

U.S. CHEMICAL SAFETY BOARD

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BUSINESS MEETING

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WEDNESDAY,
JULY 22, 2015

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U.S. CHEMICAL SAFETY BOARD MEMBERS PRESENT:

RICK ENGLER, Member, U.S. Chemical Safety
Board

MANNY EHRLICH, JR., Member, U.S. Chemical Safety
Board

STAFF PRESENT:

JOHNNIE BANKS, Team Lead, Investigator
DON HOLMSTROM, Director, Western Regional Office
MARK KASZNIAK, Senior Recommendations Specialist
KARA WENZEL, Acting General Counsel
CHERYL MACKENZIE, Team Lead, Investigator
DAN TILLEMA, Team Lead, Investigator
VERONICA TINNEY, Recommendations Specialist

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T-A-B-L-E O-F C-O-N-T-E-N-T-S

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1 P-R-O-C-E-E-D-I-N-G-S

2 (9:30 a.m.)

3 OPERATOR: Welcome to the CSB business
4 meeting. My name is Chris and I will be your
5 operator for today's call. At this time, all
6 participants are in a listen-only mode.

7 Later we will conduct a question and
8 answer session. Please note that this conference
9 is being recorded. I will now turn the call over
10 to Board Member Mr. Rick Engler. Mr. Engler, you
11 may begin.

12 MEMBER ENGLER: Good morning and
13 welcome to the CSB offices. My name is Rick
14 Engler and I am the Board Member presiding over
15 this meeting. I would also like to introduce my
16 colleague on the Board, Manny Ehrlich. Also with
17 us is Kara Wenzel, CSB's Acting General Counsel.

18 Since we don't have a huge group,
19 could we quickly go around the room and just get
20 a sense of who is here? Just name and
21 affiliation starting with you.

22

1 MS. VASSALLI: Katie Vassalli, the
2 International Liquid Terminals Association.

3 MS. PARASRAM: Vidisha Parasram, U.S.
4 Chemical Safety Board.

5 MR. SUTTON: Ian Sutton, Sutton
6 Technical Books.

7 MR. CRIMAUDO: Steve Crimaudo, API,
8 American Petroleum Institute.

9 MS. TINNEY: I'm Veronica Tinney, also
10 with the CSB.

11 MS. SANDLER: Carla Sandler, King
12 Support (phonetic). I help companies that need
13 to find buyers. So I write their solicitation.

14 MS. SWETT: Laura Swett, ASPM.

15 MS. HAASE: Karen Haase, American
16 Chemistry Council.

17 MR. SHEPPARD: David Sheppard, ATF.

18 MR. HEENAN: Dan Heenan, ATF.

19 MS. MCFARLAND: Krista McFarland
20 (phonetic), WilmerHale

21 MS. COBREN: Marcy Cobran (phonetic),
22 O'Melveny and Myers.

1 MR. PRILLAMAN: Walter Prillaman,
2 Dupont employee and also Local 900C Safety
3 Officer.

4 MR. MORAWETZ: John Morawetz,
5 International Chemical Workers Union.

6 MR. DOBBIN: Denny Dobbin, Society for
7 Occupational and Environmental Health.

8 MR. FIORUCCI: Lou Fiorucci, Fiorucci
9 Consulting.

10 MS. FLANAGAN: Susan Flanagan,
11 Institute of Makers of Explosives.

12 MR. DUDZIG: Rob Dudzig, Debs-Jones-
13 Douglass Institute.

14 MR. DRANEY: Ross Draney with
15 RedGuard.

16 MS. FENDLEY: Anna Fendley, United
17 Steelworkers.

18 MR. PAULSON: Glenn Paulson of George
19 Washington University.

20 MS. MCCORMICK: Amy McCormick, CSB.

21 MR. GREEN: Lee Green (phonetic) with
22 Katten.

1 MR. FARLEY: Mark Farley with Katten.

2 MEMBER ENGLER: Thank you. Since a
3 quorum of the Board given the current Board
4 makeup is two members, we have a quorum today.
5 Today's gathering constitutes a public meeting of
6 the Board under the Sunshine Act rules and was
7 duly announced in the Federal Register.

8 Before we get started, I would like to
9 address some housekeeping items first. In the
10 event of an emergency, please exit out the front
11 entrance and down the stairs to the lobby. Our
12 gathering point is on the corner of Pennsylvania
13 and 22nd Street.

14 The restrooms are in the hallway on
15 this floor. There are sign up sheets outside
16 this room if you would like to make a comment.
17 Cell phones, please mute them. For those calling
18 in to the meeting, please mute your phone.

19 During the comment sessions, we will
20 give those on the phone an opportunity to speak.
21 Please limit your verbal comments to three
22 minutes. You can of course submit additional

1 written comments.

2 Today's meeting focuses on core
3 mission work of the CSB. I assume everyone has
4 picked up a copy of the agenda that's been out on
5 the table. We will hear reports on some of our
6 important investigations and recommendations,
7 vote for plans at this time on the three items
8 noted on the written agenda that you should all
9 have.

10 I want to give you all a heads up that
11 there will be a motion at the end of the meeting
12 in case you're not staying until the end, to
13 alter the meeting date and also a time change for
14 future meetings.

15 There are three opportunities for
16 public comment. The first two are focused on the
17 items that we will have discussed immediately
18 prior. The last opportunity for public comment
19 at the end of the meeting is for any other
20 comments that the public may wish to make.

21 I'd also like to point out to any of
22 the media representatives on the telephone that

1 the Dupont La Porte update prepared by Dan
2 Tillema and our Denver office is now on the
3 website and you can view it there.

4 So the first item on the agenda for
5 today's meeting is an investigation update.
6 First I'd like to introduce Don Holmstrom,
7 Director of the Western Regional Office. I'm
8 sorry, Manny I apologize, I'm rushing along.
9 Manny, do you have an opening statement?

10 MEMBER EHRLICH: I do. Good morning
11 and thank you all for coming. I was informed
12 that some of the members of the families from La
13 Porte, Texas were going to be here, the Tisnados
14 and Lynette Soto. And it doesn't, I haven't
15 heard them or seen them. On behalf of myself and
16 the Board, I want to extend our sincerest
17 condolences to them and their families. I'll
18 have further thoughts about that later on in the
19 meeting.

20 I appreciate the efforts by the CSB
21 staff to prepare for today's business meeting and
22 I appreciate everyone's attendance. This is my

1 first public meeting since returning from medical
2 leave in June and since the departure from the
3 Board of former member Griffon. I'm happy to be
4 back and to be in much better health, I can walk.

5 There is much important business
6 before the agency. We have a draft report on the
7 Caribbean Petroleum explosion that occurred in
8 Puerto Rico in 2009. Since releasing the draft
9 last month, we received some significant
10 stakeholder comments which I look forward to
11 reviewing today.

12 It was important that this report be
13 completed and include realistic safety
14 recommendations that can be applied by industry.
15 The catastrophic incident in Puerto Rico in a
16 2005 explosion at the Buncefield terminal and the
17 U.K. underscored the dangers from large gasoline
18 release and vapor cloud emission.

19 I hope all companies in the sector are
20 already taking the opportunity to study the draft
21 report and the video that was released last month
22 and are reviewing the safety of their gasoline

1 storage tanks.

2 It is no secret that the CSB is facing
3 a very challenging governance situation currently
4 with only two sitting members, three Board vacant
5 seats, and no confirmed Chair. I pledge to the
6 agency and to you, I stand ready to work
7 cooperatively with Board Member Engler to
8 navigate this difficult situation.

9 We offered a power sharing agreement
10 under which Mr. Engler and I would share
11 responsibility for day to day operations. My
12 background running chemical plants and my
13 practical management experience is certainly
14 needed here.

15 Earlier this year, I toured the DuPont
16 pesticide plant in La Porte, Texas. That plant
17 was the site of a large release of toxic methyl
18 mercaptan November 14th, an incident that took
19 four lives.

20 During my visit to La Porte, I
21 received a detailed briefing from the
22 investigative team and was able to observe the

1 building where the workers died during a
2 maintenance operation on the process vent system.
3 You'll hear more on this issue today.

4 I believe the team has important
5 findings about why this tragic incident occurred
6 and has also prepared certain possible
7 recommendations to improve the safety of the
8 facility and to protect workers when production
9 is resumed.

10 I would like these draft findings and
11 recommendations to receive prompt consideration
12 by the Board and to be available to the workforce
13 and the public. Thank you and I look forward to
14 today's meeting.

15 MEMBER ENGLER: Thank you Member
16 Ehrlich. Apologies for rushing ahead.

17 MEMBER EHRLICH: Not a problem.

18 MEMBER ENGLER: With that, I'd like to
19 introduce a panel to give a CSB investigations
20 update beginning with Don Holmstrom.

21 MR. HOLMSTROM: Thank you Board Member
22 Ehrlich, appreciate that. There are actually

1 three statements from the Western Regional Office
2 that we'll be discussing today. I'll be talking
3 about the ExxonMobil investigation and Torrance
4 refinery in California.

5 The lead investigator, Cheryl
6 MacKenzie will shortly be talking about the final
7 two volumes of the Macondo investigation. And
8 Dan Tillema, also from the WRO, will be talking
9 about preliminary findings and analysis from the
10 DuPont La Porte, Texas investigation.

11 On February 18, 2015, there was an
12 explosion in the fluidized catalytic cracker,
13 also referred to as the FCC at the ExxonMobil
14 refinery in Torrance, California. The explosion
15 occurred in a piece of equipment called the
16 ElectroStatic Precipitator or ESP.

17 The blast released FCC catalyst into
18 the surrounding Torrance residential area,
19 exposing numerous members of the community to the
20 catalyst dust. At least four refinery workers
21 were injured in the explosion and subsequent
22 evacuation.

1 Debris from the exploding ESP damaged
2 nearby process units causing several leaks and
3 fires. The FCC unit converts long chain
4 hydrocarbon such gas oils into shorter
5 hydrocarbons that are blended into gasoline
6 products. ESP is a pollution control device
7 that, at that refinery, was installed in 1999,
8 excuse me, 2009 to remove fine catalyst dust from
9 the FCC process.

10 The high voltages present in the FCC
11 during normal operation generate ignition
12 sources. The ESP is not designed to handle
13 flammable atmospheres. ESPs are commonly used to
14 remove particulate dust, pollution control, and
15 various processes.

16 Soon after the incident, the CSB
17 deployed and an investigation team was sent to
18 the refinery. The investigation team has carried
19 out multiple investigative activities including a
20 number of interviews of operators, management,
21 emergency responders, eye witnesses to the
22 incident, as well as receiving thousands of

1 documents that have been reviewed thus far.

2 We have taken part in multiple
3 catalyst and hydrocarbon sample collection and
4 testing activities. We met with community
5 members offsite. We've hired contractors to
6 assist us in some of the technical analysis and
7 post incident review of equipment and some
8 modeling of what occurred.

9 We are generating, editing multiple
10 protocols to test equipment and the integrity of
11 various parts of the FCC unit including valves,
12 control systems, and analyzers.

13 The CSB investigation determined that
14 the explosion likely occurred when flammable
15 hydrocarbons within the FCC mixed with oxygen and
16 reached the electrostatic precipitator which
17 served as an ignition source.

18 ExxonMobil had numerous safety systems
19 in place to ensure that both flammables would not
20 reach the ESP and if flammables did reach the
21 ESP, it would be turned off automatically. All
22 of the safety systems put in place failed and

1 allowed the incident to occur.

2 These included failures to mechanical
3 integrity, hazard analysis, non-routine work
4 procedures, among others. The CSB investigation
5 team has identified a number of key issues that
6 are similar to issues identified in previous CSB
7 refinery investigations including the Chevron
8 investigation in Richmond, California.

9 As the investigation moved forward,
10 key issues such as the ones listed below have
11 continued to be analyzed. These include failure
12 to assess the effectiveness of safeguards during
13 a PHA as well as general failure to identify and
14 mitigate hazards. Work force involvement and
15 empowerment about safety concerns, a reluctance
16 to shut down units despite severe process upsets
17 and equipment failure, and mechanical integrity,
18 failure of equipment due to known damage
19 mechanisms.

20 The incident progress currently is,
21 we're undergoing a scoping process to identify
22 what key issues we're going to be undertaking in

1 the investigation, what type of product. A full
2 investigation report or some other product will
3 be generated from this investigation and that's
4 currently under internal review. That concludes
5 my presentation on ExxonMobil, thank you.

6 MEMBER ENGLER: Thank you. Next we'll
7 turn to Johnnie Banks, Supervisory Investigator
8 to discuss West Fertilizer and the Freedom
9 Industries investigation status. Johnnie?

10 MR. BANKS: Thank you Board Member
11 Engler and good morning everyone. I'll be
12 providing a real brief overview of the West and
13 Freedom investigations.

14 The West case initiated on April 17,
15 2013 with a tragic detonation of ammonium nitrate
16 at an ammonium nitrate storage facility where
17 there 15 fatalities. Twelve of those were
18 emergency responders, three from the public.
19 There were hundreds of injuries and significant
20 damage to homes, nursing homes, residences, and
21 the infrastructure.

22 Currently we are in the midst of

1 submitting the report for technical expert
2 review. We anticipate getting comments back from
3 that on or about July 25th of this year. And we
4 will resolve any comments that the experts
5 provide.

6 We're preparing to send the report to
7 counsel for West for confidential business
8 information review and comment. That process
9 would take about another week or so. The team is
10 continuing to work on the draft of the full
11 report with input from these previously mentioned
12 reviewers.

13 We're working to complete the report
14 and prepare for Board review and comment late
15 fiscal year '15 which would be September 30th of
16 this year or early fiscal year 2016, October 1st.

17
18 Prior to that, we'll be preparing
19 recommendations. We'll meet with the recipients
20 of these recommendations to ensure that they are,
21 the appropriate parties receive those
22 recommendations and that the recommendations are

1 appropriate. And then we'll also issue the
2 report for factual accuracy review from both
3 parties that would have the knowledge of whether
4 the facts that they didn't report are accurate.

5 The next case that I'll be providing
6 overview for is the Freedom Industries incident
7 which occurred on January 9, 2014. That was
8 where there was a failure of a tank that
9 contained methylcyclohexanemethanol or MCHM. The
10 release of this went to the river and affected
11 the water for 300,015 Charleston, West Virginia
12 area.

13 The team has been involved with this
14 investigation since January 13th of that year and
15 we're making progress on drafting the report. We
16 recently traveled to Charleston to conduct
17 interviews, follow up interviews and initial
18 interviews with parties that we had not
19 interviewed to date.

20 We toured the site and met with local
21 agencies that we've had contact with from the
22 very outset. We hope to initiate the Board

1 review for the full report in early fiscal year
2 2016 which would be October 1st. That includes
3 the report and obviously the eco-report, we're
4 here to encourage the passage of that as well.

5 MEMBER ENGLER: Thank you very much.

6 Next on the Macondo investigation, Cheryl
7 Mackenzie, the team lead who has been working
8 diligently on that.

9 MS. MACKENZIE: Thank you. A status
10 update, the final two volumes of the Macondo
11 investigation report are drafted and are in the
12 middle of our internal CSB review process. These
13 volumes are on the human organizational factors
14 that contributed to the incident as well as our
15 regulatory analysis.

16 The team received comments back from
17 the technical editor on Volume 3 this week and
18 we're incorporating any of those such edits.
19 We'll be getting Volume 3 to the Board this
20 Friday. Volume 4 is with the technical editor
21 now and will be going to the Board the following
22 Friday, the 31st.

1 After that, we have a number of
2 additional reviews which is what Investigator
3 Banks mentioned regarding stakeholder reviews,
4 recommendation recipients, et cetera. And we're
5 completing, the completion date for both volumes
6 is currently projected to be October 12th of this
7 year. We hope to release those volumes together
8 at a public meeting around that time.

9 MEMBER ENGLER: Great, thank you.
10 Member Ehrlich, do you have any questions for
11 folks concerning what was just reported on the
12 status of our investigations?

13 MEMBER EHRLICH: I do not, thank you
14 very much.

15 MEMBER ENGLER: Okay. We know you're
16 all working diligently on them and we look
17 forward to, as Board members, to having an
18 opportunity to review the latest drafts, provide
19 comments, and move forward on them. Thank you
20 for your work and of course for all the staff
21 that you work with that contribute to the core
22 mission of working on these critical reports.

1 Next on the agenda is discussion of
2 the Caribbean Petroleum investigation and I would
3 like to make an opening statement concerning
4 that.

5 The staff of the Chemical Safety Board
6 has finalized its report, which we will vote on
7 today, on the October 23, 2009 overfill incident
8 at the Caribbean Petroleum refinery in Bayamon,
9 Puerto Rico where a five million gallon capacity
10 above-ground storage tank overfilled while fuel
11 was being transferred from a tanker ship.

12 I thank the staff and particularly
13 Vidisha Parasram for her long and hard work on
14 this report. Thank you Vidisha. During the
15 overfill, gasoline spray from the tank
16 aerosolized forming a vapor cloud which pooled in
17 the secondary containment area where it leaked
18 through an open dike valve to the wastewater
19 treatment area and ignited.

20 The vapor cloud explosion led to
21 multiple tank fires that burned for two days.
22 Local community members were forced to evacuate

1 in the middle of the night. The explosion and
2 fires damaged 17 of 48 tanks at the facility,
3 caused three offsite injuries, and damaged or
4 destroyed approximately 300 homes nearby. The
5 magnitude of the incident caused President Obama
6 to declare a state of emergency.

7 The CSB found that lack of a robust
8 overfill prevention system with more than one
9 layer of protection as an independent or
10 redundant level alarm can lead to catastrophic
11 incidents. And that current safeguards
12 applicable to above-ground storage tanks do not
13 adequately protect the public from catastrophic
14 incidents that are using NFPA 704 Class 3
15 flammable liquids such as petroleum products.

16 Preventing future catastrophes
17 necessitates regulatory safeguards and industry
18 and consensus standards that require tank
19 terminal facilities to implement additional
20 layers of overflow protection, conduct a risk
21 assessment considering the proximity of
22 communities, and follow good engineering

1 practices.

2 The findings of the CAPECO
3 investigation led CSB to recommend that EPA and
4 OSHA determine the best regulatory standards to
5 require bulk above-ground storage facilities to
6 conduct risk assessments considering existing
7 populations in sensitive environments, the
8 complexity of site operations, the reliability of
9 the tank gauging system, and the rigor of gauging
10 operations.

11 To further minimize the potential of
12 catastrophic incidents such as CAPECO, in our
13 report being proposed today, the CSB asks the EPA
14 and OSHA to ensure that a tank's automatic
15 overflow prevention system be separate and
16 independent from the tank level control system
17 and follow good engineering practices.

18 In addition, the CSB recommends that
19 OSHA implement elements of this process safety
20 management standard that includes a mechanical
21 integrity program into the flammable and
22 combustible liquids standard. CSB investigative

1 findings identify the regulatory deficiencies
2 that contribute to this incident.

3 Thus, these recommendations for
4 safeguards were issued with the hope of
5 preventing future incidents such as Caribbean
6 Petroleum from occurring. I again thank the
7 staff for all their hard work in producing this
8 important report.

9 Through a written notation vote
10 process, I voted for this report and the
11 recommendations concerning this incident. The
12 notation item 2015-41 on July 6, 2015. On July
13 13, 2015 Member Ehrlich calendared this matter
14 for discussion at a public meeting.

15 And I just note that calendar items
16 now have to be brought up for discussion at
17 public meetings. They cannot be swept under the
18 rug anymore. This is something that's in our new
19 regulations that are now effective. That
20 basically makes the calendar motion an
21 opportunity for public discussion, debate,
22 transparency, et cetera. So it's perfectly

1 appropriate that the item was calendared for
2 discussion at this meeting today.

3 So I now make the following motions,
4 the Board hereby votes to adopt and release the
5 proposed final investigation report including the
6 proposed recommendations as the Board's report
7 and recommendations on the Caribbean Petroleum
8 incident as well as the accompanying video. I
9 now ask if there is a second for that motion.

10 FEMALE PARTICIPANT: Is it possible
11 for --

12 MEMBER ENGLER: No. Just to back up
13 for a second, there's been extensive public input
14 into this report. We had a public meeting on it.
15 We extended the comment deadline. So at this
16 point, we're focusing on actually taking action
17 on the report.

18 Of course, if you have additional
19 comments to submit at this point, you can always
20 submit a statement to the public record. We have
21 an open public record process here so we're
22 always open to hearing comments on draft reports,

1 final reports, et cetera.

2 Do I hear a second?

3 Hearing no second, the motion failed.

4 Do you have statements that you would to --

5 MEMBER EHRLICH: Yes I do. I wish to
6 have it known at the outset that the CAPECO
7 investigation team produced an excellent report
8 with important factual findings and did so with
9 very limited staffing and resources. For this
10 they are to be strongly commended.

11 I also commend the CSB Public Affairs
12 staff for another outstanding safety video
13 describing the causes of the CAPECO incident
14 which will greatly benefit the investigative
15 community.

16 I agree with the report's premise that
17 overfilling gasoline storage tanks is a serious
18 hazard that deserves a high level of attention
19 from industry. Both the 2009 CAPECO incident in
20 Puerto Rico and the 2005 Buncefield incident in
21 the U.K. demonstrate the potentially severe
22 consequences from gasoline vapor cloud

1 explosions.

2 Thankfully, gasoline tank incidents
3 since the 19 -- I'm sorry. Thankfully, gasoline
4 overfill incidents have been rare in the U.S. and
5 the report noted only a handful of (inaudible)
6 incidents since the 1970's. Fortunately, the
7 explosion in Puerto Rico caused no serious
8 injuries and it has been many years since a
9 gasoline tank overfill incident caused a fatality
10 in the U.S.

11 My vote was based on fundamental
12 philosophical disagreement with several of the
13 key recommendations in the draft report.
14 Specifically the recommendation for extensive new
15 regulations directed to the United States
16 Environmental Protection Agency and the United
17 States Occupational Safety and Health
18 Administration.

19 I believe these recommendations would
20 be burdensome for industry, would not reflect the
21 stated priorities of already overstretched
22 regulatory agencies, and do little to reduce the

1 risk to the public for any facilities like CAPECO
2 that fall far short of complying with existing
3 regulatory standards.

4 Their not having followed the existing
5 regulations would call into question the issue of
6 how they would adhere to stricter regulations. I
7 also believe that given the difficulty of getting
8 new federal regulations adopted, the CSB should
9 only recommend such regulations when absolutely
10 necessary. Doing otherwise simply dilutes our
11 very limited resources for recommendations
12 advocacy.

13 In suggesting that the EPA expand its
14 risk management program to encompass thousands of
15 terminals storing flammable liquids, NFPA Class
16 3, like gasoline, the draft report would greatly
17 expand a regulatory program that already lacks
18 sufficient staffing and resources to do effective
19 inspections and enforcement at major refining and
20 chemical manufacturing sites.

21 I am unique among the current members
22 and staff at the agency in having run industrial

1 chemical plants. And at one time I ran a
2 petroleum terminal in New Jersey that handled
3 products similar to CAPECO. There, however, the
4 similarity ended. At the terminal I ran, we were
5 extremely vigilant about the danger of an
6 overfill event.

7 And our standards and safeguards and
8 alarms received extensive and regular scrutiny
9 from regulatory agencies including the EPA, the
10 NJDP, the New Jersey Department of Environmental
11 Protection, and the United States Coast Guard.
12 Using the existing the rule book, that terminal
13 facility was held to an extremely high standard.

14 The draft report does an excellent job
15 documenting the fact that CAPECO, at the behest
16 of EPA and based on current regulations,
17 previously installed an electronic level control
18 system for its gasoline storage tanks. But then
19 unfortunately, allowed that system to fall into
20 serious disrepair.

21 CAPECO management continued operating
22 the facility right until the night of the

1 incident without a functioning tank level control
2 system that would meet existing EPA regulations.
3 As the EPA noted in its comments on the report,
4 the company also did not comply with existing
5 regulations to properly supervise the containment
6 dike valves to prevent the spread of any spilled
7 petroleum.

8 On the night of the incident, open
9 valves allowed the spread of the spilled gasoline
10 over a wide area and greatly increased the
11 incident severity. The lack of adherence to
12 current EPA regulations was a direct cause of
13 this incident. Had EPA regulations required
14 additional layers of protection on that gasoline
15 storage tank as suggested by the draft report,
16 there's no assurance that CAPECO would have
17 maintained these systems any more diligently.

18 As the EPA and others have pointed out
19 in public comments on the draft report, current
20 provisions of the Spill Prevention Control and
21 Countermeasures, SPCC rule, already require
22 companies to have continuous or fast response

1 tank level monitoring to prevent overfilling.
2 And to ensure the existence or design according
3 to good engineering practices and they are
4 regularly tested to ensure proper operation.

5 The EPA might best assist the
6 regulated community by providing additional
7 interpretation or values concerning the good
8 engineering practice a company should implement
9 to prevent overfills including references to the
10 appropriate and up to date NFPA, National Fire
11 Protection Association, and API, American
12 Petroleum Institute, consensus standards.

13 In light of the situation at CAPECO,
14 it would also be beneficial for the EPA to apply
15 additional resources to enforcing its existing
16 SPCC regulations, requirements, and to educating
17 the regulative community on effective
18 implementation. However, layering an additional
19 conflicting or duplicative regulations concerning
20 tank overfill prevention through the EPA risk
21 management program and/or the OSHA flammable
22 liquids standards, 29CFR1910106, it will simply

1 add cost and confusion to an already complex
2 system with little safety benefits.

3 It would also run contrary to the
4 approach directed by President Obama in several
5 Executive Orders that encourage agencies to
6 streamline and simplify regulatory approaches and
7 specify performance objectives rather than
8 specific compliance strategies.

9 My position in no way should be
10 construed to be a criticism of the staff that
11 prepared this report. They did an excellent job,
12 Vidisha and Adel (phonetic). I simply have
13 different life experiences and differing
14 perspective on how to address hazards like those
15 found at CAPECO. Thank you.

16 MEMBER ENGLER: Thank you for that
17 statement Mr. Ehrlich. I would like to respond.
18 First of all, the CSB is fundamentally a non-
19 regulatory agency. We don't propose regulations.
20 But if we think that regulations should be
21 considered, we have a duty and obligation to put
22 them forward for consideration, for further

1 debate, to go through the long process that
2 involves many, many steps before regulations
3 actually are adopted.

4 And not to propose where there are
5 clearly defined, non-duplicative, non-conflicting
6 safeguards, I see as a fundamental problem in an
7 approach to the way this agency should move
8 forward. We are not here to reflect other
9 agency's priorities frankly. If you look at the
10 statutes that establish the CSB, we're supposed
11 to look critically at OSHA, at EPA, and at other
12 entities and make recommendations about policies
13 that should be considered.

14 It doesn't say in our statutes, in our
15 enabling statute or the legislative history which
16 I've read numerous times, P.S. consider other
17 agency priorities. Of course, that doesn't mean
18 we can't interact with them and we do interact
19 with them.

20 We send our recommendations in
21 advance, as part of the draft and consultation
22 process, to agencies to get their feedback. To

1 find out, are we off base? Can we make
2 alterations? Can we improve them? That process
3 was, in my view, thoroughly done with this
4 particular report.

5 Obviously, if we suggest things that
6 make no sense to an agency whatsoever, the
7 chances of them seriously considering such a
8 proposal are much reduced. But not to make a
9 proposal based on another agency's priorities is
10 frankly, would be a dereliction of duty for this
11 agency.

12 The argument that the proposal would
13 do little to reduce risks to the public is
14 fundamentally flawed. And the logical conclusion
15 of that is simply not to have safeguards because
16 after all, if there is one bad actor out there
17 who won't adhere to them and since it won't work,
18 we simply don't need such protections. It makes
19 no sense whatsoever to me.

20 It would actually be an argument for
21 abolishing existing regulatory protections
22 because some outlier didn't follow them. So I

1 find it deeply disturbing about what it portends
2 for the future reports that we have before us.

3 In cases such as West, where it's my
4 understanding that the State of Texas has, Mr.
5 Banks you can correct me if I'm stating it
6 incorrectly here, a new law that says ammonium
7 nitrate can't be stored within 30 feet of a
8 combustibile or flammable area.

9 Now it seems to me that that may be
10 somehow inadequate as a preventive measure for
11 this problem. Does that mean that because there
12 is a philosophy of opposing regulatory
13 protections, that we should not as a Board
14 discuss the particular vaccuum of safeguards for
15 workers and communities? Not only in Texas, but
16 across the country. I think not. I'm deeply
17 disturbed by this vote today which means that the
18 report and the video will not be released in
19 final form.

20 And I intend to bring this up at a
21 subsequent Board meeting for further
22 consideration as soon as possible with the hope

1 that the Senate promptly, as soon as possible,
2 can confirm the additional Board members that
3 have been nominated who bring a commitment to
4 preventive measures, public health, worker
5 safety, and the core mission of this agency.

6 So I would like to move on, unless
7 there's any other comments from Mr. Ehrlich, to
8 the next agenda item. The next agenda items is -
9 - just to note for the record that again, the
10 motion that I made failed for lack of a second in
11 terms of the official record. Next on our agenda
12 is the BP Incident Reporting System
13 recommendation with a presentation by Mark
14 Kaszniak, our Senior Recommendations Specialist.

15 MR. KASZNIAK: Thank you Mr. Engler.
16 This recommendation was issued as a result of the
17 CSB BP Texas City refinery explosion in 2005
18 which was one of three recommendations issued to
19 BP corporate Board of Directors in the final
20 report that was released on March 20, 2007 at the
21 conclusion of that investigation at the public
22 meeting that was held in Texas City, Texas.

1 The CSB found in the report that the
2 BP lacked a sufficient reporting and learning
3 culture in its refinery and its organization. If
4 you would consult further details, you should
5 look at Section 10 of that report which is posted
6 on our website.

7 It briefly, the key elements that CSB
8 noted in this recommendation is that reporting
9 bad news in the BP organization was not
10 encouraged. That BP Texas City managers did not
11 effectively investigate accidents and take
12 appropriate correction action when those
13 accidents occurred.

14 And that a corporate audit conducted
15 the year prior to the BP Texas City explosion
16 throughout the BP corporate structure revealed
17 that there were insufficient mechanisms for
18 disseminating information from previous incidents
19 in the BP organization in 35 of BP's group
20 business units.

21 So based on that recommendation, based
22 on those findings, the CSB issued the following

1 recommendation which I will read in its entirety
2 here. Is that to ensure and monitor that senior
3 executives implement an incident reporting
4 program throughout the refinery organization that
5 A, encourages the reporting of incidents without
6 fear of retaliation.

7 B, requires prompt corrective actions
8 based on incident reports and recommendations and
9 tracks closure of action items at the refinery
10 where the incident occurred and at other affected
11 facilities. And C, requires communication of key
12 lessons learned to management and hourly
13 employees as a result as well as to industry.

14 This recommendation is also
15 tangentially related to the next recommendation
16 that was issued to BP, R13, this was R12 by the
17 way. That it also required BP to ensure and
18 monitor through its senior executives, both
19 leading and lagging process safety indicators
20 indicating measures to strengthen safety
21 performance at its refineries.

22 CSB had numerous communications with

1 the BP organization from 2007 with regarding to
2 how these recommendations were being implemented.
3 In September of 2012, BP finally provided us
4 sufficient information for both B12 and B13 for
5 the Board, for the recommendations partner to
6 evaluate to them to determine if their standards
7 changed, or those recommendations that we could
8 submit to the Board.

9 At that time, there was an evaluation
10 of the responses by the staff and the Office of
11 Recommendations and at that time, they were
12 recommended to be both closed as acceptable
13 action. The rationale for this particular
14 recommendation that prompted that recommendation
15 by the CSB staff was that in regard to Bullet A
16 of the recommendation, that BP had developed a
17 revised code of conduct in June of 2005 which
18 required prompt incident reporting by all of
19 their employees of any particular incident that
20 occurred in BP operations which was widely
21 communicated throughout its organization when it
22 was launched.

1 And that there is an annual
2 certification by BP team leader that is followed
3 to ensure that this new standard of conduct is
4 being met in the organization. This annual
5 certification is passed on up through the BP line
6 of command to the Chief Executive Officer to
7 assure that this particular provision is being
8 followed throughout the BP organization.

9 BP also developed a BP open talk, 24/7
10 multilingual help line where people could call
11 anonymously and voice concerns about incidents
12 within the BP organization. Those incidents, the
13 hotline is actually monitored by an outside
14 party.

15 And then that information is taken and
16 then referred again, back into the internal part
17 of the BP organization in an area where that
18 particular area of the plant that's being, the
19 incident was alleged, somebody can investigate
20 who is not part of that line organization. To
21 assess whether or not that particular incident
22 has been looked at or not and how BP is examining

1 that particular incident that was being alleged
2 at the hotline.

3 In addition, BP had modified its group
4 practices in the refining sector to require
5 incident investigations for both documented
6 incidents and near misses which include
7 developing of investigation teams, conducting
8 investigations using root cause analysis
9 techniques, determining causes, establishing
10 remedial actions, and then reporting the finding
11 of those investigations.

12 Once those investigations findings
13 were developed, they were placed into an internal
14 system at BP called their Traction system which
15 is designed to follow up all those
16 recommendations until they get successful
17 closure.

18 Those items in the BP tracking system
19 are also incorporated into the company's leading
20 and lagging indicators and are monitored on a
21 quarterly basis to ensure that traction items are
22 being dealt with. Particularly with regard to

1 incident investigations that aren't being closed
2 out on a prompt basis.

3 Finally, regarding dissemination of
4 lessons learned, BP has developed various
5 mechanisms both within and outside of its
6 organization to post information about these
7 incidents which include posting intranet results
8 of these investigations internally for the
9 benefit of their employees.

10 They also have email blasts available
11 when investigations get completed where people
12 can be informed of the results of investigations.
13 They produce quarterly bulletins that highlight
14 incident investigations that have occurred in the
15 organization.

16 And that BP, with regard to outside
17 participation, participates amongst various
18 industrial associations like the American
19 Petroleum Institute and also makes presentations
20 at other health safety and environmental related
21 national conferences and international
22 conferences that are convened throughout the

1 year.

2 With these many examples that were
3 provided with the BP documentation, all of that
4 could be verified. The only thing that the staff
5 could not verify at the time of this
6 recommendation was being prompted for closure,
7 was actually how the BP employees felt about the
8 implementation of these efforts.

9 Our organization is a very small
10 department, we only have three people in our
11 department to be able to follow up on over 170
12 recommendations. It is impossible for us to
13 survey the BP community to find out. We did
14 extend our outreach at the time to the recognized
15 bargaining units at the facilities.

16 And we basically got informal
17 information back that some things were working
18 and some things weren't working. But no
19 formalized information at the time. So that led
20 the staff to conclude this should be proposed to
21 the Board for an open, acceptable action.

22 As such, it was prepared for notation

1 Board vote and went before the Board, both R12
2 and R13 at the same time. R13, which involved
3 leading and lagging indicators at the BP
4 refineries was closed as acceptable by the Board.
5 However, R12 was calendared by Board Member
6 Griffon on April 19th of 2003 so that this issue
7 could be discussed in a public meeting and that
8 all affected parties would have an opportunity to
9 provide input to the Board.

10 MEMBER ENGLER: Point of information,
11 excuse me. 2013?

12 MR. KASZNIAK: Yes, 2013. And it has
13 been calendared up until then, until the recent
14 new Board provisions require it to be discussed
15 at an open public meeting which is being held
16 today.

17 So the public discussion on this issue
18 has long been overdue. However, now that several
19 years have passed since BP has revised its
20 incident reporting system, we at the CSB are
21 looking forward to hearing both from the public
22 and in particular from the company and the

1 workers about how it's performing. And whether
2 or not it is effective to this day.

3 MEMBER ENGLER: Thank you. With that,
4 I think I'd like to open the floor for any
5 comments from the public through the Board on the
6 report that Mr. Kaszniak just presented
7 concerning the issue.

8 We have none by the way, no one signed
9 up on the sign up sheet that was in the hall but
10 perhaps some folks missed it. Or if there's
11 anyone on the telephone that would like to
12 comment.

13 OPERATOR: We will now begin the first
14 public comment session. If you have a comment,
15 please press star then 1 from your touchtone
16 phone. If you wish to be removed from the queue,
17 please press the pound sign or the hash key. If
18 you are using a speaker phone, you may need to
19 pick up the handset first before pressing the
20 numbers.

21 Once again, if you have a comment,
22 please press star then 1 from your touchtone

1 phone. It looks like we have a comment from
2 Ashlee Dunham from Barton Law Firm. Your line is
3 open, please go ahead. Ashlee, if you're on
4 mute, please unmute yourself. And at this time
5 Ashlee, I have no audio, I'll be releasing you
6 back in the call. At this time we have no
7 further comments.

8 MEMBER ENGLER: We have received a
9 written submission from the United Steelworkers
10 Health Safety and Environment Department. We're
11 looking forward to reaching out to BP. Again,
12 it's our understanding that if BP is represented
13 in the room that they have chosen not to make
14 comments at this time.

15 We will make additional efforts to
16 reach out both to the United Steelworkers which
17 represents workers at BP facilities as well as BP
18 Board of Directors to see if there's any comment
19 that they would like to make before reconsidering
20 this.

21 Again, this is an example, by the way,
22 even though there's no comment, it's an example

1 of something, as Mr. Kaszniak pointed out, that
2 we actually have to do. The way our procedures
3 have worked, calendaring, my understanding was
4 originally intended so that issues would come to
5 public meetings and they wouldn't disappear. So
6 that's why this is on the public agenda for
7 today.

8 But given that there's no comments and
9 yet we seek further input, I'd like to make a
10 motion to table this item to the next, to a
11 subsequent CSB public business meeting. Do I
12 have a second?

13 MEMBER EHRLICH: I'll second the
14 motion.

15 MS. MCCORMICK: Okay I'll call the
16 roll. So on the motion to table this item for
17 discussion, Mr. Ehrlich?

18 MEMBER EHRLICH: Aye.

19 MS. MCCORMICK: Mr. Engler?

20 MEMBER ENGLER: Aye.

21 MS. MCCORMICK: Motion passes.

22 MEMBER ENGLER: Thank you. At this

1 point, because we're actually running a bit ahead
2 of schedule I think we will not have a long
3 break. Amy, do you know if Dan is ready to --

4 MS. MCCORMICK: I'll go get him. He's
5 upstairs with the families.

6 MEMBER ENGLER: Oh they are here,
7 okay. So why don't we just take a very short
8 break until Dan Tillema, our investigator who
9 will be presenting the next update on the DuPont
10 La Porte, Texas investigation is able to come
11 down.

12 I think, according to Amy McCormick,
13 he'll be accompanied by some family members of
14 the victims in that tragedy. So we'll just take
15 a couple minutes so if people need to take a very
16 quick break, please do so but we'll be
17 reconvening very shortly.

18 (Whereupon, the above-entitled matter
19 briefly went off the record.)

20 MEMBER ENGLER: Okay thank you all.
21 A number of folks have joined us since this brief
22 break. Could I request that those who have just

1 joined us in the room stand and just introduce
2 themselves, who you are, where you're from?

3 CLAY DUGAS: I'm Clay Dugas from
4 Beaumont, Texas.

5 JANE LEGER: I'm Jane Leger, I'm from
6 Beaumont, Texas as well.

7 MR. DELAUNE: I'm Justin DeLaune from
8 Baton Rouge, Louisiana.

9 LYNETTE SOTO: Lynette Soto from
10 Pasadena, Texas.

11 MICHELLE TISNADO: Michelle Tisnado
12 from La Porte, Texas.

13 GILBERT TISNADO: Gilbert Tisnado,
14 from Pasadena, Texas.

15 MR. TILEMMA: Dan Tillema from the
16 Western Regional Office.

17 MEMBER ENGLER: Thank you all for
18 joining us. Just briefly to introduce this part
19 of the agenda, some remarks. On November 14,
20 2015 after a release of methyl mercaptan at the
21 DuPont facility in La Porte, Texas, four
22 employees died in what clearly appeared to be a

1 preventable incident.

2 They were Crystal Wise, age 53, Robert
3 Tisnado, age 39, Gilbert Tisnado, age 48, and
4 Wade Baker, age 60. Before we hear a report from
5 CSB's Dan Tillema on the status of this
6 investigation, I would like to recognize the
7 family members who have joined us today. They
8 are, they just introduced themselves, Gilbert
9 Tisnado, Robert and Gilbert's father. Michelle
10 Tisnado, Gilbert Tisnado's spouse. Lynette Soto,
11 Robert and Gilbert's sister.

12 On behalf of the Board, we offer our
13 condolences on your terrible losses. We pledge
14 to make every effort to help prevent such tragic
15 chemical incidents from happening in the future.
16 To recognize the seriousness of this incident, I
17 would ask that we all stand for a moment of
18 silence in recognition and memory.

19 (Moment of silence.)

20 MEMBER ENGLER: Thank you. So Mr.
21 Tillema could you proceed with your report?

22 MR. TILLEMA: Yes, thank you. I'm Dan

1 Tillema. I'm the Lead Investigator for the CSB's
2 investigation on the DuPont La Porte incident.
3 My presentation today will cover the CSB's
4 history with the clients and some of the factors
5 that the Board weighed in making a deployment
6 decision to the La Porte incident, the basic
7 incident and investigation facts, and conclude
8 with a discussion of some serious hazards at
9 DuPont and our draft proposed recommendations for
10 the Board's consideration.

11 I should probably clarify one item
12 before we go further. It's an item that's caused
13 confusion with many people that we've talked to
14 throughout the investigation. Our investigation
15 and the findings that we are discussing today are
16 only focused on the crop protection unit where
17 the insecticide manufacturing is done at La
18 Porte. The herbicides unit and the hydrochloric
19 acid unit are not presently part of the focus of
20 our investigation.

21 In 2010, the CSB investigated three
22 serious incidents over a two day period at the

1 DuPont Belle facility. One of these incidents
2 resulted in a fatality. Then later in 2010, the
3 CSB investigated another fatality incident at the
4 DuPont Yerkes facility. And finally, just over
5 eight months ago, the CSB began its investigation
6 of the DuPont La Porte accident that tragically
7 claimed the lives of four workers.

8 Listed on this slide is our
9 recollection of important factors that weighed in
10 the Board's decision to deploy to those four
11 incidents. Factoring heavily was the seriousness
12 of this incident along with the fact that this is
13 the third fatality incident at three different La
14 Porte facilities. We believe this is a first in
15 CSB history.

16 The CSB was also concerned about
17 DuPont's process safety performance. And while
18 DuPont's personal safety performance has been
19 good, these incidents reflect poor process safety
20 performance. It's important to know and
21 understand that the CSB has been advocating for
22 companies to have a separate focus on process

1 safety since the 2005 BP Texas City incident.

2 This slide just lists some of the key
3 facts about the investigation. As we stated
4 already, it was November 15, 2014 the four
5 employees were killed. There was 24,000 pounds
6 of highly toxic methyl mercaptan released on and
7 off site. The releasing occurred inside an
8 enclosed building which is an important factor.
9 All four employees were inside the building. Two
10 of the four fatalities occurred during rescue.

11 To give people an idea of the size of
12 the La Porte facility, we listed that there's 300
13 personnel at this site at the time the incident
14 occurred, employed at the site at the time the
15 incident occurred.

16 Then just some brief comments on the
17 investigation progress. Our initial deployment
18 started on November 16th and concluded on June
19 12th. We are not finished with the
20 investigation. We concluded our initial
21 deployment in order to develop and promote
22 proposed recommendations that we're discussing

1 today.

2 During the investigation, we
3 identified serious process safety concerns. We
4 routinely communicated these to DuPont. Our
5 concerns were not kept a secret, they were well
6 known. However, on June 11th, DuPont management
7 communicated their dismissal of some key actions
8 we believe are needed in order to prevent future
9 similar major accidents. These serious hazards
10 are the focus of the proposed recommendations.

11 Next I'll cover subjects that are
12 relevant to the proposed recommendations and
13 we're going to cover these at a fairly high
14 level. The proposed recommendation document
15 provides much more specific detail on each of
16 these topics.

17 First, I'll discuss inherently safer
18 design. Following the Bhopal tragedy in 1984,
19 DuPont modified its methyl isocyanate process
20 using inherently safer design. DuPont's new
21 design included the use of an open building
22 structure and installing equipment directly to an

1 incinerator for destruction of highly toxic
2 chemicals.

3 The snippet at the bottom of this
4 slide is an important excerpt from DuPont's
5 actual design document clearly showing the
6 inherently safer design principles they applied.
7 However, DuPont did not effectively apply similar
8 inherently safer design to other highly toxic
9 chemicals at La Porte such as methyl mercaptan
10 and chlorine.

11 Since the November 2014 incident took
12 place inside the enclosed and unventilated
13 building, not effectively applying inherently
14 safer design more broadly following Bhopal played
15 a significant role.

16 The next topic is enclosed building
17 hazards. The area of the process where the
18 incident took place is inside an enclosed
19 building. At this point, we know of no
20 documented reason or design purpose that requires
21 this equipment to be located inside a building.

22 However, locating this equipment

1 inside the enclosed building introduced
2 significant hazards to workers that DuPont has
3 not effectively identified or controlled. The
4 building itself is not what companies would
5 consider a containment building. Companies in
6 the industry have made choices at times to
7 enclose highly toxic chemical manufacturing
8 equipment inside containment buildings.

9 The general idea with the containment
10 building is that if a significant leak were to
11 occur, the leak would be contained in the
12 building and then the vapors would be routed to a
13 destruction device such as an incinerator or a
14 scrubber system. Industry has recognized that
15 when containment buildings are used, there is a
16 benefit to the community because it is less
17 likely that the release will travel offsite to
18 impact the community.

19 However, industry has also recognized
20 that enclosing a leak within the building creates
21 a increased work risk to workers. The building
22 at La Porte is not considered a containment

1 building. Doors are routinely kept open, piping
2 penetrations are not sealed leaving large air
3 drafts in the building. And the ventilation fan
4 is discharged directly to the atmosphere rather
5 than an incinerator or a scrubber system.

6 So because of the building's design,
7 the building at DuPont has all the negative
8 increased risk to workers without any of the
9 benefits of decreased risks to the community.

10 Next topic I'll address is building
11 ventilation hazards. First, the ventilation fans
12 were classified as PSM critical equipment by
13 DuPont and yet neither fan was in operation at
14 the time of the incident. However, even if both
15 fans had been operating, the rate of the methyl
16 mercaptan release was just too large and the fans
17 would have not been able to prevent a lethal
18 atmosphere inside the building.

19 The ventilation fan for the area of
20 the unit where the methyl mercaptan release
21 occurred had not been operating since October
22 20th despite an urgent work order being written

1 to repair it. Also, DuPont did not add any
2 additional safety precautions such as worker
3 access restrictions, or require workers to have
4 any additional personal protective equipment to
5 access the building when the ventilation fans
6 were not operating.

7 The stairs located inside the building
8 are the primary means to access the various
9 levels and equipment inside the building. These
10 stairs are designed for fire escape and DuPont
11 has not effectively evaluated entry or escape
12 hazards for toxic or inert gas atmospheres.

13 The building stairways are designed to
14 be totally enclosed and they are not ventilated.
15 However, the internal doors between the stairway
16 and the inner portion of the building where the
17 manufacturing equipment containing hazardous
18 chemicals is located, do not provide an effective
19 barrier to keep hazardous gases from entering
20 into the stairway.

21 Our next topic is that DuPont's gas
22 detectors, and their response to these gas

1 detectors, is not effective. Overall, the design
2 of the detectors for methyl mercaptan do not
3 effectively warn workers or protect the public.

4 The detector alarm point is 25 parts
5 per million for methyl mercaptan. This is well
6 above the OSHA 0.5 part per million recommended
7 limit. In addition, the response to detector
8 alarms is not sufficient to protect the public
9 and I'll get this more on the next slide.

10 In the hours prior to the incident,
11 multiple highly toxic methyl mercaptan detectors
12 sounded but DuPont's emergency response team was
13 not notified and the area was not cleared of
14 personnel. In addition, our investigation
15 identified methyl mercaptan releases on November
16 13th and November 14th, so the day and two days
17 before this incident.

18 These highly toxic chemical releases
19 resulted in detector alarms but were never
20 reported as releases nor investigated as serious
21 process safety incidents.

22 Our next topic is DuPont's process

1 hazard analysis. We found that process hazard
2 analyses did not consider key events that took
3 place during this incident. Valves connecting
4 the liquid methyl mercaptan feed line to the
5 vapor waste gas vent header were open at the time
6 of the incident.

7 However, the process hazard analysis
8 never considered the hazard that the line could
9 create. PHAs, which is the acronym for process
10 hazard analysis, at DuPont are broken into
11 sections. Most companies do something very
12 similar. OSHA and EPA require these PHAs to be
13 re-validated every five years.

14 To spread the work load out over the
15 five year period, companies do a portion of these
16 PHAs each year so that at the end of the five
17 year period, each PHA has been reviewed. DuPont
18 has broken its PHAs into 15 sections. So
19 essentially there are 15 different PHAs done over
20 that five year period.

21 Following the incident, DuPont
22 conducted a new process hazard analysis on two of

1 these 15 sections. To their credit, DuPont
2 applied a much more robust technique to these two
3 PHAs that requires far more time and considers
4 more potential scenarios than their previous PHAs
5 had done.

6 This effort resulted in their PHA
7 teams identifying hundreds of new action items.
8 However, DuPont management stated to us back in
9 June that they were not going to apply this
10 approach to the other 13 PHAs prior to their plan
11 start up in August.

12 Our next topic is ventilation
13 evaluation. In short, the building air dilution
14 ventilation system has never been evaluated by a
15 PHA or engineering study. Even before this
16 incident, DuPont had scheduled such a review for
17 2017.

18 No evaluation of the ventilation flow
19 rate or effective distribution of ventilation air
20 had ever been conducted on the area of the
21 building where the release took place. Even with
22 the relevance of the suspicion of ventilation air

1 to the November incident, DuPont did not intend
2 to conduct this review prior to the August 2015
3 start up.

4 Our next topic is building safeguards.
5 I've been told by at least one person that this
6 slide is confusing. I think the supporting
7 information, the full 42 page proposed
8 recommendation document does a much better job of
9 what we are trying to say here.

10 But the message we want to convey is
11 that DuPont's very small process analyzer
12 buildings are equipped with sensors to verify
13 there is adequate oxygen concentration. These
14 sensors alarm and a green light at the door to
15 the building turns off to warn workers of
16 potential hazardous conditions so they don't
17 enter the building.

18 We think this is good and we are
19 pointing out that the workers who approached the
20 door to the much larger manufacturing building
21 where the incident took place have no similar
22 protections. There are no detectors inside those

1 doorways to monitor the atmosphere and warn
2 workers if it is not safe to enter.

3 The last topic I'm going to cover is
4 pressure release systems. We found pressure
5 release systems at DuPont that are improperly
6 designed and have not been evaluated to ensure
7 they relieve to a safe location as required by
8 industry codes and standards. We provided some
9 very specific details in the 42 page proposed
10 recommendation document.

11 So the proposed draft recommendations
12 for the DuPont crop protection unit are as
13 follows. These are just a high level summary of
14 the recommendations. The full text of each
15 recommendation is much more detailed, typically
16 100 words per recommendation.

17 So recommendation one, conduct and
18 implement a comprehensive inherently safer design
19 review. Recommendation two is to conduct a PHA
20 and engineering evaluation of the building's
21 design and its ventilation system.
22 Recommendation three is to perform a site wide

1 pressure release study to ensure compliance with
2 codes and standards. And recommendation four is
3 to develop an expedited schedule for robust, more
4 detailed PHAs like DuPont completed after the
5 incident for those two sections.

6 The last two slides reflect our
7 current status. We communicated to DuPont on
8 June 11th that we were going to pursue these
9 recommendations. After DuPont was provided with
10 a draft of these recommendations, they told us
11 that they would suspend the August start up to
12 address our concerns.

13 We also expect to receive some type of
14 written plan to address these proposed
15 recommendations by the end of this month.

16 Although DuPont has stated a willingness to
17 address these items, the investigation team is
18 still recommending that the Board formally adopt
19 and approve the issuance of these proposed
20 recommendations.

21 This is the CSB's formal program to
22 allow the Board to effectively track and evaluate

1 DuPont's mitigation of these serious hazards.
2 And it provides an opportunity for the public to
3 be informed of the implementation status.

4 MEMBER ENGLER: Thank you Mr. Tillema.
5 We very much appreciate the time and effort that
6 you have spent in Texas, far away from Denver,
7 for a long time working to discover the
8 underlying causes of this incident. Member
9 Ehrlich, do you have any questions?

10 MEMBER EHRLICH: Yes, I do. First of
11 all Dan, outstanding job. Read all the documents
12 you've written and Don, my same opinion goes to
13 you. You referenced the 42 page document. Is
14 that material the same as the 40 page document
15 that was issued on July the 13th?

16 MR. TILLEMA: It is. There's been a
17 couple of updates to it which extended the
18 length. But it is essentially the same document
19 that you saw.

20 MEMBER EHRLICH: Okay. And these have
21 been reviewed by DuPont to determine that there's
22 no confidential business information contained

1 within it?

2 MR. TILLEMA: It went through both
3 confidential business information review at
4 DuPont as well as factual review and we've
5 implemented their comments.

6 MEMBER EHRLICH: Okay so did they find
7 anything factually incomplete or incorrect? Or
8 has that been changed?

9 MR. TILLEMA: In general, we have a
10 very good working relationship with DuPont on
11 these type of activities. You know, there's
12 areas where I as an engineer choose a word that I
13 think means something and they suggest that it
14 might mean something else. And so we make those
15 kind of modifications. But there were no
16 material objections to the findings itself.

17 MEMBER EHRLICH: Okay, great. And the
18 reason you call them urgent recommendations, is
19 that because of an imminent hazard of danger?

20 MR. TILLEMA: Good question. From the
21 investigation team's perspective when we paused
22 on June 11th, they were imminent hazards. And

1 our process for addressing imminent hazards per
2 Board Order 22 which is publicly available on the
3 website. If you Google search CSB Board Order
4 22, you'll see our process for recommendations.
5 For imminent hazards, the only appropriate
6 recommendation is an urgent recommendation.

7 MEMBER EHRLICH: So at this point,
8 what stands between getting these recommendations
9 to the Board for final approval? Are they not
10 ready?

11 MR. TILLEMA: That might be a great
12 question for Don Holmstrom.

13 MR. HOLMSTROM: Currently given the
14 fact that we have met with DuPont and received
15 some information about the fact that there's now
16 an indefinite delay in starting up the building,
17 we are reviewing the document internally through
18 a staff review process and anticipate within, I
19 think, a relatively short period of time.

20 As Dan indicated, the document is
21 fairly mature, to be able to, once the document
22 has gone through that staff review for it go to

1 the Board for comment which ultimately, you at
2 the Board as the deciders of the recommendation.

3 MEMBER ENGLER: When do you think that
4 will happen?

5 MR. HOLMSTROM: Well we hope to have
6 it happen relatively soon. And I think that, you
7 know, we're setting up meetings, you know,
8 attempting to set up meetings even this week to
9 try to further the discussion. So I believe
10 relatively soon.

11 MR. TILLEMA: I would add that the
12 investigation team has been working with the
13 folks who make our video animation essentially
14 since the investigation started. The complexity
15 of the incident at DuPont really lends itself
16 well to an animation.

17 It's very difficult to just stand up
18 here and describe all the nuances of how the
19 piping is interconnected and people come away
20 with a good understanding of how that happened.
21 That animation is nearly complete. Our view was
22 to release them at the same time.

1 MEMBER EHRLICH: Okay. I'm, again,
2 you guys have done an outstanding job. I visited
3 the site as well, you know. And I spent 50 years
4 in the chemical industry even though I'm only 35-
5 years-old. I have to say these guys have done a
6 tremendous job in terms of finding out what
7 happened and made recommendations to see to it
8 that it doesn't happen again. Thank you both.

9 MEMBER ENGLER: Thank you Member
10 Ehrlich. Dan, what would you say the next steps,
11 if you want to comment as well Don, what are the
12 next steps moving forward in the investigation?
13 These are essentially interim recommendations,
14 preliminary to the development of a broader final
15 report. Where do you see going after this stage?

16 MR. TILLEMA: As I mentioned, we
17 paused the investigation at this point in order
18 to develop this document and issue these
19 recommendations. So we are still far from being
20 complete at La Porte.

21 So we need to finish our full causal
22 analysis and get a complete understanding of the

1 causes, to the best of our ability, at La Porte.
2 And then I think we need to start looking at what
3 the corporate oversight role was that allowed
4 these problems to exist for so long.

5 That would be our next focus, trying
6 to understand at a corporate level the various
7 things that are supposed to prevent these types
8 of accidents from happening and have significant
9 process safety management gaps at a site such as
10 corporate audit.

11 MR. HOLMSTROM: Board Member Engler,
12 I mentioned that for the ExxonMobil investigation
13 we have a Board order on scoping. And so we are
14 implementing a scoping process for the DuPont
15 investigation which is, we think a key way to
16 have the Board's input into what kind of product
17 we're going to produce, full investigation
18 report, what sort of issues we're going to
19 examine and have full input to that.

20 We currently have a draft that, again,
21 is both ExxonMobil and DuPont are recent
22 investigations. So at this point, the work plan

1 and everything else is dependent upon, is it a
2 narrow scope? Is it a broad scope? Currently
3 we're engaging in the scoping process.

4 But as Dan indicated, given the fact
5 that we've had three, actually four previous
6 incidents at two separate facilities and two
7 reports from the CSB in addition to this
8 incident, that we're going to be potentially
9 looking for linkages and issues related to those
10 investigations and potentially other issues. And
11 how that impacts, looking more broadly than at
12 just La Porte, Texas.

13 MEMBER ENGLER: Thank you. At this
14 point, I would like to open the floor for public
15 comment. On the public comment sheet, we have
16 three people who have signed up so far. First
17 I'd like to recognize Lynette Soto.

18 MR. TILLEMA: They weren't here
19 earlier. Are you having them come up here for
20 the comments or just staying where they're at?

21 MEMBER ENGLER: I think it would be
22 great if people came up to the podium, if people

1 are comfortable doing that. Thank you.

2 LYNETTE SOTO: Good morning. I
3 apologize in advance, I am very emotional. I
4 want to speak from my heart and tell you how I
5 feel. I'm here for two main reasons, the main
6 reason is to give voice to my brothers. I'm the
7 sister of Robert and Gilbert Tisnado.

8 They are just not a casualty or a
9 statistic of DuPont, they were my brothers. My
10 family is devastated, heartbroken. There is no
11 measuring the amount of pain and suffering we are
12 going through by losing these two people.

13 My brothers loved their job, loved
14 their job. A month prior to the incident, I
15 applied for a job at Valero where my oldest
16 brother Gibby's two boys work. I wasn't sure
17 about working there so when Gibby brought me over
18 these tests, I said, I don't know Gib, I'm kind
19 of worried about it.

20 He said Nette, there's a lot of
21 dangerous chemicals. He's like, but there's so
22 many safety precautions that you don't have to

1 worry about it. And my brother truly believed
2 that his environment that he worked in was safe.
3 And he was wrong. I mean he was wrong - this
4 was not an accident.

5 I live in this area. La Porte,
6 Pasadena, Deer Park, 90 percent of the people
7 that live there are related to or know somebody
8 personally who lives in those plants. There are
9 all those people are know well aware of the
10 safety hazards. The majority of my friend's
11 husbands do not come up or comment or say
12 anything because financially, they are paid well.

13 Just because you're paid well doesn't
14 mean you should have your life in jeopardy.
15 You're playing Russian Roulette with their lives.
16 This wasn't an accident, this was gross
17 negligence.

18 These issues at this plant had been
19 there for years. If it was an accident, we would
20 not be here talking to you right now because of
21 course, living in that environment, there are
22 accidents. This wasn't an accident, this was

1 deliberate neglect, letting it go for so many
2 years. And unfortunately, my brothers were two
3 of those casualties.

4 But I won't let them go without being
5 heard their voices. They should have never died.
6 My brothers were such wonderful people. I'm not
7 saying that because I'm related to them. I'm
8 saying it because it's genuine and it's true.

9 They were hard working men. My
10 youngest brother had a one-year-old, a three-
11 year-old who will never know what a bright piece
12 of sunshine that little boy was. He was the baby
13 of the family, let me tell you. He lived that to
14 the T. He was a pain, I understand that. But he
15 was a breath of fresh air.

16 And my oldest brother, he was my go-to
17 guy. For anything, going through a divorce,
18 personal, whatever it may be, Gibby had my back.
19 They worked both nights and so when he was over
20 there doing the panels, I would speak to him
21 about it.

22 I'm here to beg and plead for these

1 recommendations and this report to go through.
2 Nobody should have to go through this anymore. I
3 Googled the heck out of DuPont and their safety
4 records and I read that between 2007 and now,
5 there's been over 34 different leaks. There's
6 been 12 people, 12 deaths. I don't understand
7 what we're doing here. They need to fix it.

8 I know that the unit that my brother's
9 in is the money maker. It made over \$1 million a
10 year. And you know what, the money that they
11 make, it goes through our community. And we have
12 better schools and stuff because, yes, all these
13 chemical plants are near us. And I know this.

14 My daughter's a teacher at Deer Park.
15 I have grandchildren who live near there. But it
16 needs to be safe. Make your money. Maybe I
17 Google too much, I know that CEO, the Forbes, the
18 CEO of DuPont is Number 26. So that means she is
19 way up there and they can do what they want.

20 How many times do people have to lie
21 and cut corners and stuff so financially it's
22 better for them? If you have this facility and

1 it's making you all this kind of money, then
2 wouldn't it be smart to invest in it and make
3 sure it's safe? So you can make all the money
4 you want. But I'll be danged if you should be
5 able to kill people and use them as a casualty or
6 just, oh well we lost two today, no big deal.

7 But to the family, it was a big deal.
8 They are vital people that worked from the heart,
9 they loved their job, they loved the people
10 there. They didn't deserve to die for a profit
11 and that's what it is. I mean DuPont's got more
12 money than you can shake a stick at, I'll be the
13 one to tell you. And that's fine and dandy. I'm
14 not envy of that.

15 What I'm mad about is you have no
16 right to take my brothers. They were my life. I
17 can't describe to you the heartache, I can't put
18 into words but it's wrong. They need to fix it.
19 It's been a problem apparently, that building has
20 been here since World War Two. It never should
21 have been there.

22 I read his report. I've heard Dan and

1 I appreciate you coming to my house and
2 explaining it to my family. And not only that,
3 explain it to me like I was a five-year-old
4 because I don't get all that. I'm not into all
5 this stuff.

6 But I know that my brothers died in
7 vain and they shouldn't. DuPont has gotten away
8 with a lot of stuff and they cut these corners.
9 But when is enough? When are you going to say,
10 hey we do these recommendations and people keep
11 dying? When is there point where you say, hey
12 maybe they have a problem, maybe we should make
13 them be accountable and fix it?

14 Somebody, somewhere, I'm begging you.
15 Somebody's got to be accountable. I mean they've
16 gotten away with it for so long. Not with my
17 brothers, I mean, there's nothing we can do about
18 my brothers. No matter what I pray and I beg, my
19 brothers won't come back.

20 But nobody else should have to lose
21 their brothers, their sons, their spouses, nobody
22 for something like that. You work hard and these

1 people give their life for DuPont. And for what?
2 For you to think they're just disposable. We're
3 not disposable.

4 The people that work there, that have
5 been there 23 years, give their whole life. Mr.
6 Baker had been there 40 years. He deserved
7 better than that. He should have been able to
8 retire. He couldn't. That unit was horrible.
9 They knew I'm sure, Gibby told me that the
10 ventilation system had been broke. You see the
11 work orders.

12 I'm sure there's probably more that
13 disappeared somehow, magically disappeared. That
14 place is horrible. The ventilation system, the
15 pipes, I don't even know how to, whatever you
16 want to call it, that little thing who rigged
17 that little pipe in there, should have never done
18 that. And they should have never been able to do
19 that but they did.

20 Not just in La Porte and DuPont and
21 yet, that's my main objective because I live
22 there. But what about those plants in all those

1 places? I heard all kinds of stuff, I read so
2 much stuff. I mean when is there a stopping
3 point when we say that they need to be held
4 accountable?

5 They have the money. You make all the
6 money you want but make sure you're doing it
7 safely and not jeopardizing people that I love
8 and the community that I love. So that's all I
9 have to say, thank you.

10 MEMBER ENGLER: Thank you very much.
11 Next will be Walter Prillaman from the
12 International Chemical Workers Union.

13 MR. PRILLAMAN: Good morning. I'm
14 Walter Prillaman Jr. I'm a second generation
15 DuPonter with 36 plus years service. Sorry that
16 touched me. I know those boys, they're good
17 boys. I guess you could say that I'm just
18 (inaudible).

19 I'd like to thank the Chemical Safety
20 Board for the opportunity to be here. I'd also
21 like to thank OSHA, DuPont, International
22 Chemical Workers Local 900C which I'm the Safety

1 Officer. Thank you to the investigation team for
2 the hard work that ya'll have done. It was
3 definitely evident in the interim report and how
4 deep that you dug through this incident.

5 Their report along with OSHA's NEP
6 report has already started to have impact on
7 safety. With four new safety items started just
8 this week so thank you for that. In my opinion,
9 these recommendations, without these
10 recommendations, these changes would not have
11 started to happen.

12 We need to be held accountable. It is
13 important that this report be made public. This
14 information will identify and help make
15 corrections. The community that surrounds our
16 plant and the lives of the workers are too
17 important. Thank you.

18 MEMBER ENGLER: Thank you Mr.
19 Prillaman. Next will be Justin DeLaune, do I
20 have the pronunciation correct?

21 MR. DELAUNE: Yes sir.

22 MEMBER ENGLER: From the Smith Law

1 Firm.

2 MR. DELAUNE: Good morning ladies and
3 gentleman. My name is Justin DeLaune and I'm an
4 attorney from Baton Rouge, Louisiana with the
5 Smith Law Firm. I represent a whistleblower
6 federal False Claims Act against DuPont arising
7 out of toxic gas leaks at DuPont's Darrow,
8 Louisiana facility, also known as the Burnside
9 site.

10 The suit alleges that DuPont withheld
11 leak information from the EPA to avoid paying
12 fines. A two week trial jury commenced and
13 DuPont prevailed following an eight hour jury
14 deliberation. However, following this verdict,
15 it was discovered that DuPont withheld material
16 information from this trial.

17 On June 25, 2015 a federal judge set
18 aside the jury verdict that was in favor of
19 DuPont. The court found that DuPont had engaged
20 in misconduct that impacted the integrity of the
21 trial process by withholding information
22 regarding gas leak calculations and withholding

1 information regarding OSHA violations similar to
2 those in La Porte, Texas. I have a copy of this
3 ruling available for the Board along with several
4 other things.

5 The evidence in our case includes an
6 audio recording of a meeting led by Tom Miller,
7 the plant manager at the Darrow Burnside facility
8 since February of 2011. This meeting was
9 regarding anonymous leak reports by employees to
10 outside agencies.

11 This audio recording was accepted into
12 evidence in our case. I have a copy of the
13 recording available for the Board and also have a
14 transcript of the recording prepared by a
15 certified court reporter so that the Board may
16 follow along in the recording at a later time. I
17 will now read an excerpt for you beginning at
18 Page 7 of the transcript and continuing to Page
19 9.

20 Tom Miller, the plant manager is the
21 main speaker in this excerpt. I want to have a
22 quick inaudible -- it's a meeting, but I got

1 here, the points that was written Friday I guess.
2 About 3:00 the fire department came to the plant,
3 Alan (phonetic) was working. He called me, they
4 were responding to a gas cloud above the Burnside
5 plant.

6 I guess that's what the complaint was.
7 I can call the fire department and find out what
8 exactly happened but I don't know if you guys
9 know that this is the third complaint that we've
10 gotten from an outside entity. One from, it says
11 MBQ but it should be DEQ, one from OSHA, and
12 there's one here like in the last month.

13 And you know, I know there are folks
14 who are unhappy with the gas leak. I am too. I
15 guess that's what's prompting all of this but,
16 you know, of course these all have been
17 complaints. I don't know who is calling them in
18 but if this is coming from inside the plant, I'm
19 very disappointed.

20 You know, we've got to be in the
21 position where these things are talked about and
22 discussed. There have been a lot of people

1 working on these things, we've had two shutdowns,
2 and we've had a bunch of people up here doing all
3 these things to try to contain this thing and
4 nobody believes that.

5 Then go ask the folks that have been
6 doing it. But, you know, there was an
7 unidentified speaker, why would somebody in the
8 plant call? Tom Miller responds, I don't know
9 but I don't know why somebody would call OSHA
10 from outside the plant but who knows.

11 But the point is that whenever a third
12 party gets called, it never works out for the two
13 parties that are involved on the receiving end of
14 that. It never does. And whoever thinks it does
15 is nuts. And we've seen it time and time again,
16 both within the company and outside.

17 So you know my request is that if you
18 guys know of anybody doing this or if you're
19 doing it yourselves, then I'm telling this to
20 everybody. So I'm not picking on any one person
21 but you know, come forward with it and talk about
22 it instead of calling agencies and stuff. That's

1 my point.

2 If you know somebody doing that, then
3 tell them to stop doing it as well. We don't
4 need this kind of help. DuPont will shut plants
5 down for this. I mean, there's no doubt about
6 it, they'll shut them down for good. I've seen
7 it happen before.

8 You know, it just takes one, one iota
9 of information. Next thing you know, it grows up
10 to this big problem and you can get a lot of
11 people wrapped up in looking into it. And it
12 just becomes a big cluster. And you know, I kind
13 of want this plant to keep running. I'm sure you
14 guys do too because we all get paid, right?

15 I'll skip to his next comment. But
16 you know, I think for us to be sitting looking at
17 the outside and saying man, I wish we could have
18 done something back when, you know, when this
19 stuff originally happened instead of waiting for
20 DuPont to come and shut this plant down because
21 we're not, you know, not a safe operation.

22 That was a transcript of actual audio

1 recording from the plant manager himself. We had
2 several pieces of evidence like this in our case.
3 The evidence in our case also includes video
4 footage that depicts disturbing amounts of toxic
5 gas leaking from the Darrow Burnside facility
6 shortly after a shut down that was taken to
7 repair leaking equipment.

8 These videos clearly show that repair
9 efforts failed. This footage was accepted into
10 evidence in our case and no witness seriously
11 challenged these videos that depict what former
12 and current operators identify as toxic SO₃ gas
13 leak. There are several videos that I have made
14 available to the Board including footage from
15 cameras inside the Burnside facility.

16 There should be no further concealment
17 of information involving DuPont, they do that
18 enough. I ask the Board to be swift and thorough
19 in how it evaluates the making public of this
20 information the Board obtained from DuPont. This
21 information is key to enable the industry to
22 progress beyond the current state of the industry

1 and to progress beyond incidents like La Porte.

2 Thank you.

3 MEMBER ENGLER: Thank you very much.

4 Are there any other comments from within the room
5 here today?

6 MEMBER EHRLICH: There are two other
7 people, the Tisnados. The wife of Gilbert
8 Tisnado and the father of Gilbert and Robert
9 Tisnado.

10 (Telephonic interference.)

11 MICHELLE TISNADO: -- before making
12 vital changes to ensure the safety of the workers
13 as well as the public would not only be a
14 mistake, but would also be saying that the four
15 lives that were lost including my husband Gilbert
16 and my brother-in-law Robert, didn't matter.

17 I'm concerned not only for the workers
18 but their families as well. I do not want other
19 families to have to go through what our families
20 have gone through and are continuing to go
21 through. It is unbelievable and sickening to see
22 DuPont's disregard for the four lives that were

1 lost on that dreadful Saturday, November 15, 2014
2 at approximately 3:30 a.m.

3 DuPont claims it's motto is safety
4 first, but it is obvious that DuPont is putting
5 collection first since they are trying to reopen
6 the unit without making the necessary changes to
7 make it safer for the workers.

8 The changes that should take place
9 should have been made a long time prior to the
10 fatal incident that occurred due to gross
11 negligence which would have prevented these
12 tragic deaths that DuPont is now refusing to make
13 to prevent future loss.

14 The investigators with the Chemical
15 Safety Board and the other agencies investigating
16 the accident have worked diligently to find
17 recommendations that would ensure the safety of
18 workers as well as the public which I
19 wholeheartedly appreciate. It appears that
20 DuPont is trying to bypass these recommendations
21 in order to reopen the unit and start production
22 back up.

1 It appears to me that DuPont has not
2 learned anything from this tragedy and only cares
3 about profit. I sincerely hope that you will
4 deny DuPont's request to reopen the (inaudible)
5 unit before the required safety measures and
6 changes are implemented. Please allow the report
7 to be released and approve the urgent
8 recommendations as soon as possible. Thank you
9 for your time.

10 MEMBER ENGLER: Thank you very much.
11 Is there anyone on the phone who would like to
12 make a comment?

13 OPERATOR: Once again, if you have a
14 comment, please press star then 1 from your
15 touchtone phone. It looks like Brent Coon from
16 USW is on line with a question. Your line is
17 open, please go ahead.

18 BRENT COON: Good morning ladies and
19 gentlemen. Thank you ma'am. Yeah, our firm and
20 just for clarification, we are speaking on behalf
21 of not the USB, the USW they have their own
22 counsel, but we are designated counsel in several

1 states including Texas. I think a number of you
2 guys with the CSB know of the work our firm has
3 done in the petrochemical industry, most notably
4 in Texas City where we were lead counsel.

5 Real briefly, Don for you and the
6 others, I was not aware that the meetings this
7 morning would include commentary on some of the
8 recommendations with respect to the reporting
9 systems at BP. We are intimately familiar with a
10 lot of the tracking devices, traction systems,
11 and MOTs there.

12 We would like to weigh in further on
13 that matter at a later date if we can be steered
14 to the actual report that Mark and others may
15 have generated on that. Going specifically, and
16 just real briefly for background gentlemen, we
17 represent clients in the DuPont incident, the
18 Exxon matter, many of the BP Texas City, and are
19 the major stakeholder in the Macondo incident
20 with about 10,000 clients.

21 I want to first very briefly comment
22 on some early criticism on the meeting this

1 morning regarding the CSB and their agenda. I
2 was disappointed that the West final report is at
3 least for the time being going to be suppressed.

4 My firm has been intimately involved
5 in the petrochemical industry for 30 years. We
6 work very closely --

7 MEMBER ENGLER: For a point of
8 information, could you clarify that comment
9 again?

10 BRENT COON: Yes. We're disappointed
11 that there were some early technical criticism of
12 the CSB investigators and some of the reported,
13 what I read to be from Flint (phonetic) on their
14 activities. We've always found the CSB to be --

15 MEMBER ENGLER: I'm sorry, in which
16 investigation? We're talking about DuPont.

17 BRENT COON: I think that was just a
18 comment generally as we were going through the
19 West report.

20 MEMBER ENGLER: First of all, just to
21 clarify, I'm not aware of any such information.
22 Secondly, comments in this part of the comments

1 section are restricted and focused on the DuPont
2 situation. At the end of the meeting, there will
3 be an opportunity for any other comments about
4 any issues that the public wishes to raise.

5 BRENT COON: Okay, thank you. What we
6 would like to specifically address with DuPont at
7 this time is there's a parallel investigation by
8 a number of attorneys on behalf of claimants,
9 some of whom spoke this morning, regarding our
10 investigation through the civil system which
11 sometimes provides supplemental information
12 regarding the incidents.

13 But we rarely get up to speed on the
14 cases as quickly as the CSB due to the slow
15 process that it takes for the litigation in the
16 civil arena to move forward. As a consequence,
17 it's very beneficial for us in our parallel
18 investigations to have access to investigations
19 that are already being committed to by OSHA and
20 CSB.

21 We appreciate very much that Mr.
22 Tillema and others have engaged the victims and

1 counsel on some briefings. But we would like to
2 have better access to the actual documentation.
3 Most particularly this would include, for
4 instance, the 40 page report or urgent
5 recommendations to DuPont.

6 We had, in discussions with CSB
7 investigators, thought that this would be
8 accessible to the victims and counsel. There
9 appears to be some questions with respect to
10 whether or not that type of information can be
11 disseminated to them. So we would like some
12 clarification of that.

13 And to the extent there is
14 uncertainty, we would request that the CSB
15 resolve that in favor of the liberal construction
16 of the dissemination of those types of
17 communiques to the victims as part of an
18 extension of the victims interaction program.

19 Other than that, we concur
20 wholeheartedly with all of the findings that have
21 been made to date. They're very consistent with
22 what we have found in our independent

1 investigations. And we look forward to
2 continuing to work with the CSB and other
3 investigative agencies moving forward.

4 As others have said, they do an
5 excellent job at root cause analysis. And
6 frankly, we think that they tend to give too much
7 benefit of the doubt to the industry regarding
8 the lessons learned which really is just, in our
9 opinion, renewed reminders.

10 We concur with the sentiments of some
11 of the victims earlier that most of these process
12 safety management failures throughout the
13 industry are things that the industry is well
14 aware of. And they put their cost benefit
15 analysis and ROI factors in, which put everyone
16 at additional risk.

17 So we would like to see the CSB be
18 more proactive and to have more enforcement
19 capabilities. Because frankly, the industry self
20 regulates and OSHA, EPA, and CSB do not really
21 have the staffing and resources enforcement that
22 we would like all of them to see. Thank you.

1 MEMBER ENGLER: Thank you for those
2 comments. I'd now like to recognize Gilbert
3 Tisnado. Thank you for your patience here.

4 GILBERT TISNADO: I'd like to give
5 thanks to my sons. This is my youngest, my baby.
6 This is my eldest my firstborn. I haven't gotten
7 (inaudible). I know that accidents will happen
8 especially in plants.

9 But to me, the CSB Board was like
10 doctors coming to check out a sick plant. They
11 went through that sick plant, they found the
12 problems, they looked at them, they made
13 recommendations. I believe that, I don't think
14 anything should happen until their
15 recommendations are taken care of, until the
16 plant is 100 percent safe for everyone.

17 I mean life and limb is the most
18 important thing. I know money is important.
19 It's so sad for a man to go to work in the
20 morning and not make it home that evening.
21 That's all I want to say, is that we need to make
22 this public, let it go and let people see, learn.

1 If you've got a problem, fix it. Not
2 try to sweep it anywhere, not try and cover
3 anything. Just make it open, confront it, and go
4 with it.

5 MEMBER ENGLER: Thank you. Can I ask,
6 are these your personal photos that you're taking
7 back to Texas with you?

8 GILBERT TISNADO: Yes. They're my
9 daughter-in-law's.

10 MEMBER ENGLER: One thing that I
11 remember from the recent, well the leadership at
12 OSHA took over is that they changed I believe
13 their conference room. Some of you may have been
14 in it. And the conference room, I forget what
15 they had before, but the conference room at OSHA
16 now has photographs of people who lost their
17 lives in preventable industrial incidents.

18 I wonder, even though we feature
19 people, family members, victims in our videos,
20 whether we shouldn't have photos in this office.
21 I frankly, to be perfectly blunt, have gotten
22 caught up in a lot of the difficulties,

1 challenges, intrigue here. I think it would help
2 me to have photos to see every day of why we do
3 this work and of why CSB is in existence.

4 So I don't know if this is the best
5 way to do it -- sure and we will certainly post
6 them to remind us all. Thank you again. Other
7 comments from those on the telephone? I'm sorry,
8 did I say I'd come back to you? I did I think.
9 Go ahead sir.

10 MR. SUTTON: My name is Ian Sutton.
11 I have two technical questions about the
12 interpretation. Of the 300 employees, how many
13 were contract workers and how many were DuPont
14 employees?

15 The second question, you say the PHA
16 techniques were the before and after. What were
17 those techniques? What were they doing and what
18 did they change to?

19 MEMBER ENGLER: Normally, to be frank,
20 this is not a question and answer opportunity.
21 But since you raised it through the Chair, I will
22 bounce them from myself. Dan, if you would like

1 to respond to that.

2 MR. TILLEMA: Sure. So the first
3 question was the employees, those are DuPont
4 employees. There are other contractors on site
5 but that's not included in that number. Off the
6 top of my head, I do not have the number of
7 contractors on the site.

8 The initial PHAS were what if
9 checklist PHAS done with large notes and
10 methodology. The new PHAS is a DuPont technique
11 called a structured what if. They've published
12 at least one paper that I'm aware of on that
13 methodology.

14 MEMBER ENGLER: Are there any other
15 comments from those joining us on the telephone
16 or in the audience?

17 OPERATOR: At this time, we have no
18 audio questions or comments.

19 MEMBER ENGLER: Okay. I shall note
20 for the record that DuPont has indicated that
21 they will submit written comments. Member
22 Ehrlich, do you have any further comment?

1 MEMBER EHRLICH: No I don't at this
2 time.

3 MEMBER ENGLER: I would just like
4 briefly to say the following. This situation is
5 deeply troubling. Not only do we have this
6 incident but as Mr. Tillema talked about, there
7 have been prior incidents that CSB has
8 investigated.

9 We're now looking at a situation where
10 DuPont is thinning off and splitting up. That
11 certainly raises questions about what happens
12 when you have management subdividing and how you
13 deal with a situation like that within one,
14 essentially one standard facility around the
15 fence line.

16 We're looking carefully at the two
17 sets of citations that federal OSHA issued.
18 Including the fact that OSHA put DuPont into the
19 severe violators program. This is a very serious
20 situation.

21 So the question arises, what are the
22 opportunities for CSB? What can we do? Just to

1 clarify again, we are not a regulatory agency.
2 We have no statutory authority to say, before the
3 facility or a section of the facility can resume
4 production, the following steps must be taken.

5 With that said, we do have a rather
6 important, I guess the phrase might be bully
7 pulpit, to highlight problems, to suggest
8 solutions, and to vigorously advocate for safety
9 and prevention. I'm encouraged that DuPont has
10 indicated that they're not starting up the
11 facility on the original date that they had
12 suggested which was the August 15th date,
13 correct?

14 We don't know when they do plan to
15 start up again. I think that the findings
16 suggest that there needs to be a very, very
17 serious and prompt response by DuPont management
18 to what the staff of the CSB have found so far.
19 And there needs to be a very, very serious
20 dialogue about ensuring that preventive measures
21 are taken within a short period of time so that
22 the possibility of this type of tragedy repeating

1 itself at that facility, or frankly, in terms of
2 impact at other DuPont facilities is taken very,
3 very seriously.

4 I think I can pledge on behalf of
5 Member Ehrlich and myself that we're deeply
6 concerned about this. But that the proof of the
7 direction will not be just in written statements
8 or press releases but actual changes and
9 implementation of safety precautions, preventive
10 measures, assurance of whistleblower protection
11 at DuPont facilities.

12 So with that, unless there's any
13 closing comments by the investigators in this
14 case, I would like to close that part of the
15 discussion on DuPont. And to assure the family
16 members that we will be taking this very
17 seriously and following up.

18 By the way, I would like to meet with
19 the family members at the conclusion, if I could,
20 for a few minutes just to talk informally for a
21 couple of minutes. And with that, it's now
22 11:30. Why don't we take a 10 minute break and

1 resume at 11:40. So we'll resume promptly at
2 11:40.

3 (Whereupon, the above-entitled matter
4 briefly went off the record.)

5 MEMBER ENGLER: Thank you all. At
6 this point we will reconvene.

7 MS. MCCORMICK: Chris, we're going to
8 get started again.

9 OPERATOR: Okay, your line is open.

10 MEMBER ENGLER: Next on our agenda is
11 a presentation by both Veronica Tinney from our
12 Recommendations Office and Don Holmstrom on the
13 status of California Process Safety Management
14 Recommendations.

15 MS. TINNEY: All right, thank you. So
16 first I'm going to start with talking about our
17 overall recommendations that are currently under
18 Board vote. The Board is currently reviewing the
19 status change of 16 of our recommendations and
20 that's outlined on a handout that is actually out
21 in the hall. So you can review all of the ones
22 that are currently under Board vote.

1 This vote is taking place by notation
2 item which just means it's done by a paper vote.
3 And that voting period takes place from July 14th
4 to July 28th. These recommendations include six
5 recommendations from the Chevron investigation,
6 four from the AL Solutions investigation, and one
7 each from the Texas Tech University MSG
8 (inaudible) carbide and (inaudible).

9 The six Chevron recommendations
10 include one to the Governor and State
11 Legislature, two to Contra Costa County, and
12 three to the City of Richmond. These
13 recommendations have been suggested by staff to
14 the Board on open discussible or alternate
15 actions which just indicates that the recipient
16 has made progress towards implementing the CSB's
17 recommendations.

18 Additionally, the recommendations
19 under review also include one potential closed
20 acceptable alternative action to the American
21 Petroleum Institute as a result of the Valero
22 Refinery fire in 2007.

1 So I'm going to talk a little bit more
2 about those specific Chevron investigation
3 recommendations that I just mentioned that are up
4 for Board vote. As a result of the Chevron
5 investigation which occurred on August 6, 2012 in
6 Richmond, California and caused 50,000 people in
7 the surrounding communities to seek medical
8 treatment, the CSB makes recommendations at both
9 the local level to the city of Richmond and
10 Contra Costa County and to the State of
11 California to improve its process safety
12 management program.

13 Like I mentioned, there's six that are
14 currently in open acceptable or alternate action
15 as recommended to the Board that they're voting
16 on right now. Several of these include efforts
17 made by the City of Richmond and Contra Costa
18 County to revise industrial safety ordinances or
19 ISOs to improve process safety.

20 So those are the ordinances that deal
21 with process safety in those two jurisdictions.
22 For example, both ISOs added language regarding

1 reducing risk to the greatest extent feasible,
2 adding language relating to inherently safer
3 systems analysis, and additional safeguards or
4 process hazard analyses.

5 The CSB commends the City of Richmond
6 and Contra Costa for initiating changes to its
7 ISOs to address the CSB recommendations and looks
8 forward to working with both to ensure that the
9 intent of these recommendations is fully met.

10 And now Mr. Holmstrom is going to talk about the
11 recommendations that we made to California
12 regarding its process safety management.

13 MR. HOLMSTROM: Thank you Veronica
14 Tinney and I appreciate all the great work that
15 you've done by our recommendations group on these
16 California PSM recommendations and the great
17 cooperation we had working together to further
18 these recommendations. Thank you for your hard
19 work.

20 Also out of the Chevron investigation,
21 the CSB issued three reports, two of which
22 contained recommendations to the State of

1 California to make specific improvements to their
2 process safety management regulations. The State
3 of California in part in reaction to the incident
4 itself as well as to CSB recommendations
5 initiated changes to their general industry
6 safety order. And promulgated a draft, over time
7 several drafts, a document entitled Process
8 Safety Management for Refineries.

9 So this is specific process safety
10 changes that apply to petroleum refineries in the
11 State of California. In September and October of
12 2014 and May of 2015, the California Department
13 of Industrial Relations released these drafts of
14 the proposed rule for public comment, Versions 1,
15 2, and 4.5, respectively.

16 The CSB provided oral and written
17 comment on the June 22, 2015, on that date to the
18 California Department of Industrial Relations or
19 DIR, 4.5, which is the latest version dated May
20 26, 2015. These comments are available under the
21 open government portion of our website and will
22 be briefly summarized as follows.

1 The CSB has previously reviewed
2 Versions 1 and 2 of the draft regulation and
3 expressed that it was greatly encouraged by the
4 DIR and Cal/OSHA's leadership in advancing
5 process safety management protections for workers
6 and communities. The CSB has also stated that
7 California can be a model.

8 We know that there's obviously
9 currently the executive branch is reviewing
10 reforms in terms of process safety management.
11 That California can be a model for reforms that
12 are being considered at the federal level by the
13 Executive Order 13650.

14 However, the CSB finds that Version
15 4.5, in our view based on the recommendations
16 that the Board adopted both in our first report
17 and second report to the State of California,
18 does not go far enough to require real risk
19 reduction to prevent major accidents.

20 Without risk reduction measures for
21 refineries to work towards, and with no clear
22 role for the regulator, it is unclear how the

1 draft proposed rule is an improvement upon PSM
2 regulations that are currently in place. Some of
3 the major concerns that the CSB has are as
4 follows.

5 The first is a concern that the
6 majority of the language that's requiring risk
7 reduction be implemented to the greatest extent
8 feasible has been removed between Draft 2 and
9 4.5. So the current draft has most of that
10 language removed. And as we had pointed out,
11 some of that language, the way it's phrased, it's
12 not clear that it would apply to remedial actions
13 or recommendations or corrective actions.

14 The remaining performance measures are
15 inconsistent, with the CSB counting ten different
16 performance goals referenced in the draft
17 proposed rule. Removing the central feature
18 returns PSM to a list of required activities that
19 lack real goal setting attributes of risk
20 reduction.

21 Our concern is that PSM standard is
22 intended to be a goal setting standard but lacks

1 real effective goals that are established with
2 the standards. Without clear performance
3 measures, the CSB is concerned that refineries
4 will satisfy the intent of the regulation by
5 submitting the required process documentation but
6 without actually reducing risk of major
7 incidents.

8 Preventative role of the regulator,
9 there's very little language in 4.5 that relates
10 to the role of the regulator in helping to
11 prevent potentially catastrophic chemical
12 incidents. Version 2 allowed the division,
13 that's the earlier version, to review submitted
14 hazard control analysis, HCAs.

15 In addition, where the division
16 identifies deficiencies, the division can require
17 the employer to submit further information,
18 perform a real analysis, and submit a revised HCA
19 and modify the HCA to incorporate changes
20 proposed to for example, inherent safety
21 measures.

22 Version 4.5 eliminated this language,

1 removing the ability of the regulator to ensure
2 that the employer has properly controlled hazards
3 prior to a potential catastrophic incident. And
4 we want to emphasize that the process safety
5 management standard is intended to focus on major
6 accidents, on preventing potentially catastrophic
7 incidents occurring.

8 The inspection strategy that focuses
9 on response to incidents, complaints, and
10 referrals is not an effective strategy for
11 potentially catastrophic incidents. It's not
12 acceptable for a catastrophic incident to occur
13 and expect change to happen in response to an
14 investigation of that incident solely. There has
15 to be preventative inspections, preventative
16 actions by the regulators.

17 And that certainly was the intent of
18 the original compliance directive that OSHA
19 issued in response to the PSM standard back in
20 1992. The CSB believes that the regulator can
21 play a critical preventative role in reducing
22 risks of accidents through inspections and audits

1 to ensure that refineries are adequately reducing
2 risk.

3 Pursuant to its recommendations, the
4 CSB believes language should be included that
5 outlines the role of the regulator. Conclusions,
6 the CSB appreciates the substantial effort
7 involved in the development of the draft proposed
8 rule in implementing our recommendations.

9 However, the CSB is concerned that the
10 current draft, if finalized without the
11 recommended changes, will not be effective in
12 reducing risk of incidents at refineries. The
13 CSB urges the DIR to make the previously
14 mentioned changes prior to finalizing the
15 proposed rule in addition to those described in
16 our written comments submitted at the June 22nd
17 meeting available on our website.

18 The CSB welcomes any additional
19 conversation on how to improve the draft proposed
20 rule and looks forward to further dialogue on how
21 to improve refinery safety in California. Thank
22 you.

1 MEMBER ENGLER: Thank you. Member
2 Ehrlich, do you have any questions?

3 MEMBER EHRLICH: I do not, thank you.

4 MEMBER ENGLER: I have a question. Is
5 California the leading state, in a sense, doing
6 this? Are there efforts in other states? Or is
7 California really the one path that's being gone
8 down, that's being explored? Is there anything
9 else going on in other states where this is
10 really critical?

11 MR. HOLMSTROM: I apologize, I meant
12 to say Member Ehrlich a minute ago, I mean Member
13 Engler.

14 MEMBER ENGLER: Well we both begin
15 with E.

16 MR. HOLMSTROM: Member Engler,
17 California I think, because they put out a draft
18 and they are pursuing these reforms, I think
19 California is leading, as we've said, is leading
20 the country in trying to improve PSM. As we
21 know, as we've said in several reports, the PSM
22 standard has not be substantively changed.

1 There have been some minor changes
2 relative to, you know, hazard communication. But
3 it has not been substantively changed since it
4 was promulgated in the early '90s. So we think
5 California is, as we said in the reports that
6 have been issued by the Board, we think that the
7 PSM standard needs to be strengthened based on
8 the number of incidents occurring, particularly
9 in oil refineries.

10 California is certainly taking the
11 initiative of being proactive and moving that.
12 There are other arenas. Veronica mentioned
13 Contra Costa County in California which is also
14 in California. But also the State of Washington,
15 we understand has been meeting with the State of
16 California to try to understand their process
17 because we made similar recommendations to the
18 State of Washington.

19 So there's also activity in the State
20 of Washington pursuant to the recommendations we
21 made in the Tesoro and Anacortes investigation
22 that was issued about a year and a half ago.

1 MEMBER ENGLER: Okay, thank you. And
2 thank you both for your work.

3 MEMBER EHRLICH: Can I change my mind?

4 MEMBER ENGLER: Sure.

5 MEMBER EHRLICH: Did they not, in
6 California put on a whole group of inspectors to
7 follow up and enhance the inspection program?
8 What, they put on 13, was it?

9 MR. HOLMSTROM: Right. In response
10 to, again CSB recommendations as well as the
11 incident itself that occurred at the Chevron
12 refinery, the State of California has undertaken
13 several actions to improve process safety
14 including the hiring of a number of additional,
15 not only inspectors inspecting for TSM, but who
16 have more technical qualifications.

17 A number of them, I think a majority
18 of them are engineers. So the CSB, in our
19 reports, have noted that it's important that the
20 technical qualifications of the people who
21 inspect highly technical process plants, they
22 have equivalent technical backgrounds and

1 experience of those operating the plant so they
2 can understand and play a preventative role in
3 that process.

4 Much like, for example, the Nuclear
5 Regulatory Commission hired, \$1 billion budget
6 entity that's hired really hundreds of nuclear
7 engineers to do, to look at those highly
8 technical issues there.

9 MEMBER EHRLICH: Are you familiar with
10 the SBREFA efforts? Have you heard about that?
11 It's coming out of small business and the
12 Executive Order. Rather than ask you if you've
13 heard of it, I was in a meeting where the fellow
14 that runs it commented on it.

15 He says that the two big players in
16 there are OSHA and EPA, and he thinks they're
17 going to have legislation or formal documentation
18 in no greater than 120 days to address a lot of
19 these issues. Veronica, you shake like you've
20 heard of it.

21 MS. TINNEY: Yes, and you can correct
22 me, but OSHA is currently conducting its SBREFA

1 panel on PSM, further additions to PSM.

2 MEMBER EHRLICH: SBREFA, just for
3 those any of who you are not familiar with it, is
4 a process by the Small Business Administration to
5 basically, structure panels of business, small,
6 medium, and perhaps larger as well to review the
7 impact and the cost and benefits of particular
8 regulations.

9 It's an extensive and lengthy process
10 that has been used to identify issues but in my
11 view, frankly, has been also used to slow down
12 the needed adoption of safeguards. So it has its
13 benefits, but it also has its challenges to deal
14 with.

15 MEMBER ENGLER: Thank you. If there's
16 any public comments, we'll defer public comments
17 on this presentation because we do have another
18 public comment period coming up. Veronica,
19 you're up again on Laboratory Safety Guideline
20 Recommendations to the American Chemical Society.

21 MS. TINNEY: Sure. So one of the one
22 recommendations from that that we would like to

1 highlight is the recommendation to the American
2 Chemical Society who is here with us today. So I
3 look forward to their comments.

4 This was made out of a result of the
5 Texas Tech University laboratory explosion which
6 in 2010, severely injured a graduate student
7 there. As part of the investigation, the CSB
8 found that a comprehensive hazard evaluation
9 guidance for laboratories did not exist. And as
10 a result, the Board recommended that ACS develop
11 guidance for assessing and controlling hazards in
12 research laboratories.

13 The full text of the recommendation
14 which is Number 2010-05-I-PX-R2 reads, develop
15 good practice guidance that identifies and
16 describes methodologies to assess and control
17 hazards that can be used successfully in a
18 research laboratory.

19 So in terms of any CSB actions, the
20 CSB issued this recommendation in October 2011
21 and the ACS responded in December 2011 indicating
22 that they would not only create the guidance

1 documents that we recommended, but that they
2 would also initiate a task force on safety
3 culture and draft a document to aid institutions
4 on establishing a safety culture at research
5 institutions.

6 As a result of that, the Board voted
7 to designated it as open acceptable action in May
8 of 2012. The ACS published its first report
9 which was entitled Creating Safety Cultures in
10 Academic Institutions, A Report of the Safety
11 Culture Task Force of the ACS Committee on
12 Chemical Safety in December of 2012.

13 Then in September 2013, ACS completed
14 the draft of its guidelines which is entitled
15 Identifying and Evaluating Hazards in Research
16 Laboratories, Guidelines Developed by the Hazards
17 Identification and Evaluation Task Force of the
18 American Chemical Society's Committee on Chemical
19 Safety.

20 Even though, at that time, we decided
21 that generally the document met the intent of the
22 recommendation, we did not put it up for Board

1 vote until the document was finalized which
2 happened on May 28, 2015. While those documents
3 that were created are consistent with the
4 recommendations, we're just going to focus on the
5 second document which pertains more to our actual
6 recommendations.

7 So a little bit about the document,
8 the guidance document. The scope says that it's
9 supposed to apply and provide guidance for
10 laboratory researches including all levels of the
11 institution, undergraduate students, graduate
12 students, post-docs, instructors, clinical
13 investigators, technicians, and chairs.

14 The document identifies and describes
15 five different methodologies for identification,
16 analysis, and selection and control of hazards.
17 The document discusses the strengths,
18 limitations, and potential applications of five
19 of those methodologies which include chemical
20 safety, levels of control banding, job hazards
21 analysis, what if analysis, checklists, and
22 structured development of standard operating

1 procedures.

2 The document also addresses the
3 variable nature of work conducted in research
4 laboratories and states that change should be
5 evaluated against the current hazard analysis to
6 determine if the hazard now continues to be
7 sufficient.

8 It also provides practical examples of
9 changes that might require that type of analysis
10 and factors the effect recognition such as an
11 individual perception of risk. And provides
12 organizational strategies for ensuring the
13 recognition and appropriate response to changes
14 in the research laboratory.

15 Consistent with the CSB's case study,
16 the document also emphasizes the importance of
17 near misses and close calls and discussing those
18 incidents. The ACS publication also emphasizes
19 the importance of striving for continuous
20 improvement and using lessons learned to inform
21 future hazard analysis.

22 The document also references the first

1 publication which was the Creating Safety
2 Cultures in Academic Institutions. So our
3 conclusion and what we recommended to the Board,
4 we decided that this should be a CE
5 recommendation where the call for ACS to develop
6 good practice guidance was met.

7 As evidenced by the various aspects
8 that I just talked about, the ACS guidance
9 finalized this year is not only extremely
10 thorough but we believe that it actually goes
11 above and beyond what we actually recommended.
12 Further, ACS communicated to us that following
13 the release of this, they will create an online
14 portal.

15 It's a very lengthy document so they
16 intend to make it more user friendly and
17 searchable. For this reason, we have, like I
18 said, recommended that it be closed exceeds
19 recommended actions. We are very pleased that
20 this report and recommendation has been
21 implemented and that there now exists a
22 comprehensive guidance to help evaluate and

1 control hazards. And that concludes our staff
2 recommendation.

3 MEMBER ENGLER: Thank you. Member
4 Ehrlich, any questions?

5 MEMBER EHRLICH: No, I don't have any
6 questions. Nice job, thank you.

7 MEMBER ENGLER: I'm very pleased to
8 hear that a recommendation is proposed, that
9 we're potentially commending the American
10 Chemical Society for exceeding what we
11 recommended which is a nice thing to happen.
12 Just to be clear, we're not doing all of our
13 business in public.

14 This is one issue that's currently
15 pending in a set of notation votes that we do
16 through reviewing documents and indicating
17 whether we support them, oppose them, calendar
18 them for a public meeting, or not vote. That
19 process is currently pending. I'm optimistic
20 that my vote on this last matter will be
21 affirmative. So thank you very much for that.

22 Before public comment, we have one

1 other item of business. And this is a proposal
2 to remove the September business meeting from the
3 schedule and change the time. On May 6th, the
4 Board voted on a schedule of upcoming public
5 business meetings. The next meeting was
6 scheduled for September 16th and the following
7 meeting was scheduled for October 21st.

8 However, because the Interim Chair, in
9 his brilliance, figured out that the office was
10 moving during that precise time, and that things
11 like the IT system and the hook ups to remote
12 commenting by people on the phone, would be
13 difficult if not impossible. And we had a
14 subsequent meeting in October that basically, it
15 added up to, based on staff recommendations, that
16 we would like to remove the September 16th public
17 business meeting from the schedule.

18 I should note that under our new rules
19 where we said we have to have four public
20 business meetings annually in Washington D.C.,
21 we're meeting that requirement through the
22 meetings we've had per quarter. We will still

1 meet that requirement by an October meeting.

2 Additionally, folks on the west coast
3 and I apologize for being so New Jersey centric,
4 all this Washington, national stuff is new to me.
5 They pointed out that getting up at 6:30 in the
6 morning for a CSB meeting was not the funnest
7 thing.

8 So this motion will basically says
9 that our September 16th business meeting is
10 cancelled and that we will change the start time
11 of future meetings to 1:00 p.m. Eastern Time. I
12 make that as a motion. Do I have a second?

13 MEMBER EHRLICH: Second.

14 MS. MCCORMICK: I'll call the role.

15 On the motion to remove the September 16th public
16 business meeting from the schedule and change the
17 time of future meetings to 1:00 p.m. Eastern,
18 Member Ehrlich?

19 MEMBER EHRLICH: Aye.

20 MS. MCCORMICK: Member Engler?

21 MEMBER ENGLER: Aye.

22 MS. MCCORMICK: Motion passes.

1 MEMBER ENGLER: As our second to final
2 agenda item, this is an opportunity for public
3 comment on any issues that we've addressed today,
4 other concerns that the public may have.

5 Comments are, of course, very much encouraged.

6 Please do not make negative comments about
7 specific individuals inside or outside the CSB.

8 Please try to keep remarks to approximately three
9 minutes.

10 The floor is open for comments. We do
11 have a comment sign up list from five people who
12 are here. I'll start with David Sheppard from
13 ATF. Is David Sheppard on the phone by any
14 chance? Walking down the street on his cell
15 phone? No, okay.

16 Dan Heenan from also ATF. Is he here?
17 No, okay. Katie Vassalli from ILTA.

18 MS. VASSALLI: Good afternoon. I am
19 Katie Vassalli, the Manager of Member Education
20 Services for the International Liquid Terminals
21 Association. ILTA represents owners and
22 operators of above-ground storage tank facilities

1 that store petroleum products, chemicals, and
2 other liquids.

3 Our members operate in all 50 states
4 and in 39 countries. I thank the Board for the
5 opportunity to speak today regarding the agency's
6 report on the October 2009 CAPECO incident. My
7 comments reflect those previously provided by
8 ILTA and serve to support the conclusions
9 expressed by Board Member Ehrlich earlier this
10 morning.

11 CAPECO is not an ILTA member. And
12 ILTA supports the findings concluded in the draft
13 report. The agency's findings clearly laid out
14 the case that the CAPECO facility was poorly
15 managed and had a long and troubled history of
16 compliance violations.

17 Yet, rather than addressing the
18 problems inherent with a known repeat offender,
19 the draft report's recommendations call for an
20 expansion of OSHA's and EPA's regulatory
21 authority. Thereby indicting an entire industry
22 that, as Member Ehrlich's remarks reflect, have

1 routinely demonstrated flawless safety record
2 while complying with existing regulatory
3 requirements and industry standards.

4 In fact, there is nothing in the draft
5 recommendation to tackle how to drive compliance
6 among repeat violators. In light of the fact the
7 report was not finalized today, ILTA encourages
8 the CSB to use this as an opportunity to revise
9 the recommendations so that they can effectively
10 address the root causes of the incident.

11 As outlined in our June 17 comment
12 letter to the Board, ILTA offered three
13 substitute recommendations. One, recognize the
14 role that industry standards have in fostering
15 compliance with existing regulations.

16 Two, promote the use of management
17 systems as a tool for improving operational
18 integrity. And three, prompt the regulatory
19 agencies to assess the effectiveness of their
20 compliance verification activities. Thank you
21 again for the opportunity to provide comment
22 today and for your further consideration in this

1 matter.

2 MEMBER ENGLER: Thank you for your
3 comments. Next will be Stephen Crimauddo from the
4 American Petroleum Institute.

5 MEMBER EHRLICH: I think he left too.

6 MEMBER ENGLER: Okay. Next on, do we
7 have anyone on the phone, on the telephone line?

8 OPERATOR: Once again, if you have a
9 comment, please press star then 1 from your
10 touchtone phone. And currently we have no
11 comments pending. Pardon me, I'm sorry, it looks
12 like we just got a comment. Celeste Monforton
13 from the Safety Board is on line with a comment.
14 Your line is open, please go ahead.

15 CELESTE MONFORTON: Hello, this is
16 Celeste Monforton. Can you all hear me?

17 MEMBER ENGLER: Yes.

18 CELESTE MONFORTON: Okay, great.
19 Thank you so much. I am a public health and
20 worker safety consultant. I live in San Marcos,
21 Texas. I had two comments. The first was I was
22 really pleased to hear Board Member Engler

1 discuss having photos of workplace fatality
2 victims posted at the Chemical Safety Board's
3 headquarters.

4 I want to give credit to an
5 organization called United Support and Memorial
6 for Workplace Fatalities. They are the
7 organization that provided the photos to OSHA
8 which appear inside of their conference room
9 which is what Board Member Engler was referring
10 to.

11 Just briefly, I was troubled, I was
12 extremely troubled to hear the statement from
13 Board Member Ehrlich regarding the CAPECO
14 recommendations. And specifically his opposition
15 to those calling for new OSHA and EPA
16 regulations.

17 I took some time over the last couple
18 weeks to look at previous recommendations by the
19 Chemical Safety Board, I counted more than 700.
20 Less than 40 of them, only about 5 percent, were
21 actually calling for regulations at the local,
22 state, and federal agencies.

1 I see it as, if anything the CSB has
2 been missing its opportunity to use its authority
3 to identify and make recommendations on gaps in
4 worker safety regulations. I'm speaking from my
5 own experience as someone who was an investigator
6 of the Sago Mine disaster in 2006 which killed 12
7 coal miners. And the 2010 Upper Big Branch
8 explosion which killed 29 coal miners.

9 Our investigation team was appointed
10 by the Governor of West Virginia. We were
11 charged with identifying the factors that caused
12 the disasters and to make recommendations so it
13 didn't happen again.

14 Some of our recommendations were
15 directed to the industry, you know, outreach
16 activities and training, and to research
17 institutions. But we did identify inadequate and
18 outdated mine safety regulations that needed to
19 be addressed. And it would have been a
20 dereliction of our duty and an abandonment of our
21 duty had we scrapped those regulatory
22 recommendations.

1 Board Member Ehrlich talked about, you
2 know, recommendations that might, regulations
3 that might be burdensome to the industry or
4 because our agencies were overstretched. Well
5 that's not an appropriate to not make those
6 recommendations. And it's not for the Chemical
7 Safety Board to make those determinations.

8 It's for the Chemical Safety Board to
9 make those recommendations and then for those
10 agencies to go through the process and determine
11 whether it's too burdensome or whether it's
12 unnecessary. So that's what I wanted to say.

13 I think that this is something that
14 definitely deserves more attention and discussion
15 by the Chemical Safety Board and the staff and
16 other stakeholders.

17 MEMBER ENGLER: Thank you very much
18 for your comments. United Memorial folks were
19 here for our June 10th stakeholders meeting which
20 we much appreciated their input. We should
21 follow up with them for some of the photos that
22 may overlap with some of the CSB investigations.

1 MEMBER EHRLICH: Thank you for your
2 input.

3 MEMBER ENGLER: Anyone else on the
4 phone, on the telephone?

5 OPERATOR: At this time, we have no
6 further comments.

7 MEMBER ENGLER: Okay. The last
8 speaker at this moment, I will call for any other
9 speakers after that in case someone is suddenly
10 moved to say a few words, is John Morawetz from
11 the International Chemical Workers Union.

12 MR. MORAWETZ: Firstly, I support what
13 Celeste just mentioned. I think that the CSB has
14 done an excellent job of looking for the findings
15 as to what happened in that incident, what are
16 the root cause analysis, and made
17 recommendations. Where the facts go, and the
18 recommendations lead to organizations like the
19 American Chemistry Council, the education that
20 you've just voted on.

21 Whether it means other voluntary
22 associations, whether it means regulations, we

1 just have to look where the facts go and follow
2 up on them. I think that's what the CSB has done
3 an admirable job on.

4 I'd like to also say that I wrote a
5 letter after the original meeting about CAPECO.
6 And I think that, in particular, the community
7 around that area deserves to have a report for
8 people to hear what happened. Further, I think
9 that it's good to see an incident that I believe
10 there any weren't any fatalities in that
11 situation.

12 But that the aim is to avoid them.
13 And I think that's exactly what the CSB is doing
14 an excellent job. Thank you for doing that as
15 well as having these public meetings. In
16 particular for the chemical workers, having the
17 opportunity for some of the family members from
18 DuPont to come to talk, to see the preliminary
19 report.

20 It's a similar vein of seeing
21 preliminary findings, being able to use them,
22 take them back to the community, it's a very

1 useful function. And thank you for doing the
2 regular meetings. Thank you.

3 MEMBER ENGLER: Thank you. Anyone
4 else in the audience or on the phone?

5 KERI MOSS: Hi my name is Keri Moss
6 and I'm delighted to be here on behalf of the
7 American Chemical Society. We are grateful for
8 the CSB staff recognition of our work on the
9 report Identifying and Evaluating Hazards in
10 Research Laboratories.

11 On behalf of the Chemical Safety
12 members or the ACS members who work in chemical
13 safety, we would like to say we really
14 appreciated this collaboration and this
15 opportunity to collaborate. Our members are
16 eager and available to work with the CSB,
17 collaborate with the CSB on any future projects.

18 Our chemical safety members would also
19 like to say that we have utmost respect for your
20 investigative team and the level of technical
21 competence that you demonstrate in your
22 investigations.

1 We hope that throughout this time of
2 transition, that CSB, that you will continue to
3 maintain the same admirable level of technical
4 standards in your reports. Thank you very much.

5 MEMBER ENGLER: Thank you very much.
6 With that, I'm going to close the public comment
7 period of the meeting. We're approaching the
8 closure of the meeting overall.

9 I want to remind people that the next
10 public business meetings of the CSB will take
11 place on October 21st, January 20th, and April
12 20th. All of those meetings will be noted
13 through the Federal Register. We'll include the
14 topics that will be discussed at the meeting in
15 the register. We'll endeavor to get advance
16 materials where we can on the CSB website.

17 I would also suggest that, starting in
18 October people not show up here because we will
19 have moved. And the new address will be 1750
20 Pennsylvania NW which is actually an adjunct of
21 the White House.

22 Because of the size of our agency and

1 its influence, those in the Executive Branch
2 decided that they wanted us much closer so we
3 could far better coordinate our expectations for
4 chemical safety moving forward. So it's 1750
5 Pennsylvania Avenue.

6 We also anticipate with the release of
7 reports that we will be holding meetings in the
8 communities affected by the incidents. Those
9 meetings are incredibly important to engage with
10 the local communities.

11 At the point in the future, if we
12 approve the CAPECO report of course, I think
13 there are some important outreach to be done in
14 Puerto Rico. I've already talked to Vidisha
15 about developing a potential, and I have to
16 underline potential because it's pending a re-
17 vote on that issue, plan to get out the video
18 that in fact is completed but not approved to the
19 local community.

20 And take other steps to assure that
21 those who were affected by that incident and the
22 fact that there's a continuing operation of the

1 facility there, will have as much information as
2 they can to prevent future incidents.

3 With that I am going to close the
4 meeting. Thank you all for attending. Thank you
5 to the staff for their very important
6 contributions to this meeting today and of
7 course, stakeholders.

8 OPERATOR: Thank you ladies and
9 gentlemen, this concludes today's conference.
10 Thank you for participating.

11 MEMBER ENGLER: No it doesn't, stop a
12 second.

13 MEMBER EHRLICH: First of all, I want
14 to thank our staff both here and from the Denver
15 office for what they've done. I know that
16 there's been some disagreement. I certainly
17 appreciate the work you've done and we'll get
18 through that. For everyone that made the time
19 and effort to come here, thank you very much.

20 Again, I want to make sure the record
21 reflects that the condolences go out to the
22 family members here and their family for the

1 tragedy that occurred in La Porte. So with that,
2 thank you all very much.

3 MEMBER ENGLER: And with that, the
4 meeting is closed. Thank you again for
5 attending.

6 OPERATOR: Thank you ladies and
7 gentlemen, this concludes today's conference.
8 Thank you for participating. You may now
9 disconnect.

10 (Whereupon, the above-entitled matter
11 went off the record.)
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C E R T I F I C A T E

MATTER: Business Meeting

DATE: 07-22-15

I hereby certify that the attached transcription of page 1 to 159 inclusive are to the best of my professional ability a true, accurate, and complete record of the above referenced proceedings as contained on the provided audio recording; further that I am neither counsel for, nor related to, nor employed by any of the parties to this action in which this proceeding has taken place; and further that I am not financially nor otherwise interested in the outcome of the action.

Neal R Gross

NEAL R. GROSS

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**ATTACHMENT A:
STAKEHOLDER COMMENTS**



July 21, 2015

The Honorable Manuel Ehrlich and Rick Engler
Board Members
U.S. Chemical Safety Board
2175 K Street, NW
Washington, D.C. 20037

RE: DRAFT FINAL INVESTIGATION REPORT; CARIBBEAN PETROLEUM TANK TERMINAL EXPLOSION AND MULTIPLE TANK FIRES; REPORT NO. 2010.02.I.PR

Dear Mr. Ehrlich and Mr. Engler,

On behalf of the Agricultural Retailers Association (ARA), I am writing in response to the Chemical Safety Board's (CSB) Draft Final Investigation Report on the Caribbean Petroleum Corporation (CAPECO) Tank Terminal Explosion and Multiple Tanks Fires (Report No. 2010.02.I.PR) released to the public on June 11, 2015. ARA is a not-for-profit trade association that represents the nation's agricultural retailers and distributors. ARA members provide goods and services to farmers and ranchers which include: fertilizer, crop protection chemicals, fuel, seed, crop scouting, soil testing, custom application of pesticides and fertilizers, and development of comprehensive nutrient management plans. Retail and distribution facilities are scattered throughout all 50 states and range in size from small family-held businesses or farmer cooperatives to large companies with multiple outlets.

CSB Investigation Findings Do Not Warrant Expanded Regulations and Stricter Standards

ARA appreciates the opportunity to provide constructive input regarding the CSB's thorough investigation of the CAPECO terminal explosion and multiple tank fires. ARA is in general agreement with the CSB as to basic facts that led up to this accident. It is very clear from this investigation that CAPECO repeatedly failed to comply with existing federal regulations, especially as it relates to the Occupational Safety and Health Administration's (OSHA) Process Safety Management (PSM) standards and the U.S. Environmental Protection Agency's (EPA) Spill Prevention, Control, and Countermeasure (SPCC) plan requirements. For example, CSB notes that EPA cited CAPECO in 1993 and 1996 for poor housekeeping, including oil in tank berm areas and inadequate control of vegetation in the secondary containment areas as well as not employing engineering controls to prevent a spill. CAPECO subsequently complied with these EPA recommendations by 2001 but cited again in following the October 23, 2009 incident for not having "fail safe engineering."

The history of this CAPECO facility clearly show repeated violations of existing federal regulations and industry standards due to operational and compliance problems. ARA has worked closely with EPA's Office of Solid Waste and Emergency Response (OSWER) on extensive outreach efforts with

ARA members and the agricultural industry to educate facilities on the compliance requirements of the SPCC regulations, including webinars, mailings, and multiple presentations by EPA officials at industry events such as the National Agronomic Environmental Health & Safety School (NAEHSS) - a non-profit organization of dedicated industry and government volunteers whose mission is to provide industry personnel with training and information that will aid them in meeting state and federal regulations. The unfortunate accident at the CAPECO facility is clearly as case of failing to comply with existing regulations, rather than a lack of robust

regulations to prevent oil from reaching navigable waters and adjoining shorelines, and to contain discharges of oil.

The CSB notes the lack of resources for EPA to inspect all covered facilities. Today the nation faces an ever growing U.S. national debt, currently over \$18.3 trillion dollars as a result of annual federal budget deficits over \$500 billion. It is puzzling how the CBS believes expanding regulations will increase compliance among industry since both federal agencies and industry already struggle with the significant financial and man-power costs to follow existing regulations and standards. Now more than ever it is important for increased outreach efforts between federal agencies and industry to educate facilities of their federal regulatory requirements.

ResponsibleAg

ARA and The Fertilizer Institute (TFI) in 2014 launched a stand-alone program called ResponsibleAg (RA), a non-profit organization founded to promote the public welfare by assisting agribusinesses as they seek to comply with federal environmental, health, safety and security rules regarding the safe handling and storage of fertilizer products. ResponsibleAg provides participating businesses a federal regulatory compliance audit relating to the safe storage and handling of fertilizers, recommendations for corrective action where needed and a robust suite of resources to assist in this regard. The program has compiled a checklist of federal regulatory requirements applicable to the storage and handling of fertilizer. The checklist, developed by a technical committee comprised of industry regulatory professionals, contains more than 320 questions. Auditors credentialed under the ResponsibleAg Certification Program will use this checklist to assess compliance with federal regulations at each participating facility. ARA believe this type of pro-active, voluntary industry program is the best approach to address the lack of regulatory compliance with facilities such as CAPECO, rather than piling on additional regulations that only create more costs, confusion, and decrease the ability of U.S. agribusinesses to compete in a global marketplace. For more information, go to www.responsibleag.org.

ARA agrees with the Targeted Recommendations Proposed by the International Liquid Terminal Association (ILTA)

ARA in general agrees with the targeted recommendations provided to the CSB by the International Liquid Terminal Association (ILTA) in their June 17, 2015 letter in response to the CSB CAPECO Draft Final Investigation Report. Rather than expand the current regulations, the agencies should work with industry to promote regulatory compliance and the adoption of industry standards as an effective means to promote safety and prevent unnecessary spills, fires, or explosions.

Conclusion

ARA believes the CSB investigation clearly shows a facility that did not follow existing regulations or its own internal procedures. We request CSB encourage federal agencies such as EPA and OSHA to work more closely with industry on compliance outreach efforts, co-branding of educational materials, as well as support for voluntary, industry compliance assistance programs such as ResponsibleAg. Thank you for your review and consideration of our comments. Feel free to contact me at 202-595-1699 or richard@aradc.org if you have any questions.

Sincerely,



Richard D. Gupton
Senior Vice President, Public Policy & Counsel

DuPont Statement
U.S. Chemical Safety Board Public Business Meeting
July 22, 2015

DuPont appreciates the opportunity to submit this statement to the U.S. Chemical Safety Board (CSB) regarding the incident that resulted in four employee fatalities in the La Porte facility's Insecticide Business Unit (IBU) on November 15, 2014. Our deepest concern and sympathies remain with the families and friends of our four co-workers who lost their lives.

From the time that the CSB first deployed to the site in the days after the incident, DuPont has cooperated completely with the agency. Throughout the course of the investigation, we have facilitated the interviews of numerous employees, coordinated laboratory tests and field visits, and produced over 100,000 pages of information and data. We value the CSB's perspective, and we remain committed to cooperating with the agency throughout its investigation.

After the incident, DuPont immediately convened its own investigative team comprised of experts who have extensive technical experience and a proven commitment to safety. These experts have conducted a systematic and rigorous analysis of the complex circumstances associated with the incident, and have developed recommendations that will address the causal factors to help ensure that such an incident never happens again. We have already started to implement corrective actions based on the investigation team's analysis.

DuPont representatives recently met at the CSB's Western Regional Office on July 7, 2015 to understand the CSB's concerns. At this meeting, DuPont made clear that the La Porte IBU will not resume operations until we are certain that we can restart and operate safely. We also explained that we are developing a comprehensive and integrated plan for the resumption of operations that would address issues identified by all of the government agencies, as well as recommendations identified by DuPont's incident investigation team. DuPont agreed it would share this integrated plan with the CSB and solicit the agency's input.

We will continue to cooperate and communicate with the CSB. As part of our commitment to process safety improvement, we take seriously any recommendations resulting from the agency's investigation. We will learn from this incident, share the critical lessons, and do all that is necessary to ensure that such an event never happens again.

Comments to CSB board regarding Recommendation 2005-4-1-TX-R12

The United Steelworkers (USW) represent the workers at two (Whiting, IN and Toledo OH) of three remaining BP owned refineries in the US as well as workers on the Alaska North Slope.

Neither of the BP refinery locals were able to send a representative to this meeting nor was the North Slope group. They did send comments and the USW International Union has compiled the responses and is passing them along in this communication.

Although the recommendation specifically references the refineries, the operation of BP facilities whether production, pipeline or refining were all a concern to the represented employees and the recommendation was pursued at all locations.

In addition, with the sale of BP properties that were once under this recommendation; do they now get a free pass because the employer has changed? Much of the problem is still at the site. In the case of the former BP Texas City refinery where the explosion that killed 15 workers triggered the CSB investigation, programs that BP had implemented to help address some of these issues are now being dismantled by the new employer, claiming that was BP not us, but the members see the same problems remaining in the facility. There should be an audit to see if they were/are complying with the recommendation and if not the same hazards exist and somehow need to be addressed.

The locals have been less than enthusiastic about progress and report they are seeing a move back to blame the worker and behavior programs. This personal injury focus was blamed as a driver for the lack of attention to process safety concerns in the BP Texas City accident.

The North Slope group has tried to use the Ombudsman set up for confidential reporting (reporting of incidents without fear of retaliation) but he has been in ill health for some time and is of no help. The deputy who employees assume has been handling the role is not an independent anonymous resource that it was promoted to be.

There is a longstanding list of safety issues that have not been addressed claim workers. Employees are still required to be in non-blast proof zones with lack of egress from upper floors in manifold buildings. Valve maintenance is not at the level it should be including access to wells for water/mud injection to kill runaway or burning wells. To the company's credit, there has been an emergency valve maintenance program initiated.

The workers are concerned that once federal oversight and prohibitions are removed, BP will revert back to its old ways; they expect things to be as they were before.

The most important safety concern for the workers is the failure to address structural, mechanical and operational integrity. With oil prices being down, budget concerns are an issue at all locations. Capital jobs are being assessed and reassessed to determine whether they are still needed. Some of the fire and safety systems are old and not being well maintained, there is concern whether they will work when needed.

Incident reporting was improved at one location, but there were not productive actions being taken as a result of the reporting. At another facility, workers said incident reporting has not been encouraged and operators still feel the fear of retaliation, often with discipline involved, for reporting incidents.

In the lower 48 the anonymous outside reporting is said to be a feel good exercise without much happening; it is not functional.

The workers have stop work authority but it is not easy to implement and make work.

There is a concern about staffing levels that echoes through all three locations.

These are the latest responses in regard to this recommendation (this year) below are responses to the same question asked in 2013:

- a. encourages the reporting of incidents without fear of retaliation
- b. requires prompt corrective actions based on incident reports and recommendations, and tracks closure of action items at the refinery where the incident occurred and other affected facilities; and
- c. requires communication of key lessons learned to management and hourly employees as well as to the industry.

Response from the BP locals is that the company has not fully filled this recommendation in their opinion. Some examples given to support this follow.

Site 1: One incident with an amine release on a process unit caused four H₂S alarms to go off and a unit was evacuated. There was some discipline given but no investigation of the event was conducted.

Some of the events are being tracked in a system and there is limited sharing of some of the incidents, but the overall quality is low. There is a feeling of going through the motion and not much opportunity for feedback or review.

The events can be technically claimed as done because there is encouraging of reporting and some incidents are shared with the industry, but it has a feeling of just checking off the box.

Site 2: (a) Fear and reality of retaliation for reporting is clear at this site.

(b) No, far from prompt corrective actions, taken over 1½ years to address one issue with a loading rack. Only a call to OSHA has been able to move this item.

(c) Yes, they are good at making it look like they are doing a good job by a large paper trail to shift blame to the employees.

Site 3: (a) Issued a 'stop unsafe work' card to every employee

(b) Have a tracking system in place which assigns and tracks to completion all action items that arise from incident investigations and reports.

(c) Communication of lessons learned occurs through mandatory meetings; weekly 'Tailgates', monthly stand downs, monthly unit safety committees, monthly learning forum which reviews industry accidents and lessons learned. They are happening, but not effective.

As you can see, not much has changed from the original response. The workers feel that the only reason they are seeing any action on the items in the recommendation are due to the scrutiny of federal agencies (CSB and OSHA) and are fearful that if this recommendation is seen as acceptable and closed, the company will quickly revert back to where it was before the BP Texas City report was issued and no one will pay any attention.

The locals feel that there is still a lot of work to be done and would appreciate some follow up to judge what level of the recommendation has been completed and what work is left to be done to meet this recommendation.

Thank you for your consideration of these responses in regard to the disposition of Recommendation 2005-4-1-TX-R12.

Submitted by

Kim Nibarger

USW HSE Department