asserts that it lacks the authority to implement our recommendations on worker participation. Member Engler noted that Dr. Michaels asserted that OSHA did not have whistleblower protection authority offshore either. So we find ourselves in a situation where we have two agencies, each saying, “Not us.” One’s assertion is taken at face value and the other’s is rejected.

Moreover, left out of Member Engler’s analysis altogether is a third entity, the United States Coast Guard. And the issues around the memorandums of understanding between OSHA and the Coast Guard were an element of our recommendations department’s analysis. And OSHA’s own analysis, which asserted that workplaces on vessels greater than three miles offshore, the Macondo prospect was about 40 miles, were under the purview of the Coast Guard, which did then and does now have whistleblower protection provisions.

So the story behind the evolving memorandum of understanding between OSHA and the Coast Guard and the court case that challenged OSHA’s authority to assert its jurisdiction beyond three miles is all very interesting and has not been [inaudible] today so I’m just going to briefly just throw that in there. I would be interested to hear a rebuttal on this specific point because Member Engler’s analysis did not address the Coast Guard as the third entity that

may ultimately have the authority to regulate whistleblower protection in this case.

Regardless, I agree that having access to the full Department of the Interior Solicitor's legal opinion would be very helpful in understanding BSEE's argument better. And I support having our Office of General Counsel weigh in on this.

So, at the moment, I am swayed by the facts presented by our recommendations department on the Coast Guard issue. However, if they agencies continue to point fingers in other agencies' direction, I agree that a legislative remedy and clarification may be needed to finally resolve this. So I look forward to hearing what our general counsel has to say and learning more about the rationale for BSEE's rejection of their…of their authority in this…in this case.

With regard to the documentation of cases of whistleblower retaliation, I…I hear what you're…what Member Engler is saying about the history of whistleblower retaliation reports in the Gulf, but that was not in our report. So our report did not have a foundation for the whistleblower retaliation as being a causal or even connected to this particular incident. So it would be… So I just leave that there as a… You know, when I'm reading a case, when I'm reading a report, I'm looking for linkages between what

happened and what we're saying. And I hold a higher…I hold to a higher standard the evidence required to make a recommendation for regulatory remedy than I would to make a recommendation, say, to issue guidance, which is non-binding in the case of the prior recommendation that we're discussing today.

So I'm just going to…you know, we can have our conversation. But I'll leave off now by saying that in no way… First of all, I haven't made up my mind yet. And in no way should a reconsider vote, should that be what we come down on, be interpreted as statement by the CSB that worker participation without retaliation is unimportant. Nothing could be further from the truth. I think it is possible to care about this issue deeply and also care that it is done correctly and by the appropriate regulators.

VANESSA ALLEN SUTHERLAND: Thank you. And Member Ehrlich, thoughts, reactions, statements?

MEMBER EHRLICH: Well, yeah, a lot of thoughts, a lot of reactions. I don't have as detailed a statement as Dr. Kulinowski had. I tend to agree with most of what she said. I too think that the Coast Guard…we missed an opportunity or perhaps we didn't, but I think we need to find out what that involvement was and how that goes forward.

I…I really want to say that the team that did this report did an outstanding job on it. Okay. It was 1,200 pages, if I recall correctly, and I did my share of complaining about it when I was trying to read through it. But they really did an outstanding report. And…and I have a lot of confidence in what they've done. And by the same token, I have the utmost confidence in the recommendations group in terms of their analysis of the situation.

One of the questions that kind of rolls around in my mind is what authority do we have to say another government agency screwed up, okay, where it's not right. And I think that's important. And I'd like to…I'd like to echo what Dr. Kulinowski said. I think most of you know I've been in the chemical industry for over 50 years. And I think worker safety and worker protection is vitally important. And when I go into the field and do outreach and advocacy, I talk about that, outside of the provisions of whistleblowing and other issues.

So I…I'd like to hear what else…what other folks have to say and perhaps come back to my comments.

VANESSA ALLEN SUTHERLAND: So, I mean… Given that this is truly an interactive conversation, I paused to make sure that if you all had any introductory remarks, that you could give them.

But now it’s really… I mean it’s sort of as we would discuss it around a table.

I want more time to digest. I’m more of a…I’m a digester. So this is a lot to digest in, you know, in a few minutes, without having had it previously. But I’ll say this. I’ll say two different things. I’ll give my reactions and response, but I want to make sure that I say the obvious to the Board.

We have two different questions on the table and I…for us to be efficient, I want to make sure we remember that. One is the vote on R7 and R15. And while we may be raising broader policy questions about driving chemical safety change, we calendared two recommendations and we are going to have to dispose of them at some point. And our Board Order 22, if anyone wants to take a look at it later, [inaudible] 11, says we get information, we ask questions of the recommendations team. We then deliberate and debate it. But then we vote. And so we have policy questions embedded about how we carry out the mission and how we… That’s different from do you approve it, disapprove it, etc. So I appreciated you at the end clarifying and saying, “I’m asking… This is what I’m asking of the…of the staff.” Because I don’t…or the Board Members. I don’t want those two to get conflated as we have this conversation.

And my reaction to the…the comments so far is…because I do think it's our job to hold everybody accountable—regulators, the regulated, anybody who can advance chemical safety change. That's what we do. But we have to also make sure that the people we're asking to do it are actually positioned to do it. And so if we have a question, a fundamental question, about whether this was the right entity, the way I think of it, having been a regulator, is I may read my own statutory authority and think that I have no authority [inaudible] to implement a particular action. There is longstanding Supreme Court jurisprudence on this point. If it's… And maybe…I think maybe, Member Engler, I think I heard a little bit of Dr. Kulinowski's point, that maybe the recommendation should have been made to Congress, that we have this going on.

Trying to be…you know, beleaguer and browbeat a particular agency who has looked at through their own lens, technical and legal, and said, "We don't believe we have the statutory authority to do this." I certainly think that Chevron case…Chevron's case law and deference, which is a doctrine of administrative deference, is going to say to people if they don't believe they have the statutory authority and they've looked at it, even if we issue or even if we have a legal opinion, which I have asked [inaudible] Member Engler, even if we have a dispute, that's still ultimately

their responsibility and their right to say, “We disagree with you.” That is fully based in Supreme Court law.

And I think our comparison and their comparison, even if we conclude we think you are the right entity, the question then becomes if they’re not going to take any action, do we continue to spin our wheels for six more years while they figure out whether or not they have this jurisdiction? That’s when you use a Congressional conversation. And we should figure that out and, as a Board, can figure out post-vote if this is happening in the federal government, which is not a new thing, then what is our role in facilitating the conversation instead of holding somebody’s feet to the fire because we issued a recommendation?

And I’m not saying that…you know, that the idea of driving a broad national chemical safety change is in any way mitigated. And I’m positive all four of us agree that worker participation in safety…a good safety culture is a…it’s a gateway item. It’s a precursor to having a safe environment. I don’t think anybody disputes that.

The question for me is was this recommendation borne of a causal link, based on our facts, and… I’m going to… I hate to dig up our…our own guiding documents, but since we’re focused on operational health and following what we say we’re going to do, our

public Board Order 22 on our website says that the recommendations team will consult with investigations. I know they did it in this case. As well as the recommendation recipient. And the draft evaluation shall contain a clear rationale that links the basis of the recommendation as found in the investigation with conclusions that factually support the evaluation of the actions of the recipient, that reflect the consensus of the investigation and recommendations wherever possible, and have been discussed with recipients prior to submission to the Board.

So going from the latter upwards, I know we talked about [inaudible] have multiple exchanges of information and communication that you heard from Member Engler. And…and so I think we did a good job trying to figure out…the recommendations team did a great job trying to understand that the…the basis upon which they rejected implementation of R15. I know, having talked to investigations and recommendations, that they conferred and had basic level agreement about the lack of robust causal links between the recommendation and the fact of this investigation. Upon that, they do not disagree.

And I thought the supporting documentation contained a very clear rationale that, based on the…this going on among federal agencies… For those on the phone, that's me pointing in two

different directions. And the…looking at the factual basis upon which we would have derived this recommendation, that they took all the three things that we say govern our recommendations process and concluded we should reconsider it. Which did not foreclose us from working with BSEE separately or OSHA and BSEE separately or Congress separately, to address a very important policy issue.

But from a procedural perspective, if we look at how we tell people we're going to govern ourselves, which we have made publicly available, and we look at what the recommendations team did, they did that. And they presented to us a factual basis upon which to make a recommendation. And it's up to us to either vote approve, disapprove, or abstain because I can't make a decision.

And so my read of the materials, coupled with our own imposed procedural governance, is that I think the recommendations team made a fairly compelling case that the recommendations, not having a clearly articulated and more robust causal link from the fact of Macondo to the recommendation as drafted, BSEE's lack of, I guess, willingness or interest or, they think, ability to even implement the regulation or include these types of committees and for the fact that they did everything that we say we're going to do, which is present the information and provide an opportunity for the Board Members to question and critique them before we make a decision, it

seems to me that the real question we are talking about is not voting on R7 or R5. It's a different question. Because we have enough information… I mean I will ask my fellow Board Members what information do we need to make a decision based on the packet as present, as proposed.

The question we are talking about is should…does and should CSB make recommendations to drive broad scale change irrespective of whether there's a causal link. That is the question on the table. Not to be convoluted with R7 and R5. We just heard that we don't have any dispute on R7. Right, we'll probably vote but there's nothing there to deliberate.

What I heard on R15 is this is a really good idea, with which I agree with Member Engler. Having workers and regulators and employers talk, no one's ever going to dispute that that absolutely enhances awareness, communication, information, and safety. But that is a completely different conversation than should the Board, absent factual basis, decide that an issue is so important that we want to make a recommendation to a recipient. I'm not prepared to answer that question today. But I am prepared to say that I will digest the…the statement from Member Engler and welcome other thoughts and feedback on how we get to the policy question.

But the policy question means we should be revising our Board Order, which doesn't say…it says causal links. I mean… That's self-imposed. But if we want to have a conversation at a subsequent Board meeting about revising the Board Order and revisiting our own statutory authority and whether or not that statutory authority broadly gives us the authority irrespective of facts to issue recommendations to parties, I think that's fine. We can have that discussion. But the fact it says study. This wasn't a study. This was an accident investigation. One could argue the breadth of it may make it look like a study. 1,200 pages does [inaudible] a study. More than a Ph.D. thesis. Fair point [inaudible]. But I think that's a more dynamic conversation than the recommendation team gave us a proposal. Now we have to be members and decide whether we're going to support the proposal, vote it down, or abstain. And all the other policy conversations, we should have those. But we shouldn't have it in the context of our responsibility to vote based on what the team did, because they did what we've [inaudible].

MEMBER KULINOWSKI: But for me the question on R15 is, is it going to be voted "reconsidered, superseded" or voted "unacceptable". Unacceptable means I accept that BSEE has the regulatory authority to make the changes that we requested and they

refused to do it. Reconsidered/superseded means we made a mistake and we've reconsidered who…new facts have come to light that say they weren't really the right ones to have the recommendation made to. Maybe we should have made it to another agency. That's important. That's not just a policy question.

VANESSA ALLEN SUTHERLAND: But that would be… In my… I totally agree with you, 100%, what you just said. That, to me, is a dissenting opinion. That's a…I disapprove this proposal for recommendation. Here's my dissenting opinion because I believe that BSEE was the right [inaudible] and there was a causal link, etc., etc., etc.

So there is a mechanism to address that piece, which is then I propose that it be given back to the recommendations department for, you know, "closed, unacceptable." So I…

MEMBER KULINOWSKI: It's a technical argument. It's a legal…it's technically a legal argument as to who was the right recipient for this one. And that's why…that's at the heart of the…of the dispute.

VANESSA ALLEN SUTHERLAND: I'll say, you know, a flavor of what you said, which is… I think I just indicated I don't think that there is a causal link and that they were the right recipient. And even if…

MEMBER KULINOWSKI: [inaudible]

VANESSA ALLEN SUTHERLAND: So if they have…if we decide let's go revisit, then the statutory authority question becomes, yes, they may have the statutory authority. But they're not going to…they're not going to implement R15. Then, yeah, we would have a discussion about whether that's closed, unacceptable. I get it. We don't have the legal memo.

But irrespective of the legal memo, I'm…I'm struggling with the threshold question, which is was there a causal link and should we have made the recommendation to them in this manner in the first place. Once you get past that, if the answer's no, then you don't really need the legal memo.

MEMBER KULINOWSKI: And I'm struggling with that, that question, whether or not we should have the latitude to be able to make bigger picture recommendations on an investigation of just such a magnitude.

VANESSA ALLEN SUTHERLAND: Mm-hm. Members Ehrlich, Engler?

MEMBER EHRLICH: I think… I tend to go back and look at the Board Order and without a causal link, I think there's a major issue here in terms of how we do business long term and how we've done business in the past. And I think that's something that needs

to be…be resolved. Because I didn't find a causal link, either, in the data that I've read.

MEMBER ENGLER: A couple of comments. One, one is the difficulty of proving causation. In this situation, workers died. As we've found in other investigations, you…you know, people die, they can't be interviewed. There were a variety of factors that led to very late occurrence of worker interviews.

But the broader question is can we ever really prove that the existence of certain policies would prevent a fire, explosion, or major release? We have never really, really prove that. And at some point, there's some judgment required. I'm not even sure that the regulatory threshold for OSHA has such a degree of proof. We're making recommendations. We're not issuing mandatory standards or regulations.

I think that's part of the difficulty here. So, for example, to use…to use an example from my experience, in New Jersey, when the Worker and Community Right to Know Act was proposed in the early 1980s, opponents said, "How can you prove that this would save lives?". It's really difficult to prove that because if workers and community residents knew the names of the chemicals they were working with, which they often did not know at the time, they had a sense of what the health or safety hazards were, which

they probably didn't know since they didn't even know the names of the substances involved. If that knowledge had been absorbed, became part of common discourse, perhaps a lot of people, and there's been very limited scientific or academic studies of this, would have better health and there would not have been fatalities.

But there is an enormous difficulty in actually proving that. I'm not a… I wish I had your logic chart, Dr. Kulinowski, because I'm not an expert. Others might… I'm probably setting myself up for a comment at not being an expert in logic. But I've been struggling with this, too, is that does it require, in every single investigation, no matter the fact pattern, the fat pattern, and the obvious gaps, that this Board cannot take action to address an issue.

A situation where…on whistleblower protection. The report to the President on the Deepwater investigation says whistleblower protection is important. Where the National Research Council says whistleblower protection is important. Our own report has references such as number 281 to a BSEE report on…on worker fear of losing jobs in another rig in the Gulf.

So it's…it's a difficult…it's a difficult problem. And I don't raise this lightly. But I do raise it because I think that this was a very significant investigation that produced… And I

think here we're somewhat dealing with semantics, a report, a study. It was clearly a regulatory gap analysis amidst a investigation of a specific incident. And I can…I can show other CSB products which have been in the same sense…in a sense inconsistent, but in a sense maybe it didn't matter. I mean our oil tank protection investigation, the product was called a study based on three investigations that seem to be quite well documented.

So I think there's a difficulty. I think this is…this is a very difficult question.

And the second one where I'd like to perhaps demonstrate understanding because we may have multiple routes to…to go, to develop here, is that if we made a mistake on the particular agency, the question is whether the issue, the matter of that if workers do not have the ability to feel comfortable speaking out about danger, in a sense, trumps the particular specific process.

And I would argue that it's not a matter of…of getting into a finger pointing with…with BSEE. It's perhaps more important to see, moving forward, if we could have a dialogue to discuss the substance of the issues, which might help us address the vote going forward.

In other words, on other recommendations that have come back to us, the recommendations department has looked at them and said, “Well, the company said we couldn’t do this, but we could do that.” And we said that seems reasonable. And voted in accordance with the recommendations department. Perhaps there are options here. I mean I would welcome an indication from BSEE that it’s not simply a legal question but that, as a matter of policy, they’re open to having a conversation about this.

And I think that would very much inform our judgment looking…looking forward. That’s why I recommended that the second…that the Board Members consider this second proposal, that we make another attempt at having a direct dialogue with BSEE.

VANESSA ALLEN SUTHERLAND: So I would say it is hard to prove a negative, having been a regulator [inaudible] my colleagues here. It is difficult to prove that X will prevent. It’s more… If it’s not hard data, it is difficult. I mean you raised the perennial problem of how do you prove a negative. We didn’t have an incident that was directly attributed so now that we have these committees, we communicate more and we’re safer and incidents go down. So that is a challenge.

But we have in the past, in our own investigations, identified where training deficiencies, lack of well-rounded PHA committees,

were in fact a contributing factor leading up to an incident. So if…it is possible and we have done it. So if this issue were…if...for me, coming to us with a recommendation and we said they had this committee but it didn't work and no one was…you know, they were specifically told in email and interviews, don't ever use your stop work authority, and we found evidentiary support and then derived a recommendation that said, no, this is clearly a problem and it's prevalent and we had data to back it up, then I'd feel more comfortable saying, you know, we should probably go back to discuss it one more time.

But, based on the…the material that we have, I don't know where I'm going to go or what other additional information I'm going to get from recommendations that convinces me this is going to…if we talk to them one more time, [inaudible] statutory authority. Because even if we ask…if we engage them to do something different, that won't address the issue of R15. R15 is…is separate. If we want to talk to them about how we partner with you and OSHA, that still doesn't prevent us from disposing of R15 because R15 is what it is. It's prescriptive. You are going to do these things and they said no.

And I think it's really… The question I pose to you guys is isn't it incumbent upon us through outreach, articles, our other

Board Member responsibilities, legislative suggestions, bully pulpit, maybe even doing a full-blown study to get data and information on this. Isn't that the way to drive the kind of national change we're talking about, rather than deciding that in a particular incident we can…we can add a really meaningful and important recommendation because it's the right thing to do but doesn't have any link to the facts that we just investigated?

So I'm having a hard time wrapping my brain around what that would look like in practice. We don't need to…and I don't mean this in any way to be flip, but why do we deploy? We can just come up with the things that we think are good ideas for safety and issue them as recommendations and hopefully investigate the right recipient. Because if…if the real tenet of what we're talking about is do we really need a causal link… What if it's a good idea? Then I would want more time to think about, well, then why do we need investigations. Because the entirety of the investigation is for us to do a comprehensive root cause analysis of all factors, whether or not they're in a regulation, whether or not they're embedded in the standards, and make recommendations that might have a national impact. But it's borne of the incident to which we deployed.

If want to do a study and then make broad recommendations about certain categories, I support us talking about that. But I…shoe-horning that in now, in the face of our statutory history and practice of what we had been doing, which is not that… Because I don't think most people would say, "Oh, the CSB investigations, you just drop good idea tree recommendations in." They…they usually say this is a causal link.

And so I guess the question for us would be if we're going to really turn the corner, what does that mean for our other sort of bully pulpit-ish outreach activities, which is, to me, where that convener role and that driver of chemical safety change role should be. The investigations, in my opinion, should be the investigations. And the facts dictate who we contact and who can prevent that type of incident in that industry or that type of practice from doing it again. Because otherwise it…it feels to me, without sort of thinking it through more, that the credibility of our investigations are going to be it doesn't matter anymore whether we deploy or this or that. We have an idea and we think it's a good idea and let's put that in a recommendation. Or if we get the recipient wrong, well, let's work on it and focus…

And I…I don't think we're saying it in that kind of a flip way. But I'm just saying… I'm just saying to you guys, because we

never have a chance to talk, it feels kind of flip to me without being based in data.

MEMBER KULINOWSKI: So it's interesting that this one came up in conjunction with R7 because when I was thinking about the causation issue, I was looking at both of those together since they came to us together to vote. And the question could be asked was the absence of regulation ensuring greater, you know, Boards of Directors' engagement on safety, was that…was that causal or would that have led to change if they had been more engaged. And if shareholders had known more about the safety risks, could they have pressured the companies to implement safety measures or even measured the right things, the leading indicators? And I found that in that…in R7, we did look at other cases in the companies involved, particularly BP, where the shareholders had put pressure on the company on the issue of climate change. And they applied pressure. There was some shareholder activism that went on there that produced a result.

And so I thought the team, with the weight of that example that was highly relevant and specific to the companies involved in this case, could they make a case…they could have, if they had been informed, if the shareholders also had put pressure on the boards in the area of safety. And so…and because that, coupled with the

fact that R7 was not a recommendation for regulation but merely guidance…not merely guidance. Guidance is important. That…that was a low bar for me and I was able to clear it to come to the unacceptable recommendation.

The other issue is, you know, going along with what you said, Chair Sutherland, about our advocacy program. It's second of our three strategic goals and it's not just about issuing recommendations. So in our reports, in our case studies, in our bulletins, they also have key lessons or key findings. Sometimes we call them different things. But they are things that we think are very important that nonetheless don't, for what…a variety of reasons, maybe they're impracticable, rise to the level of a recommendation, that we then must track and seek to close one way or the other.

And so I still don't know if these good ideas would have been key lessons or key findings from this incident. But I guess I might have been a little bit more comfortable accepting them in that regard rather than as a recommendation for regulatory change.

So we could have said we find that it's important that worker…I mean we found it in the report, right? You mentioned…you cited a…Member Engler cited a specific passage where our investigators talked about safety culture and the importance of

strong worker participation in safety activities to promote that culture. So that's a key finding.

VANESSA ALLEN SUTHERLAND: Okay.

MEMBER KULINOWSKI: That doesn't necessarily mean that we need to issue a recommendation for…for change. So just some thoughts about that.

And one final thought on the…on the studies versus recommendation. It's interesting how we define that. Study seems like it comes from more than one incident of a type. Like our hot work study, for example. Does one major, big, huge, catastrophic accident equal X number of small incidents that give rise to a study? Just food for thought.

MEMBER EHRLICH: Good question.

MEMBER ENGLER: One historical piece that I would like to just add is, you know…so people understand that this…even the decision to investigate this incident, I think…although none of us were on the Board at the time, was…had some controversy attached to it, including the anticipation of getting federal funding to do the study, then getting no money what…whatsoever. But still, the Board at the time did actually take a vote on the investigation and what was to be included in the investigation, including the technical issues, the safety system performance, organizational factors,

safety culture, contractor management, and the effectiveness of laws, regulations, and enforcement.

I recognize this Board can do what it chooses to do as the constituted Board at this point. But the framework that the investigation staff worked under, the direction that was provided by the Board, not a unanimous vote, was to essentially do a study in the midst of a incident report. So I…I admit that. I think that, in fact, is the case. Do I think, in fact, it could have been better documented? I think there are cases, and I know from looking at my memos during that period prior to us approving…unanimously approving the report, that there were areas that I wish had been addressed and wished that we had taken even a little bit more time than we did to get this report out.

But I do think that there are very significant matters of not just principle. It's also fact. So that when you look at the whistleblower issue in particular, and you see thousands of whistleblowers across industries filing claims of retaliation under 22-plus different whistleblower protection laws, and then you see none, perhaps… We're going to see this? [inaudible] our General Counsel's report back. I'm quite skeptical that this protection actually exists and so many…everybody from, you know, the report to the President missed it all the way 'til now. Let's see what that

opinion says. I think that will be important for figuring out how to move forward.

VANESSA ALLEN SUTHERLAND: Let me ask you this. If…if we had a legal opinion that said, yes, it appears that BSEE has the authority to implement R15, walk me through. What would the next step be? What…what would your… We have a calendared notation item. Tell me the next two to three or two to five steps that you would want to take following…if it happens that way, [inaudible] BSEE does appear to have the authority to [inaudible].

MEMBER ENGLER: IF BSEE does or does not?

VANESSA ALLEN SUTHERLAND: Does.

MEMBER ENGLER: I… On this particular issue, given the gravity of the investigation, the importance of the investigation, even if one could argue with deficiencies in the investigation itself, I would like to have direct dialogue with BSEE to better understand their reasoning. I think that's something that can be done potentially prior to the voting. There's a mention in the…one of the investigators' responses to the effect that if we agreed…and I forgot which of the four, because there are four distinct proposals, they nonetheless said they didn't have the authority.

But I think that moving forward, understanding not based on a dismissal, based on…entirely on a legalistic analysis, which of

course we want to be in a legal framework to understand what agencies can do and what they can't do, but understanding what their goals are at this point would be…would be actually quite important.

I think there may be reasons not to… I mean I think this agency, frankly, has somewhat of a mixed history in relating to other federal agencies. Maybe that's a nice way of putting it.

VANESSA ALLEN SUTHERLAND: You mean the CSB?

MEMBER ENGLER: Yeah, including BSEE. And that…and that reaching out and trying to have a dialogue with them, I think would be very productive for the Board. Even if it does nothing but clarify that they…that they don't want to move forward. Because there are four specific…there are four specific proposals and we really have to parse them. And the question will also be if the memo comes back and says really this was written to the wrong recipient, whether it [inaudible] how we handle the situation again, closing out three other parts of the…you know, of that particular recommendation. Because if there's a mistake in one, does it mean that the other three have no merit? Now that may be a lesson moving forward for how recommendations are better written and they should have been separate recommendations with separate

analytic…you know, separate assessment. But now we are dealing with a situation where they were grouped and we have four.

VANESSA ALLEN SUTHERLAND: So I'll say this and then [inaudible] my other fellow Board Members. The way that I'm going to do this is almost like a flowchart. Because I'm not jumping to where they…whether they have the legal authority or whether we think they do or not. Because I'm going to get stuck on Chevron and Mayo[?] and other Supreme Court [inaudible] that very clearly articulate that these federal regulators have the ability to determine how they are going to interpret their statute that they administer and how they're going to carry that out.

So, you know, getting into a duel with another federal agency about whether the way they read their own statute is…you know, I don't know that that's a good use of our time, if we know the issue we want to tackle.

But for me, the flowchart is, is there a causal link or not? If no, I don't know that we…that I would spend a whole lot of time on the authority question because if there's no causal link, I…I don't know whether I'm going to get over the hump of we have a recommendation that's not borne of the facts of the investigation. So that's flowchart number one.

If there is a causal link, then you have to ask, okay, then is this the right recipient? If no, well, then that's another dead end. And if yes, are they going to implement this irrespective of a conversation or us sending a memo that we believe they in fact do have statutory authority. Plus I think…when I get to that flowchart, I guess the… Member Engler, my thought is really how to tackle the broader issue that you are raising which is still unaddressed. And I don't know that we're going to address it by putting out [inaudible]. The issue is what is our Board strategy for dealing with an issue that we've identified as a gap.

I don't think we're going to get past the causal link. I mean we can have reasonable disputes. But I…I think, you know…based on our own internal conversations and if we go back and talk to our own teams and we reread the report again, that's going to be question number one. Even if we get past there, that yes, we still think there is one, the right recipient question to me is a little bit of a red herring because then we're going to be in dueling statutory discussion about whether BSEE's interpreted their statute correctly.

So I don't…I don't know that that's going to be a positive outcome anyway. They've already told us in multiple ways, "We don't think it's us." So I don't know because we produce a memo,

they’re going to go, “Oh, my gosh, we didn’t know.” I think they’re going to say, “Okay…”

[multiple voices]

VANESSA ALLEN SUTHERLAND: …you memo. I mean we can do it for our own edification. But I think the issue is how do we jump to our strategic plan, goal number two, with strategic advocacy and outreach on issues that we think are critical safety challenges that have not yet been moved or are not being addressed on a national level? And that is a different question for me. I think I pretty much…in listening to you guys, I think I am…even though I need to reread this in quiet time, I think I am… I think I do know where I’m going to come out. But I also think that the policy question that we’re [inaudible] that we’re raising are still worthy of a debate among us about how do we want to address things that are really important, that are [inaudible] before which we haven’t yet collected data or done an investigation. That’s number one.

And, number two, when we do address these kinds findings [inaudible], how do we address them and how do we want to allocate our resources for highlighting or shining light on something we think is important?

So I still think we should have that conversation in November, as well, because we have to vote anyway in November. But I’d be

interested to have…to hear what you all think to inform how do we in FY18 look at these types of issues and even if we don't have a body of work upon which to base our conclusion or decision, but it's still an important safety issue, how do we address that? And how do we want to, you know, dedicate our staff time and dollars on it in order to make sure that people are aware of it?

And I don't know that shoe horning, you know, a topic into a very snug fit or having a debate about trying to persuade someone that they really do have a statutory authority to do something they've already told us they don't want to do…we could use that time… My opinion is I think we'd be better served using that time and dollars to figure out how do we get this issue highlighted. And maybe that's bringing people together. But I…I think when the staff collected the information from BSEE, engaged them, saw the excerpts from their general counsel about BSEE's interpretation of statutory authority, conducted back and forth email, was more than adequate and sufficient for my liking, for me to be able to…to look at the materials and make an informed decision. So…

What do you all think about in November trying to figure out what the…what the advocacy plans are, if there's no investigative body of work upon which to really talk about an issue? Studies, meetings…

MEMBER KULINOWSKI: I have a hard time with us making statement, doing advocacy on issues that are not based in our work.

VANESSA ALLEN SUTHERLAND: Right. I do too.

MEMBER KULINOWSKI: Because we are supposed to be speaking from the authority [multiple voices] of the data that we collect and the analysis that we do. So I think the solution is a little bit more of a longer-term solution, which is if we do see a big gap somewhere, a case comes along where the facts fit, then we hit it. And we have the weight of the investigation and…and the analysis behind it and we can speak with a greater authority. That's not to say that I don't… That's not to say either one of two things. That I don't think this issue is important or that we're going to go looking for a case to fit, you know, an issue that we want to. But I would be more comfortable if…if the things that we say, especially big issues, are derived from our work.

MEMBER ENGLER: I would add a couple of things. One is that this agency has a history of doing things like holding public hearings and roundtables on different issues. And I would certainly support…because I don't think… I don't think… I think the agency as a whole could benefit from a more common understanding of the strengths and weaknesses of…for example, of joint safety and health committees. I think it's something that's

taken for granted that a lot of people are aware of, but there hasn't been a vibrant discussion of what their weaknesses are and what their strengths are, what that means going forward for some time. And that applies, perhaps even more to onshore facilities than even offshore facilities.

[multiple voices]

MEMBER ENGLER: I'm suggesting that there's sources of work that [inaudible] when you said, "Not based on our work." Well, our work has involved doing public hearings on fatigue, on…on safety indicators, on other areas that are work and looking at policy gaps and looking at the literature and the lack of literature and seeing how it ties back, of course, to investigations, which is the…the…ideal approach.

And, secondly, what I'd like to say about this is I do think it's very important to lay some groundwork, shall we say, on this issue. To understand the agency's…range of agency's position. Because if you look at and take at face value the current administration's approach to regulation, it does not seem likely that there will be too many regulations. For example, the…for every one new regulation, the policy in place to cut back on two regulations. I'm not positive I have that exactly right, but that's, I think, the spirit of it.

And so my view is that we're laying some groundwork for perhaps future actions. And that the fact that an agency right now, in this rather short period of time, doesn't want to do something is not a reason not to pursue it and to explore it and to try to lay a documented groundwork for action in the future at a…at a different point in history.

Now, I'll use the example of hazard communication. The OSHA Hazard Communication Standard took decades to achieve and now everybody takes it for granted. There's widespread support. There might be arguments over definitions or…or standards of proof, but everyone now, I would say, for the most part, thinks the Hazard Communications Standard is an accepted OSHA regulation that gives workers access to training, names of chemicals, labeling, etc. And…but that was actually the result of a very long-term process. It took years of work in different states and at the national level. And I would suggest that on an issue like this, the groundwork we lay for future advances is very, very important. And that includes understanding the position of different agencies and whether or not they want to proceed, whether it's because they don't have regulatory authority, or because they simply don't agree that…that further enhancements to the SEMS program are…are the right path to follow.

MEMBER KULINOWSKI: Can I just respond briefly? Because I don't want people to be left with an impression that somehow [inaudible] on a dime with a change in administration and suddenly has a new position they didn't have a year ago. Because I don't think that's accurate. So I hear what you're saying and I agree that…that it's important for us to, you know, work with the agencies in any way that we can. And…and understanding that there may be a different climate today than there was a year ago. But this…these issues preceded, you know…

VANESSA ALLEN SUTHERLAND: So having been the only one in the federal government for four years before we all started working together, and doing that as a regulator, there was in fact a very broad initiative. You're laughing. But there was a broad initiative to do a retrospective reg review. And there was a massive undertaking to do a paperwork reduction act review, to reduce the burden on industry at multiple agencies. That's not new. That's not unique to this administration.

MEMBER KULINOWSKI: No, that's kind of my point.

[multiple voices]

VANESSA ALLEN SUTHERLAND: We had lovely spreadsheets exactly detailing how we were going to drive down the paperwork impact on industries, how we were going to really strategically look at

regulatory reform. And that was what the retrospective reg review was for. When that…on that… I was in the ELT[?] meeting every week, at least in my agency, to discuss that very [inaudible]. So that is a continuation and there are many rules that I can recall in my time, my tenure at DOT, that we would have wanted to get out and they languished. No names about the rules, but the languished for three to five years so…just saying. Putting it in perspective.

So I hear what you're saying and I think what I envision for us is we are independent and we're non-regulatory. We [inaudible] coming up with the tools in the toolkit that are not heavily weighed down on…on one side. It's our job to say, look, you need regulations but you also need better training. We need better guidance. We need better standards. We need better blah, blah, blah. And…and so I think as these issues arise, part of what I see us doing is exactly one of the things you just described, Rick, is being the convener to get the people together in a joint group, forum. Call it, you know, learning session. To figure out…help us figure out how to crack the nut. Because I don't think the conclusion is always…it'll only be fixed by a standard. It'll only be fixed by a regulation. I'll only be fixed by whatever.

I think the people who are overseeing regs and the enforcement and the investigations and the standards development and

implementation if they're in industry, really probably just…we could help facilitate a conversation about how do we…how do we deal with the gap here.

So I think your point is very well taken, that a roundtable or forum, something of that sort, where we can hear from people, particularly given that we don't have the data, significant body of data, how do we get that so that we can then make informed recommendations that are weighted in data. Not necessarily weighted in a feeling that we know how we should be better but we don't have any real concrete information to back it up.

I will say in the interest of time, we still have a couple other items just [inaudible] opening up the phone and the floor to any thoughts or comments, and then a quick summary of what our next meeting will be. And I want to make sure we end…we said we'd end at 3:00 and I want to give people a lot of time on the phone and in the room if they have comments about other topics or this one.

So I will ask, going down the row, if you will have any other comments or questions that we could be speaking about over the next couple of weeks that you want to put out for the other members.

MEMBER EHRLICH: I do not.

MEMBER KULINOWSKI: No, this has been a great discussion.

VANESSA ALLEN SUTHERLAND: Okay. Well, I would say thank you for raising all the questions so that we could discuss them and do it in a Sunshine Act session. We never have a chance to do this. And we will obviously in November be doing a vote…voice vote on these two recommendations. We technically, I guess, if we…what I heard on R7 is there really isn't…people are prepared to vote. There's no additional information or debate that needs to occur. So I will probably ask the team to do a notation item for R7 independently and [inaudible] it like that. And we will hold off on voting for R15 until we have additional comments heard by the Board Members.

So at this time, I'd like to open the floor up for anyone who has a public comment. And please present your comments, ideally in three minutes or less. We will begin with the list of anyone who has signed up on the table out front. No one? Okay, then we'll just do it by show of hands. And, Richard, for those who are listening on the phone, you can unmute them momentarily. But if you are on the phone and you want to email your comment instead of saying it, use meeting@csb.gov. Our first hand in the front.

JORDAN BARROB[?]: Thank you. My name is Jordan Barrob. I spend a fair amount of time working at OSHA and the Chemical Safety Board. I…quite frankly, this is about the…the most recent

conversation and warn me when I'm like 30 seconds away from three minutes.

I'm troubled by this for a variety of reasons. First of all, I think it's clear that BSEE probably has the authority because they have done work…I mean they have some regulations, even if they're soft, on worker participation. When you move from that to whistleblower, they kind of go together. You can't actually have worker participation unless you have some protection for workers who are participating. So they aren't two separate things. And if…if BSEE has actually done work on worker participation, I think that…that also includes any kind of…some kind of whistleblower.

Second of all, in terms of the whole causation issue, look back at, I mean, the history of the CSB. If you just…if the CSB had just focused only on things that were direct causation, they would never have done more than look why the widget broke. And clearly the CSB and the added value of the CSB is to go beyond that and to look at government policies. I mean you can look at… I mean just to bring up a couple of things, couple of studies that I'm most familiar with.

MFG[?], where, you know, they focused a lot…you all focused a lot on…on emergency response plans because some police got sent to the hospital. There was no…there's no proof that lack of an

emergency response plan led to the police being contaminated. But nevertheless, all the literature shows that having an emergency response plan and implementing it actually will prevent that kind of thing.

You look at [inaudible]. I mean there's no proof that if you had had a public employee legislation in Florida that that would have directly prevented the incident or directly led to the incident, the lack of that. But nevertheless, the CSB recommended the…the…you know, that there would be public employee participation. I mean public employee bill because there was a lot of evidence that that, you know, helps in this area.

Same thing here. I mean you don't need to really do a roundtable or a study on worker participation. There's a huge amount of information on that. There are regulations, there are guidance. You know, you can look anywhere, anywhere you look from OSHA to [inaudible] it's not really a question about whether it's effective or not.

I…I'd have to read the report over again but I think there was a lot of information in the report that workers…there wasn't sufficient worker participation there. Whether workers felt intimidated, I don't know. You know, I'd have to look back there again. But to show the need for anti-retaliation language, you

don’t actually have to prove retaliation because one of the effects of retaliation or threat of retaliation is…is basically people just generally being afraid to speak out, even if they haven’t been retaliated against yet. And if you’ve got people that have said they were afraid to speak out, then I think that’s pretty good direct evidence that, you know, there’s some need for some kind of anti-retaliation language there.

That’s all.

VANESSA ALLEN SUTHERLAND: And still time to spare.

JORDAN BARROB: Oh, let me think. [laughter]

VANESSA ALLEN SUTHERLAND: Thank you for that. Any other comments…

[UNIDENTIFIED]: My question is similar but a little more fundamental. The Board’s single most important investigation pertained to things that didn’t happen. If you guys [inaudible]. The MIC[?] tank wasn’t hit. Yet the investigation honed in on that. Believe me, as a reporter, the company pointed out to me quite a number of times that this investigation was of the wrong thing because the MIC [inaudible] when it comes to Domingas[?], when it comes to ExxonMobil, the HF. The precipitator blew up but it didn’t hit the HF tank.

I'm more concerned that you guys are limiting your charge and this result in missing some of the most important studies that you've done because it's really not causal with this particular accident. Business…the companies have lobbied for this for years and I've asked you, Dr. Sutherland, about this several times. And I haven't gotten a clear answer on exactly how you decide when you're going to go [inaudible] this particular thing that actually happened.

VANESSA ALLEN SUTHERLAND: You mean to deploy?

[UNIDENTIFIED]: No, not to deploy. To investigate. Because really the…if you…well…cause, that's what I'm trying to wrestle with. I think my point's clear. I can go on about this but I don't…it's been a long meeting. But that's… To me, it seems…I'm more concerned about that.

VANESSA ALLEN SUTHERLAND: Okay. Anyone else in the room as well? Richard, there are no hands in the room. We'll still take questions but is there anyone in the queue on the phone?

OPERATOR: [inaudible] * then 1 for any questions on the line. We have a question on the line from Fred Millard. Please go ahead, your line's open.

FRED MILLAR: Hi, this is Fred Millar calling. I'd just like to put a question on the…on the agenda that you guys maybe are

dealing with already in your…in your investigations at Atchison and at Arkema. And that has to do with whether the evacuations that were ordered in those situations are adequate or not, were adequate or not. And…and…and what…on what basis are the evacuations being ordered? I think it would be very useful to compare in each case the actual evacuations that were ordered in the…in the incident with the worst case scenario information from the risk management program documents filed by the companies. I've…those documents are not currently public in terms of how far the evacuation…how far downwind the worst case scenario says a facility accident could go. But as you can imagine in case of chlorine and hydrogen sulfide and others, it's quite a long distances.

So the final element in that would be to look at what…what…what has been the impact of a unified command where industry folks come in with the local emergency responders and in many cases the industry folks are the only ones who have any documented expertise on HAZMAT, like in the Mosier, Oregon case, where…were Union Pacific called in to advise 12 HAZMAT…12 fire chiefs, I should say, from local fire departments that their initial evacuation of one-half mile was not…was not necessary. They could reduce that to one-quarter mile, which the…which advice the local responders did take.

Now, I…luckily that turned out that there was no wind that day and there was no disaster in Mosier. But…in terms of lives lost. But it…it was…it was an astonishing assertion that from…from many miles away in Portland, a…a railroad official could call in and say, “Here’s how we want you to deal with this.”

So I just…I just think these three aspects of unified command and comparison with a risk management program and…and analyzing the…the analysis, analyzing the adequacy of evacuation would be very helpful.

The second point I’d like to raise is there’s a new AAR petition to the Federal Railroad Administration which…about asking that there be a…a broad allowance of LNG shipment by rail in the United States. That will no doubt lead to the railroads considering adopting the business operations they’ve adopted for ethanol and crude oil, which is unit trains.

This could have implications for the Chemical Safety Board insofar as it probably would involve approving various kinds of new loading and unloading facilities for unit trains at fixed facilities. So I think it would just be interesting to have…to make sure that…that CSB realizes that there’s a whole new level of threat that’s being envisioned and the momentum for this is actually quite strong because it’s already LNG by rail being used

in Europe and already in Japan. And now there's a model project that FRA has approved for a small railroad up in Alaska. So there's very, very strong industry interest and railroad interest in…in trying to get LNG operations onto the US rail lines and that will mean, of course, loading and unloading operations at fixed facilities.

VANESSA ALLEN SUTHERLAND: Thank you, Mr. Millar, for that. You can't see us but everyone's taking notes. Thank you.

FRED MILLAR: Okay.

VANESSA ALLEN SUTHERLAND: Richard, are there other calls in the queue?

OPERATOR: Yes, we have a caller on the line, Steve Sellmans[?] from United Steelworkers with a question. Please go ahead.

STEVE SELLMANS: Good afternoon. Thank you for the opportunity to be able to offer some comments. I have two items. First, I would like to thank the Chemical Safety Board. At a U.S. [inaudible] represented workplace in Deridder, Louisiana, there were three fatalities at a location where the Steelworkers represent the workers there at that paper mill. We greatly appreciate the work that the staff has done, as well as everyone

else associated with the work that's been done on this…this investigation.

It is our hope that that investigation will stop the deaths that have been occurring in the pulp and paper sector and…and we look forward to the full report and video, as I'm sure we will be able to use this in many, many training sessions that we have with our members and those in the industry. So having been involved in multiple fatalities in the paper sector, we just can't thank you enough for being involved in this and working closely with the management officials involved, as well as our local union representatives.

And I want to point out about how important worker and representative participation is. Specifically when I've been involved in fatality investigations with the CSB, be it Deridder, Louisiana or other ones that I've been involved in, clearly the CSB recognizes the advantage to have workers and their representatives' participation in the investigation, as well as OSHA, as well as many other agencies. So clearly this would also extend to workers having involvement in their workplace and having not just the authority to stop the line but also to raise issues and concerns with their employers so that the CSB does not have to investigate fatalities and life altering incidents.

And one of the best ways of doing this is through worker participation and the only way to have worker participation is making sure that there is provisions without the fear of consequences for participating. And so I just want to point out that we believe this is one of the foundational items of health and safety systems in any workplace. And if we really want to get on the side of prevention, and how we can learn and get better, we believe fundamentally this should be involved in all aspects of a health and safety management system.

And we're encouraged that the Board is discussing this and it is our hope that we'll see positive movement around this arena. So we appreciate your time and courtesy to let us participate in the…in the proceeding.

VANESSA ALLEN SUTHERLAND: Thank you very much. And I wish all of our investigators who participate or are participating in Deridder were on…could hear that. We will definitely share that. I think they try to reach out very broadly and want to hear from everyone in the…in the investigation.

So thank you very much for those comments and I will make sure that they are taken back to our team.

STEVE SELLMANS: Thank you.

VANESSA ALLEN SUTHERLAND: Richard, are there other callers in the queue?

OPERATOR: We have no further questions on the line.

VANESSA ALLEN SUTHERLAND: We're looking for the moment at meeting@csb.gov. Okay. So any final comments in the room, based on what you just heard from other participants? Going once, twice. If not, then thank you to everyone who provided a comment here today and additional topics for the Board to discuss offline.

I want to thank the staff for their awesome and amazing continued teamwork and dedication on these issues. We can't discuss it if they don't prepare the work and brief us and provide these kinds of proposals and make us think.

So I also want to thank my fellow Board Members for the numerous contributions and their thinking and discussion today. And I think we could clearly say all of us have the same interest in trying to figure out how do we drive prevention of chemical incidents further and how do we drive safety change more broadly. So thank you, guys. You were awesome.

Also, for everyone on the phone and in the room, I know this was a long meeting, longer than usual, longer than some of our more recent ones. But I appreciate you sticking around for the entirety of it and waiting until the end to be able to contribute. We

really appreciate the comments that you give us. If there's something you think about afterwards, please email that to public@csb.gov because we continue until the next meeting to talk about these issues.

Our next public meeting is tentatively scheduled for November 14th, same time, 1:00 p.m. Eastern. And then after that, we will have one again in January. January 31st, 2018, is that tentative date. All of the meeting times and dates will be listed on our website, csb.gov, the Federal Register, and if you have signed up to get alerts from us, your inbox. We do regularly try to keep this up to date on Twitter, Facebook, our website, and certainly you can always, again, call and ask through public@csb.gov.

So thank you very much for your attendance and patience and with that, the meeting is adjourned until next month.

OPERATOR: Thank you, ladies and gentlemen. This concludes today's conference. Thank you for participating. You may now disconnect.