U.S. CHEMICAL SAFETY BOARD + + + + + TESORO ANACORTES RELEASE AND FIRE + + + + +PUBLIC MEETING + + + + + THURSDAY, MAY 1, 2014 + + + + +U.S. CHEMICAL SAFETY BOARD MEMBERS PRESENT: RAFAEL MOURE-ERASO, Ph.D., Chairperson, U.S. Chemical Safety Board MARK A. GRIFFON, Member, U.S. Chemical Safety Board BETH J. ROSENBERG, Sc.D., M.P.H., Member, U.S. Chemical Safety Board STAFF PRESENT: RICHARD C. LOEB, General Counsel HILLARY COHEN, Communications Manager LAUREN GRIM, Investigator DON HOLMSTROM, Director, Western Regional Office JOHN LAU, Deputy Managing Director DAN TILLEMA, Team Lead This transcript produced from audio provided by the U.S. Chemical Safety Board.

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Adjourn

1	P-R-O-C-E-E-D-I-N-G-S
2	(12:23 p.m.)
3	CHAIR MOURE-ERASO: Good evening,
4	and welcome to this US Chemical Safety Board
5	Public Meeting that we are organizing today as
6	announced in the Federal Register for this
7	specific date.
8	My name is Rafael Moure-Eraso, and
9	I am the Chairperson of the Chemical Safety
10	Board. At the entrance, you saw that there
11	are copies of the agenda on what we are going
12	to be covering today, and also a copy of the
13	final report that we are going to be that
14	the Board is going to be voting on today.
15	I am here in this on the
16	platform with my fellow Board Members, Dr.
17	Beth Rosenberg and Mark Griffon to my left.
18	To my right, I have Mr. Richard C. Loeb, the
19	General Counsel of the Chemical Safety Board.
20	We have at the next table the
21	Western Regional Office's Director, Mr. Don
22	Holstrom, and he is accompanied by the CSB's

1	investigator lead for the Tesoro
2	Investigation, Mr. Dan Tillema, and other
3	members of the team that are going to be
4	introduced later on in the program.
5	Also with us here from the
6	Washington Staff is Mr. John Lau, the Deputy
7	Manager Director, and (inaudible) other
8	members of the CSB Communications Department.
9	I have to point out to you the
10	exits if there will be a fire or a problem in
11	this building during our meetings. You have
12	to become aware of the exits that we have on
13	the three sides for emergency, if necessary.
14	Also, I would like to ask that you
15	mute your cell phones so that they don't
16	interrupt the proceedings.
17	This meeting is specifically to
18	record a public vote of the Board on the final
19	version of the investigation report
20	catastrophic rupture of heat exchanger Tesoro
21	Anacortes Refinery, and the hard copy text of
22	the report we are voting on, as I said, is on

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1	the table at the entrance.
2	This vote will bring to a
3	conclusion the CSB investigation process and
4	will deliver to the families of the Tesoro
5	workers, their loved ones, friends and
6	stockholders and members of the public our
7	dedicated effort in determining what were the
8	causal factors of the accident, and our
9	recommendations to prevent similar actions in
10	the future.
11	As you will see in the report, we
12	have dedicated this report as follows. This
13	report is dedicated to the two women and five
14	men who lost their lives in the Tesoro
15	Anacortes Refinery incident on April 2 of
16	2010.
17	I would like to mention their
18	names and ask for some moments of silence to
19	honor their memory. They are Kathryn Powell,
20	Donna Van Dreumel, Daniel Aldridge, Matthew
21	Bowen, Matthew Gumbel, Darrin Hoines, and Lew
22	Janz.

1	So, we're dedicating this work to
2	the seven people that lost their lives, and
3	
	this report is the culmination of four years
4	of work of the Chemical Safety Board, and
5	represents what I believe is the agency's
6	finest hour in terms of the report's quality
7	of the technology investigation and the
8	analysis of public policy.
9	We do recognize that it took
10	longer than you and we will have liked. But
11	I hope you all will agree that in the end, it
12	left no stone unturned in the report of what
13	happened and what needs to be done.
14	The CSB Tesoro investigation team
15	has spent literally thousands of hours on this
16	investigation and the production of this final
17	report. As you remember, the Chemical Safety
18	Board presented the last staff graph of the
19	report on January 31st, 2014, at this same
20	hall, and requested for the workers of the
21	Tesoro Anacortes and other stakeholders on the
22	results of the investigation to provide public

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1	comments on this last staff report. This was
2	done January 31st, in this place.
3	We also put the report in our
4	website and requested that anyone who wanted
5	to submit reading comments should should
6	submit it to our website in their report.
7	We got hundreds of pages of
8	comments that were evaluated by the CSB
9	investigation team. Almost 200 comments from
10	52 different parties. The staff evaluated the
11	comments and incorporated them with the CSB
12	Board Members comments that were submitted
13	when appropriate in a separate 120-page
14	document, that is also available on our
15	website: the comments and our responses.
16	These comments came from a variety
17	of sources, from the American Petroleum
18	Institute, from the Refinery Action
19	Collaborative, from the United Steelworkers,
20	local and international, and also from a
21	consortium of 38 national organizations, which
22	specifically expressed strong support to our

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1	call on the report for the adoption of
2	inherently safer technologies in such areas as
3	piping and other equipment in the process as
4	it appeared in the report.
5	Of a special note in the written
6	comments are the comments of the Tesoro
7	Council of United Steelworkers, which
8	represent the workers of all Tesoro facilities
9	in the United States, represented by the
10	United Steelworkers.
11	In their comments, the Tesoro
12	Council endorsed again recommendations to
13	institute inherently safer technologies, and
14	recommendation so substantially improve the
15	personally, including the families of the
16	victims about this terrible accident. Again,
17	our thoughts and our hearts go to them for
18	their terrible losses.
19	I have stated that this was a very
20	difficult report to produce. Technically, it
21	required repeated methodological analysis that
22	took the better part of a year to conduct. It

1	included computer simulations of the process
2	that you can examine and look at the report.
3	You can see the results and you
4	can see the appendix, the computer simulation.
5	It includes an exhaustive analysis of a
6	reliable safety test that is called the Nelson
7	Curve, that failed to prevent this explosion.
8	The CSB also conducted a
9	comprehensive regulatory analysis that allowed
10	making recommendations for very significant
11	goal-oriented process of safety management
12	improvements.
13	The most important finding of this
14	investigation is that in order to prevent
15	additional fatalities and catastrophic actions
16	in the US refineries, the nation needs to move
17	forward to a new 21st Century regulatory
18	regime.
19	We need to move forward from the
20	current 20-year-old OSHA process safety
21	management of PSM or PSM regulations that are
22	the current (inaudible) of refinery safety.

1	We need to move, as I said, toward
2	the 21st Century with a goal-oriented process
3	safety regulatory framework with a more
4	vigorous safety management regulatory regime.
5	We are proposing in this report through our
6	recommendations to the State of Washington the
7	necessary changes to move ahead on process
8	with a safety regime with the robust
9	attributes that will reflect the lessons the
10	Chemical Safety Board has learned in our
11	investigations in the refinery sector.
12	It has to be clear that
13	perpetuating the current safety management
14	system, the sign in the last century is not
15	going to prevent deaths or major chemical
16	fires or explosions in this sector.
17	Our experience is that it's not
18	working. Also, it will not (inaudible) do
19	working. Also, it will not (inaudible) do
	enough to fix our very real refinery safety
20	
20 21	enough to fix our very real refinery safety
	enough to fix our very real refinery safety problems. We're finding some recommendations

1	well as it applied to the entire refinery
2	sector in the US.
3	We offer, if you will see the
4	agenda, a very complete report from the staff
5	on our recommendations. I am going to give
6	you some highlights on them where I think are
7	the most important parts.
8	The report makes 16 detailed
9	recommendations. The recommendations are made
10	to the EPA, to the Washington legislature, the
11	Washington State legislature, and to the Labor
12	and Industry (inaudible) to the Tesoro
13	Corporation and to the Tesoro Anacortes
14	Refinery, and to the United Steelworkers.
15	All are aimed to prevent accidents
16	in the refinery sector in the State of
17	Washington and nationwide.
18	The three most notable are first
19	to the Washington State. We are going to
20	(inaudible) the existing system process safety
21	management regulations for refineries with new
22	and more rigorous goal-setting requirements.

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1	The details will be presented by the staff.
2	The CSB also recommended to the
3	State of Washington that they develop an
4	effective three-part guide participatory
5	system with equal representatives of the
6	regulator, the company and the workers'
7	representatives to oversee the enhanced
8	safety management system in the Tesoro plant
9	and in the plants in Washington State.
10	To the EPA, we are asking to
11	revise regulations to require inherently safer
12	technologies in the hierarchy of controls when
13	establishing safeguards to process hazards.
14	And lastly, to the Tesoro Corporate and
15	Anacortes Refinery, we are recommending that
16	they implement a continuous improvement
17	process safety culture program, as I mentioned
18	before, with effective participation of the
19	state regulatory agency, EPA and the United
20	Steelworkers.
21	This continuous improvement safety
22	culture program is aimed to change the

1	attitude of accepting non-routine risk as
2	normal and also to implement a revised API 941
3	that deals with alloys for hydrogen service at
4	high temperatures that requires a specifically
5	and generally safer technologies on the
6	selections of metal alloys to protect from
7	high temperature hydrogen attack.
8	A detailed presentation of all the
9	critical recommendations will be done, as I
10	say, by the staff. Now, this is the end of my
11	introductory remarks. I would like to ask my
12	fellow Board Members if they have any opening
13	statements. Dr. Rosenberg?
14	MEMBER ROSENBERG: Thank you.
15	Good evening. I'd like to offer my
16	condolences to the family, friends and
17	community of the seven people who died here.
18	I hope that the work that the CSB has done
19	will provide some closure and help prevent
20	further tragedies.
21	The report covers many topics, but
22	I would just like to highlight a few. The

1	first is the practice of running maintenance
2	and doing repairs on equipment that is
3	running. We understand that the heat
4	exchangers have been redesigned so that they
5	cannot be partially shut down.
6	That is good for the people
7	working on this particular heat exchangers,
8	but Tesoro and the whole industry needs to
9	stop this dangerous practice.
10	The second thing the report
11	recommends is specific changes to the PSM
12	regulation that will make refineries safer,
13	and those will be elaborated on in the report.
14	More broadly, the idea of an
15	alternative regulatory regime that is used in
16	the UK and Australia called the safety case is
17	discussed. We, the Board, and the
18	investigators and everyone at this table are
19	absolutely unified in our commitment to worker
20	health and our disgust and aspiration with the
21	status quo.
22	We are divided about whether a

1	safety case regime in the US would benefit or
2	harm workers. I have serious reservations
3	about a three-party system that relies on the
4	equal part of labor, government and industry.
5	I worry that in the US two of the
6	three parties, labor and government, are too
7	weak to counterbalance the power of industry.
8	While the notion of a safety case regime is
9	raised in this report, no recommendations flow
10	from it. But I look forward to further
11	discussion of this topic.
12	Lastly, as a near term improvement
13	to refinery safety, the report supports more
14	inspectors for Labor and Industry. Labor and
15	Industry currently has four inspectors to
16	inspect more than 250 PSM-covered facilities.
17	We understand that the idea of an
18	annual of a full annual inspection of all
19	refineries in the state has been under
20	discussion. The CSB strongly supports a
21	better resourced Labor and Industry.
22	If this investigation will help

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1	get more well-compensated, well-trained
2	inspectors, the seven tragic deaths will not
3	be in vain. Thank you.
4	CHAIR MOURE-ERASO: Thank you, Dr.
5	Rosenberg. Mark Griffon, Board Member,
6	introductory remarks?
7	MEMBER GRIFFON: Thank you, Mr.
8	Chairman. I wanted to also express my
9	condolences to the family and friends of the
10	seven workers tragically killed in this
11	incident.
12	I also want to apologize for how
13	long it has taken us to complete this report.
14	Four years is way too long, and the CSB needs
15	to do better.
16	Having said that, I'm very happy
17	that we're here tonight with a final report
18	and I'm hopeful that the findings and
19	recommendations will be helpful in improving
20	safety in the refinery sector.
21	This report highlights
22	deficiencies of the facility, as well as

1	deficiencies with process safety regulations.
2	First at the facility level, it must be
3	emphasized that this incident wasn't simply a
4	result of not using the correct material for
5	the heat exchanger. The badly corroded metal
6	was a symptom of broader process safety
7	problems.
8	Other adequate process controls;
9	can anything be changed to slow the rate of
10	failing? Can the inspection process be
11	improved? I hope that Tesoro and the industry
12	as a whole continue to look at the spectrum of
13	safeguards, including the use of safer
14	materials that can be put into place to reduce
15	the risk of this type of incident.
16	It is my understanding that some
17	of these factors have already been considered
18	by Tesoro, and that process modifications have
19	been made such that heat exchangers only
20	require change out every three to four years,
21	rather than every six months, greatly reducing
22	the frequency of required shutdowns and

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1	restarts. This is a positive change in my
2	view.
3	The second facility level issue,
4	and perhaps most important, are the
5	organizational findings and the findings
6	related to safety culture. It seems as though
7	there was a complacency about the hazards and
8	risk faced in this type of operation.
9	I'm not talking about workers
10	becoming complacent, but rather about
11	organizational complacency. The idea of
12	paying attention to the small problems which
13	may highlight system weaknesses must come from
14	the top, and Tesoro management should take a
15	close look at this.
16	Lastly, the regulations and the
17	regulator. A key finding in the report is
18	that the regulator, the Department of Labor
19	and Industry's division of Departmental
20	Occupational Safety and Health, DOSH, is not
21	adequately resourced, specifically with regard
22	to process safety management, PSM, inspectors.

1 More inspectors to cover more than 250 facilities. 2 The CSB is recommending that the 3 4 state address this issue, by increasing the 5 number of PSM inspectors at DOSH. As far as the regulations, our final report identifies 6 7 several gaps in the current process safety management regulation, and we are recommending 8 9 specific improvements to this regulation. 10 The report also discusses other 11 approaches to regulating high hazard 12 facilities including an approach known as the 13 safety case. The Board has raised several 14 questions about the effectiveness of the 15 safety case approach, and about the challenges to such a regime change in the United States. 16 17 While this type of change is not recommended in the Tesoro report, it will be 18 studied further. This incident had a 19 20 devastating affect on the entire community, 21 and I hope that our investigation and the 22 recommendations to the company and the state

1	and the regulator can lead to changes to help
2	prevent such tragedies in the future. Thank
3	you.
4	CHAIR MOURE-ERASO: Thank you,
5	Member Griffon. The next issue on the agenda
6	is the presentation of the CSB report by the
7	staff. So, I am going to ask Mr. Don
8	Holmstrom to describe how this part of the
9	meeting is going to go, and to introduce his
10	investigative team. So, Don?
11	MR. HOLMSTROM: Thank you, Dr.
12	Moure-Eraso. Good evening. My name is Don
13	Holmstrom. I'm the Director of the CSB's
14	Western Regional Office in Denver, Colorado.
15	In January, we presented the
16	investigation findings, and proposed
17	recommendations of the Tesoro Anacortes
18	Refinery investigation for public comment.
19	Tonight, we will discuss the
20	public comments that we received and their
21	impact on the draft report, and deliver out
22	updated proposed recommendations to the Board.

1	The Board will then have the
2	opportunity to discuss the report and ask
3	questions of the team. The Board will then
4	vote on the report and the proposed
5	recommendations.
6	Tonight, investigators Dan Tillema
7	and Lauren Grimm will present updates on the
8	report, and I will deliver the teams's
9	proposed recommendations.
10	Dan Tillema will now discuss the
11	selection of the public comments received.
12	Dan?
13	INVESTIGATOR TILLEMA: Thanks,
14	Don. We received 193 comments from 53
15	different groups and individuals. We'd like
16	to thank everyone who submitted comments.
17	These individuals and organizations are listed
18	on the slide. We carefully considered each
19	comment that was considered.
20	The United Steelworkers submitted
21	comments to the CSB. One comment submitted is
22	that they believe fouling(phonetic) was the

1	root cause of the Tesoro incident.
2	The CSB does not present its
3	findings in terms of root causes. Instead,
4	there are many causal factors that contribute
5	to the occurrence of a major process safety
6	incident. We make recommendations to prevent
7	certain causes and causal factors.
8	The CSB recognizes that major
9	chemical accidents have multiple causes, that
10	may include technical, organizational and
11	regulatory causes.
12	The axi map, located in appendix A
13	of the report, shows all of the identified
14	causal factors. Tube side following is
15	included. The causal factor the CSB decided
16	to focus its recommendations on, which will
17	result in the greatest possible prevention of
18	this type of incident, is material of
19	construction, inherently safer design, or
20	using materials that are less susceptible to
21	HTHA could have prevented this incident.
21 22	

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1	the hierarchy of controls, whereas tracking of
2	fouling rates administrative control.
3	APIRP 571 specifically guides its users that
4	stainless steels and high chromium allow
5	steels are not susceptible to HTHA at
6	conditions normally seen in refineries.
7	The America Petroleum Institute,
8	API, submitted comments to the CSB. Some of
9	their comments included proposed additional
10	assumptions to include in the model, such as
11	a lack of heat transfer due to (inaudible)
12	bypass stream, evaluation of a higher
13	percentage of fouling in the A&D heat
14	exchangers, and considering a mail
15	distribution of flow between the two heat
16	exchanger banks.
17	However, CSB's (inaudible) model
18	was based upon data gathered during the
19	investigation. Due to the distance between
20	the shell inlet nozzle and the CAN1-CAN2 weld
21	seam, at which severe HTHA occurred, as well
22	as a small baffle to shell clearance, the CSB

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1	is confident that heat transfer occurred
2	between the shell inlet and CAN1-CAN2 weld
3	seam.
4	In addition, as discussed in the
5	report, the following distributions model are
6	based upon visual observations of fouling when
7	the heat exchangers were brought offline for
8	cleaning.
9	The CSB has no evidence to support
10	higher percentages of fouling in the A&D heat
11	exchangers, and finally Tesoro's measured
12	process data does not support a flow
13	mail(phonetic) distribution, such as a 60/40
14	split, rather than a 50/50 split.
15	The CSB would like to note that
16	the investigation team offered to discuss the
17	HISIS(phonetic) model, its assumptions and the
18	model inputs in detail with API, but API
19	ultimately declined this offer.
20	API also communicated to the CSB
21	that their reference performance based
22	language, which CSB considers permissive

1	language that uses a mixture of should and
2	shall type language, should be considered a
3	feature of API standards and not a criticism.
4	However, the CSB strongly believes
5	that when the industry identifies a technical
6	issue that if unmitigated can lead to a major
7	process safety incident, it is API's
8	responsibility to require its users to take
9	action to prevent such an occurrence.
10	The CSB will continue to make
11	recommendations to API, to ensure that its
12	standards contain minimum requirements to
13	effectively prevent major process safety
14	incidents.
15	API proposed a new carbon steel
16	nelson curve location, different than the
17	CSB's proposed carbon steel location for non
18	post-weld heat treated carbon steel.
19	This proposed curve would be 50
20	degrees Fahrenheit below and 50 PSIA hydrogen
21	partial pressure to the left of the current
22	curve, which we'll show on the next slide.

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1	This proposed location is based upon several
2	failures below the carbon steel nelson curve,
3	which were within 50 degrees of the curve.
4	The CSB does not think that this
5	proposed location is sufficient. Post-weld
6	heat treating is low on the hierarchy of
7	controls and subject to error. One carbon
8	steel nelson curve would help to ensure
9	prevention of HTHA on all carbon steel
10	equipment.
11	This graph shows the API proposed
12	location of the new non-post weld heat treated
13	carbon steel nelson curve in red. You can see
14	that this curve is not below the process
15	conditions estimated by the CSB at which HTHA
16	occurred in Tesoro B and the heat exchangers.
17	The CSB proposed location of the
18	carbon steel nelson curve shown here in orange
19	is a conservative approach to prevent HTHA.
20	The CSB's carbon steel nelson curve is located
21	below estimated conditions, at which HTHA
22	occurred at Tesoro.

1	A public comment was submitted,
2	which disagreed with the idea of using a
3	minimum number of personnel as a requirement.
4	The comment stated that if an operation isn't
5	safe enough for seven, then it isn't safe
6	enough for one. The CSB whole-heartedly
7	agrees that any personnel exposure to a
8	hazardous condition, whether it is one person
9	or seven people, is unacceptable.
10	However, in hazardous or
11	potentially hazardous operations, best
12	practice is to reduce the individuals present
13	to essential personnel only. Many of the
14	employees present at the Tesoro heat
15	exchangers on the night of the incident would
16	not have been considered essential personnel.
17	The Tesoro Council of the United
18	Steelworkers of the (inaudible) file union
19	leaders at Tesoro refineries across the
20	country expressed additional concerns stating,
21	"The Tesoro Council supports the CSB's
22	recommendation that Tesoro improve its process

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1	safety culture."
2	Our members have years of
3	experience working in refineries and for
4	Tesoro, and believe that Tesoro's safety
5	culture is severely lacking and in dire need
6	of strengthening."
7	On February 12, 2014, another
8	Tesoro refinery located in Martinez,
9	California, experienced a process safety
10	incident where two of its employees were
11	sprayed with sulfuric acid from a sampling
12	station shown in this photo.
13	Workers were again sprayed with
14	acid at the same refinery, within the same
15	unit, one month later. Because of the
16	occurrence of these various process safety
17	incidents, the CSB will be further evaluating
18	Tesoro's corporate-wide process safety
19	culture.
20	The CSB received strong a
21	favorable support for the inherently safer
22	technology recommendations by a majority of

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1	the individuals and organizations who
2	submitted public comments.
3	These parties believed that the
4	only foolproof way to prevent tragic
5	consequences is through the use of safer
6	chemicals and processes. And when safer
7	alternatives are available, effective and
8	feasible, they should be required.
9	The Tesoro Council of the United
10	Steelworkers also strongly supports the CSB's
11	recommendation to the EPA for inherently safer
12	technologies.
13	Correct second communicated their
	Several groups communicated their
14	concerns about recommendations to the EPA on
14 15	
	concerns about recommendations to the EPA on
15	concerns about recommendations to the EPA on inherently safer technologies. These groups
15 16	concerns about recommendations to the EPA on inherently safer technologies. These groups believe that IST decisions are extremely
15 16 17	concerns about recommendations to the EPA on inherently safer technologies. These groups believe that IST decisions are extremely complex and cannot be and should not be
15 16 17 18	concerns about recommendations to the EPA on inherently safer technologies. These groups believe that IST decisions are extremely complex and cannot be and should not be determined by a governmental agency.
15 16 17 18 19	concerns about recommendations to the EPA on inherently safer technologies. These groups believe that IST decisions are extremely complex and cannot be and should not be determined by a governmental agency. They believe there is no one-size-
15 16 17 18 19 20	concerns about recommendations to the EPA on inherently safer technologies. These groups believe that IST decisions are extremely complex and cannot be and should not be determined by a governmental agency. They believe there is no one-size- fits-all method to ensure one process or

1	CSB would like to clarify to these
2	groups that the CSB recommendations do not ask
3	that EPA identifies what IST approaches
4	companies must use. Rather, the CSB is
5	recommending that EPA require facilities to
6	perform a documented inherently safer systems
7	analysis when establishing safeguards.
8	It will still be up to individual
9	facilities to evaluate their operation, and
10	determine how to implement inherently safer
11	design. This analysis will be subject to
12	regulatory review.
13	The CSB acknowledges that there
14	often is no one-size-fits-all approach to
15	inherently safer design and rigorous analyses
16	must be performed by the operating company to
17	determine the best inherently safer design
18	approach.
19	Investigator Lauren Grimm will now
20	present changes made to the report.
21	INVESTIGATOR GRIMM: Thanks, Dan.
22	We did make several changes to the report due

1	to public comments, as well as conversations
2	with our Board. Many of these changes were
3	language clarifications due to some of the
4	public comments that we received.
5	We will now summarize some of the
6	content changes that were made to the report.
7	The CSB team now proposes to recommend a new
8	API RP941 carbon steel nelson curve that is a
9	right angle, which indicates HTHA can occur at
10	conditions greater than 400 degrees Fahrenheit
11	and 50 PSIA hydrogen partial pressure.
12	Multiple individuals who submitted
13	comments found that the flat 400 degree line
14	was confusing, and we agreed.
15	Many of the public comments
16	submitted to the CSB expressed concern that
17	the EPA would be determining what safeguards
18	are required to implement inherently safer
19	technology. The intent of this recommendation
20	is for EPA to require facilities to perform
21	inherently safer system analyses, and the use
22	of a hierarchy of controls in establishing

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1	safeguards for process hazards.
2	This analysis will then be subject
3	to regulatory review. The language of this
4	recommendation was restructured to clarify its
5	meaning.
6	Following CSB's investigation of
7	the Tesoro Martinez, California sulfuric acid
8	process safety incidents, the CSB determined
9	that the regulator should be involved in
10	implementing Tesoro's process safety culture
11	continuous improvement program.
12	The proposed recommendation has
13	been rephrased to reflect this change. The
14	investigation team is also now proposing
15	updated regulatory changes to the Board for
16	the State of Washington, rather than
17	prescribing a change to a specific model or
18	regime, the investigation team is proposing
19	more rigorous process safety management
20	attributes and features based on the team's
21	regulatory analysis.
22	These changes are intended to

1	augment the current PSM regulations. The
2	emphasis is on preventative inspection and
3	audits by the regulator to ensure appropriate
4	process safety management features are in
5	place to help prevent the occurrence of
6	process safety incidents.
7	Proposed features of the enhanced
8	PSM model for the State of Washington include
9	development of a more comprehensive process
10	hazard analysis. This includes applying
11	inherent safety and the hierarch of controls
12	to drive risks to as low as reasonable
13	practical, or ALARP.
14	In addition, facilities will
15	document that their safeguards are effective,
16	and include an evaluation of damage mechanism
17	hazards. Another proposed feature is an
18	increased role of the regulator.
19	The team proposes that Washington
20	establish a regulator that is well-funded,
21	well-staffed, and technically qualified. This
22	group will also review PHA's and conduct

1	preventative audits and inspections.
2	The team also proposes that safety
3	standards used as (inaudible) have minimum
4	requirements to help prevent major process
5	safety incidents. And finally, we propose
6	greater involvement in process safety
7	strategies by both the workers and their
8	representatives.
9	Don Holmstrom will now deliver the
10	team's proposed recommendations.
11	MR. HOLMSTROM: Thank you, Lauren
12	Grimm. I'm going to be going through the 16
13	recommendations the CSB draft report contains,
14	which we're proposing or presenting to the
15	Board for a vote this evening.
16	I would emphasize that these
17	recommendations are what we refer to as the
18	engine that drives safety change. Our
19	investigation obviously is very important but
20	the recommendations adoption is key to what
21	drives change and leads to greater prevention
22	of these types of incidents.

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1	At the CSB, once the
2	recommendations are voted on by the Board,
3	they are then we have a recommendation
4	staff that tracks them. We send out
5	notifications. We follow them and track them
6	to completion and implementation.
7	As part of that process, the Board
8	votes on the status of those recommendations,
9	where they are opened at acceptable response
10	or unacceptable, etcetera, in the final
11	disposition of the recommendations in terms of
12	whether they're successfully adopted and that
13	status is a vote of the Board.
14	So, we don't just issue reports.
15	We take very seriously, like other agencies
16	such as the National Transportation Safety
17	Board we model after.
18	Our first recommendation is to the
19	Environmental Protection Agency. That's
20	recommendation number one. Revise the
21	chemical accident prevention provisions to
22	require the documented use of inherently safer

1	systems analysis in the hierarchy of controls
2	to the greatest extent feasible when
3	facilities are establishing safeguards for
4	identified process hazards.
5	Goals shall be to reduce the risk
6	of major accidents to the greatest extent
7	practicable. To be interpreted it's
8	equivalent to as low as reasonably practical,
9	or ALARP. Include requirements for inherently
10	safer systems analysis to be automatically
11	triggered for all management of change,
12	incident investigation and process hazard
13	analysis reviews and recommendation prior to
14	the construction of new process, process unit
15	rebuilds, significant process repairs and in
16	the development of corrective actions.
17	Recommendation 2 to the EPA:
18	Until recommendation 1 is in effect, enforce
19	through the Clean Air Act's general duty
20	clause the use of inherently safer systems
21	analysis in the hierarchy of controls to the
22	greatest extent feasible when facilities are

1	establishing safeguards for identified process
2	hazards.
3	In recommendation number 3 to the
4	EPA, development guidance for the required use
5	of inherently safer systems analysis in the
6	hierarchy of controls for enforcement.
7	Recommendation 4 to the EPA:
8	Effectively participate in the Tesoro
9	Anacortes Refinery Process Safety Culture
10	Survey Oversight Committee, as recommended in
11	recommendation number 15. Incorporate the
12	expertise of process safety culture experts in
13	the development interpretation of the safety
14	culture surveys.
15	Ensure the effective participation
16	of the workforce and their representatives in
17	the development of the surveys and the
18	implementation of corrective actions.
19	Our next set of recommendations is
20	to the Washington State legislature and the
21	Governor of Washington. Recommendation 5:
22	Based on the findings of this report, augment

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1	your existing process safety management
2	regulations for petroleum refineries in the
3	State of Washington with the following more
4	rigorous goal-setting attributes.
5	A: A comprehensive process safety
6	hazard analysis written by the company that
7	includes, One: Systematic analysis and
8	documentation of all major hazards and
9	safeguards using the hierarchy of controls to
10	reduce those risks to as low as reasonably
11	practical or ALARP.
12	Two: Documentation of the
13	recognized methodologies, rationale and
14	conclusions used to claim that safeguards
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15	intended to control hazards will be effective.
15 16	
_	intended to control hazards will be effective.
16	intended to control hazards will be effective. Three, document damage mechanism hazard
16 17	intended to control hazards will be effective. Three, document damage mechanism hazard reviews conducted by a diverse team of
16 17 18	intended to control hazards will be effective. Three, document damage mechanism hazard reviews conducted by a diverse team of qualified personnel.
16 17 18 19	intended to control hazards will be effective. Three, document damage mechanism hazard reviews conducted by a diverse team of qualified personnel. This review shall be an integral
16 17 18 19 20	intended to control hazards will be effective. Three, document damage mechanism hazard reviews conducted by a diverse team of qualified personnel. This review shall be an integral part of the process hazard analysis cycle and

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1	The damage mechanism hazard review
2	shall identify potential damage mechanisms and
3	consequences of failure, and shall ensure
4	effective safeguards are in place to control
5	hazards presented by those damage mechanisms.
6	Require the analysis and
7	incorporation of applicable industry best
8	practices and inherently safer design to the
9	greatest extent feasible into this review.
10	Four: Documented use of inherently
11	safer systems analysis in the hierarchy of
12	controls to the greatest extent feasible in
13	establishing safeguards for identified process
14	hazards.
15	The goals shall be to drive the
16	risk of major accidents to as low as
17	reasonably practical, or ALARP. Include
18	requirements for inherently safer systems
19	analysis to be automatically triggered for all
20	management of change and process hazard
21	analysis reviews prior to the construction of
22	new processes, process unit rebuilds,

1	significant process repairs and in the
2	development of corrective actions from
3	incident investigation and recommendations.
4	B: A thorough review of the
5	comprehensive process hazard analysis by
6	technically competent regulatory personnel.
7	Also for the State of Washington,
8	C: Required preventative audits and
9	preventative inspections by the regulator. D:
10	Require that all safety codes, standards,
11	employer internal procedures and recognize and
12	generally accepted good engineering practices
13	or RAGAGEP used in the implementation of
14	regulations contain adequate minimum
15	requirements.
16	E: A model for the regulator, the
17	company and workers and their representatives
18	play an equal and essential role in the
19	direction of preventing major accidents; ¹
20	require an increased role for workers in
21	management of process safety by establishing
22	a rights and responsibilities of workers and

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¹ Prior to the public meeting, this language was removed from the final recommendation that was ultimately voted on and approved by the CSB board.

1	their representatives on health and safety
2	related matters.
3	The election of safety
4	representatives and the establishment of
5	safety committees with equal representation
6	between management and labor to serve health
7	and safety related functions.
8	The elected representatives should
9	have a legally-recognized role that goes
10	beyond consultation in activities such as the
11	development of the comprehensive process
12	hazard analysis, management change, incident
13	investigations, audits and identification, and
14	effective control of hazards.
15	The representatives should also
16	have the authority to stop work that is
17	perceived to be unsafe or that presents a
18	serious hazard until the regulator intervenes
19	to resolve the safety concern.
20	Workforce participation practices
21	should be documented by the company and
22	regulator. And F: requires reporting of

1	information to the public to the greatest
2	extent feasible.
3	We have the comprehensive process
4	hazard analysis, which includes a list of
5	safeguards implemented and standards utilized
6	to reduce risk, and process safety indicators
7	that demonstrate the effectiveness of
8	safeguards and management systems.
9	Recommendation number 6 to the
10	State of Washington: Establish a well-funded,
11	well-staffed, technically qualified regulator
12	with a compensation system, meaning salary and
13	benefits, to ensure the Washington Department
14	of Labor and Industry regulator has the
15	ability to attract and retain a sufficient
16	number of employees with a necessary skills
17	and experience to ensure regulator technical
18	qualifications.
19	Periodically conduct a market
20	analysis and benchmarking review to ensure
21	that compensation system remains competitive
22	with Washington State petroleum refineries.

1	Recommendation 7 to the State of
2	Washington: Work with a regulator, petroleum
3	refinery industry, labor and other relevant
4	stakeholders in the State of Washington to
5	develop and implement a system that collects,
6	tracks and analyzes process safety leading and
7	lagging indicators from operators and
8	contractors to promote continuous process
9	safety improvement.
10	At a minimum this program shall A:
11	require the use of leading and lagging process
12	safety indicators to actively monitor the
13	effectiveness of process safety management
14	system and safeguards for major accident
15	prevention; include leading and lagging
16	indicators that are measurable, actionable and
17	standardized; include indicators that measure
18	safety culture such as incident reporting and
19	action item implementation from that reporting
20	culture.
21	Require that the reported data be
22	used for continuous process safety improvement

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1	and accident prevention.
2	B: Analyze data to identify trends
3	and poor performers and public annual reports
4	with the data at facility and corporate
5	levels.
6	C: Require companies to publically
7	report required indicators annually at
8	facility and corporate levels.
9	For the State of Washington,
10	again, D: Use process safety indicators, one,
11	to drive continuous improvement for major
12	accident prevention by using the data to
13	identify industry and facility safety trends
14	of efficiencies and two, to determine
15	appropriate allocation of regulatory resources
16	and inspections.
17	E: Be periodically updated to
18	incorporate new learning from worldwide
19	industry improvements in order to drive
20	continuous major accident process safety
21	improvement in the State of Washington.
22	Next set of recommendations is for

1	the Washington State Department of Labor and
2	Industry's Division of Occupational Safety and
3	Health. Recommendation 8: Perform a
4	verification audit at all Washington petroleum
5	refineries to ensure, A: Prevention of HTHA
6	requirement failure and safe operation of the
7	equipment; audit HTHA prevention and process
8	condition monitoring techniques used at all
9	Washington petroleum refineries. Verify that
10	all effective equipment in use meets the
11	requirements contained in recommendation R10.
12	B: For non-routine work, a written
12 13	B: For non-routine work, a written hazard evaluation is performed by a multi-
13	hazard evaluation is performed by a multi-
13 14	hazard evaluation is performed by a multi- disciplinary team and where feasible conducted
13 14 15	hazard evaluation is performed by a multi- disciplinary team and where feasible conducted during the job planning process prior to the
13 14 15 16	hazard evaluation is performed by a multi- disciplinary team and where feasible conducted during the job planning process prior to the day of the job execution.
13 14 15 16 17	hazard evaluation is performed by a multi- disciplinary team and where feasible conducted during the job planning process prior to the day of the job execution. Verify that each facility has an
13 14 15 16 17 18	hazard evaluation is performed by a multi- disciplinary team and where feasible conducted during the job planning process prior to the day of the job execution. Verify that each facility has an effective written decision-making protocol
13 14 15 16 17 18 19	hazard evaluation is performed by a multi- disciplinary team and where feasible conducted during the job planning process prior to the day of the job execution. Verify that each facility has an effective written decision-making protocol used to determine when it is necessary to shut
13 14 15 16 17 18 19 20	hazard evaluation is performed by a multi- disciplinary team and where feasible conducted during the job planning process prior to the day of the job execution. Verify that each facility has an effective written decision-making protocol used to determine when it is necessary to shut down a process or safely perform work or

1	safety book related to hazardous non-routine
2	work.
3	C: Effective programs are in place
4	to control the number of essential personnel
5	present during all hazardous non-routine work.
6	Recommendation 9 to L&I:
7	Effectively participate in the Tesoro
8	Anacortes Refinery Process Safety Culture
9	Survey Oversight Committee as recommended in
10	recommendation 15.
11	Incorporate the expertise of
12	process safety culture experts in the
13	development and interpretation of the safety
14	culture survey results. Ensure the effective
15	participation of the workforce and their
16	representatives in the development of the
17	surveys and in the implementation of
18	corrective actions.
19	Next set of recommendations is to
20	the American Petroleum Institute.
21	Recommendation Number 10: Revise American
22	Petroleum Institute recommended practice 941,

1	entitled, "Steels for hydrogen service at
2	elevated temperatures and pressures, petroleum
3	refineries and chemical plants."
4	Two: Clearly establish the
5	minimum necessary shall requirements to
6	prevent HTHA equipment failures using a format
7	such as that used in the (inaudible) AIHA Z10
8	2012 standard, entitled, "Occupational Safety
9	and Health Management Systems."
10	Require the use of inherently
11	safer materials to the greatest extent
12	feasible. Require verification of actual
13	operating conditions to confirm that material
14	of construction selection prevents HTHA
15	equipment failure and prohibit the use of
16	carbon steel and processes that operate above
17	400 degrees Fahrenheit and greater than 50
18	PSIA hydrogen partial pressure.
19	Recommendation 11 to the API:
20	Revise American Petroleum Institute
21	recommended practice 581, entitled, "Risk-
22	based Inspection Technology," to clearly

1	establish the minimum necessary shall
2	requirements to prevent HTHA equipment
3	failures using a format such as that used in
4	ANCI HIHA Z10 2012, Occupational Health and
5	Safety Management Systems.
6	Prohibit the use of carbon steel
7	in processes that operate above 400 degrees
8	Fahrenheit and greater than 50 PSIA hydrogen
9	partial pressure, and require verification of
10	actual operating conditions to determine
11	potential equipment damage mechanisms.
12	The next set of recommendations is
13	to Tesoro Refining and Marketing Company,
14	Recommendations 12 and 13: Participate with
15	API in the recommended practice 941 revisions
16	to establish minimum requirements to prevent
17	HTHA failures and to require the use of
18	inherently safer design.
19	Following the API RP941 revisions,
20	develop and implement a plan to meet the new
21	RP941 requirements. Improve process safety
22	management programs for damage mechanisms

1	hazards to require the hierarchy of controls
2	and the use of inherently safer design.
3	Recommendation 14 to Tesoro
4	Corporate: Revise and improve current Tesoro
5	programs to identify and control damage
6	mechanisms hazards.
7	The next recommendation is to the
8	Tesoro Anacortes Refinery, Recommendation 15:
9	Implement a Process Safety Culture Continuous
10	Improvement Program at the Tesoro Anacortes
11	Refinery, including a written procedure for
12	periodic process safety culture surveys across
13	the workforce.
14	The Process Safety Culture Program
15	shall be overseen by a tri-part committee of
16	Tesoro management, United Steelworkers
17	representatives, Washington State Department
18	of Labor and Industries Division of
19	Occupational Safety and Health, and the US
20	Environmental Protection Agency.
21	The process safety culture program
22	shall include a focus on items that measure at

1	a minimum: Willingness to report incidents,
2	normalization of hazardous conditions, burden
3	of proof of safety and plant process safety
4	programs and practices and management
5	evolvement and commitment to process safety.
6	The periodic Process Safety
7	Culture Report shall be made available to the
8	workforce. The minimum frequency of Process
9	Safety Culture surveys shall be at least once
10	every three years.
11	Finally to the United Steelworkers
12	Local 12-591, Recommendation 16: Effectively
13	participate in the Process Safety Oversight
14	Committee to continually improve any
15	identified process safety culture issues at
16	the Tesoro Anacortes Refinery.
17	That concludes the staff
18	presentation. The Board will now give
19	comments and questions on the draft report.
20	Chairman Moure-Eraso, thank you.
21	CHAIR MOURE-ERASO: Thank you, Don
22	and the Tesoro Investigative Team. As is

1	custom in this type of meeting, the Board will
2	have the opportunity to have some discussions
3	and questions to the staff that prepared the
4	report.
5	I would like to get started with
6	one question that I make to anybody on the
7	team. We have in this report extensive
8	recommendations for the State of Washington.
9	My question is has the staff had any contact
10	with the State of Washington to gauge their
11	willingness to act on these recommendations,
12	and what kind of context or predictions do you
13	make on the possibilities of action on this?
14	INVESTIGATOR TILLEMA: We have had
15	some very preliminary discussions, but I think
16	they were intrigued by the idea of making
17	improvements to the process safety system and
18	were willing to work with us going forward.
19	CHAIR MOURE-ERASO: Thank you. I
20	would like to ask Board Member Rosenberg if
21	she has questions. No? Board Member Griffon,
22	do you have questions?

1	MEMBER GRIFFON: Really just one.
2	I'm very interested in the section on
3	organizational failures in the safety culture
4	parts. I wondered I know we're not going
5	through the whole report and findings, but can
6	you highlight or give an overview of some of
7	the findings supporting Recommendations 15 and
8	16, the Process Safety Culture Continuous
9	Improvement Program? Because I think I'd be
10	interested in hearing those on the record.
11	Just an overview of it.
12	INVESTIGATOR TILLEMA: I will in
13	just a minute. So, at the bottom of
14	Recommendation 15, we talk about the
15	
	willingness to report incidents. Part of that
16	willingness to report incidents. Part of that stems from the top investigation of the
16 17	
-	stems from the top investigation of the
17	stems from the top investigation of the multiple leaks and fires, and there was some
17 18	stems from the top investigation of the multiple leaks and fires, and there was some complacency related to those identified in
17 18 19	stems from the top investigation of the multiple leaks and fires, and there was some complacency related to those identified in that investigation.
17 18 19 20	stems from the top investigation of the multiple leaks and fires, and there was some complacency related to those identified in that investigation. The normalization of hazardous

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1	of these exchangers.
2	The burden of proof of safety
3	relates really, this is a bigger issue that
4	goes back to the damage mechanism hazard
5	reviews that were being conducted as far back
6	as when Shell owned the refinery.
7	The damage mechanism hazard
8	reviews were using the design conditions of
9	the heat exchangers to make a determination of
10	whether or not each THA was a susceptible
11	damage mechanisms for the heat exchangers.
12	Based on the design conditions,
13	the analysis was consistently that these
14	exchangers were not susceptible to HTHA.
15	So, when we talk about burden of
16	proof of safety, what we're talking about
17	there is that the culture of those analyses
18	being done by experts that Tesoro hired; the
19	culture of those evaluations was such that the
20	assumption would be that you had to prove
21	there was a hazard, rather than prove to me
22	that these design conditions are truly

1	applicable, and that I don't need additional
2	instrumentation, or that we don't need to look
3	at upgraded materials of construction,
4	especially when you consider the frequency of
5	the following.
6	The management involvement and
7	commitment to process safety is more of just
8	a high level necessary feature of a process
9	safety program to ensure that the program will
10	be effective.
11	So, that stems more from what is
12	necessary of a process safety culture program
13	to make it an effective system, rather than
14	stemming from actual incident causes.
15	MEMBER GRIFFON: Thank you. The
16	only other thing I wanted to say is I wanted
17	to just sort of add on to the Chairman's
18	question. I think we have quite extensive
19	recommendations to the state and several parts
20	and subparts, and I think it is going to be
21	critical going forward that we work pretty
22	closely with them on the intent of of

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1 strengthening the current process safety 2 management system. 3 I'm sure we will do that. So, 4 thank you. 5 **INVESTIGATOR TILLEMA:** I would say we agree with that, and it is our intent to 6 7 meet with them. CHAIR MOURE-ERASO: Are there any 8 9 more questions from the Board to the staff? 10 Okay, so, we are going to move to the next 11 item of the agenda. This is the Board vote. 12 I make a motion. I move that the Chemical 13 Safety Board approve Investigation Report 14 21008IWA, Catastrophic rupture of a heat 15 exchanger at the Tesoro Anacortes Refinery that occurred in April 2, 2010, with all 16 17 findings and recommendations as contained in the May 1st, 2014 final report. Do I hear a 18 19 second? 20 MEMBER ROSENBERG: Second. 21 CHAIR MOURE-ERASO: This has been 22 moved and seconded for the approval of the

1	report. Is there any discussion? Anybody
2	from the Board want to make any comments?
3	I have a comment to make that is
4	related to the report. I feel that I feel
5	very encouraged by the suggestions and the
6	remarks of Board Member Griffon on the the
7	desirability to study the safety case in the
8	US experience.
9	I intend to engage the agency to
10	work on the suggestion. I still feel that the
11	sector that will be benefitting the most from
12	this type of study of the safety case is the
13	refinery sector. So, that's the comment that
14	I offer in relation to the report. Any other
15	comments?
16	MEMBER GRIFFON: Yes. Just to
17	follow up on that, and I do support further
18	study of the safety culture idea. I mean the
19	safety case idea. As many people know, this
20	was a recommendation in a Dreft(Phonetic)
21	Chevron report as well. I think it is clear
22	to me the further study of this is needed to

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1	look at the effectiveness of it, as well as
2	hurdles to implementation in the United
3	States.
4	I'm glad and encouraged that we're
5	separating it out and moving ahead with this
6	report. So, I look forward to working with
7	the staff going forward on that issue.
8	Thanks.
9	CHAIR MOURE-ERASO: Thank you,
10	Mark Griffon. Then I will call the question,
11	and I pass the microphone to the General
12	Counsel of the Agency.
13	MR. LOEB: The question is on the
14	table. I will call the roll. Dr. Rosenberg?
15	MEMBER ROSENBERG: Yes.
16	MR. LOEB: Mr. Griffon?
17	MEMBER GRIFFON: Yes.
18	MR. LOEB: And the Chairman?
19	CHAIR MOURE-ERASO: Yes.
20	MR. LOEB: The motion is approved.
21	MEMBER ROSENBERG: I don't think
22	my mic was on, but yes.

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1	MR. LOEB: It was approved
2	regardless.
3	CHAIR MOURE-ERASO: Thank you very
4	much for the vote, and I am I would like to
5	make a comment. I'm very glad that this is a
6	unanimous decision from the Board, and that we
7	are going to proceed.
8	This is only the beginning of the
9	process. We make recommendations, and now we
10	have to try to get actions of these
11	recommendations. That is a long it's a
12	very difficult road to hoe, as you can
13	imagine. But this is just the beginning of
14	the process, not the end of it.
15	I would like to state that this
16	concludes the business portion of the meeting.
17	Of the people that are here, if any of you has
18	any additional remarks on top of the ones that
19	we heard on January 31st, I request that you
20	give your remarks and limit them to three
21	minutes.
22	We would like to finish the

1	meeting in 30 minutes. If you have further
2	questions or comments on any matter that
3	refers to the report, we encourage you to
4	approach us here and discuss it either with
5	the staff and/or with the board on additional
6	questions.
7	Now, do I see anybody that would
8	like to make a statement or to talk on the
9	report?
10	MR. GARY: My name is Steve Gary.
11	I'm President of the United Steelworkers Local
12	12-591. The report was not available to me
13	until earlier today. I haven't really had
14	time to evaluate it.
15	So, others may have comments to
16	specifics in the report, but I just wanted to
17	share a little bit about what this process
18	felt like.
19	It is a bittersweet moment for us.
20	I'm very happy for a final report, but I
21	remain extremely frustrated it has taken so
22	long. I want to just give you a sense of who

1	we are, and why we feel this way.
2	When I say we, it's more than just
3	union members and coworkers, or neighbors.
4	We're family here. We had two fathers working
5	in the refinery at the time of the tragedy.
6	One responded to the tragedy.
7	Each father had a son involved in
8	the tragedy, and both fathers had jobs to do
9	without knowing whether or not their son
10	survived.
11	We are the ones who lost our
12	lives. We are the ones who shut down those
13	units and put out those fires. We're the ones
14	who located the bodies. We are the ones who
15	helped and comforted those who are still alive
16	but could not really be saved. Nothing could
17	be done.
18	We're the ones who wept with the
19	family members and tried to find words when no
20	words were possible or meaningful. Finally,
21	we're the ones who became determined to learn
22	and to do all that was necessary to ensure

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1	that no more tragedies occurred in an industry
2	characterized by too many injuries, too many
3	fatalities. As one video says, "An industry
4	out of control."
5	We knew we couldn't do this on our
6	own. We knew we needed help. People with
7	white hats, so to speak, coming to help us.
8	CSB had a good reputation in 2010.
9	They looked like such an organization. CSB
10	assured us that they could produce a full
11	report in a timely manner. They assured us
12	that open communications with us would be
13	maintained.
14	We feel CSB should consider the
15	good reputation they had in 2010 with
16	stakeholders like ourselves and compare that
17	with what it is now; that many of those
18	assurances have not been met.
19	We hope you can more effectively
20	manage yourselves to avoid creating a legacy
21	of internal strife, division and broken
22	promises that we have experienced. Because

1	the white hats that we thought you were four
2	years ago have sometimes seemed more like the
3	white hats our senior managers wear, managers
4	who often say the right things, while too
5	often failing to do the right things. The
6	kind of right things that could've prevented
7	this tragedy.
8	We are prepared to move forward.
9	We are still determined. We will work with
10	others, equally determined to reduce risk in
11	this industry that has not shown an ability to
12	do this on their own.
13	We will use this report and others
14	that may follow to do all we can to reduce
15	risk. When we reduce risk, we protect our
16	own. We remain determined and committed to
17	that goal. Thank you very much.
18	CHAIR MOURE-ERASO: Thank you very
19	much. For the record, if you can, please
20	identify yourself.
21	MR. NIBARGER: My name is Kim
22	Nibarger. I work for the United Steelworkers

1	Health Safety and Environment Department, and
2	this is also my home local.
3	The USW, which represents a
4	majority of workers at the Tesoro Anacortes
5	Refinery is concerned about the breakdown of
6	the CSB management system that caused the
7	report on the failure of the exchanger on the
8	CRE to take four years to produce.
9	We are also disturbed that we were
10	not able to get a revised copy to us to review
11	before this morning so we could offer some
12	constructive comments on the final report
13	being presented here for approval by the
14	Board.
15	We question the value that a
16	report four years old brings. The company has
17	long since rebuilt the damaged equipment,
18	using a material that is less susceptible to
19	high temperature hydrogen attack, HTHA.
20	We feel that the report has not
21	given adequate emphasis to a number of
22	contributing factors that deserve more

1	attention than what they reserve, considering
2	the claim that this report was four years in
3	the making.
4	The fouling of the tubes that led
5	to the six-month exchanger cleanings was a
6	huge contributor to the wear and tear suffered
7	by the exchangers in the process. Had this
8	issue been identified and corrected, the
9	exchangers may have operated three to five
10	years between necessary cleanings.
11	This would've eliminated numerous
12	heat up and cool down cycles. The company has
13	made operational changes to reduce the fouling
14	of the tubes and to prolong operational life
15	between the cleanings.
16	The poor flow control systems, the
17	manual valves as opposed to automatic
18	controlled valves, contributed to the
19	fluctuation of temperatures on start up. Had
20	the controls been automated sooner, operators
21	would've been better able to maintain a
22	temperature on the exchangers. Not only

1	during startup, but also during operation.
2	This would've enabled control of
3	temperatures inside of the nelson curve, and
4	may have slowed the high temperature hydrogen
5	attack. Short time durations for a large
6	number of temperature cycles can increase the
7	susceptibility to HTHA.
8	The increase of hydrogen to the
9	unit and additional points of feed may have
10	likely contributed to the demise of the
11	exchangers.
12	A robust management change
13	conducted on any of these issues would've also
13 14	conducted on any of these issues would've also identified potential areas of additional
14	identified potential areas of additional
14 15	identified potential areas of additional review that may have allowed deviations to be
14 15 16	identified potential areas of additional review that may have allowed deviations to be identified and rectified, which would've
14 15 16 17	identified potential areas of additional review that may have allowed deviations to be identified and rectified, which would've prevented this disaster.
14 15 16 17 18	identified potential areas of additional review that may have allowed deviations to be identified and rectified, which would've prevented this disaster. The fact that the exchanger was
14 15 16 17 18 19	identified potential areas of additional review that may have allowed deviations to be identified and rectified, which would've prevented this disaster. The fact that the exchanger was not post-weld heat treated was quite likely
14 15 16 17 18 19 20	identified potential areas of additional review that may have allowed deviations to be identified and rectified, which would've prevented this disaster. The fact that the exchanger was not post-weld heat treated was quite likely the weak point in the construction that

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1	recognized in the heat affected zone and the
2	failed exchanger separated along those same
3	weld seams.
4	The CSB report notes eight
5	identified failures of vessels below the
6	nelson curve. But they failed to mention that
7	these failures were all carbon steel vessels
8	that were not both weld heat treated.
9	All of these factors contributed
10	to the failure of the exchanger, yet were
11	sacrificed in the report in favor of HTHA.
12	While the dominant mechanism of failure may
13	have been HTHA, it does not manifest itself
14	without these influencing factors.
15	The USW strongly supports the use
16	of inherently safer technology, but does not
17	want employers who read this report to
18	downplay the importance of maintenance and
19	inspection in these aging facilities.
20	We agree that maintenance and
21	inspection is lower on the hierarchy of
22	controls, but that does not mean it is not

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1	important. There's no other way to determine
2	if equipment is susceptible to failure without
3	inspection.
4	IST is inherently safer. Not fail
5	safe. Any time a replacement of equipment is
6	determined from proper inspection protocols,
7	IST should be a determining factor in the
8	replacement.
9	Any new construction should also
10	use IST as a criterion for determining
11	equipment construction as well as process
12	parameters, including temperatures, pressures
13	and volumes of hazardous properties of
14	ingredients.
15	So, recommendations: Use of as
16	low as reasonably practicable, or ALARP, or
17	greatest extent feasible, are objectives we
18	should work to achieve. But it can't be put
19	into place without defining ground rules as to
20	how it is determined.
21	There needs to be some definition
22	to what these terms encompass. We appreciate

1	the change in recommendation R5 to strengthen
2	the current PSM standard. This should be the
3	first objective: improve and strengthen what
4	we have in place.
5	We do support what elements of the
6	safety case may be beneficial, and work toward
7	incorporating them into the PSM standard. The
8	USW has proposals on improvements to PSM, as
9	well as suggested elements to the safety case
10	that may be advantageous to add to the PSM
11	standard.
12	The fact that you have replaced
13	the word safety case throughout the report
14	with more rigorous goal-setting attributes or
15	similar language is not lost on this. The USW
16	supports leading and lagging indicator
17	collection and analysis as well as
18	dissemination not only to workers, but to the
19	community as well.
20	The USW has done extensive work on
21	indicators, and that is the number of
22	suggested indications that should be tracked.

1	The USW would support a third party assessment
2	under guidelines we have developed, not only
3	for adequacy of the company's PSM elements,
4	but also safety assessments by the employees.
5	The USW has contributed to the
6	governor's task force recommendations in
7	California and our Anacortes local has had
8	numerous meetings with L&I on how to make
9	these facilities safer.
10	Do not forget that no matter how
11	many technical issues are identified, only if
12	they are corrected will there be any reduction
13	to injury and death to the workers. That is
14	our ultimate goal: to ensure that all workers
15	go home at the end of the day in the same
16	conditions they arrived.
17	No matter how stringent the
18	regulations are, ultimately unless the
19	employer executes their own written plan, this
20	type of tragedy will continue to happen in the
21	petrochemical industry in this country.
22	As was stated in the OSHA report

1	on an accident that took place almost a
2	quarter of a century ago, the most critical
3	responsibilities for chemical process safety
4	rests not with government agencies, but with
5	industry, and specifically with each
6	petrochemical producer at each location and
7	workplace.
8	Through regulation, enforcement
9	and technical assistance, training and other
10	means, OSHA acts to ensure that employers
11	fulfill their responsibility with regard to
12	chemical process safety for employees as well
13	as other types of worker hazards.
14	OSHA's role, however, is not that
15	of a supervisory body for the industry or for
16	individual plants; as specified in the OSHA
17	act, responsible for the safe operation of any
18	work place always remains with the employer.
19	That fact has not changed.
20	We had hoped you would've
21	considered our written comments, as well as
22	several other contributors, who mirrored many

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1	of our points and made the changes suggested
2	to reflect the failed management systems that
3	caused or allowed this tragedy to take place.
4	We hope you will consider this for
5	your future written reports and
6	recommendations. Thank you.
7	CHAIR MOURE-ERASO: Thank you. I
8	would like to request we limit the comments to
9	three minutes so that everybody has the same
10	time.
11	MR. CLEAVE: Good evening. My
12	name is Walter Cleave. I'm a proud member of
13	Steelworkers Local 12591. I stand here
14	tonight on my own behalf.
15	I appreciate the opportunity to
16	address you in particular, Dr. Moure-Eraso,
17	once again in a public setting. I realize the
18	final report became available this morning,
19	and I have had a few minutes to review it.
20	Without rehashing the history of
21	our interactions, this late timing I think is
22	yet another in a string of disrespectful

1	gestures on the part of CSB management.
2	I can't I can accept the report
3	as it is presented, but there is a degree of
4	disrespect in it too. The report does not
5	represent four years of work. Most of the
6	information and analysis in the report was
7	available within a year or so of the tragedy.
8	Nevertheless, here we are four-
9	plus years later, debating a report that is
10	still incomplete. When I say incomplete, I
11	want to be absolutely clear. The incomplete
12	report is not the fault of the investigators.
13	It is purely, simply a failure of CSB
14	management.
15	Incomplete I think is a fair
16	assessment since a number of major issues are
17	only briefly mentioned or not dealt with in a
18	meaningful way.
19	For example, high temperature
20	hydrogen attack is the focus of the report,
21	and all other possible contributing damage
22	mechanisms have been virtually ignored.

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1	Any mechanism responsible for						
2	causing damage to those exchangers should've						
3	been explored in depth. Also, the training						
4	aspect of this tragedy continues to be						
5	overlooked.						
6	Had only personnel been trained on						
7	the specific hazards of the unit, been allowed						
8	to operate the equipment, operators from other						
9	teams would've likely been needed. They						
10	would've been likely on overtime.						
11	And so, seven additional operators						
12	would not have been onsite at the time.						
13	Additionally, the importance of thorough						
14	mechanical integrity program including						
15	effective equipment inspections seems to be						
16	minimized by the report.						
17	It seems that almost any						
18	inspection technique applied, sophisticated or						
19	not, would've found a crack 3/10th of an inch						
20	deep and 48 inches long.						
21	Finally, the process safety						
22	culture plays an important part in several						

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1	aspects of these deaths, yet the cultural						
2	(inaudible) recommendations are few.						
3	In contrast to the omissions, the						
4	report goes to great depth to present a safety						
5	case, now referred to as a robust, goal-based						
6	regulatory approach as a remedy for each and						
7	every identified cause.						
8	Certainly, there are positive						
9	aspects, positive elements of the safety case						
10	regime that could be used to improve existing						
11	process safety management language.						
12	But the safety case is clear:						
13	superiority over existing PSM language is not						
14	supported by the report. No statistical						
15	evidence of clear superiority is offered, and						
16	according to public comments from individuals						
17	with regulatory and process safety experience,						
18	this hard evidence of safety case superiority						
19	does not exist.						
20	This report seems to be somebody's						
21	private agenda.						
22	All that said, there are positive						

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1	aspects to the report, and they are much
2	appreciated. I look forward to seeing a four
3	party process safety culture committee in
4	action, and I look forward to seeing
5	meaningful improvements made to existing
6	regulatory language.
7	Maybe now with the release of an
8	acceptable final report, each of us can get on
9	with our safety related efforts. Again, thank
10	you for the opportunity to speak.
11	CHAIR MOURE-ERASO: Thank you very
12	much. I appreciate your remarks.
13	MR. ANDERSON: My name is Ryan
14	Anderson. I too am a proud member of Local
15	12591, United Steelworkers, as well as the
16	Tesoro Unit Chair, and a member of the Tesoro
17	Nationwide Council.
18	I just wanted to speak tonight
19	briefly. First off, thank the investigators
20	and all the hard work everyone put in on this
21	investigation. I thank the Board Members for
22	being here to vote on this and finalize it.

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1	I had prepared remarks, but I too						
2	didn't have access to the report until this						
3	morning, nor did I have access to the						
4	responses by the CSB to the public comments,						
5	nor did we have information on the format of						
6	this meeting so that I could properly prepare						
7	comments.						
8	So, they're going to stay in my						
9	back pocket. I'm just going to kind of go						
10	from what I've seen and what I've heard						
11	tonight. I'll speak briefly to the reference						
12	to the Tesoro Nationwide Council's comments as						
13	far as our strong support to inherently safer						
14	technologies.						
15	Yes, we do support inherently						
16	safer technologies. However, we all work at						
17	facilities that were built very long ago. Our						
18	facility was built in 1955. There's numerous,						
19	numerous sites built previous to that. Very						
20	few built after that.						
21	So, the realities that we live in						
22	is equipment that is 50-60 years old. The						

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1	reality we live in as an industry is it has
2	been and still is out of control; that their
3	MO is to run to failure, not to replace
4	equipment until it catastrophically fails,
5	breaks, or is no longer usable.
6	So, while the hierarchy of
7	controls may be low as a causal factor for
8	inspection, it is absolutely mandatory and we
9	feel that it should've been highlighted and
10	brought forth more as a recommendation to the
11	industry. Because without inspection, this
12	old equipment will fail. A crack one-third of
13	an inch deep and four feet long is
14	unacceptable. Had somebody crawled inside
15	that shell, they would've seen it with a
16	flashlight.
17	Secondly, the tube fouling.
18	Again, tracking the tube fouling, while it may
19	be low on the hierarchy of controls as a
20	causal factor, it is old equipment. It is
21	absolutely imperative that these companies
22	evaluate what is creating these issues and fix

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1 them. 2 Yes, we can engineer away the 3 That takes money. Something they problem. 4 don't like to spend. So, again, I will state that I am 5 disappointed in the lack of communication and 6 7 forthrightness with this final report. It is reminiscent of, as my colleague Steve said, 8 9 some of the white hats that manage our own 10 refinery. 11 They give us as little information 12 as possible and let us guess what's going on. 13 Thank you very much and I appreciate your 14 time. 15 CHAIR MOURE-ERASO: Thank you. MR. MILLER: Good evening. 16 My name is David Miller, and I'm the Standards 17 Director of the American Petroleum Institute, 18 19 API. API appreciates the opportunity to 20 provide these comments at tonight's meeting. 21 The oil and natural gas industry 22 is committed to operating in a safe and

1	responsible manner, while minimizing our						
2	impact on the environment. Protecting the						
3	health and safety of our workers, our						
4	contractors and our neighbors is a moral						
5	imperative and a top priority for the						
6	industry.						
7	No incident is acceptable. Our						
8	industry takes every incident seriously and						
9	continued vigilance is essential to helping						
10	prevent future incidents.						
11	An integral part of our efforts to						
12	improve refinery safety is our standards						
13	program. The standards program is accredited						
14	by the American National Standards Institute,						
15	or ANSI, which is the authority on standards						
16	here in the United States. The program						
17	undergoes regular audits and the program is						
18	one of API's longest-running programs.						
19	The standards are referenced in						
20	federal regulations by six agencies,						
21	approximately 130 API standards are						
22	referenced, and here in the State of						

1	Washington there are 180 API standards cited
2	over 3,300 times in state regulations with 33
3	here in Washington State cited 130 times.
4	Part of the work that we do of
5	course is continuous improvement and looking
6	at revisions to our standards. When we had an
7	opportunity to review the draft report, we
8	undertook an exhaustive review of it, and we
9	met with the CSB's Denver Investigation Staff
10	to better understand the use of modeling
11	techniques and the subsequent analysis.
12	After that meeting, we provided
12 13	After that meeting, we provided written comments to the CSB draft report. Our
13	written comments to the CSB draft report. Our
13 14	written comments to the CSB draft report. Our comments addressed three primary areas being
13 14 15	written comments to the CSB draft report. Our comments addressed three primary areas being API standards and their initial
13 14 15 16	written comments to the CSB draft report. Our comments addressed three primary areas being API standards and their initial characterization in the draft report, aspects
13 14 15 16 17	written comments to the CSB draft report. Our comments addressed three primary areas being API standards and their initial characterization in the draft report, aspects of the CSB modeling, and some of the draft
13 14 15 16 17 18	written comments to the CSB draft report. Our comments addressed three primary areas being API standards and their initial characterization in the draft report, aspects of the CSB modeling, and some of the draft recommendations.
13 14 15 16 17 18 19	written comments to the CSB draft report. Our comments addressed three primary areas being API standards and their initial characterization in the draft report, aspects of the CSB modeling, and some of the draft recommendations. Regarding the API standards, we
13 14 15 16 17 18 19 20	<pre>written comments to the CSB draft report. Our comments addressed three primary areas being API standards and their initial characterization in the draft report, aspects of the CSB modeling, and some of the draft recommendations. Regarding the API standards, we appreciate the CSB response in the comment</pre>

1	We are already working on, and I						
2	provided these comments in my written report,						
3	and also in the comments we made in January,						
4	work on the next edition of RP941. That draft						
5	document should be available for public review						
6	very shortly.						
7	Regarding the use and the adequacy						
8	of the modeling used to prepare the draft						
9	report, again we've provided substantive						
10	information and engineering analysis,						
11	including our concerns that the model's high						
12	sensitivity to baseline assumptions and inputs						
13	especially when coupled with the relatively						
14	small sample size led to conservative						
15	recommendations.						
16	Based on our review, I would like						
17	to highlight our comments regarding the draft						
18	recommendations prohibit the use of carbon						
19	steel above 400 degrees F. We believe that						
20	this recommendation, along with the comment						
21	that the carbons nelson curve is inaccurate						
22	and cannot be relied upon is based again, as						

1	I said, on this erroneous modeling it is not						
2	supported by the operational experience in						
3	proven engineering practices.						
4	One other quick note. As I said,						
5	we did meet with the staff in advance of						
6	preparing the comments. We did have the						
7	discussion about the possibility of a follow						
8	on meeting in keeping with some of the other						
9	comments about how tight the time schedule						
10	was, the offer for the time to meet was						
11	roughly two days or so before the comments						
12	were actually due.						
13	In closing, I'd like to say that						
14	the effectiveness of any safety program is						
15	only as good as the commitment made to its						
16	preparation, implementation and execution, and						
17	has been stated the site operator is						
18	ultimately responsible to ensure safe						
19	operations.						
20	In closing, every incident is both						
21	one too many and a powerful incident for API						
22	and the industry to improve training,						

1	operating procedures, technology and our						
2	industry standards.						
3	Our thoughts remain with the						
4	families of those who lost their lives in this						
5	tragic accident. However, we also stand ready						
6	to work with the CSB and all interested						
7	stakeholders to improve refinery safety.						
8	Again, thank you for the						
9	opportunity to present.						
10	CHAIR MOURE-ERASO: Thank you.						
11	Are there any other comments? Okay, I would						
12	like to say in closing that I feel like, again						
13	as I said in my opening remarks, I believe						
14	that this report is the finest hour of the						
15	Chemical Safety Board.						
16	I believe it is an excellent						
17	report, and I am very proud of the work of						
18	this staff that took so many years to produce.						
19	So, not having any other comments, I declare						
20	this meeting closed.						
21	(Whereupon, the above-entitled						
22	matter went off the record at 1:54 p.m.)						

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