UNITED STATES OF AMERICA

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CHEMICAL SAFETY AND HAZARD INVESTIGATION BOARD

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PUBLIC MEETING

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BAYER CROPSCIENCE EXPLOSION AND FIRE PUBLIC MEETING

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APRIL 23, 2009

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The hearing came to order at 6:30 p.m. in the multipurpose room of the Wilson Building of West Virginia State University, 103 University Union, West Virginia. John Bresland, Chairman and CEO of the CSB, presiding.

PRESENT:

JOHN BRESLAND, CHAIRMAN AND CEO CHRIS WARNER, ESQ., GENERAL COUNSEL WILLIAM B. WARK, BOARD MEMBER WILLIAM E. WRIGHT, BOARD MEMBER JOHN VORDERBRUEGGEN PE, INVESTIGATIONS SUPERVISOR JOHNNIE BANKS, CFEI, INVESTIGATOR CATHERINE CORLISS, PE, INVESTIGATOR LUCY SCIALLO, GSP, INVESTIGATOR

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Adjourn

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1 P-R-O-C-E-E-D-I-N-G-S (6:30 p.m.) 2 CHAIRMAN BRESLAND: Good evening 3 and welcome to this public meeting of the 4 United States Chemical Safety Board, or as we 5 refer to it, as the CSB. I'm John Bresland, 6 7 Chairman of the Board, and with me today are Board Members William Wark and William Wright. 8 And also joining us today, sitting beside me, 9 is our general counsel, Chris Warner, and 10 various CSB staff members whose efforts have 11 facilitated this meeting, and whom you'll be 12 13 hearing from later this evening. The independent, 14 CBS is an non regulatory federal agency that investigates 15 major accidents at fixed chemical facilities. 16 investigations examine all aspects 17 The of chemical accidents, including physical causes 18 19 related to equipment design as well as inadequacies regulations, 20 in industry standards, and safety management systems. 21 Ultimately, safety 22 we issue

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1	recommendations which are designed to prevent
2	similar accidents in the future. The purpose
3	of this evening's meeting is for the CBS
4	investigative team to present their
5	preliminary findings into the investigation of
6	the August 28th, 2008 chemical processing tank
7	explosion at Bayer CropScience, which fatally
8	injured two workers.
9	At this time, please allow me to go
10	over this evening's agenda which is on slide
11	number two.
12	First, we'll hear from the
13	investigation team, and then following the
14	team's presentation, the board will be given
15	an opportunity to ask questions of the
16	investigation team.
17	The board will then hear from a
18	panel of outside witnesses. This evening's
19	panelists are listed on slide three, and we
20	will be welcoming those and giving you more
21	details on who they are, but they are all
22	here. They are all sitting up front and we
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appreciate you taking the time to get here.
 Thank you very much.

After the panel portion of the 3 floor 4 meeting, we'll open the to public comment, and I'll say a little bit more about 5 6 public comments later on, in terms of how much 7 time we're going to have for each person to 8 comment.

But before we get into the "meat" 9 10 of the meeting, I'd like to thank West Virginia State University for hosting the 11 CSB's public meeting, and I would now like to 12 13 invite Dr. Hazo W. Carter, Jr., president of the university, to the front of the room to 14 15 make an opening statement.

Dr. Carter.

Thank you very much. 17 DR. CARTER: Good evening. Welcome to the beautiful campus 18 19 of West Virginia State University. I extend board 20 greetings to the members and the United States Chemical investigators of 21 Safety Board, the panelists and guests. This 22

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is a historic 118-year-old campus. To walk on
these hallowed grounds is to step in the path
of thousands of students, faculty and staff,
who helped to shape West Virginia, our
society, and our nation.

Those of you who are familiar with 6 7 our campus community realize that West Virginia State University is truly a special 8 place. West Virginia State University prides 9 10 itself on being a living laboratory of human relations. We have one of the most diverse 11 faculty, staff, and student bodies 12 of anv 13 higher education institution, public or private, in West Virginia. 14

Those who work and learn here do so 15 16 in an environment that accurately reflects the diversity of America. The very aspects of 17 thought, backgrounds and opinions found at 18 19 this living laboratory of human relations prepares students for the life experience of 20 living successfully in a multicultural, 21 multigenerational global society. 22

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It is in this atmosphere of understanding and acceptance that West Virginia State University is pleased to host this meeting that is conducted by the United States Chemical Safety Board.

As an important part of the Kanawha 6 7 Valley, and being in close proximity to a chemical plant complex, the university is 8 concerned with all safety issues that could 9 10 potentially impact our students, faculty and staff, and the day to day operations of our 11 My family and I live for this campus. 12 campus. 13 It is my hope that this meeting will be a learning experience and a foundation on which 14 to build the best possible safety procedures 15 for all of us who live, study and work in the 16 Kanawha Valley. Aqain, thank 17 you for attending this important meeting. 18

19 CHAIRMAN BRESLAND: Thank you, Dr. 20 Carter. Congressman Shelley Moore Capito was 21 unable to attend this evening, but her 22 district director, Mary Elizabeth Ekerson is

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here, and she would like to read a statement
 from Congresswoman Capito.

MS. EKERSON: Thank you, Mr. Bresland, and thank you, Dr. Carter, for opening up your campus this evening.

"Dear Mr. Bresland, the U.S. 6 7 Chemical Safety Board, and members of the community. While I'm unable to attend this 8 evening's meeting due to my congressional 9 10 responsibilities that require me to be in Washington, D.C., I would like to thank the 11 U.S. Chemical Safety Board for 12 hosting 13 tonight's public hearing and the extensive work and effort they have put into their 14 15 preliminary report. I would also like to 16 thank the members of the community who are in attendance tonight. 17

18 "The seriousness of this incident 19 has been well-documented, and there is little 20 question that those of us who live in the 21 Kanawha Valley deserve a full account of the 22 events surrounding the August 28, 2008

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explosion at the Bayer CropScience facility in
 Institute.

"As many of you may be aware, we 3 heard testimony on this incident at a House of 4 Representatives subcommittee hearing 5 on 6 Capitol Hill earlier this week. The facts and 7 actions referenced in that hearing, and investigators 8 documented by and other officials, paint a troubling picture of the 9 10 day in question.

know, without dispute, that 11 "We serious there breakdown of 12 was а 13 communications between Bayer and first local responders. The brave men and women who put 14 15 themselves in harm's way can only keep us safe 16 when they have the necessary information to do The information which finally did reach 17 so. first responders and local residents was often 18 19 delayed and incomplete. These are troubling scenarios that demand a full and transparent 20 inquiry. 21

22

"I believe Bayer and the community

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1	are working together to significantly improve
2	this process. Today, we will see the
3	preliminary findings of the U.S. Chemical
4	Safety Board, and I look forward to the
5	board's conclusions and recommendations.
6	Sincerely, Shelley Moore Capito."
7	Thank you.
8	CHAIRMAN BRESLAND: Thank you.
9	Before we begin this evening's
10	proceedings, I would like to point out some
11	safety information. There are exits that are
12	marked, so if there is a need to befor us to
13	leave in an emergency, please exit through the
14	ones that are marked Exit.
15	If, however, anticipating the next
16	commentif, however, we have to shelter in
17	place, this is the shelter-in- place room in
18	the university. So the doors will close and I
19	will leave and everybody else will stay here.
20	[Laughter]
21	CHAIRMAN BRESLAND: This is the
22	shelter-in-place room, and over on the left-
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1	hand side, there actually is an emergency box
2	which has all of the appropriate emergency
3	communications equipment. So hopefully we
4	will not have to spend the evening here.
5	I also would ask that you would
6	mute your cell phones before we begin, so that
7	we don't interrupt the speakers.
8	Thank you.
9	On August 28, 2008, a powerful
10	explosion occurred within the methomyl larvin
11	unit at the Bayer plant. The explosion
12	occurred during the re-start of the methomyl
13	section of the unit. The blast fatally injured
14	two employees, Barry Withrow and Bill Oxley.
15	To those of you in the audience,
16	who lost friends or family members, please
17	allow me to extend my deepest sympathies.
18	I believe that the main reason we
19	investigate this action was the tragic loss of
20	life, as well as the impact which this
21	facility has on the surrounding community.
22	The facility stands in a populated
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1	area along the Kanawha River, about ten miles
2	west of Charleston. Chemical safety has been a
3	major issue in Kanawha Valley for decades,
4	fueled in part by concerns about the number of
5	major chemical plants, the density of
6	settlement, the local geography, and the
7	potential difficulty of evacuating the area.
8	Many of you here this evening live
9	in the Valley and have a personal interest in
10	the safety of this facility. I should just say
11	as a side, in spite of my accent, I have lived
12	in West Virginia off and on for about 12
13	years. I currently live in Jefferson County.
14	The public meeting is our chance to
15	discuss our opinions about the team's
16	preliminary findings. If anyone in the
17	audience wishes to comment publicly after the
18	investigator's presentation, please sign up at
19	the tables in the check-in area. I will call
20	your name at the appropriately time and I'll
21	first call those people who have signed in and
22	then I will ask for anyone who wishes to

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1 speak.

2	Please note, and I know we've got a
3	large crowd here this evening with standing
4	room only, but please note that we do have to
5	limit public comments to three minutes each.
6	We have a little timer up here that we hope
7	that you will abide by.
8	Also note that we aren't able to
9	take questions for those investigators
10	directly from the audience. And so I'll ask
11	that all comments be directed to me as the
12	presiding official at this meeting.
13	Now, if there is a point that is
14	raised in your comment where I believe that
15	the investigation staff can provide some
16	immediate clarification, I'll ask them to do
17	so.
18	I would like to thank the team for
19	their diligent work on this investigation. Our
20	investigation continues. This is what we call
21	a mid-term meeting. We're about halfway
22	through the investigation, but we are here to
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give you an update on what we have found so far, and also to also hear from the community about what concerns or questions that you may have.

Finally, let me say a word about the secrecy claims that have been made by Bayer concerning the information collected during our investigation.

many of you know, 9 As Bayer has 10 sought to designate several thousand pages of information as sensitive security information, 11 under the Maritime 12 SSI, Transportation or 13 Security Act. You may have read about this in the local newspapers. 14

15 While the status of these documents 16 has not yet been resolved, I do want to assure you that the presentation tonight will include 17 the fullest possible discussion of all of the 18 19 issues, including the issue of methyl isocyanate or MIC. We at the Chemical Safety 20 Board remain firmly committed to the public's 21 right to know. 22

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1	As was mentioned, there was a
2	congressional hearing in Washington, DC this
3	past Tuesday that I participated in. The
4	president of Bayer Cropscience, at that
5	meeting, stated that Bayer's reason for
6	raising the SSI issue to the Chemical Safety
7	Board in February was, and I quote, a desire
8	to limit negative publicity generally about
9	the company or the Institute facility, to
10	avoid public pressure to reduce the volume of
11	MIC that is produced and stored at Institute
12	by changing to alternative technologies, or
13	even called by some in our community to
14	eliminate MIC production entirely. End quote.
15	I was deeply disappointed with
16	Bayer's conduct in this matter. I can assure
17	the public that the CSB will continue to
18	conduct a thorough investigation of all the
19	issues and recommend whatever changes will
20	best protect the work place and the public.
21	I will now recognize the other
22	Board members for an opening statement. Mr.
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1	Wark, Mr. Wright. So at this time, I would
2	like to introduce the investigation team.
3	It's headed up by John
4	Vorderbrueggen. He's the supervisor of the
5	investigation, sitting over on the far right.
6	Sitting next to him is Mr. Johnnie Banks.
7	Sitting on this end is Catherine Corliss. I
8	should tell you that she's also a resident of
9	West Virginia. Sitting right beside Catherine
10	is Lucy Sciallo. They will all be talking to
11	you at some point this evening.
12	So at this point, let me turn it
13	over to Mr. Vorderbrueggen and he will start
14	his presentation, which I should point out,
15	will be quite lengthy, so we'd like to move
16	through it as quickly as possible without any
17	interruption. You will have an opportunity
18	later on to ask questions and make comments.
19	But if we can get through it without
20	interruption, it will certainly make for a
21	more efficient evening. Mr. Vorderbrueggen?
22	PRESENTATION OF THE CSB'S PRELIMINARY FINDINGS

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1	MR. VORDERBRUEGGEN: Thank you,
2	Chairman Bresland. Members of the Board,
3	general counsel, ladies and gentlemen, to
4	start this presentation, I want to summarize
5	some of thee activities and what we have done
6	since the incident occurred back on August
7	28,2008.
8	The team spent in excess of a month
9	on-site collecting data, interviewing eye
10	witnesses. We interviewed other parties. We
11	interviewed the management staff all the way
12	up to the top at the site. We have interviewed
13	some of you in the community. We have
14	interviewed emergency responders, part of the
15	Metro 911 Call Center. We've collected this
16	data. We've taken, maybe, thousands of
17	photographs of the incident scene.
18	We've preserved evidence that is important to
19	our investigation.
20	Over the last seven months, we have
21	been analyzing this data. We are still
22	collecting more data. There are outstanding
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document requests to Bayer Cropscience and
 they are processing these requests and we will
 have more.

We also intend to interview a few more folks. As the team assesses and evaluates the data that we have, we come up with new questions, new concerns, new issues, and all of that will be addressed by our team over the upcoming months.

10 Our qoal is to complete this investigation before the end of the calendar 11 year, but that is certainly predicated on the 12 13 data that we do need, some of the modeling activities that we need to conduct -- chemical 14 15 testing that we have even yet to determine 16 what some of that will be, so bear with us. It will take time, but our goal is to have a 17 comprehensive report of what happened, why it 18 19 happened, and most importantly, what will we be presenting to the Board for consideration 20 for recommendation such that this type of 21 event will not happen in the future. 22

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Furthermore, in the hopefully unlikely event it happens, the goal is to make sure that the community is promptly and appropriately and correctly informed so that the proper steps can be taken. So with that, I will move forward.

7 I'm going to summarize the facility unit overview. I'11 provide 8 and the an incident summary or the team will. We will be 9 10 doing some hopping and skipping here, so bear with us as we switch back and forth. We will 11 present a time line of the emergency response. 12 We will summarize the fatalities and injuries. 13

Again, this is a tragic event and the team's condolences to families, friends, and co-workers to Mr. Withrow and Mr. Oxley.

We will then summarize the facility and the off-site damage. We will talk about the properties of the chemicals involved in this incident and the possible chemicals that might have resulted from decomposition and fire. We will then present our preliminary

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1 findings that we are pursuing. Then we will 2 briefly discuss the path forward for the team. Some of you recognize some of these 3 dates and understand this. Some of you don't. 4 But this facility started out in 1943 and 5 operated until 1947 in support of World War II 6 7 effort in the manufacturing of rubber products. 8 Carbide Union purchased the 9 10 facility in 1947 and operated it until 1986. Rhone-Poulenc purchased the facility in 1986 11 and operated it until 2000. Aventis, which is 12 13 a merger of Rhone-Poulenc and Herck, took over the facility in 2000 to 2002. Finally, Bayer 14 15 CropScience purchased the facility and has 16 operated it since 2002. This is a photo of the sign at the 17 entrance to the facility, which I believe is 18 19 Carbide Road, and is still called Carbide Road. It is a multi-tenant facility. This sign 20 shows the seven tenants at this property. 21 Some of these tenants share feed 22

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1 stock with other tenants and even some of 2 those tenants actually provide feed stock for other tenants. 3 In particular, FMC and Adisseo are actually 4 employees 5 operated by Bayer through contractual equipment. The equipment is owned 6 7 by FMC or Adisseo. Bayer employees operate. Furthermore, I will talk a little 8 bit about FMC's link with the methomyl larvin 9 10 unit a little bit later in the discussion. As it relates to Bayer CropScience, 11 the 12 13 corporation is located in Germany. There are 17,800 employees than 120 14 some in more 15 countries world-wide. Their US headquarters is 16 in Research Triangle, Park, North Carolina, which is in the Raleigh-Durham area on the 17 eastern side of the state. 18 19 The Institute plant has approximately 520 Bayer employees. There are 20 three manufacturing centers at this facility. 21 The first is East Carbamoylation, which is on 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W. WASHINGTON, D.C. 20005-3701

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1	the east side closest to the University where
2	we are tonight.
3	The West Carbamoylation is
4	essentially everything west of, I believe,
5	Carbide Road.
6	And then Rhodimet is its own unit,
7	which sits very close to Carbide Road.
8	This is an ariel view of the
9	facility. I hope you can see the pointer here.
10	We don't have a laser pointer with us tonight,
11	so we improvised. Oops and bear with us as we
12	deal with it.
13	The view is to the north of the
14	facility. The north is to the top of the
15	picture and the I-64 is out of the picture to
16	the north. As you can see, Main Street, which
17	is Route 25, runs right across east to west
18	across the top of the facility.
19	The Kanawha River is to the south
20	of the facility. As you can see, on the right
21	hand side if the picture, is the edge of the
22	University that abuts the eastern end of the
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1 property.

2	The methomyl larvin unit where the
3	incident occurred on August 28 is shown and
4	circled in the lower left portion of the
5	picture. It is approximately 800 feet north of
6	the river, about 800 or so feet off the west
7	property line and a little over 1000 feet off
8	of Route 25.
9	This is a close-up view, a zoom-in
10	view, of the methomyl larvin unit. What is
11	shown is in the center of the picture,
12	that's the methomyl larvin unit proper I
13	apologize. I think I may just deal without the
14	arrow. I apologize.
15	Almost in the exact center of the
16	picture is where the explosion occurred in
17	this unit. To the extreme left of the picture,
18	you'll see a large rectangle, black
19	rectangular structure. That's the two story
20	control room that housed the control room
21	operators and other activities for this unit.
22	The north-south dark line in
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roughly the center of the picture -- the control room is, as I said, to the lower left. The pipe rack is roughly to the center. It runs north to south, top to bottom in the picture.

The explosion epicenter, again, as 6 7 is said, is roughly along that road is immediately south of the methomyl larvin unit. 8 I'll now move into the process 9 10 description. The methomyl larvin unit was actually designed and fabricated and put in 11 service in 1983. In the summer of 2007, the 12 larvin end of this unit or the larvin portion 13 -- the control system was upgraded to a new --14 15 it was called a Siemens System -- and we'll 16 talk about the difference between Siemens and Honeywell a little bit later. 17

In the summer of 2008, the methomyl 18 19 unit was upgraded. There extended was an 20 outage. The control system was upgraded to match the larvin portion of the unit and a new 21 residue treater was installed. The reason for 22

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the new residue treater is the old residue treater had -- it was at its end of useful life.

picture of the old 4 This is а residue treater after it was removed from the 5 6 unit this past summer. It's approximately 8 7 feet in diameter, about 14 feet tall. It happens to be lying on its side. The new 8 residue treater looks just like this treater 9 10 except it was pretty stainless steel and it sat vertically. It was installed in the unit 11 in the summer of 2008. 12

I will now move into the process description and please bear with me as I go through this diagram. If you look on the left side of the diagram, in the box, it says MIC Production Unit. That's the Methylisocyanate Production Unit.

19 It is located on the eastern side facility. In that 20 of the unit, they mix methylamine and ultimately 21 phosgene and 22 produce the methylisocyanate. Ιt is stored

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underground in that facility. Many of you have some familiarity and maybe extensive familiarity with that unit, at least in understanding its basic process. From that unit, they distribute the

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5 methylisocyanate to the four process units in 6 7 the facility that uses it as a feed stock. That is typically handled in overhead pipe 8 racks. The dash lines show the transfer lines 9 10 from the center production unit of methylisocyanate to the process units that use 11 it. 12

13 In particular, the MIC day tank, which is at the lower bottom, receives the 14 15 methylisocyanate, and it supplies the daily 16 production needs for methlyisocyanate to both FMC carbofuran unit, which again, 17 the is operated by Bayer; owned by FMC. It feeds the 18 19 methomyl larvin unit.

Looking at the top of the picture, we'll go back to the beginning of the methomyl process. We are not going to get into the

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larvin end of the unit. That's the next item downstream. We are only focusing tonight on methomyl.

the methomyl unit, the first 4 In basic step is the acetaldoxime and chlorine 5 6 are combined and they end up -- and I'm not 7 going to pronounce that. I'm just going to use the abbreviation CAO. combine sodium 8 They methylmercaptide with the the 9 CAO and 10 resulting material is -- I'll use the short name -- oxime. 11

the oxime product 12 From or 13 intermediate product it's called, they combine the methylisocyanate in what is shown in that 14 15 vertical hash line. It's essentially a pipe 16 system and the methylisocyanate reacts with the oxime and ultimately methomyl is produced. 17 It is sent to the crystalizers where they 18 19 crystalize it. Methomyl is a solid material in its final stage. 20

From the crystalizers, it moves to the centrifuges to remove the solvent that is

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used throughout the first run -- first portion of the process.

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So on this next slide, we're coming 3 into the crystalizers at the top center of the 4 picture -- I'm sorry -- from the crystalizers 5 6 to the centrifuges. The centrifuges are like 7 large washing machines. They spin. They actually do some washing, if you will. They 8 run some solvents. They spin. They dry it. The 9 10 dry methomyl is now packaged in 55 gallon drums or something of that approximate size, 11 stored in a warehouse. 12

Some of that methomyl is sold as direct sales to other chemical companies for their production purposes. Some of that material is stored and used, ultimately moved into the larvin end of the production unit.

Coming out of the bottom of the centrifuge is the liquid. The liquid is a concentrated -- it has some amount of methomyl in it and it has other products because there's other chemistry involved in this

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process. They recover the solvent to re-use it.

There are many thousands of gallons 3 of liquid solvent used in this process and so 4 it is recovered in what is called a flasher, 5 6 which simply, if you can call chemistry 7 simple, is simply a method of boiling the solvent, sending the vapor into the vapor 8 recovery system. You can dense it back to a 9 10 liquid. Now you have a clean, relatively pure solvent that is returned into the process 11 unit. 12

The flasher bottoms is the waste material, the last bit of material that cannot be recovered from the centrifuge flow. That is what the residue treater was intended to process, before the final liquid was sent to the boiler house for burning.

So the flasher bottoms fed into the residue treater. The purpose of the residue treater was simply to decompose the remaining amount of methomyl that survived the process

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down through the solvent recovery flasher because they could not out the methomyl into the auxiliary fuel tank and burn it for various purposes.

One of the important features of 5 the residue treater that I'm just going to 6 7 point out here is where it says the solvent pre-fill. In the unit start-up, the first time 8 you re-start the residue treater, it 9 is 10 critical that the treater be pre-filled up to a certain level with clean 11 solvent, such that the flasher bottoms is then 12 13 introduced into the solvent, and SO it's

14 immediately diluted.

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So that's what the purpose of the solvent pre-fill in the residue treater is.

So we now have a hopefully somewhat clearer understanding of how this process worked up through the residue treater, which was a waste treating device.

21 This next slide shows a more 22 detailed view of the residue treater. This is

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the device that failed the night of August 28. Again, bear with me as I try to go through this.

Down in the lower left side is the solvent feed line. The operators would manually open that valve at the lower part and they would start filling the residue treater to some 20 or 30 percent. The re-circulation pump would then be started.

10 The first step, which is a critical step to starting the second step, since the 11 first is filling it. The second step is to 12 13 heat the solution, the solvent. So the system was designed to run the liquid through a steam 14 15 heater, which you see on the right center of 16 the page with kind of a pink and red color and it says steam -- is there. So steam heated the 17 material. 18

Once the residue treater contents was up to the required operating temperature, the computer system was intended to control and allow what is called the feed control

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valve, which is over on the extreme left sideof the photo, to open.

That valve would then allow the 3 4 methomyl solvent, from the liquid from the 5 flasher bottoms, to now enter the residue 6 treater that's been pre-filled and pre-heated. 7 There's quick dilution and because the temperature is at their operating temperature, 8 methomyl will self-decompose 9 the into а 10 material that they can then transfer into the auxiliary fuel tank. 11

12 So there temperature was а 13 transmitter control temperature or а transmitter that was connected to the feed 14 15 control valve and there was -- bear with me. 16 Ιt the flow transmitter where was two important transmitters that helped control the 17 feed control valve. 18

Once the unit was up and running, the methomyl decomposition creates heat, so the computer system was intended to automatically switch from the heating cycle to

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a cooling cycle and from then on, for weeks on 1 2 end -- however long they were making methomyl -- they would actually take a little bit if 3 heat out of the system to ultimately control 4 the pressure in the residue treater. 5 I'll now move into the summary, the 6 7 incident summary, of what happened the night of August 28. 8 methomyl unit 9 The re-starts 10 activities actually began a week earlier on August 21. 11 things 12 There's many it's complex _ _ а 13 activity. There's many people in a control room and working in the unit, especially when 14 15 there's been changes to the equipment. It's not a simple activity. It's not a normal 16 17 activity. It had been an extended outage. It 18 19 was the first time use of a brand new control system on the methomyl unit. Although 20 the experience 21 operators had some or had experience with the same control system on 22

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larvin, but you're talking about a different process unit. It has different critical parameters. It has different adjustments. So it was the first time use of their control system.

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6 It was the planned beginning of an 7 extended production run to meet а new international demand. In fact, Bayer was in 8 the process of hiring new employees and there 9 10 was a good opportunity for Bayer, and the larvin product is the end product coming out 11 of this unit. 12

13 The actual methomyl production started on August 27, so they spent about a 14 15 week preparing equipment adjusting and 16 equipment. They were continuing to adjust to the new control system, displays in computer 17 input method. 18

19 What Ι mean by that is the and the personnel in the control 20 operators continuing familiarize 21 room were to themselves. So that was an ingoing activity, 22

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both on the control console displays, as well as how they entered data to tell the computer what to control in the system.

The operators and the other unit 4 personnel were also focusing on the upstream 5 equipment. There were some performance start-6 7 up issues. That is somewhat typical. Again, there are adjustments to be made, things to be 8 clarified, checked, and because of the new 9 10 control system, that even compounded that challenge. 11

12 So they were continuing with 13 control tuning and process trouble shooting 14 throughout the week prior to the incident, 15 including the day of the incident.

We're now at Thursday, 5:00 in the morning. The status of the residue treater as the level indication read was 0 percent full. It effectively was empty. Its temperature was 40 degrees Centigrade, which is 104 degrees Fahrenheit. The devices to control temperature and flow were bypassed.

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1 When Ι showed in that earlier 2 picture, there was a temperature control on the feed valve and a flow limit on the feed 3 valve. They were in a bypass mode, which means 4 that they were ineffective. 5 6 At that point in time, empty 7 residue treater and cold residue treater, the flasher bottoms feed valve 8 was manually The computer did not make 9 opened. that 10 control. The control was switched to manual 11 and it was manually opened. Thirteen and a half hours later, 12 13 the liquid level is now 49 percent, which is plenty of liquid in this. fact, 14 In it 15 typically operated around that range. 16 Temperature is at 145 degrees Fahrenheit, which is actually above its intended operating 17 temperature. So the temperature actually 18 19 climbed. 20 The reason the temperature is climbing is because the feed that's going into 21

the unit is pre-heated. It doesn't come in

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cold. It comes in at some higher temperature and there is some amount of decomposition occurring from the methomyl which creates heat.

this small 5 So amount of 6 decomposition was bringing temperature up. But 7 for all intents and purposes, up until now, the control room operations personnel are 8 seeing this temperature climb -- and I'll show 9 10 you a chart in a minute -- and it appeared normal. At that time, 6:25, was the first time 11 the re-start pump was started. 12

About four hours later -- it's now 13 10:20 15, 20 minutes before the 14 pm, or 15 incident, the residue treater is at 58 16 percent. That's still within operating range. temperature is climbing. 17 The It's significantly climbing, and the pressure is 18 19 now unexpectedly increasing.

The control board operator saw that on his console. That was the first time that there was recognition that something didn't

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1 appear to be correct.

2	This graph is an actual graph of
3	the pressure and the temperature during the
4	time. It starts a little after 4 pm on the
5	afternoon of August 28. The bottom line, the
6	red line, is the pressure curve, and it was
7	normal. They pre-pressurized the reactor to a
8	small amount so it was sitting there running
9	fairly normally.
10	The temperature is the black line,
11	and up until about 6:43 pm, which is about the
12	time they started the re-circ pump,
13	temperature was flat. Start the re-circ pump,
14	start mixing things, and now e get a little
15	bit of methomyl decomposition occurring, and
16	the temperature starts climbing.
17	What the operator what typically
18	was seen was a curve like this and the
19	assumption would be that the heater was doing
20	its job. So there was nothing to be concerned
21	about from 6:00 until just before 10:19 pm and
22	again, it's a very small blip in this curve

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that it starts to go towards a vertical, which is telling the operator that the pressure has gone up over a short period of time.

this point 4 Ιt was at that he started to take corrective action. Within a 5 6 few minutes, he asked one of the outside 7 operators to check the residue treater vent system. The residue treater has a vent system 8 to remove gases and they had historically had 9 10 problems with that vent system over the operating time because there are some solvent 11 material, so the vent system would tend to 12 13 plug up, which is not necessarily a safety issue, but it meant that the operator had to 14 15 go out and make sure the vent line wasn't 16 plugging because that would result in а pressure climb. 17

Within a few minutes, the second outside operator was asked to assist. Again, these are the two gentlemen that did not survive.

As they were approaching the

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1 residue treater -- they were walking down the 2 roadway, the residue treater relief valves opened. Those are the emergency vent valves to 3 4 start relieving pressure. They could hear Other people in the unit could hear 5 that. that. Now the unit alarms are starting to 6 7 sound. That actually lasted for about four minutes before the actual rupture occurred. 8 right about 10:35 9 But pm, the 10 residue treater violently ruptured. Approximately 2500 gallons of methomyl solvent 11 liquid was suddenly released into the roadway 12 13 and a fire almost immediately erupted. This methomyl solvent liquid 14 is 15 highly flammable. It's a solvent and as soon 16 as that residue treater ruptured and was blown into the unit -- we'll show you some pictures 17 sparks were created from steel hitting 18 _ _ 19 concrete, steel hitting steel. Wires were being ripped, electric wires -- high voltage, 20 low voltage instruments, piping. There was a 21 spark ignition source there virtually as quick 22

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1 as it ruptured. Solvent piping, then headers, 2 and other process equipment were damaged, 3 destroyed as the residue treater came apart. 4 This is a shot of the unit after 5 the explosion had occurred. The picture -- the

the explosion had occurred. The picture -- the white section in this picture is what was the approximate location of the residue treater and the approximate size. It actually sits behind that debris pile and that's where it physically was.

We are looking basically northwest in this view. The roadway, the street, is to the left of the picture, and it's pretty obvious the amount of energy that was released when the treater came apart and all the steel was thrown -- steel and piping.

The treater was driven into the unit and in the next picture we'll show where it came to rest.

That large, somewhat shiny chunk of steel was a brand new pressure vessel. It traveled approximately 50 feet into the unit

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1 and the piping was of course ripped out. A lot 2 of electrical conduit and other things were ripped out as a result of this explosion. 3 Our preliminary findings -- why did 4 the residue treater blow up? That's the easy 5 part of our investigation, actually. The hard 6 7 part is figuring out the management system deficiencies that resulted in these specific 8 actions or conditions to occur on August 28, 9 so that's what we are looking for. That is our 10 goal. 11 But we do know that the minimum 12 13 temperature safety interlock was bypassed, so therefore, methomyl could be introduced into 14 15 the residue treater well below the required safe minimum operating temperature. 16 Also, the minimum re-circulation 17 flow interlock was bypassed, so in fact, this 18 19 valve could have opened even when re-circ was not occurring, although in this case, it was. 20 Re-circ was occurring. 21 And then finally, the feed valve 22

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was put in the manual mode and opened so that introduced when the residue methomyl was treater was essentially empty and it was cold. dilution and So there was no no rapid decomposition as it was intended to occur.

So looking back at this picture, 6 7 the problem, the immediate physical problem, is the two devices that have the X's had been 8 over-ridden, de-activated, such that the feed 9 10 control valve on the extreme left could be manually opened. This was done way before the 11 residue treater was properly prepared and the 12 13 residue treater violently ruptured.

This is a curve. This is the rest of the curve from the previous one with the remaining time shown from about 10:19 pm when the operator in the control room observed that there was an issue, a problem. To the point, the black line is when the residue treater ruptured and the signal was lost.

In the red curve, the pressure is now uncontrollably increasing. You see a small

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blip in that curve, if you will. It kind of drops off. That was the relief valve opening and the pressure dropped off for a little bit and then went back to climbing because the runaway chemical reaction was overwhelming the relief.

At 10:35, based on the various time stamps, the vessel ruptured. The top curve, again, clearly the temperature is running away, unable to control it at this point in time.

Other preliminary findings, as I've 12 mentioned a couple times, the residue treater 13 pre-filled with the solvent 14 was not as 15 required by the procedure. The solvent was not 16 pre-heated the minimum operating to required by the operating 17 temperature as procedure. The flow of methomyl mixed solvent 18 19 mixture to the residue treater had actually begin at 5 am the previous morning or that 20 morning, and had continued all day at a very 21 low rate, but that's where the liquid was 22

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added to the residue treater. 1

2	The residue treater re-circ began
3	around 6 pm. Ultimately, there was a sudden
4	uncontrolled exothermic meaning heat-
5	releasing, heat-generating decomposition of
6	methomyl.
7	In fact, some preliminary numbers -
8	- and these are subject to further refinement
9	but it does point to a significant
10	deviation from the permitted conditions. But
11	the concentration of methomyl, in the residue
12	treater, was probably significantly in excess
13	of 20 percent.
14	Yet, the relief system was sized
15	for not to exceed about a half a percent
16	concentration, and it was clearly documented
17	in the safety analysis and the operating
18	procedure. Obviously, the residue treater
19	violently ruptured, solvent methomyl lines
20	were severed, and the contents were ignited.
21	We'll move into a new segment. I
22	will ask Mr. Johnnie Banks to come up and
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discuss the emergency response consequences
 and community impact.

3 MR. BANKS: Thank you, Mr.
4 Vorderbrueggen.

5 Chairman Bresland, Board members, general 6 counsel, ladies and gentlemen, good evening.

7 For the next portion of our presentation, I'll be presenting an overview 8 of the emergency response and time-line, 9 the 10 consequences of this incident, and the community impact. 11

the team's review Based on of 12 13 control room records and charts, we estimated that this incident occurred at about 10:35 on 14 15 the night of August 228, 2008. At about one 16 minute into the incident, a local citizen reported an explosion to Metro 911. 17

At about that same time, the Tyler Mountain Fire Department alarm sounded, alerting members to report for deployment to the incident at Bayer. Also at about this time, the Bayer gate guard attempted to call

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1 Metro 911.

2	It's important to add here, through
3	an interview within the executive director of
4	Metro 911 and the supervisor at Verizon that
5	the Metro 911 call center fielded over 2700
6	calls on the night of this incident.
7	There's a finite amount of calls
8	that can be effectively handled at any one
9	time. If the caller calls during that time, he
10	gets a fast bust signal. He has to hang up and
11	re-call.
12	At about four minutes into the
13	incident, Metro 911 called the Bayer main gate
14	in an attempt to gather information on the
15	nature of the incident. At about seven minutes
16	into the incident, the Kanawha County sheriff
17	ordered Route 25 closed. This route runs just
18	north of the main entrance into the plant.
19	Metro 911 called the main gate
20	again. Concurrent with this call, the gate
21	guard was attempting to call Metro 911,
22	realized that he was connected, and at that
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1 point, requested an ambulance for а burn 2 victim.

At ten minutes into the incident, 3 4 the Bayer emergency operations center was activated and crews A and B were notified 5 6 through a ring-down system. This was an effort 7 to bring personnel to the plant to assist with 8 the emergency.

Also about this time, 9 at the 10 Institute Volunteer Fire Department chief arrived at the main gate, notified the Bayer 11 incident commander of his 12 presence, and 13 offered any assistance that he might offer. At that point, he was told to stand by and await 14 15 instructions.

16 At 14 minutes into the incident, the Nitro and Dunbar Police Departments closed 17 I-64, which is a bit more north of the plant. 18 19 At 15 minutes into the incident, the Institute fire chief tells Metro 911 that the Bayer 20 incident commander reported that no dangerous 21 chemicals were being released. 22

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1	This was based on the incident
2	commander's observation of the intensity of
3	the fire and the notion that any chemicals
4	would be consumed in that fire. However, this
5	was not based on feedback from any monitoring
6	electronic or otherwise to give them the
7	feedback on the nature of the chemicals being
8	released, if any.
9	At 24 minutes into the incident,
10	consistent with procedures, Bayer notified
11	Metro 911, West Virginia State University,
12	West Virginia Rehabilitation Center, and
13	Reagent Chemicals.
14	At 25 minutes into the incident,
15	the Saint Albans fire chief notified Metro 911
16	that he would be advising a shelter in place
17	if additional information wasn't forthcoming.
18	Based on his observation of a vapor cloud that
19	appeared to be heading toward Saint Albans, he
20	made the announcement to Metro 911 to that
21	effect.
22	At 44 minutes into the incident,
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1	Metro 911 announced a shelter in place in the
2	area around Bayer. They also, at that time,
3	started a reverse 911 ring-down notification
4	to citizens in the affected areas.
5	At 49 minutes into the incident,
6	the Bayer incident commander recommended to
7	Bayer emergency operations center to contact
8	Metro 911 to shelter in place in Saint Albans
9	and Nitro.
10	Based on an interview with the
11	Metro 911 personnel, unfortunately this
12	transfer of information did not occur.
13	At 59 minutes into the incident,
14	the Kanawha Putnam County Emergency Management
15	Director activated the county emergency alert
16	system. This alert activated a shelter in
17	place for the areas west of Charleston to
18	Putnam county.
19	A little over two hours into the
20	incident, Bayer reported the incident to the
21	National Response Center.
22	In this scene, the area that was
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affected by the shelter in place zone, 1 is 2 shown in the gray area. It's important to note that there was a slight wind direction to the 3 southwest towards Saint Albans. The areas that 4 were affected by the shelter 5 in place are Dunbar, Institute, Jefferson, Nitro, Saint 6 Albans, and South Charleston. This shelter in 7 place affected approximately 40,000 citizens. 8 A little over three hours into the 9 10 incident, а Bayer spokesman held а news conference. At that time, advised that the 11 fire was continuing, but contained. 12 At three hours and 30 minutes into 13 the incident, Metro 911 cancelled the shelter 14 15 in place. At three hours and forty minutes, 16 Bayer reported that the fire was out. At six hours and 15 minutes after the incident, Bayer 17 reported an all clear with the exception of a 18 19 small fire that was allowed to burn in the larvin unit on ruptured relief line piping. 20 Next, we'll take a look at the 21 consequences of this incident. On the night if 22 **NEAL R. GROSS**

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this incident, in response to rapidly changing conditions in the plant, an operator went outside to make operational changes and to check the plant to see if he could make the corrections that were necessary to correct the conditions that Mr. Vorderbrueggen just showed you.

8 Shortly after he went out, a few 9 minutes later, a co-worker went out to assist 10 him. Both these operators were in the plant at 11 the time of the incident and fell victim to 12 the result of the rupture of the residual 13 treater tank.

One victim died from his injuries almost immediately. The other one, the second outside operator succumbed to his injuries about 41 days later at the Burn Center in Pittsburgh, Pennsylvania.

19There were also reported suspected20chemical exposure symptoms reported that21night.

They would affect five Tyler Mountain

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volunteer firefighters, two Norfolk Southern
 employees, and one Institute volunteer
 firefighter.

included 4 Symptoms headache, abdominal pains, and diarrhea. The symptoms 5 6 developed the next morning after they returned 7 to quarters for the five Tyler Mountain firefighters. 8

9 The next day, Friday, the Institute 10 volunteer firefighter went to the emergency 11 room for additional treatment. He was seen, 12 treated, and released.

Next, we'll take a look at the over 13 pressure damage from this incident. On site, 14 the new residual residue treater vessel was 15 16 completely and totally destroyed in this incident. Associated process 17 piping and equipment was also destroyed. There 18 was 19 moderate overpressure damage to control room and nearby structures. 20

21 In this scene, we have a photo of 22 the **NEAL R. GROSS**

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1 residue treater tank post-incident that was 2 taken to a laydown area.

This next photo shows some of the 3 damage that was typical of offices that were 4 in the control room center. Typical of the 5 6 damage was ceiling tiles that were dislodged 7 from their molding and ceiling lights that were torn from their anchors. Some bookcases 8 were also noted to be moved. 9

In the photo on the right, which is a building that was of the control near center, you'll note that the door was knocked 12 13 off its hinges by the overpressure.

conducing our 14 In assessment, we 15 also became aware of damage to businesses and 16 homes in the area. This damage consisted primarily of window breakage 17 and minor structural damage. 18

19 То date, there have been approximately 57 submittals for claims for 20 damage. The damage ranges from mobile homes, 21 residences, and vehicles, and totaled about 22

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1 \$37,000.

2	One of the businesses that was
3	damaged in this incident was across the
4	Kanawha River, about one half mile away. There
5	were several windows that were broken on this
6	business establishment.
7	The photo below is in a private
8	residence. It's typical of the damage that we
9	observed, with cracks in the ceiling and
10	walls.
11	This next scene is a report of
12	property damage where we attempted to capture
13	the distance and direction of the damage as
14	reported. While most of the damage is
15	clustered in a one half to one and one half
16	mile direction from the epicenter of the
17	event, damage was noted as far away as a
18	little over seven miles near Charleston and as
19	far north as Poca, which is a little over six
20	miles. Each of the lines depicted in this
21	diagram is meant to capture the direction and
22	distance from the epicenter.

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This next diagram is an attempt to capture how the communication was conducted on the night of the incident.

All of the parties in the boxes on 4 the right are of municipal fire and police 5 services that are familiar with, conversant, 6 7 and compliant with the National Institute NIMS, process 8 Management Systems, or and Most, if all, of their 9 protocols. not 10 communications that night went through Metro 911 followed the unified 11 and command 12 structure.

Communication within the Bayer EOC, as directed by the Bayer incident commander, showed a number of hand-off of information from one source to another and did not follow unified command structure.

important to note that in It's 18 19 spite of the concerns that were raised about the communication between the various entities 20 and responders that we have seen no evidence 21 indicate 22 that there delayed to was any

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1	treatment for the injured in this incident.
2	Our emergency response findings, in
3	the area of personal protection equipment or
4	PPE for hot zone responders, the use of self-
5	contained breathing apparatus or SCBA or
6	respirators was not clearly conveyed to
7	outside responders.
8	At the conclusion of this incident,
9	outside responders did not de-contaminate on-
10	site before returning to quarters and remained
11	in their clothing and returned with their
12	equipment.
13	With regards to incident command
14	coordination, the Bayer incident command
15	structure did not use a unified command
16	structure. There were multiple EOC's
17	established when this incident occurred, both
18	inside the plant and outside.
19	The shelter in place decision
20	process was complicated by a lack of clear
21	information and the decision-makers made their
22	choices based on the best information that
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they had at the time they made the calls. 1 2 Communication between BCS, Metro 911, County EOC -- the gate guard followed 3 emergency communications 4 Bayer procedures. Metro 911 experienced an extremely high call 5 volume on the night of this incident. To their 6 7 credit, their staff self-reported, volunteered, came out, pitched in, and did a 8 commendable job in handling the rigors of this 9 10 incident. In talking to the staff at Metro 11 911, this is the largest event that they've 12 13 ever handled and they can stand proud. The responders 14 emergency that 15 fought the fire in the plant performed 16 commendably. In spite of challenging odds, they stood their posts. 17 That concludes my portion of the 18 19 presentation. Ms. Sciallo will take you to the next portion of our presentation. That you for 20 your attention. 21 MS. SCIALLO: Thank you, Mr. Banks. 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W.

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1 Good evening.

2	We understand that there is a great
3	community concern for a possible chemical
4	release on the night of the incident. For the
5	next portion of the presentation, I'm going to
6	describe the characteristics of methomyl and
7	I'm going to list some of the human toxicity
8	elements.
9	After that, I'm going to list some
10	of the hazardous chemicals that may be formed
11	when methomyl breaks down or decomposes.
12	Then I will cover the toxic effects
13	of methyl isocyanate and I will describe what
14	conditions present on August 28 might have
15	resulted in a release of methyl isocyanate.
16	First, I'll talk about methomyl.
17	Methomyl is a carbonate pesticide and it is a
18	cholinesterase inhibitor. Cholinesterase
19	inhibitors disrupt the function of the
20	peripheral and central nervous system.
21	Methomyl can have irreversible and reversible
22	effects on the nervous system, depending on

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1 the duration and the concentration of the 2 exposure.

Methomyl is a white crystalline 3 solid. It can be harmful to humans when it is 4 absorbed through the skin, inhaled, 5 or ingested, 6

7 Acute symptoms include ocular effects, such as blurred vision, pin point 8 pupils, muscle twitching, 9 tremors, 10 gastrointestinal effects such as nausea and abdominal 11 pain. At higher concentrations, 12 respiratory arrest, coma, and even death can 13 occur.

include Chronic symptoms liver 14 15 damage, anemia, and nervous system damage due 16 to prolonged cholinesterase inhibition.

Was methomyl released on the night 17 of the incident? When the residue treater 18 19 ruptured, methomyl concentrated solvent was released from the treater and associated pipes 20 and equipment. 21

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residue the treater's Now,

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1 function, as Mr. Vorderbrueggen explained, is 2 break down methomyl the intended to so chemistry or the intended decomposition of the 3 methomyl was taking place in the treater prior 4 to and during the residue treater's rupture, 5 as there was a rapid temperature increase. 6 7 Besides decomposition, some burned, intense fire on the unit there was an 8 as almost immediately after the residue treater's 9 10 rupture. Some remained on the ground and nearby equipment and some of the methomyl 11 might have been carried in the air. There's a 12 13 tremendous heat current that might have locked the methomyl into the air. 14 Here is a photo of methomyl unit 15 16 equipment taken a couple of days following the incident. The yellow arrows point to methomyl 17 residues observed by CSB investigators. 18 19 Now, when I discuss what could have of the residue 20 happened to the contents

22 have burned in the fire. When methomyl burns,

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treater, I mention some of the methomyl might

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might form 1 it breaks down and hazardous 2 chemicals, some of them in trace amounts. The list includes acetonitrile, dimethyl 3 hydrogen 4 disulfide, cyanide, oxides of nitrogen and sulfur, methyl thiocyanate, and 5 6 methyl isocyanate. Bayer provided the 7 CSP with а

thermal decomposition analysis that 8 listed chemicals of of the 9 some methomyl 10 decomposition. The CSB also referenced safety 11 methomyl material data sheets and pesticide literature for the formation of this 12 13 list.

Methyl isocyanate is an extremely 14 15 toxic material and is used in the methomyl 16 Ιt stored near the residue process. was treater. It's highly reactive with water and 17 it's highly flammable. It has a relative vapor 18 19 density of 1.4. This means that it is heavier than ambient air and it 20 lays low to the ground. 21

It has an immediately dangerous to

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life and health or IDLH concentration of three parts per million. The IDLH is defined by the National Institute of Occupational Safety and Health. Methyl isocyanate has a boiling point of 39 degrees Celsius 102 or degrees Fahrenheit, and it readily evaporates, especially in summertime temperatures.

Possible of sources methyl 8 а isocyanate release. There are a few conditions 9 10 that could have resulted in a release of methyl isocyanate on August 28. One would be 11 if MIC supply piping and equipment was broken. 12 13 Bayer reported that the equipment was not broken and the MIC day tank was not damaged. 14

15 There are vent systems or scrubbers 16 the unit that are designed to on remove hazardous chemicals before they're released to 17 the atmosphere. These vent systems 18 were 19 damaged, which could have resulted in an MIC is raw material in 20 release, as MIC а the process and might have been present in the 21 system. 22

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Also, as I mentioned previously, MIC might be
 a product of methomyl decomposition in trace
 amounts.

16 monitors 4 There are on the methomyl larvin unit capable 5 of detecting methyl isocyanate. The CSB has recently 6 7 learned that these alarms or monitors were not operational on the night of the incident. 8 There are also stationary perimeter or fence 9 10 line monitors around the facility that are designed to detect multiple chemicals. 11

The investigation team intends to further examine the operational status and sensitivity of these monitors in the ongoing investigation.

16 Now, I'm going to list some of the chronic 17 acute and symptoms of methyl isocyanate exposure. Acute symptoms include 18 19 eye irritation, ocular damage, respiratory skin irritation, 20 distress, pulmonary edema, chemical burns, nausea, abdominal pain, coma, 21 and death. Chronic symptoms include 22 lunq

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1 damage and blindness.

2	Now, I talked about methomyl and
3	MIC. Now, I'm going to summarize the chemical
4	properties of other chemicals, some used on
5	site and some used in the methomyl process to
6	exhibit the relative toxicity of these
7	chemicals. I'll describe how they can be
8	identified.
9	I'll list the chemicals in the left
10	hand column because I know the font is small.
11	We have methyl isocyanate, methomyl, phosgene,
12	chlorine, ammonia, and methyl isobutyl ketone,
13	MIBK.
14	The column to the right lists the
15	IDLH or the immediately dangerous to life or
16	health defined concentration. The column to
17	the right of that is the odor threshold.
18	Notice for methyl isocyanate, the IDLH is
19	three parts per million and the odor threshold
20	is two parts per million.
21	If one were exposed to methyl
22	isocyanate, they may experience some of the
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irritating effects such as eye irritation or
 burning or throat or burning at levels at
 around .4 parts per million.

So this means that odor is not a 4 sign warning for methyl 5 qood isocyanate 6 exposure because you may be experiencing the 7 effects of the exposure, the damaging effects to your eyes or your respiratory before you 8 actually smell it. 9

Also notice phosgene's IDLH is two parts per million and the odor threshold is much lower in comparison to methyl isocyanate. It's 0.4 parts per million.

Then the column to the right of that, I list some of the odor characteristics for each chemical. The last column on the right indicates whether or not these chemicals are covered by the Environmental Protection Agency's Risk Management Program.

20 An aspect of the EPA's Risk 21 Management Program, or RMP, quantitatively 22 estimates the impact of a chemical release in

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1	the community. If facilities have an RMP
2	listed chemical in a specified quality, they
3	are subject to the Risk Management Program.
4	MIC, phosgene, chlorine, and ammonia are RMP-
5	covered chemicals.
6	Now, for the next portion of the
7	presentation, MR. Vorderbrueggen will now
8	explain the Risk management Program in depth.
9	MR. VORDERBRUEGGEN: Thank you, Ms.
10	Sciallo.
11	As the previous slide showed, in
12	the chart, the RPM regulation under the EPA
13	standards identify a number of toxic chemicals
14	Ms. Sciallo showed the slide, the precious
15	slide, that had the RPM a series of
16	chemicals that fall under the EPA's Risk
17	Management Program requirements. In fact, in
18	these chemicals that were listed, they are all
19	toxic chemicals.
20	There is also a class of flammable
21	chemicals that fall into RMP, but our interest
22	tonight is the toxic list.
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1	Within the United States, the EPA
2	Risk Management Program requirement comes into
3	play when
4	methyl isocyanate we'll talk only MIC
5	tonight is handled in quantities exceeding
6	10,000 pounds.
7	It turns out that Bayer Cropscience
8	in Institute, West Virginia is the only
9	facility in the United States that we have
10	identified that falls that handles more
11	than 10,000 pounds of methyl isocyanate and
12	therefore, of course, they must have an EPA
13	Risk Management Program, which is a
14	comprehensive program to manage all aspects of
15	handling methyl isocyanate.
16	It's similar to the OSHA process
17	safety Management standard, and we'll talk
18	briefly about that later. There is significant
19	overlap in the various program elements.
20	The Bayer Risk Management plan a
21	risk management plan is a document that the
22	company is required to submit to the EPA that
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lists certain parameters and elements of the
 process that handles the covered chemical, in
 this case, methyl isocyanate.

The Risk Management Plan summarizes some of the protective systems. It summarizes quantities and that type of information. There are two what are called accident scenarios that must be reported -- must be evaluated and reported as part of the Risk Management plan and I will now talk about those.

The first one is called the worst case scenario, and it is, in fact, what one would consider to be a worst case. The regulation requires that the company identify the largest quantity of the covered chemical in the single largest container.

In the case of Bayer Cropscience, it's reported to be 200,000 pounds of methyl isocyanate. That does not necessarily mean that that is the largest quantity on site. The contents of the day tank would be additional, possibly. The contents of the piping systems

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and other components might increase this, but the single largest container at the Bayer Cropscience facility is 200,000 pounds.

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The worst case scenario requires a 4 computer model analysis to determine how large 5 of a plume would occur and the extent that 6 7 that plume would travel in the community should that entire 200,000 pounds of content 8 be essentially instantaneously released. Now, 9 there's some variations, but it's within a few 10 minutes. Might well it's 11 as assume 12 instantaneous.

13 In the end, it requires that you assume that it releases and it goes out in all 14 15 directions. Ιt ignores the typical wind 16 direction of the facility and other wind conditions. Ιt does specify specific 17 wind conditions, but it assumes it's going outward 18 19 in all directions at some specific wind conditions and terrain conditions. 20

21 In the case of the Bayer 22 Cropscience facility, more than 300,000 people

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would be affected within 25 miles of this release. 25 miles, by the way, is the limits of the computer models. It cannot predict beyond 25, so that is the de facto end point for this particular scenario.

Now, a more logical scenario that is required by the Risk Management plan or the program that is written into the plan is what is called the alternative scenario.

10 That is a scenario that the company 11 determines to be -- and I'll use the term 12 credible, the most credible scenario -- and 13 they evaluate their piping systems. They get 14 credit for their management systems and their 15 controls and other devices. The company then 16 identifies what could be a credible scenario.

of 17 Tn the case the Bayer Cropscience facility, it's effectively a leak 18 19 in a flange on a pipe in the methyl isocyanate in facility. 20 system somewhere the It's predicted to release 125 pounds of gaseous 21 this 22 methyl isocyanate in over and

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scenario, there is credit taken for the wind direction, so the end point is based on the average wind direction or the prevailing wind direction within a year in this facility. They don't report what direction that is, but it is the prevailing wind direction.

In the case of methyl isocyanate, it's 58 people would be affected by the chemical within just under a half a mile in the prevailing downwind direction.

11 So those are two important elements 12 that are put into the EPA Risk Management Plan 13 document as part of the EPA Risk Management 14 Program, which is 40 CFR 68, for anybody that 15 wants to read up on it.

16 With that, we'll talk about methyl 17 isocyanate issues. I think most of you are 18 here for this reason.

The investigation team is working on and we will be looking at the on site inventory, this 200,000 pounds or more is a large inventory. It is the only inventory of

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this quantity in the United States.

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2	We will be asking Bayer Cropscience
3	to provide us some of the bases for why they
4	consider that inventory to be safe and
5	manageable and controllable. That is something
6	we will be looking at and we will be reporting
7	to the Board in our final report our findings
8	on that issue.
9	We also will be looking at the
10	methyl isocyanate day tank at the methomyl
11	larvin unit and its proximity to the explosion
12	epicenter. It was about 80 feet away.
13	We will be looking at the adequacy
14	of the safeguards that would prevent or
15	mitigate a toxic release of methyl isocyanate.
16	Again, preventing it that's the
17	first goal. Don't let it get out of the pipe.
18	If it does get out of the pipe, the next
19	critical element is to mitigate it. What can
20	be done? What is done?
21	Water is a good mitigator for
22	methyl isocyanate when it's being released
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because it does break down. Fire is a good
 mitigator for methyl isocyanate releases
 because it burns. There are other ways to
 mitigate. You contain it. You control it.

Ultimately, of course, ideally, is 5 there an alternative to storing such large 6 7 quantities of methyl isocyanate? There are industries -- there is at least one company in 8 the United that actually produces 9 States 10 methyl isocyanate and uses it as quick as it's produced so that at any given time, there are 11 only a few pounds of MIC in their production 12 13 unit at any given time.

alternatives. There They're 14 are complex, though. We can't just stand here and 15 16 say they need to do that. There are economic and other issues that 17 issues have to be addressed and we will be looking into that as 18 19 part of our investigation.

facility, just 20 At the а quick the large quantity is 21 summary, stored underground in the methomyl production unit on 22

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the east side of the plant. As I said, the single largest container is 200,000 pounds in presumably, an underground tank.

How do they handle methomyl? I'm sorry -- MIC, Methyl isocyanate. How is handled? How is it controlled? How it is safely handled? They have operated a plant a long time. Bayer is not the only operator of this plant. It was Union Carbide, then Rhone Poulenc, etcetera.

They do pump it to the production 11 on a daily basis. They use 12 units jacketed 13 piping, which is a pipe in a pipe. That way, if the internal pipe that contains the MIC 14 15 were to spring a leak, it's captured in an outer pipe. This jacket space between the two 16 pipes has leak detection devices to monitor, 17 do we have a leak in the pipe? 18

19 The transfer piping is drained and purged it's 20 nitrogen after used, so the transfer piping, the long runs of transfer 21 piping, typically do contain methyl 22 not

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isocyanate, except for the time that it is transferred from the production unit to the end, to the receiving unit.

Finally, on the long runs of pipe, 4 limit the quantities that could 5 to be released, there are multiple valves 6 in the 7 pipes, such that they can isolate shorter sections of pipe, to again, reduce 8 quantities should a segment of this long run -9 10 - in some cases, they may be 2000 feet long because they're going from the east end of the 11 unit to the west end -- so minimizing the 12 13 individual quantities and having isolation valves is a way to help control that risk. 14

There are other features with the 15 16 methyl isocyanate day tank in the methomyl larvin unit that are important to its safe 17 operation. First of all, it's a stainless 18 19 steel pressure vessel that contains this liquid. The vessel is eight feet in diameter 20 and 19 feet tall. It is rated for up to 75 21 pounds per square inch gauge for its maximum 22

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1 pressure.

2	This day tank holds up to 37,000 pounds in any
3	full filling for the daily use.
4	Two units use this, the FMC unit
5	and the methomyl larvin unit.
6	At the time of the incident, there
7	was 13,800 pounds in the MIC day tank. I'll
8	come back to the picture and give you a little
9	bit more detail on that previous slide.
10	On this slide, this shows the
11	location of the MIC day tank with relation to
12	the residue treater explosion epicenter. That
13	is about 80 feet t the southwest of the
14	epicenter. Primarily, the liquid came out of
15	the residue treater in the direction of the
16	MIC day tank and the residue treater went to
17	the northeast into the unit, as you saw in
18	those earlier pictures.
19	It was a violent destruction that
20	occurred. Then, of course, an immediate fire
21	that occurred in the unit. There was some fire
22	in the roadway due to pooling of flammable
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1 solvents, but there is no indication that 2 there was direct fire over at the MIC day tank area, as show in this picture. Although, there 3 was some heat exposure, but not direct fire. 4 This is another shot of the MIC day 5 tank. This view is looking to the southwest, 6 7 so in the hills -- way in the background is Saint Albans, for those of you who 8 are familiar with the area. 9 10 The MIC day tank is underneath that structure, that steel structure. The residue 11 treater would have been in the lower right 12 13 hand corner of this picture, some 80 feet In this picture, you can see there's 14 away. 15 some additional interferences between the day 16 tank and the residue treater that would have

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toward the MIC day tank.

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had to have been compromised if the residue

treater had traveled the opposite direction

perspective. The MIC tank is on the left hand

side. The residue treater, its location is on

One more view, to give you

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the

the right hand side. The methomyl unit is on 1 2 the extreme right. We looking, are essentially, due west. The control room would 3 have been past the elevated pipe rack there. 4 MIC piping is in some of that elevated pipe 5 6 rack that is sued to transfer the MIC, both 7 from the day tank into the unit, as well as re-filling the day MIC tank from the 8 production unit. 9 10 А few other features. Ιt is а refrigerated and insulated pressure vessel. It 11 has redundant pressure temperature and level 12 13 instruments. If a pressure instrument were to mal-function, there's a second one as a back-14 15 up. 16 There are area air monitors and alarms within the methomyl larvin unit 17 and around the day tank. 18 19 There is an emergency dump tank on the MIC day tank system that is sized such 20 that it can hold the entire contents of the 21 day tank and all of its associated transfer 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W.

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piping should one or more of those devices become compromised, spring a leak. The unit operators have the ability to rapidly transfer the contents into a back up tank to prevent any further release or to prevent a release if, in fact, there's something that is near releasing.

Finally, there's a concrete liquid 8 containment wall liquid 9 or concrete а containment wall, around the base of this tank 10 that is the capacity of -- that containment 11 area is enough to hold the entire contents of 12 13 the day tank should it leak and the leak cannot be stopped. 14

By controlling it, you don't want it to spread. You control it and there's some control on the boil off that is helpful to mitigating the release.

Finally, the blast blanket debris shield that surrounds the day tank. That blast blanket debris shield was installed in 1982. In 1994, the then-owner, which I believe was

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Union Carbide, installed the top section above 1 2 the vessel. The squirrel is showing that in the picture. 3 So that's above the vessel and that 4 protects the piping, the relief system above 5 6 the vessel. That top section happens to be 7 larger wire rope diameter than the original sections. 8 2008, after the explosion of 9 In 10 August 28 -- sometime in the early fall of 2008, Bayer Cropscience removed the existing 11 wire rope blast blanket 12 as part of the 13 refurbishment of that vessel and they day tank system and replaced the sections with, as we 14 15 understand, a larger wire rope diameter. We 16 understand it's on all sections. All of this is some of the areas that we are continuing to 17 look at. 18 19 That tank is in service. Something 20 AUDIO TECHNICIAN: is wrong. Pick up that other mike. 21 This 22 MR. VORDERBRUEGGEN: is one **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W.

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1 taped to the floor. 2 AUDIO TECHNICIAN: Let this. Want to use that one? 3 4 MR. 5 6

VORDERBRUEGGEN: Is this mike coming in okay? Can everybody hear me now? Okay, I'm seeing some hand waving. That's a 7 good sign. Okay, thank you. 8 Let's look at a close-up of the 9 10 blast blanket itself. The picture on the left is actually what it looks like. It's heavy 11 wire rope, as I said. It's a very heavy steel 12 13 blanket. The 14

picture the right on is 15 actually the framework that this blanket hangs 16 on. What you see in that picture is the actual MIC day tank that was behind it. This was 17 removed so that Bayer could refurbish and 18 19 clean up.

The insulation is removed in this 20 They re-insulated and they put it picture. 21 back in service because the FMC unit still 22

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needs the methyl isocyanate. So it operates
 today.

These three pictures 3 are representative of the kind of debris that we 4 observed in the area near the MIC day tank. 5 The picture on the left -- there's electrical 6 7 wire. There's conduit. It's liqht weight, small stuff, that type of thing, but a mess. 8

9 The top right hand picture was a 10 control valve in the methomyl larvin unit that 11 was thrown 60, 70 feet possibly. It probably 12 weighed 100 pounds.

In the lower picture on the lower right is another small valve that probably weighed two or three pounds. It was 60, 70, 80 feet away from the methomyl larvin unit.

MIC storage issues. 17 So the The question remains, is it appropriate to have 18 19 centralized production as they currently operate? They make MIC and distribute it. Or 20 could it be locally made at the unit and 21 22 consumed?

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locally 1 Whether it's made or 2 immediately or locally consumed made and stored in much smaller quantities, that's a 3 4 question that the investigation team is looking into and will be reporting on to the 5 Board as part of our ongoing investigation. 6 7 There are some advantages and there are some disadvantages, and there are some 8 questions. It could or would reduce storage 9 10 inventory. It might require more locations to handle phosgene. 11 Phospene is one way to make methyl 12 13 isocyanate. So now, you might have multiple

14 locations of a phosgene production. It may be 15 small quantities, but the more you have to 16 handle, the more equipment you have to have, 17 and the greater the chance of an issue.

Chemistry is available that might eliminate phosgene, so there's many questions to be addressed as part of our investigation.

21 We do know that there is continuous 22 produce in use. In fact, there is a history

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related to the Kanawha Valley. DuPont ultimately moved their operation and they implemented in LaPort, Texas in their facility back in 1985 -- they eliminated the need to transport MIC via rail car.

Prior to 1985, they transported 6 7 rail cars full from the northeast, not from this community but from the northeast part of 8 the country, all the way to LaPort, Texas to 9 10 make the final products. They now make and consume MIC in a very small section of the 11 There's only 12 piping system. а few pounds 13 available at any given time.

In fact, DuPont patented this process and received an award in 1987. So we will be looking at this technology and we will be considering that as it applies or could be applied at the Bayer Cropscience facility.

With that, we'll move one more time into the unit operations as it relates to PSM and RMP, and Ms. Catherine Corliss will come up and present this section. Thank you.

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1	MS. CORLISS: Thank you, John, and
2	good evening, ladies and gentlemen.
3	I will be talking about unit start-
4	up issues with respect to equipment, the man-
5	machine interface used, fatigue, and
6	procedures, and then evaluate all of this with
7	a perspective from the OSHA process safety
8	management standard and EPA's Risk Management
9	Program, which you've already heard about.
10	There were many unit issues to deal
11	with the week of the explosion related to a
12	start-up after an extended shutdown and a new
13	computer control system on a complex sensor
14	process was installed.
15	I will talk about some of the more
16	important issues relative to the residue
17	treater. To begin with, the instrument drip
18	system was redone during the shutdown, but a
19	valve wasn't installed on one of the pressure
20	taps. Instead of a drip, there was a steady
21	stream of a solvent, MIBK, going into the
22	column.

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This put excess MIBK in the column and dropped the level of MIBK in the supply tank, which was something that was noticed in the process of troubleshooting this issue. Because the instrument drip system wasn't working properly, there was dilution going on that made the column operate poorly.

8 MIBK Hexane column temperature and base liquid 9 level controls were still in need of 10 adjustment on Thursday because of what had 11 happened prior to that day.

personnel 12 Unit were working on 13 these controls both Wednesday and Thursday. In fact, the controls in 14 were manual, not automatic control, on Thursday evening because 15 16 all the adjustments had not been made.

That is not unusual in a start-up situation, but I am sharing those details with you so that you will understand what unit personnel were dealing with as they were working that week.

Because of these control problems

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1 and the extra MIBK that the column had, the 2 column itself was not in its normal steady state operation on Thursday. The solvents were 3 mixed to a certain degree, which affected 4 other process steps in the crystallizer, the 5 6 centrifuge, the flasher, and ultimately, the 7 residue treater. Process controls were also an

8 Process controls were also an 9 issue. Valves, flow meters, and ratio 10 controllers are different with the new Siemens 11 operating system, and they all had to be 12 adjusted.

13 Solvent flow was lower than desired 14 during the solvent run, which preceded the 15 start-up. This is a normal way to go about 16 commissioning a process after it's been done 17 and empty.

But there was a problem, as will occur in any start-up -- several problems, to put it mildly. There was a blockage in a valve that took awhile to trouble shoot and correct. Because of that blockage, the flow wasn't

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adequate during the solvent run in some areas of the process. Because of that, final adjustments to the controls had not been made prior to start-up. These adjustments were ongoing on Thursday.

And then, finally, two centrifuges 6 7 are typically run in the unit and two centrifuges are needed to increase the level 8 in the crystallizer to its normal operating 9 10 range. With one centrifuge down, which was the case for the majority of the start-up, it was 11 necessary to run the system at a lower than 12 13 normal rate.

This affects the methomyl content in process flow streams leading to the flasher and hence, the residue treater.

The new control system had totally different screen images. The Honeywell system showed bars for process variables, while the Siemen system showed real equipment images with process measurements on those.

There were six screens available to

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1	this particular unit's operation. One of them
2	was dedicated to alarms, which left five
3	screens to monitor unit operations.
4	Some equipment, however, would need
5	as many as three screens to effectively
6	monitor the process during certain situations.
7	That makes it problematic having just five.
8	Three overview screens were created
9	just the week prior to the explosion because
10	operators identified a need for them.
11	Processing speed is much improved
12	with the Siemens control system, however the
13	user interface is slower. The user interface
14	was changed. With the Honeywell system, an
15	operator would type on a keyboard certain
16	control sequences and they would occur.
17	With the new system, a mouse would
18	be used to click on a device on the screen and
19	then a value would be typed in and then the
20	system would respond.
21	There were other issues with the
22	ratio controls during start-up. The process
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were different. 1 measures The Honeywell had 2 used percent volume or percent range, while the new Siemen's system used engineering units 3 4 like gallons or pounds. This meant that operators were looking at different numbers 5 than they were used to seeing. 6

Overtime rates had been high for 7 more than a year in the methomyl larvin unit. 8 For June through August of 2008, the average 9 10 overtime rate for the trained operators, excluding the trained 11 new operators 47 operators average overtime rate 12 was 13 percent.

To make sense of that, if you were working 47 percent overtime, your 40 work week would be 59 hours for three months in a row. Some operators even worked 60 to 70 hours per week.

Research has shown that fatigue has negative effects on performance. Fatigue can cause certain behaviors that may have played a role in the accident.

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1	Impaired judgement, impaired
2	decision-making, task-shedding, and cognitive
	tunneling are possibilities. Task-shedding
3	
4	means that you would not be doing certain
5	tasks that you typically would do when
6	overwhelmed and tired. Cognitive tunneling is
7	a term used to describe a fixation on one
8	aspect of a process to the exclusion of the
9	bigger picture.
10	Some of the decisions made and not
11	made by all unit personnel, not just
12	operators, in the days before the explosion
13	affected the residue treater. Fatigue may have
14	played a role in these choices and it's an
15	ongoing investigatory topic of concern.
16	We've talked about the residue
17	treater to some degree already. I want to make
18	a couple points.
19	The system was not capable of
20	attaining the target temperature without the
21	addition of methomyl containing residue, as
22	mentioned before and called flasher bottoms.
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The heater gets it close to the operating temperature, which is when the decomposition will occur when the methomyl contained fluids are introduced.

5 In the past, start-ups would get 6 the temperature within 5 to 10 degrees of the 7 required temperature, as found in the 8 operating procedure, and then methomyl containing residue would be introduced, and 9 10 the exothermic, or heat-producing reaction, would occur and raise the temperature to the 11 point, 12 set found in the operating as 13 procedure.

There was a work-around in place, which involved bypassing a temperature interlock to open the flasher tails speed valve and introduce the methomyl containing residue to the residue treater.

Now, I'd like to talk about operating procedures. The procedures had not been updated to reflect the switch from the Honeywell system to the Siemens system. This

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was not just a name change issue.

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2	For example, in the past, if you
3	wished to bypass a safety interlock, you would
4	do what is called pinning a relay. That is
5	actually introducing a physical object into an
6	electrical device that moves to prevent that
7	movement from occurring.
8	Now, if you wished to bypass an
9	interlock, you need a password, you access the
10	control system, you've got the required
11	authorizations, and then you can change the
12	computer logic.
13	Inputting the proper ration for the
14	MIBK hexane column is also not in the
15	operating procedure. As mentioned, that caused
16	difficulty during this start-up.
17	There are other changes required by
18	earlier process hazard analyses that were not
19	reflected in the operating procedure as well.
20	Both the process hazard analysis
21	and the operating procedures specify the
22	importance of the residue treater methomyl

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1 concentration to not exceed half a percent. 2 Yet, sampling was not done or required to 3 ensure this was the case. Sampling wasn't done 4 at the residue treater. It could only be done 5 at the flasher feed and the discharge of the 6 residue treater. I will talk about this more 7 in a minute.

8 Now, we will take a look at these 9 issues from a regulatory perspective. The 10 Institute site is covered under both OSHA's 11 Process Safety Management Program and EPA's 12 Risk Management Program. The first I'll call 13 PSM and the second, RMP.

This particular unit is covered by 14 15 PSM because it has more than 250 pounds of methyl isocyanate and more than 100 pounds of 16 phosgene. It's also covered by RMP due to the 17 phosgene, MIC, and flammable solvent 18 19 inventories maintained in the unit.

Both of the programs are similar and they simply intend to prevent the unexpected release of toxic, reactive, or

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flammable liquids and gases. They require the
 same actions by covered facilities.

They do have different а 3 perspective. OSHA has an employee focus. It's 4 also referred to looking inside the fence 5 looking line. EPA has а community focus, 6 outside the fence line at what the facility 7 might release to the community. 8

Both of them, I'll refer 9 to as 10 requiring, as we talk about the subsequent elements. Process hazard analyses are studies 11 that are intended to identify, evaluate, and 12 13 control hazards in a process. А team of knowledgeable people will conduct 14 such а 15 study. It's required that recommendations that 16 come from these analyses are resolved in a timely and the resolutions 17 manner are documented. 18

In this case, audits have revealed that the Bayer process hazard analysis did not evaluate or control the hazards identified. The operating procedures did not provide clear

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instructions for safely conducting activities
 involved in each covered process.

We've talked about the residue treater and the sampling that did not occur. That's what I'm talking about.

And the operating procedures shall 6 7 address, at least, the following elements, including start-up following a turn around. 8 operating procedure for 9 The the methomyl 10 larvin unit had been out of date since October 2007 regarding the control system of 11 and considerably longer for recommendations that 12 13 had resulted from process hazard analyses.

We've already talked about the residue treater temperature as specified in the operating procedure being unachievable. The workaround that was used on start-ups was not included in that procedure.

Both the process hazard analysis and the operating procedure identified the need to keep the methomyl content in the residue treater below a certain value to

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was not done to ensure that that happened.

start-up safety reviews 3 Pre are another element of both PSM and RMP. 4 They require operating procedures to be in place 5 6 and adequate before you start up a unit. In 7 this case, the operating procedure was not revised for the control system change so it 8 considered in place, 9 not nor it was was 10 adequate for successful operation of the residue treater. We've already talked about 11 the work around. 12

Management of change is another element of these programs. It is a written procedure that requires change to be managed for technology and equipment and personnel. It requires operators to be trained in the change prior to start-up.

The written procedure to manage change covers these elements, yet the work around had not been included in a review as required by the management of change

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1 procedure.

2	Bayer assumed that familiarity with
3	the Siemens system on the larvin unit and a
4	brief review of a few other significant
5	changes for the methomyl process was adequate
6	training for methomyl unit operation with the
7	new control system.
8	In fact, it was not adequate. The
9	methomyl process was not a batch process like
10	the larvin. It was, rather, a continuous
11	operation, more complex and more sensitive to
12	upset conditions.
13	We've already talked about the
14	changes to the screens that the operator used
15	made as recently as a week before the
16	accident.
17	PSM and RMP both require action
18	items to be followed up on. Action items
19	result from these programs from process hazard
20	analyses, incident investigations, and
21	compliance audits. What they specifically call
22	for are action items to be promptly addressed
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1 and resolved and documentation of that 2 resolution.

Bayer's action tracking system was lacking. A response plan was not created over the past years. Actions were not tracked and documentation of resolution and corrective actions did not occur. There were a number of open high priority action items at the time of the explosion.

For example, there were more than 25 open action items from a process hazard analysis conducted in August of 2004. That was five years earlier and wouldn't be considered prompt treatment to have not been corrected in that period of time.

16 Finally, documentation of the also inadequate. 17 corrections was In many responses to some of these action items in the 18 19 system used, it's unclear whether plans made to correct the items were actually executed. A 20 plan is fine, but it has to be completed to 21 consider item the action being properly 22

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1 resolved.

2	Now, Mr. Vorderbrueggen will
3	complete the presentation by talking about the
4	investigation path forward.
5	MR. VORDERBRUEGGEN: Thank you, Ms.
6	Corliss.
7	It's been a long night, so I'll go
8	through these quickly. Most of these have been
9	addressed or at least mentioned. Please bear
10	with us. We hope it's useful.
11	The investigation team is going to
12	continue identifying additional documentation
13	that is needed for our investigation and
14	request that from Bayer.
15	We will conduct follow up
16	interviews with some site personnel. They'll
17	be some new interviews and we may be talking
18	to some additional emergency response
19	individuals in the community.
20	We will continue collecting
21	information on the community impact. We will
22	acquire the missing methomyl larvin unit's
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security camera and MIC monitor data that we
 just became aware of in recent days.

Then, the meat of it is to review 3 design documents associated with 4 the the methyl isocyanate operations. We do intend to 5 run some air modeling to predict what kind of 6 7 chemical release might occur in the impact zone. We intend to do some chemical testing on 8 some of the samples we collected back in the 9 10 fall.

Of course, ultimately, the team will develop the report and the formal written recommendations for consideration by the Board at the end of our activities in a format similar to this, and hopefully, a vote at the public meeting.

17 So with that, Mr. Chairman, I will 18 turn the floor back over to you and if the 19 Board has any questions, we're ready to 20 respond.

21 BOARD QUESTIONS

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MR. BRESLAND: Thank you, Mr.

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Vorderbrueggen. We thank the team for your
 excellent presentation.

Let me ask the Board members. We'll start with Board member Wark. See if they have any questions.

MR. WARK: Thank you, Mr. Chairman. 6 7 In the interest of time, I am not going to ask a bunch of questions. I have a bunch of 8 regarding 9 questions emergency planning 10 preparedness and response, and at some time in the future, I'd like to be able to discuss 11 this with the appropriate personnel regarding 12 13 what happened here, talk to the LEPC's, talk about on-site, off-site emergency planning, 14 15 and how that can be hardwired together -- the 16 same as in an area that I worked in quite a bit, the radiological emergency preparedness 17 around commercial nuclear 18 programs power 19 plants, and what applications there might be there. 20

Finally, I would just mention that in this regard, I'm happy to say that we are

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completing -- one of our videos is going to be 1 2 planning preparedness on emergency and response. We would hope that some of the 3 lessons learned here, we'll be able to take 4 nationally and be able to protect and assure 5 6 the health and safety of people across the 7 country. Thank you. MR. BRESLAND: Board member Wright? 8 MR. WRIGHT: I too, in the interest 9 of time, will forego any questions. Most of 10

mine are technical in nature, and I'll discuss those with the staff at headquarters. Thank you.

MR. BRESLAND: Thank you. Let me just ask a couple of questions. How many air monitors are located on the fence line of the property and what was their status in the time of the incident?

19 MS. SCIALLO: There are three monitors on the perimeter of the facility. The 20 Chemical Safety Board has received results for 21 monitors two of the three that 22 were

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operational on the night of the incident.

MR. BRESLAND: One clarification 2 question for Mr. Banks, which is on slide 34, 3 where you talk 49 minutes into the incident, 4 Bayer recommended -- I don't remember 5 the exact wording, but there was a recommendation 6 7 for a shelter in place. Can you just clarify that? I think there may be some issues or 8 differences of opinion or I didn't 9 maybe 10 exactly understand what you said. MR. BANKS: Okay. At 49 minutes into 11 incident, the Bayer incident commander the 12 13 recommended to Bayer emergency operation center to issue a shelter in place for the 14

This was based on his observations of a pool fire that was advancing towards a warehouse where methomyl was stored. This wasn't based on any electronic monitors or feedback from monitoring systems.

Saint Albans and Nitro area.

21 MR. BRESLAND: So it was a 22 communication that went from one part of the

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106 1 Bayer facility to another part? 2 MR. BANKS: Yes. MR. BRESLAND: But then --3 MR. BANKS: Yes. I'm sorry. I didn't 4 complete that. The Bayer IC relayed that to 5 6 the Bayer EOC and asked that that information transferred 7 be to Metro 911. That unfortunately wasn't done. 8 BRESLAND: So that information 9 MR. 10 was not transferred, so that did not ever --MR. BANKS: Yes. 11 Okay, thank 12 MR. BRESLAND: you. 13 Thank you. Did Bayer have any portable monitors and were 14 they used on the night of the incident --15 16 portable monitors for chemicals in the atmosphere? 17 MR. BANKS: Not that I'm aware. We 18 19 have no evidence that we found to indicate that. 20 PANEL TESTIMONY AND BOARD DISCUSSION 21 WITH 22 PANELISTS **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W. (202) 234-4433 WASHINGTON, D.C. 20005-3701 www.nealrgross.com

1	MR. BRESLAND: Do we have any other
2	questions from the Board members? Thank you.
3	We will now move along to our panel
4	discussion. Actually, by shortening the Board
5	member questions, we're back on schedule
6	again, I'm happy to say. Thank the Board
7	members for that.
8	Let's start with the panel members
9	on we asked them to do a four or five
10	minute presentation on the issues that they
11	see coming out of this investigation. We'll
12	start with Mr. Sterling Lewis, who was
13	appointed as the state fire marshal on May 1,
14	2000.
15	We've had a very professional
16	relationship with Mr. Lewis over the last
17	couple of years on investigations that I've
18	been doing here in West Virginia. We very much
19	appreciate his help. Mr. Lewis?
20	MR. LEWIS: Thank you, Mr. Chairman.
21	Members of the Board, members of the team,
22	investigators. Again, Mr. Chairman, I would
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like to thank you for the privilege to get to work with your investigators -- some of the most professional, knowledgeable individuals that I get to work with at the state fire marshal's office. We certainly appreciate that.

Along with my duties as the state 7 fire marshal, I am also the director for the 8 regional response teams in the state of West 9 10 Virginia, which we cover HazMat and WMD 11 mitigation, mass casualty, USAR with West Virginia Task Force 1, which all falls under 12 13 the umbrella of the Governor's Mobile Response Units. 14

On the night of the incident, I 15 16 received a call from the West Virginia Department of Homeland Security and Emergency 17 Management advising me that Metro 911 had 18 19 called them and asked for the regional response teams to be put on stand by. That's 20 our process. The county calls the state and 21 22 then the state director Jenneta and I, we work

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together to decide whether we're going to
 respond the units out.

asked the emergency management 3 Ι 4 operator why do you want regional response team assets? She advised me that she did not 5 know, that Metro 911 called and said they need 6 7 the regional response team on stand-by, but they didn't know what the problem was, but 8 they knew that it was a Bayer Cropscience 9 10 plant.

11 At that time, I advised her I would 12 respond personally to the incident to see if 13 regional response team assets were needed.

In my response, coming in from Nitro form the west end, coming into the plant, I was in a tremendous amount of smoke and could smell unusual stuff that you don't smell when you go through Nitro usually.

At that time, I got on the radio with Metro 911 and asked -- which is a normal question when we do a HazMat response -- what are we driving into? What are we responding

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to? Again, this was 15 minutes after I had departed my residence. We do not know -- 1770, which is my unit number -- we have not been told yet.

arrived 5 Т on scene at Bayer Cropscience and pulled up to the gate and of 6 7 course, showed my identifications and my badge. I was asked to turn over and park on 8 the side, that someone would call me, and they 9 10 did. The Response I got was we have had an explosion in the larvin unit. We have 11 one individual being 12 that is transported bv 13 ambulance, and we have one individual that is unaccounted for. 14

15 After approximately 40 minutes that 16 we got into the plant, into the plant's EOC, we were ushered into a room, a number of us. 17 We waited approximately 20 minutes at that 18 19 point in time to get someone to us and we asked what is going on. I got the response of 20 we had an explosion in the larvin unit. 21 We 22 individual being transported have one by

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ambulance and we have one individual
 unaccounted for.

At that time, I figured I didn't have enough information that I needed, so I went back out to where the first responders were because they were the ones that were actually responding into the units and coming back out and changing manpower in and out.

9 To make Response short and leave 10 time for the others, at the end of the night, 11 I knew no more walking into the aftermath than 12 I knew driving up the Interstate 64, and that 13 was approximately six hours later.

I advised the company that I would not remove the victim until daylight. They asked, since they were having shift change, that the men that were coming into work were a little uneasy about it and I understand, so I agreed with -- Mr. Janetta and myself, we went into the situation.

I asked if the environment we were walking into was a safe environment. I was

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1	assured that it was and we went on that
2	assumption because they were the
3	professionals.
4	After that, the West Virginia state
5	medical examiner came in and did what they
6	needed to do and removed the victim. I'll be
7	happy to answer questions.
8	MR. BRESLAND: Thank you, Mr. Lewis.
9	Do we have any questions? Board member Wright?
10	MR. WRIGHT: Marshall Lewis, I'm
11	just curious as to whether in your
12	professional opinion, you thought that your
13	denial of access was for your own protection
14	or a situation based upon the fact that maybe
15	they didn't know what situation they had going
16	in there?
17	MR. LEWIS: I could have gone that
18	way, but I'm sort of like Dr. Phil. This is
19	not my first rodeo.
20	It was a very rehearsed speech that
21	I got from every employee at Bayer
22	Cropscience. They train their employees well.
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1 I wish I could train my fire marshals that 2 well.

But no, I don't think there was any 3 mistake. I'm not sure they knew exactly the 4 situation they had because when I looked at 5 6 the destruction inside there, Ι knew immediately that all the destruction there was 7 way above the pay grade of any of my fire 8 marshals and knowledge of my fire marshals, 9 10 and that's why I'm so glad to have the team come in because we relied and always do, on 11 their expertise. 12 13 But no, I don't think it was just a mistake. 14

MR. WRIGHT: Thank you.

16 MR. BRESLAND: Just quick one question. You may not be exactly the right 17 person to ask, but what sort of HazMat, 18 19 outside HazMat Response capabilities would there be in the area for a situation like 20 this? 21 Are you saying other 22 MR. LEWIS:

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1	than the regional response teams?
2	MR. BRESLAND: Well, maybe including
3	the regional response teams.
4	MR. LEWIS: The regional response
5	teams are made up of 19 units around the state
6	of West Virginia, geographically located to
7	respond.
8	There are a number of our fire
9	departments and we're very lucky in the valley
10	that with our fire departments we have here in
11	the Kanawha Valley they make up a large
12	number of those HazMat Response units.
13	We were able to pull out one unit
14	and we did air monitoring around the perimeter
15	because we wanted to be sure since we
16	couldn't find out what was going on inside, we
17	wanted to be able to protect the citizenry on
18	the outside. We set up our air monitors
19	outside the plant. Luckily and by the grace of
20	God, we had nothing that registered on our
21	monitors.
22	MR. BRESLAND: Okay, thank you.
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1 Let's move on to Mr. Dale Petry, who currently 2 serves as the director of Emergency Management Services for the Kanawha County Commission. 3 4 Mr. Petry? PETRY: Well, first of all, I 5 MR. would like to also thank you the Board and the 6 7 investigative team for what I thought was a very informative investigation. I'm just glad 8 that they saw it necessary to come and do the 9 10 investigation for us. role as the emergency county 11 My director 12 emergency services is or to 13 coordinate response efforts, to protect life, property, and environment. 14 15 Effective communication is imperative to fulfill this mission. 16 28, 2008, our public 17 On Auqust safety forces was prepared to do whatever was 18 necessary to protect human life and assist 19 site mitigating 20 Bayer's Institute in the emergency situation within their compound. 21 Unfortunately, Bayer's 22 lack of **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W.

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communication that night undermined our best efforts unnecessarily. I'm disappointed to report to you that I learned more about the explosion and fire at the Institute site from sitting in the hearing in Washington, DC this week than I did during the incident and the days that followed.

However, I will report to you that 8 we have learned some key lessons from this 9 10 experience that will ensure that certain events of that evening do 11 not repeat themselves. 12

The Kanawha County emergency plan contains guidelines specific to emergencies inside plant facilities. These guidelines have been developed and updated over the years by emergency services and the Kanawha Putnam Emergency Planning Committee, which includes plant representatives.

20 Chief among these plans is protocol 21 for informing Metro 911 of emergency 22 situations within plant facilities, including

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redundant communication methods. The plan assumes that our chemical plants will call us when an incident occurs on their property -even a minor incident that requires no public warning.

Although a local telephone network 6 was stressed that night due to the huge volume 7 of 911 calls, Bayer has radios tuned to our 8 public safety channels 9 to use as an 10 alternative method of contacting Metro 911 and with to communicate public safety 11 our personnel who respond to plant emergencies. 12 13 Bayer has long participated in weekly tests of this radio system, but did not use it that 14 15 night.

Only after 911 operators called the 16 plant, we finally made contact. We received no 17 information. useful What telephone 18 19 communication we received from Bayer that night came from a security guard at the main 20 gate and was seriously lacking in substance. 21

It was hours into the incident

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before we idea of the chemicals 1 had any 2 involved. This information came too late to take proper actions to protect the public and 3 our first response personnel. 4 After midnight, a plant official 5 reported to our emergency operations center as 6 7 requested. He was less helpful to us than the security guard at the main gate. 8 Bayer been forthcoming with 9 Had 10 accurate information about what was going on inside their compound, we could have initiated measures to warn the public within ten minutes

10 accurate information about what was going on 11 inside their compound, we could have initiated 12 measures to warn the public within ten minutes 13 after the explosion was reported. Their lack 14 of communication delayed those efforts for 35 15 minutes after Bayer refused to tell us what 16 had exploded.

We will not wait on information again. Kanawha County has already instituted a policy that says we will wait no longer than 15 minutes for accurate information about an incident at a chemical facility.

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If we're not getting information,

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we will issue a shelter in place warning as a 1 2 protect our citizens. precaution to The legislature has followed our lead and that 3 same time limit is now a state law. 4 We have also installed a direct 5 line to the Institute site and I will now 6 7 carry contact numbers for key personnel at the site so that we can bypass the security guard 8 apparently couldn't tell 9 who us anything. 10 These are just a sample of measures that we

11 have taken to improve our Response efficiency 12 and we don't think we're finished.

Despite the crafted public assurances that Bayer intends to correct their communication failures, Kanawha County has been responsive with actions to see that the failures and confusion that night will not be repeated.

MR. BRESLAND: Thank you very much, Mr. Petry. Board member Wark, you have a question?

MR. WARK: Yes, I do. First of all,

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1	I'd like to commend you for the improvements
2	that you're making in your emergency response
3	capability.
4	One question I do have you
5	mentioned that you have a plan, emergency
6	plan. How often do you exercise that plan
7	drill it?
8	MR. PETRY: We drill that plan, I
9	would say, quarterly. We do any improvements
10	that we need to try to make the plan better.
11	We try to continually update our plan on any
12	instances and any failures that we occur.
13	MR. WARK: What's your relationship
14	with the local emergency planning committees?
15	Do you sit on their committees, for instance?
16	MR. PETRY: We meet every other
17	month with our local LEPC, which includes all
18	the chemical plants and emergency response
19	personnel.
20	MR. WARK: Okay, thank you.
21	MR. BRESLAND: I had a question
22	today when we did a news conference this
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and I

2 think you could probably help me with this, Mr. Petry. 3 4 The question was, the 911 operators, when they receive a call about a 5 chemical plant emergency, which is probably 6 7 something that happens with relative frequency here in the Valley because of all the chemical 8 plants, do they have a form that they would 9 10 use to ask questions of the person who is calling in, to try to gather information on 11 exactly what's going on? 12 13 PETRY: Yes, there is a form MR. that they have to look at to try to gather 14 15 information. Unfortunately, that night we couldn't get any of it. 16 MR. BRESLAND: During the emergency 17 on August 28, did you receive any requests for 18 19 a shelter in place from inside the facility? MR. PETRY: No. It was after that we 20

morning. I wasn't able to answer it

21 recommended a shelter in place before we
22 received anything from the plant requiring the

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1 same. MR. BRESLAND: Okay, thank you very 2 much. 3 Next speaker is Mr. Nick Crosby, who is the 4 vice president of operations at 5 the Bayer Cropscience facility. Mr. Crosby? 6 MR. CROSBY: Thank you, Mr. Chairman 7 and fellow Board members. Good evening. 8 I want to speak to you this evening 9 10 not only as an engineer and business leader, of the Kanawha but member Valley 11 as а community here. 12 On August 28, we suffered a tragic 13 accident at the Institute site. I want to make 14 the point perfectly clear. Our employees, our 15 16 neighbors, and the community is and must remain our highest priority. 17 Over the past seven months, Bayer 18 19 Cropscience, the CSB, and others have been working together to examine this incident, to 20 learn from it, and to identify opportunities 21 22 to improve the systems and processes. **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS

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1	We've also been conducting our own
2	investigation. On Tuesday, I took part, along
3	with others in our community, in a
4	congressional hearing on the accident. At the
5	hearing, I discussed our commitment to further
6	engagement with our neighbors and greater
7	community. We will fulfill that commitment.
8	On the night of August 28, our
9	emergency responders did a tremendous job
10	under very difficult circumstances. They
11	followed the communication protocol set forth
12	in our region's emergency response plan.
13	After the fact however, we came to
14	understand that our communications in the
15	initial minutes after the incident fell short.
16	We have apologized for that.
17	Many members of our community
18	became concerned upon hearing an explosion and
19	seeing a fire. They did not receive the
20	immediate reassurance that they were not in
21	danger.
22	We've already taken many
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1	significant actions to improve our emergency
2	communications with the community. For
3	example, we have new procedures for
4	communicating with Metro 911. We have
5	installed a telephone hotline and have new
6	radios to avoid overloaded phone lines to
7	Metro 911.
8	The task of alerting Metro 911 has
9	been re-assigned to our perimeter leader and
10	not a security guard. We have a new checklist
11	of critical information that he should
12	communicate to Metro 911.
13	We have hired an emergency services
14	leader to enhance our coordination and
15	emergency communications with Metro 911 and
16	the community.
17	And we have equipment from 911 with
18	the same real-time computer based system that
19	we use for modeling and monitoring chemical
20	dispersions that we use at a site.
21	During the incident, there was no
22	delay in ordering the shelter in place. The
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1 incident commander promptly assessed the 2 situation, observed the characteristics of the fire, and concluded that no chemicals were 3 being carried beyond the facility. 4 He made the decision that shelter in place was 5 not required and it was the right call. 6 7 Approximately 45 minutes later,

however, he observed that the fire was heating 8 up nearby storage bins. As a precaution, he 9 10 recommended а shelter in place for two neighboring communities. This information was 11 relayed to Metro 911. Post-incident testing 12 13 confirms that only trace amounts of methomyl were able to be found. 14

15 methyl isocyanate MIC or is а critical and necessary building block for the 16 products at the Institute site, which are used 17 in important insecticides that help protect 18 19 crops, both in the United States and around the world. 20

21 Bayer Cropscience and the prior 22 owners of the Institute site have invested

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heavily to ensure that we employ the safest production strategy for chemical processes. We have examined other technologies for MIC and we have determined that our process is as safe as those alternatives.

At no time was any MIC released 6 7 during the incident. We have multiple and redundant layers of protection which, working 8 employees, 9 together, protect our our 10 neighbors, and their community from the harmful release of MIC. Those layers 11 of intended 12 protection worked as during the 13 incident to protect the MIC day storage tank.

We've shared details of these layers of protection with the CSB and other government officials. Above all, the safety of our employees and neighbors from the community remains our highest priority.

We've taken a number of steps to prevent another incident like the one that happened on August 28. We have conducted an extensive internal investigation that

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1 identified the factors leading to this 2 incident.

Based upon the results, we have implemented several measures, including safety improvements, additional operating procedures and safe guards, and an extensive training and compliance regime to ensure that this kind of incident will not occur in the future.

Finally, let me be clear. The Bayer 9 10 Cropscience has fully cooperated with all agencies, including the CSB, giving them our 11 facilities, 12 support, access our to our 13 employees, and their records.

this 14 Ι truly hope my comments 15 evening have helped provide to some 16 clarification to address concerns and to inform about the positive steps we are taking 17 forward. Again, I welcome the opportunity to 18 19 address our neighbors here this evening. We remain committed to the community and focused 20 on the safe operation of our facility and the 21 safety of our employees, our neighbors, and 22

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1 the community.

2 We look forward to demonstrating cooperation with our public emergency our 3 response officials in enhancing an 4 active dialogue with our neighbors. 5 6 Ιf people do have questions, 7 comments, or concerns about this incident, our reconstruction activities or anything else, 8 please do not hesitate to contact us. We have 9 10 established an e-mail address, which is institutequestions@bayer.com to enable us to 11 listen to what you, our neighbors, have 12 to 13 say. We take our responsibilities to our 14 community seriously and we intend to 15 meet Thank 16 those responsibilities. you, Mr. Chairman. 17 MR. BRESLAND: Thank you, 18 Mr. 19 Crosby. Board member Wark, do you have any questions? 20 MR. WARK: Yes, I have a couple. Do 21 you have a -- you know, in the area that I'm 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W. WASHINGTON, D.C. 20005-3701

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1 familiar with the radiological emergency 2 the chemical preparedness program and stockpile emergency preparedness 3 program, there's what we refer to as alert notification 4 which involves 911 ring-down. 5 system, Ιt 6 involves sirens, for instance. Have you been addressing that at 7

all prior to this incident, as far as -- I 8 mean, do you have alert sirens to tell the 9 10 community off-site that something bad is happening and that they should be paying 11 attention to the alert notification system? 12

MR. CROSBY: We have an internal emergency alarm notification system, which is designed for internal use only.

16 When our alarm sounds, we have a duty and we have an agreed protocol whereby we 17 will call Metro 911 and inform them of the 18 19 type of incident. It is our duty to provide the necessary information and the necessary 20 communications to allow Metro 911 to be able 21 relevant actions take the within the 22 to

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1 community.

There are community sirens. There
are systems that are available, but those
systems are managed or controlled through Mr.
Petry and his 911 organization.
MR. WARK: The other question that I
have is, we've heard from the investigators
regarding monitors and I would like to ask you
this.
In your written statement for
tonight's meeting, which you provided to us
yesterday, you said that we monitor for MIC
and there's no indication that MIC was
released the night of August 28. End of quote.
My question is, were all of the MIC
air monitors in the facility turned on and
working properly that night, for your
perspective?
MR. CROSBY: We had an issue with
some local general monitors, which are used to
really detect what I would call very minor
leaks that evening.
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The monitors that we refer to in 1 2 terms of ensuring that our neighbors and our community is safe are our fence line monitors. 3 They pick up a variety of compounds and would 4 readily detect any MIC if it were to leave the 5 6 site. Those monitors that night, detected 7 no sign of any release of toxic chemicals 8 outside of our fence line. 9 10 MR. WARK: And they were operational? 11 MR. CROSBY: They were in operation. 12 13 Yes, sir. MR. WARK: That's all I have, Mr. 14 15 Chairman. 16 MR. BRESLAND: Board member Wright? WRIGHT: Mr. Crosby, how many 17 MR. monitors are around the perimeter of the 18 19 facility? CROSBY: We have a number of 20 MR. various monitors around the facility, two of 21 actually manage chemical 22 which detect _ _ **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W.

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1 activity around the fence line.

2	MR. WRIGHT: So only two of an
3	unknown number of monitors detect toxic
4	chemical activity?
5	MR. CROSBY: We have monitors which
6	are strategically placed, actually permanent
7	monitors on the fence line.
8	We also have a number of portable
9	monitors, which we can take out into the
10	community and can be used to actually detect
11	the same compounds. They can be set up on an
12	as-needed basis.
13	MR. WRIGHT: Okay, so let me get
14	back to the basics. How many monitors do you
15	have that will detect toxic chemicals?
16	MR. CROSBY: We have a total of six,
17	two of those are permanently installed and
18	four of those are mobile monitors.
19	MR. WRIGHT: And none of those
20	detected any toxic releases on the evening of
21	the 28th?
22	MR. CROSBY: We used the two fixed
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monitors, sir, and neither of those monitors 1 2 detected any releases. That's correct. MR. WRIGHT: Would you agree with me 3 4 that the system broke down miserably that evening for your company and your obligation 5 and duty to notify the 911 operator or the 6 7 emergency services center? MR. CROSBY: I think, sir, there's 8 two parts to our response. One thing and I 9 10 will answer the question. The one thing that I am very, very proud of that evening is the way 11 that our emergency squad responded to that 12 13 incident. They did an absolutely fantastic job on the site and I was very proud of them. 14 MR. WRIGHT: I agree with that. 15 MR. CROSBY: What Ι fully 16 acknowledge is communications 17 that our to Metro 911 broke down that evening. That was 18 19 not by design. We believed that we made the right communication protocols. We hadn't. 20 We need to fix it. 21 We've been working with Metro 911. 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W.

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We are, in fact, planning a joint drill towards the end of next month, where we will test the changes and the enhancements and the improvements that we've made to our communication systems.

WRIGHT: My follow up question 6 MR. 7 to you, sir, is do you believe you had adequate information based upon the number of 8 monitors that you employed that evening? Had 9 you had the correct information and shared it 10 with the public that the public would have 11 been safe and possibly assured of their own 12 13 safety, had you shared that with them?

always 14 MR. CROSBY: I've been 15 assured, sir, that the analysis that we 16 carried out at the time of the incident, the way that the incident commander responded to 17 that and the decisions that we made about 18 19 shelter in place were the right decisions. MR. WRIGHT: Thank you. 20

21 MR. BRESLAND: Mr. Crosby, you said 22 that you have two fixed monitors. I've driven

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around the facility and it's quite a large you qivinq installing more fixed monitors as a result of CROSBY: question, Chairman Bresland. We will be reexamining the systems that we've got on-site.

Are

MR.

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Monitors are actually placed, to 9 10 the best of my knowledge, in the areas where closest to the neighbors in 11 we are our 12 community. Ι mean, they're placed 13 strategically for those reasons. They were placed full consultation with the 14 in 15 consultants with whom we purchased the system from with the safety assistance. 16

But we will be reviewing this as 17 part of our incident review of the types and 18 19 locations of our monitors to see whether there are enhancements that can be made, yes. 20

MR. BRESLAND: Are these specific to 21 MIC, phosgene, chlorine? 22

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That's a very

1	MR. CROSBY: They detect volatile
2	organic carbon compounds, chlorine. They look
3	for a number of other components.
4	They aren't specifically designed
5	for MIC, but they would certainly pick up MIC,
6	as well as a range of other chemicals on the
7	site.
8	MR. BRESLAND: What about the
9	portable monitors that you talked about? Are
10	those like drager tubes or more sophisticated
11	than that?
12	MR. CROSBY: They are, in fact,
13	portable versions of the installed monitors.
14	They can be taken out and they can be placed
15	within, I believe, about a three mile radius.
16	They have a radio link back into the safer
17	modeling and dispersion system that we use
18	within out emergency operations center.
19	MR. BRESLAND: Was there a reason
20	they weren't used on the evening of the
21	MR. CROSBY: All of the information
22	we were receiving was that there was nothing
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1 actually leaving the site.

2	We did, in fact, dispatch one of
3	our environmental staff up into the Cross
4	Lanes area to some portable monitoring with an
5	alternative handheld monitor, and he too,
6	confirmed that there was noting being detected
7	at that time.
8	The other one final set of
9	monitoring that we carried out was we did use
10	the offer from the Nitro volunteer fire
11	department. We were using their firefighters
12	that evening to actually walk and patrol and
13	to assess what was actually happening around
14	the fence line. Again, we found no evidence of
15	any release.
16	MR. BRESLAND: Okay, thank you very
17	much. Any other questions? We'll move on to
18	Mr. Michael Flynn, who's with the
19	International Association of Machinists, which
20	I understand is a union that represents
21	employees of the facility. Is that correct?
22	MR. FLYNN: Yes, sir. I would like

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to thank Chairman Bresland for the opportunity
 to express our views on this most important
 matter.

First, on behalf of the International Association of Machinists and Aerospace Workers, I want to remember the loss of two union brothers, Bill Oxley and Barry Withrow, as a result of this August explosion.

9 Going through an investigation of 10 an event of this magnitude to determine the 11 root causes takes time and creates additional 12 stress to their family members, friends, and 13 co-workers.

At the conclusion of this process, 14 15 it is our hope that those two tragic deaths and the subsequent findings will contribute to 16 making work sites safer, not only here in 17 Institute, but throughout the chemical 18 19 industry.

20 On the morning of August 28, I was 21 contacted by Don Holmstrom, an investigator 22 with the CSB. This was my first notification

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of the incident that occurred at Bayer
 Cropscience.

He told me at the time that he did 3 not have the details of the explosion, but due 4 to the manufacturing and storage of the MIC, 5 the chairman, along with four other 6 7 investigators had already departed to the site. He requested assistance in notifying our 8 local union representatives to ensure the CSB 9 10 would have the correct union contacts when they arrived. 11

Through our territorial general 12 13 vice president's office, I was able to contact Joe Gresham, the business representative at 14 15 the facility. He forwarded me the names and 16 the contacts for the local union safety representatives, which I then forwarded to the 17 CSB. 18

Now, this was a normal CSB request, since it is our experience that the Chemical Safety Board involves all parties related to their investigation. This is why I want to

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speak on the subject of the necessity for the Chemical Safety Board to have unfettered access to a plant they are investigating and the ability to involve the workers, the community for that investigation as it's taking place.

Historically, Bayer Cropscience in 7 Institute and our local union have had in 8 place sound functioning safety committees. 9 10 Over the years, the committee has been both proactive and reactive to the issues 11 or raised as resulted to 12 concerns safety and 13 health.

For the most part, throughout this 14 15 investigation, that continued. Our safety 16 committee was involved with the OSHA inspection process, the ATF 17 and the CSB, including interviews of the witnesses. 18

From my perspective though, that cooperative spirit of working together toward a common goal began to be compromised when Bayer Cropscience's legal counsel started

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raising issues that challenged the CSB's
 planned activities under the Maritime
 Transportation Security Act.

injury to 4 То add insult, the company's legal counsel sought out our notes 5 6 the union representatives had taken during the 7 interview process. To respond, we had to legal department resources utilize our in 8 objecting to that request. 9

As I observed this challenge taking place, it became apparent that the critical work of the Chemical Safety Board was also being affected due to their time and resources being spent to respond to legal matters.

I was immediately suspicious of these legal maneuverings, where the efforts of an overzealous lawyer pulling out all stops just to stymie any and all investigation.

The acknowledgment at the recent congressional hearing before the Subcommittee on Energy and Commerce that this was a public relations tactic to prevent negative

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information from being disclosed is in itself most troubling.

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As a union that represents workers 3 America North 4 across in the aerospace, shipbuilding, nuclear defense industries, we 5 are well versed and respect the need to 6 7 protect national security concerns. However, we must be wary of national security concerns 8 being invoked for frivolous reasons such as a 9 10 company's public relations.

work of the CSB, including The 11 public hearings and their final reports, are 12 intended to prevent similar accidents in the 13 future. Whether 14 you are а company, а 15 shareholder, or worker in a plant, or a member 16 in the community where the plant is located, the information garnered from the 17 CSB investigation is not only beneficial, but can 18 19 prevent future catastrophes.

The American public would ultimately pay the biggest price if all companies involved in future Chemical Safety

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Board investigations exercised similar use or misuse of national security

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3 regulations to prevent a thorough and4 transparent investigation.

5 Bayer Cropscience here in Institute 6 has a proud and experienced work force. They 7 have been committed to safety and our local 8 union leadership has built excellent safety 9 committees, negotiated language in collective 10 bargaining contract that serves our members 11 and employees well.

No one cares more about the safety and health than the workers who live in this community, along with their most precious assets, their family and friends.

16 I want to close as I opened and remember that it was Barry Withrow and Bill 17 Oxley who paid the ultimate price. It is my 18 hope that lessons learned from this tragedy 19 will benefit family, 20 their friends, COworkers, and community. Thank 21 you, Mr. Chairman. 22

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MR. BRESLAND: Thank you, Mr. Flynn. I certainly appreciate those comments and I tried to make the same comment earlier this evening and also in my congressional testimony earlier this week.

Just from a practical point of 6 7 view, having worked in the Chemical Safety Board for a long time, but since February 12, 8 when this issue came up, the work of this 9 10 Chemical Safety Board has been directed -- I say exclusively -- but wouldn't closely 11 exclusively to dealing with this legal issue 12 13 that had been brought up and it brought our investigation of this incident and another 14 15 very serious incident that killed 14 employees 16 in Georgia, basically to a halt, so I really appreciate your comments. Thank you. 17 Board member Wark? 18

MR. WARK: Yes. I have a couple of questions. The CSB investigators noted that fatigue was a potential factor in the accident with operators working 12 hour shifts many

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1 days in a row and sometimes up to 18 hours at 2 a time.

I would like to know your view on 3 operator fatigue as an important safety issue 4 for the industry in general and also, to what 5 extent you would condone this extra overtime, 6 7 which having grown up on a farm, I know you work 12, 14 hour days for a long time and you 8 get pretty loopy, so what do you have to say 9 10 about that? MR. FLYNN: Well, first of all, each 11 of our contracts are locally negotiated. 12 The 13 overtime rules, the rotating shifts, the longer days are determined by our membership 14 15 in a democratic fashion when they negotiate 16 and vote on their collective bargaining 17 agreement.

With that said, any critique, any investigation -- all the cards go on the table, and not all the time it's comfortable for a lot of parties. It's just not the company.

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1	There are times that we have to
2	look at ourselves. We do an awful lot of
3	training, HazMat emergency response training
4	for our members and joint labor committees.
5	The biggest part of that is to look at our
6	entire process and work product.
7	There's lessons learned.
8	Now, Mr. Crosby said that they had
9	completed an investigation. Well, that
10	investigation our members participated in,
11	but I would say the investigation is not
12	complete until all the data is in from all the
13	investigative bodies.
14	That issue certainly rises to the
15	top and it's an issue that we deal with
16	throughout the union. Especially in an economy
17	like today, it's cheaper to pay somebody for
18	12 hours than to hire an additional body. A
19	lot of times, it's driven. The economy drives
20	that.
21	At the same time, people need to
22	work it. If the second wage earner in the
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1 family has lost their job, they're going to all 2 the overtime. With the take other pressures going on, a lot of times it becomes 3 an economic issue. 4 But it should be looked at 5 iust like any other issue needs to be looked at, in 6 7 a very transparent and candid manner. MR. WARK: So you would say it would 8 be fair to say that in addition to an economic 9 10 issue, that it's a safety issue? MR. FLYNN: Certainly, fatigue is a 11 safety issue. There are plenty of studies that 12 will prove that and I would say everything 13 should be looked at, yes. 14 MR. WARK: Thank you. 15 MR. BRESLAND: I have no questions. 16 Let me move on to Mr. Hendershot. I'll just 17 take a few second to introduce Dennis. I have 18 19 known him off and on over the years. He's a chemical engineer, BS, MS. 20 He worked for Rohm and Haas for 35 years. He's 21 involved with one of the country's experts on 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W.

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inherently safer design. He was 1 intimately 2 connected with an investigation that we did of the Texas City explosion because he was hired 3 by the independent safety panel headed up by 4 former Secretary of State James Baker, which 5 posted its report on safety culture of the BP 6 7 Texas City refinery. So we've asked him to come and talk 8 about general chemical process safety issues, 9 10 keeping in mind his expertise in this area. Mr. Hendershot? 11 MR. 12 HENDERSHOT: Thank you, Mr. 13 Chair and Board and everybody. The Board staff asked me to talk 14 15 about a couple of issues. First of all, just a 16 few brief comments about personal some experiences I've had with Bhopal. Also, to 17 talk more extensively about inherently safer 18 19 design. In December of 2009 -- this coming 20 December will be the 25th anniversary of the 21 Bhopal tragedy. In December of 2004, on the 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W.

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20th anniversary, I was privileged to participate in an international conference to mark that anniversary and to share progress that the process industries have made in that intervening time to prevent such things from happening in the future.

After that conference, 7 I, along with a number of other attendees from 8 the conference able to actually tour 9 was the 10 Bhopal plant and the city and the area. That was a very memorable experience, seeing the 11 equipment where the release occurred, meeting 12 13 many people in the community who were injured tragedy, talking with 14 by the emergency 15 response personnel who had to deal with those 16 consequences, talking to plant operating personnel, including some who were off-duty at 17 the time and were at home with their families 18 19 and were actually impacted by the tragedy as members of the community. 20

21 Maybe the biggest impression of all 22 was visiting clinics and talking to doctors

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who are still dealing with long-term health
 consequences 20 years later.

One thing that really struck me 3 earlier this week when I was listening to the 4 congressional hearings on this incident and 5 6 just a few minutes ago when Marshal Lewis was 7 speaking, was how similar the experience of Valley 8 the Kanawha emergency response personnel to that that the Bhopal India police 9 10 chief described to me as his experience in December 1984, in terms of not being aware of 11 what was going on. 12

13 It was almost the same words.

CSB also asked me to talk briefly 14 15 about the concept of inherently safer design. 16 Inherently safer design is a philosophy for design operation of 17 and any technology, including chemical processing. It's not 18 а 19 specific technology or a set of tools and activities, but it's really an approach to 20 it's design and of thinking 21 а way for engineers at all stages in process development 22

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and design. 1

2	What do we mean by inherently safer
3	design? One dictionary definition of inherent
4	is existing in something as a permanent and
5	inseparable element. What that means is that
6	the safety features are built right into the
7	process, not added on. Hazards are eliminated
8	or significantly reduced rather than
9	controlled or managed.
10	The means by which you do this are
11	so fundamental to the design of the process
12	that they're really difficult or impossible to
13	change or defeat.
14	But again, there are some important
15	things that we have to recognize. When we
16	describe a process design as inherently safer,
17	we need to remember that first of all, we're
18	describing it as inherently safer relative to
19	one or more alternative designs.
20	I never use the word inherently
21	safe. If by safe, we mean that it's the
22	complete absence of all hazards and risks,
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then I'm not aware of any technology that could ever be described as absolutely inherently safe. We talk about something as inherently safer relative to something else.

Also, we're generally talking about inherently safer in the context of one or perhaps several of the multiple hazards that are associated with any kind of a process or technology. But it may not be inherently safer with respect to all hazards.

We have to remember no good deed 11 goes unpunished and oftentimes, any change in 12 13 technology, when it's intended even to eliminate or reduce a particular hazard, has 14 15 the potential to increase other hazards or 16 introduce new hazards.

17 And so, when you make these technology choices, it is really important to 18 19 fully understand all of the implications of all of the various alternatives. 20 That is really essential. 21

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There's been a lot of discussion of

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1	the potential for other inherently safer
2	processes to manufacture the products which
3	are produced at Institute. Other companies
4	have reported successful implementations of
5	alternative technologies and we saw some
6	mention of that in the slides earlier for
7	some of the materials produced in this plant.
8	It's not clear to me as an outsider
9	and from the information that is available to
10	the public how thoroughly those alternatives
11	have been evaluated at Institute. You really
12	can't tell. Society does not insist that a
13	technology be inherently safe. We insist that
14	it be safe.
15	High reliability organizations
16	operating inherently hazardous technology can
17	be quite successful. For example, air
18	transportation. I almost took that out after
19	my experience trying to get here today.
20	But you know, the Navy submarine
21	program, the deck of a modern aircraft carrier
22	we can do this.
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1 In Pudd'n Head Wilson, Mark Twain suggests put all your eggs in one basket and 2 watch the basket. The important thing there is 3 watch the basket is in all capital letters. 4 What he's saying is that if you're going to do 5 that, if you're going to put all your eggs in 6 7 one basket, you have to be really good and you have to be really good all the time -- not 90 8 percent of the time, not 99 percent of the 9 time. You have to be good all the time. 10 Here at the University, if you get 11 a 95 percent on a test, you'll probably get an 12 13 Α. Ιf you're dealing with a high risk technology and you get a 95 percent on a test, 14 15 you're not going to get an A, so you have to be good all the time. 16 As a chemical engineer and a strong 17 proponent of inherently safer design, I can be 18 19 convinced either way with regard the to Institute because Ι 20 processes at haven't really seen a lot of information about how the 21 choice was made. 22

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1 With regard to changing technology, early in my career, I worked for 15 years in 2 process research and development. Over that 3 time, I encountered a lot of really good ideas 4 able successfully 5 that not to we were implement -- sometimes for economic reason. 6 7 Sometimes because you just couldn't get them work properly on a production scale. 8 to Sometimes because we encountered unanticipated 9 10 safety, health, and environmental issues. In one case, we had a new plant 11 that was half built and millions of dollars 12 invested when we decided we couldn't make the 13 process work and we abandoned it. 14 Details really matter. They matter 15 a lot in chemical processing, so you can have 16 what looks like a trivial change in chemical 17 structure that can have major impacts 18 on 19 things like chemical reaction selectivity, rate, solubility, and other things that are 20 important in designing a manufacturing plant. 21 22 It's not my purpose here to try and

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1 explain why Bayer and for several previous 2 owners to have chosen not to change technology at Institute -- I'm really not qualified to do 3 that. I'm not familiar with that technology, 4 I would just be speculating, and there 5 so really is little information publicly 6 7 available. There could be good technical and economic justifications for this decision and 8 I notice that even the report of Dr. Lapkin 9 for the Good Neighbor Project acknowledges 10 some potential difficulties. But difficulties 11 often can be overcome, but not always. 12 But 13 they need to be looked at. It's very clear to me, from the 14

14 concern in this room and from the continuing 15 public concern going all the way to the United 17 States Congress, that the various operators 18 over the years at the Institute plant have not 19 been able to convince this community that they 20 have made a good decision. Thank you.

21 MR. BRESLAND: Thank you, Mr. 22 Hendershot.

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1 The program that you were involved with at the 2 BP Texas City accident was a study of the 3 safety culture of BP. What lessons did you 4 learn from that that could be transferred --5 without obviously understanding too much about 6 Institute, but what lessons on safety culture 7 did you learn?

MR. HENDERSHOT: I've always thought 8 the most important recommendation from 9 that 10 the Baker panel report was the first one, which dealt with leadership, leadership 11 throughout the organization. 12

13 Again, leadership is just not the CEO and the work manager and so forth, but 14 15 everybody in the organization is a leader. But 16 the leadership does need to start at the top and it needs to be real and genuine and a full 17 commitment because if you don't have that 18 19 leadership and that top management commitment, none of the other recommendations from the 20 really going 21 Baker report are to matter because they won't happen. 22

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I think that's absolutely critical. 1 2 As I was listening to the description of this incident, there are a lot of similarities 3 between this incident and Texas City, in terms 4 of having it occur during a start-up, in terms 5 of issues with excessive overtime and fatigue 6 7 and procedures that are inadequate and so forth. 8 It really comes down, I think, in 9 10 many cases to really having a good effective safety management system, which, 11 process I think, most importantly provides feedback to 12 13 management as to whether it is functioning properly or not. I think 14 in many cases, 15 systems are put out there and assumed to be 16 working, and what management needs is bad 17 news. They need to get the bad news about 18 19 what's not working because that's not what they need to fix. Management needs to welcome 20 They need to look for bad news 21 bad news. because that tells them what their job is. 22

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1	You don't need to fix what's
2	working right. You need to fix what's broken,
3	but if you don't find out what's broken if
4	your system does not provide feedback about
5	what you might think is happening but is not,
6	in fact, happening, then you're not going to
7	be able to fix it.
8	MR. BRESLAND: Thank you, Mr.
9	Hendershot. Finally, Maya Nye has been sitting
10	here patiently since 6:30 this evening. I
11	assume you still want to speak.
12	MS. NYE: I do. I might sound a
13	little jittery. It's a bit cold in here.
14	MR. BRESLAND: Ms. Nye is the
15	spokesperson for People Concerned About MIC.
16	Thank you.
17	MS. NYE: Chairman Bresland, thank
18	you and Board members, thank you. Community
19	members, thank you for coming.
20	My name is Maya Nye and I am the
21	spokesperson for the community organization
22	People Concerned about MIC.
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1 I am also a community activist and 2 an accidental environmentalist. I'm also a union member. 3 People Concerned About MIC is a 4 community organization in the Kanawha Valley 5 dedicated to the protection of health and 6 7 safety of all of those who reside, work, and study in the vicinity of local chemical plants 8 producing highly toxic chemicals. 9 10 The group formed because concerned learned community members that methyl 11 isocyanate, commonly referred to as MIC -- the 12 13 same chemical and killed and injured hundreds of thousands of people in Bhopal in 1984 was 14 15 being produced in our backyard. 16 a child when People Now, Ι was Concerned About MIC was formed in the mid-17 1980's. I barely remember the Bhopal disaster 18 19 and I vaguely remember evacuating 8 month incident that occurred 20 after the here in

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the hospital, including

Institute that sent more than 100 people to

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and

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1 Nixon.

2	But I tell you what, I clearly
3	remember the incident that occurred in 1993,
4	in August, that occurred near the MIC tanks
5	and it killed two workers and it sent many
6	people to the hospital.
7	I was sitting in my living room,
8	about a crow's mile away from the plant and I
9	felt and heard a loud boom. I thought a tree
10	might have fallen on my house and the next
11	thing I knew I lived on a one way street
12	and the next thing I knew, there was a fire
13	truck going down my road the wrong way, saying
14	there's a shelter in place in effect. Close
15	all doors and windows and turn off all air
16	conditioners and ventilation systems until
17	further notice.
18	As you can imagine, I was pretty
19	panicked at that point, so I called my father,
20	who, yes, was a Union Carbide employee, and I
21	called to ask him what to do and with no
22	information, he told me to hang tight. So I

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1 hung up the phone and the smell had already 2 invaded my house. I called my father again, only this 3 time I couldn't get through because the phone 4 lines were jammed. 5 Frantically, I grabbed some duct 6 7 tape and I started taping around the windows and taping around the doors like they taught 8 in school, only it didn't work 9 to do us 10 because there were too many windows and too many doors and the smell had already invaded 11 my house. 12 So I sat there with my dog crying 13 and hoping that that wasn't the last phone 14 15 call I was ever going to have with my father. 16 I was 16 years old. My story is only one of thousands 17 in this community and in communities across 18 19 the world, in harm's way of a chemical plant. It is a story that has occurred time and time 20 again. Unfortunately, it continues to occur. 21

I recently spoke to a friend who's

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1	been diagnosed with cancer and she attributes
2	her cancer
3	and her recently deceased neighbor to living
4	within spitting distance of a chemical plant.
5	I asked her if she would give an
6	interview to a newspaper reporter and she
7	responded, what can I say that I haven't
8	already said for the last 25 years?
9	So I sit before you today, not
10	because I am an ominous fanatical activist as
11	Bayer's press strategies would allow you to
12	believe, but because 15 years ago, almost to
13	the day, my life was changed forever when the
14	methomyl larvin unit exploded, the exact same
15	one.
16	Again, I felt the explosion, only
17	this time I was 10 miles away in Charleston.
18	Again, it killed two workers. Again,
19	notification of the incident severity was not
20	given in due time to the people who are
21	immediately affected by the incident.
22	Again, it caused lots of property
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damage to local residents, which Bayer wasn't entirely interested in addressing until the watchful eye of Congress came down. Again, many side effects have been caused to our community that we may not fully understand for years. the plant So while names and managers have changed, the effects to our they biocommunity remain the same and accumulate across lines, phone, or ship. did not form We community our this chemical plant. This chemical around plant was formed in our community and it planted itself right next to a historically black university in unincorporated, an primarily African American neighborhood that is adjacent only to mountains, rivers, and poor white neighborhoods. Now, the history of discrimination is clear to us and to anyone who would look at history without bias. The continued our discrimination is clear when 25 years later,

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the same voices are saying the exact same things and little has been done to change the talking points.

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4 For 25 years, People Concerned About MIC has made great strides to ensure 5 6 effective communications with the Institute 7 facility, regardless of entity control. Our establish access qoals have been to 8 to information about the dangers existing in our 9 10 community and to eliminate as many of those possible in the production of 11 dangers as highly toxic chemicals. 12

Our efforts have been modeled and 13 orchestrated not only national community right 14 15 to know laws, but the worst case scenario modeling that you saw earlier this evening. In 16 fell August of 2008, 17 one sweep in Bayer Cropscience slammed the door on 25 years worth 18 19 of community efforts, visualized only by the still locks 20 chain that the qate to our evacuation route to this day. 21

Our group has been accused by some

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NEAL R. GROSS COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W. WASHINGTON, D.C. 20005-3701 of trying to eliminate jobs and to this, I retort, the chemical industry put food on my table so don't tell me I don't understand the need for industry. Chemical dollars and scholarships sent me to college.

We understand the need for 6 7 industry, however, we deserve the kind of jobs and the kind of industry that does not cause 8 the untimely death and preventable death of 9 10 workers or the bio-accumulation of toxins in our children's bodies. 11

We deserve an economy that is not solely based on extractive and chemical industries that tell us that we must choose between jobs and health. We are not acceptable risk factors.

We come before you today asking that you finally hear our voices, and I think you have started listening, and I appreciate it. We ask that you make recommendations to our government and industry that stop this systematic exploitation of our community.

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We are tired -- I think that's an 1 understatement -- but we are tired of smoke 2 and mirrors and cagey non-answers and 3 our lives in your hands and we deserve to know the 4 truth about the dangers that exist 5 in our community. We shouldn't have to, months and 6 7 months later, go to DC and watch folks testify before before Congress we qet that 8 information. 9 10 We hope that the CSB recommends that the fox can no longer guard the henhouse 11 and that corporate arguments based on non-12 13 operational monitoring systems will no longer be acceptable. 14 commend the Chemical 15 Т want to Safety Bard for requesting our presence on 16 this panel because, especially after 17 the public relations strategies to marginalize us. 18 19 Thank you for your continued effort include community 20 to concern into the conversation regarding chemical safety. 21 It's one of the most important voices that you'll 22 **NEAL R. GROSS**

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1 ever have.

2	We request a thorough and
3	comprehensive investigation and even more
4	thorough recommendation to industry and
5	government that addresses the underlying
6	issues at hand and looks across the lines of
7	ownership. Thank you.
8	MR. BRESLAND: Thank you, Ms. Nye.
9	Let's see if the Board members have any
10	questions.
11	Board member Wark?
12	MR. WARK: I don't really have any
13	questions to speak of. I do want to extend my
14	condolences, which I did not do earlier, to
15	the gentlemen who died in this incident and
16	also to your friends that perished previously.
17	I agree 100 percent that there's
18	this law out there called EPCRA, which is
19	Emergency Preparedness and Community Right to
20	Know Act, and that's something that we have to
21	start taking more seriously, not just here in
22	Institute, but throughout the country.

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1 We go out on investigations once in 2 awhile and the ones that I've been out on -the few that I've been out on -- the next day, 3 4 there's а talking head interviewing а community member local 5 on TVand they're 6 standing there saying I didn't know that was 7 there. I didn't know what they had on-board. In some cases, it wasn't anymore than from 8 the back of the 9 here to room from the 10 facility. that we will do a Ι just feel 11 complete job here 12 thorough, and let the 13 recommendations and they chips fall where they may. Thank you. 14 15 MS. NYE: Thank you. MR. BRESLAND: Board member Wright? 16 MR. WRIGHT: I just have a comment, 17 a statement. I gather that you agree with me 18 19 that public relations should take a backseat to public safety. 20 MS. NYE: Yes. 21 MR. who's 22 BRESLAND: As someone **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W. (202) 234-4433 WASHINGTON, D.C. 20005-3701 www.nealrgross.com

worked or did work in the chemical industry 1 2 for many years and dealt with community issues similar to the one that you were describing 3 and the one that we're hearing about this 4 evening, how would you -- Ms. Nye, how would 5 you assess the relationship between the 6 7 community and Bayer? I don't necessarily mean your organization, but the community in 8 general, in this area? 9 MS. NYE: Well, I think you could 10 probably see from the show of concern in this 11 room that there's not a whole lot of trust in 12 13 the efforts that have been put forward by 14 Bayer. 15 MR. BRESLAND: If you were to make 16 suggestions to Bayer for ways to improve it, what would you do? 17 MS. NYE: Crucial information in a 18 19 timely fashion would be truthful. Yes, truthful information in a timely fashion, most 20 definitely. 21 Truthful information that 22 impacts **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W.

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1 us. I mean, such as what the chemicals are 2 that are being released that we may not know are impacting us 3 because the reports that were given earlier in 4 regards to the firefighters are not the only 5 reports that there were of health concerns. 6 7 Т would like that to be 8 acknowledged. There were many reports from community members that were not listed there 9 10 and I'm not sure how we compile that information. Not everyone the 11 went to hospital. A lot of people are just used to 12 13 suffering and dealing with it. PUBLIC COMMENTS 14 15 MR. BRESLAND: Okay. Well, thank you 16 very much. Thank you to all of the panelists for being here this evening and expressing 17 some very interesting points of view and very 18 19 interesting observations for us on the issues. We come to the final part of the 20 agenda this evening, which is the opportunity 21 for the public to speak. We do have a public 22 **NEAL R. GROSS**

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1 sign-up sheet that I have a number of names 2 on. I think I'm going to call them two 3 at a time to perhaps save a little time. We'll 4 get the first two up and that is K. Nybarger 5 6 from United States Steel Workers and Philip 7 Nimkus. you can spell your name and If 8 please -- it's getting late. People have to go 9 10 to work in the morning. I have to catch a plane at 6:30 in the morning. I'd like to get 11 a little sleep before I get on the plane. So 12 please limit your -- and we're very interested 13 in hearing what you have to say. 14 15 MR. NYBARGER: I would first like to 16 offer my condolences to the friends and family of the two brothers that were killed in the 17 Bayer accident. 18 19 Good evening. My name is Kim Nybarger. I'm a health and safety specialist 20 employed the United Steel Workers 21 by International and Health Safety and 22 Union **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W. (202) 234-4433 WASHINGTON, D.C. 20005-3701 www.nealrgross.com

1 Environment Department.

2	I'm also a dues-paying member of
3	the USW and I've been a union worker in
4	several industries for a number of years.
5	I've been associated with the
6	activities of the Chemical Safety Board since
7	their inception. In fact, the oil industry
8	oil refiner that I come out of was the topic
9	of the first published work of the CSB, a
10	safety bulletin in August of 2001 on the
11	subject of management of change.
12	This followed a workplace accident
13	at my refinery that took the lives if six of
14	my co-workers. The company, through their
15	legal representatives, initially expressed a
16	concern of publicly reporting all the events
17	that took place, including root causes. The
18	assumption was fear of legal proceedings.
19	The union pressed for a full
20	disclosure and that the information be shared
21	not only among our sister facilities, but all
22	refiners who may have coking operations so
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that the lessons learned may help one of them avoid learning the same way we did through the loss of workers' lives.

I was deeply disturbed when I read initial reports that Bayer apparently, through their legal department, was using a Department of Homeland Security Law to prevent certain information from being made public, claiming that material might aid in terrorists and is protected as sensitive security information.

I do appreciate the job the Coast 11 is required Guard does and to do under 12 13 Homeland Security. However, when you learn that the number of terrorist attacks 14 on facilities 15 industrial which use highly 16 hazardous chemicals and compare that to the releases, fires, and other emergency events at 17 these facilities, it would appear that 18 the 19 greater potential harm is from the day to day operation. 20

There is a greater good to the public to be made aware of the seriousness of

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the effects of a release of methyl isocyanate. 1 2 The neighbors of this Bayer facility must know what the potential consequences are from a 3 release and they need to know what to do in 4 the event of a release of MIC to avoid the 5 same tragic end as the residents of Bhopal. 6 7 This is in part what CSB public meetings like this accomplish. 8 The future may have other companies

9 10 using Homeland Security issues to mask deadly chemicals disclosure of their 11 on premises. I conceive facilities claiming the 12 13 same privacy rules as a matter of trying to cover any anticipated liability. 14

This process appears to be more the tactics of legal maneuvering than any concern of safety sensitive information being released.

There are many steps that can be taken to help a company not be a target of terrorist activities. Substitution of a safer Chemical is one step or reducing inventory to

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1 a minimum for the process. In other words, 2 cutting down on the amount of the hazardous material in Redundant 3 storage. process controls and emergency disposals systems are 4 other ways to minimize the chance of an on-5 site release. 6 Leaks, fires, and process upsets 7 happening on a weekly basis at 8 are our refining, and gas plants. 9 Chemical, These 10 issues of safe operations pose а greater hazard to the communities surrounding these 11 facilities than an attack from the outside. 12

The failure of the facilities to adhere to the minimum requirement of safe operation directed by the government in the OSHA process safety management standard found in the Federal Code of Regulations 29, part 19, under 1910.119 has, in some instances, had

A recent national interest program of OSHA inspections at the nation's refiners has shown a severe lack of compliance with the

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process safety management standard.

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2	Now, keep in mind that this no high
3	performance program, but merely the bare
4	minimum legal requirements and any fee for the
5	nation's Chemical manufacturers is coming next
6	year.
7	It's a sad fact that unless a body
8	count is high enough to get public attention,
9	few people notice the hazards killing workers
10	on the job. Over the last five years, an
11	average of 5,680 have died every year and we
12	usually don't hear anything because they only
13	die 1 or 2 at a time.
14	It is oftentimes only through the
15	scrutiny of investigations conducted by the
16	CSB that the public has an opportunity to
17	learn of the potential health risks posed by
18	facilities in their neighborhood.
19	The CSB does not issue penalties,
20	but only strives to find all the underlying
21	causes and make them known puts the results
22	of their investigations into the public domain
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so that other companies can hopefully learn 1 2 from these investigation without having to kill a handful of workers to discover failures 3 in their management systems that allow these 4 catastrophic events to take place. We cannot 5 6 allow the legal manipulation of companies to 7 trump critical safety information for the public. 8 giving Thank for 9 you me the 10 opportunity to address this group. BRESLAND: Phillip Nimkus? MR. 11 We like the comments to be addressed to the Board 12 members. Please remember the three minute rule 13 and if you have written comments, we'd be more 14 15 than happy to take them and put them into the 16 record. MS. HENDRIX: Okay, well, I have an 17 e-mail from Philip Nimkus, who is affiliated 18 19 with the Coalition Against Bayer Dangers in Germany. He said that he was requesting to 20 have it read into the record. 21 22 MR. BRESLAND: Fine.

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MS. HENDRIX: But I will submit it. 1 2 He sent me an e-mail and he said that the Congress's investigation was very good, 3 but did not mention the early warnings and the 4 involvement of Bayer's board of management. So 5 he wanted me to read this letter and submit it 6 7 to you. He says Dear Chairman Bresland, The 8 Coalition Against 9 Bayer Dangers, an 10 international network based in Germany has been monitoring Bayer for 30 years. 11 We're working on a broad range of 12 13 issues. Emissions of Bayer plants, hazards caused by Bayer products, accidents in Bayer 14 15 plants, corporate influence, etc. 16 The group was built up after an explosion in a German Bayer factory in 1978. 17 In cooperation with groups from West Virginia, 18 19 we've been working on the Institute plant for several years. 20 10, 21 Last year, on March we introduced a counter-motion to Bayer's 2008 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W. (202) 234-4433 WASHINGTON, D.C. 20005-3701 www.nealrgross.com

shareholder meeting in which we stated, quote, 1 2 whereas the volume of super toxic agents like phosgene and MIC stored at the German Bayer 3 following 4 plants was reduced the Bhopal catastrophe, the tanks in Institute remained 5 as they were. They Bayer board of management, 6 7 Bayer's responsibility for the high pollutant the emissions, frequent occurrence of 8 incidents, and the constant risks caused by 9 10 the storage of MIC and phosgene -- he says you can review the complete text on the Bayer 11 website. 12

He says we also spoke in the meeting, which took place on April 25, four months ahead of the Institute explosion.

16 Attending were the Bayer board and supervisory board, the media, and about 4000 17 Aqain, shareholders. we criticized the 18 19 frequent spills of chemicals and demanded to dismantle MIC and phospene tanks at Institute. 20 Bayer CEO Werner Wenning replied, 21 stating verbatim, that the plant had, quote, 22

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the newest security installations and an excellent safety record since 2002, end of quote -- that the plant was, quote, explicitly lauded by authorities for its safety record and that no action was necessary.

After the August explosion, we demanded, in cooperation with local groups, that the Institute plant becomes an MIC and phosgene-free facility.

In Germany, Bayer produces carbonate
pesticides without utilizing large quantities
of MIC.

Until today, the company has not apologized for the gross negligence by which the methomyl unit has been operated for the past years.

Particularly disturbing to us is that Bayer's recently published annual report does not mention the Institute explosion and the death of their workers with a simple word. We therefore again introduced a counter-motion to Bayer's next shareholder

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meeting, which takes place May 12. Quote, highly hazardous substances like phosgene and MIC do not belong in mass production, and certainly not in the vicinity of residential areas.

Ever since the company became 6 7 established, Bayer has endeavored by exerting pressure and making threats to suppress 8 information and even more, criticism. It uses 9 10 its economic power indiscriminately in order to protect its profits, the truth, and the 11 interests of humans and the environment are 12 13 left by the wayside.

The board of management and the supervisory board have not taken any steps to substantially improve the safety situation in Institute or to enlighten the general public.

We ask you to discuss these early warnings and Bayer's denials of any safety problems. Since Bayer dismantled their tanks with highly hazardous substances in Germany, we're demanding that they do so also at

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1 Institute.

2	So I would like to submit this for
3	the record. In the interest of time, I'll
4	forego reading my statement, but my statement
5	basically says that I've been so frightened by
6	the incident with the chemicals here that I
7	wouldn't live here and I'm moving. It was
8	very, very frightening.
9	MR. BRESLAND: Okay, thank you very
10	much. The next two people I have on the list
11	are Regina Hendrix and Jenna Frazier.
12	MS. HENDRIX: That was mine, and I'm
13	going to submit it for the record.
14	MR. BRESLAND: Okay, then we got
15	you. The next person will be Janet Frazier
16	from Marshall University, followed by
17	Demetrius Paparuchas? Pardon my pronunciation.
18	MS. FRAZIER: First off, thank you,
19	Chairman Bresland, for coming to us, this part
20	of West Virginia to discuss the incident that
21	happened at Institute in August.
22	I have been doing some research on
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1 the MIC handling at the LaPort, Texas facility 2 and I was hoping that in your investigation, that you evaluate as to what that sort of MIC 3 in 4 handling and processing can't be done to whether it's Institute --5 to see as а financial issue or an economic issue. An 6 7 economic issue being different in that it values more than just the dollar signs. Ιt 8 values the costs and benefits of its effect on 9 10 human life and human health and welfare, as opposed to just finances. 11 So with that, I found that LaPort's 12 handling of MIC -- how they make it on demand

13 and in as-needed quantities, it's not very 14 15 time consuming. It's often more efficient, 16 although because the Institute plant make sit on-site and uses it on-site, it may not be as 17 efficient, but generating it in smaller 18 19 quantities has proven to be safer and has produced a better safety record at the LaPort, 20 Texas facility owned by DuPont. 21

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So investigation as to why that

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1	sort of means of handling and creating MIC
2	can't work in Institute, I would greatly
3	appreciate it. I think that would highly
4	benefit the community as well. Thank you.
5	MR. BRESLAND: Thank you very much.
6	Mr. Demetrius?
7	MR. DEMETRIUS: Yes, sir. That would
8	be me. My original question was answered
9	earlier just by listening to what the panel
10	actually said. Realistically, I guess that
11	brings up another question.
12	How many more instances do we have
13	to have before something actually happens?
14	That's all I have to say.
15	MR. BRESLAND: Thank you. The next
16	two speakers are Gerald Hankins from West
17	Virginia State University and Rich Ford,
18	followed by Gary Zuckett. Three of you up
19	here.
20	MR. HANKINS: I would like to thank
21	you, Chairman Bresland and the rest of the
22	committee for opening up the floor for public
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1 comments.

2	My name is Gerald Hankins. I'm an
3	assistant professor of biotechnology at West
4	Virginia State and secondarily an assistant
5	professor of neurological surgery at the
6	University of Virginia and a part-time
7	resident of Saint Albans.
8	One thing I'd like to note from the
9	earlier comments of the two fixed monitors
10	that were in use. Neither one of these, from
11	everything that I've heard and read in
12	testimony, were located on the part of the
13	perimeter of the plant to which the wind was
14	blowing.
15	It was blowing toward Saint Albans.
16	The monitors are not there. That is not where
17	the cloud was observed by the Saint Albans
18	fire chief and therefore, any toxic chemicals
19	that were blowing outside of the plant would
20	have not been detected by those monitors. So
21	they were totally inefficient and ineffective
22	to have two monitors there.

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1	The second point that I would like
2	to make and economics and cost has been
3	mentioned quite a bit and you might expect
4	that I was going to talk about effects on the
5	nervous system or of the chemicals but we
6	are in a situation and it's been alluded to in
7	the past, earlier, where the economics is a
8	situation.
9	Historically, people out of power -
10	- blacks and other forepeople have effectively
11	subsidized the industries that have been
12	placed in their midst in order to keep their
13	false love.
14	So to the extent that cost and
15	economics is a consideration, the question is
16	to what extent do people have to subsidize the
17	operations of the plant with their health and
18	financially, actually, through the extra costs
19	that the people have to bear and the
20	institutions not just the University in
21	order to try to protect themselves against the
22	hazards that are produced in the plant?

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1 So I certainly hope that these 2 economic consideration also consider the fact that Bayer is being subsidized by the 3 community and by this University. 4 MR. BRESLAND: Thank you. Mr. Rich 5 Ford? 6 MR. FORD: Hi. Richard Ford, member 7 Virginia State University 8 of the West community, and more to the point, I live and 9 10 work downwind of the Bayer plant. Mostly, I want to thank the Board 11 for taking a serious interest in this and 12 13 underlying most of the panel testimony. Hankins said less money to 14 Dr. 15 save, but to be very clear, is there any reason why the chemical industry should not 16 the of Virginia 17 bear cost West State University's preparation for such emergencies? 18 19 It's going to cost us an awful lot to deal with that. Thank you. 20 MR. BRESLAND: Mr. Gary Zuckett, who 21 will be followed by Mr. William Taylor. 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W. WASHINGTON, D.C. 20005-3701

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MR. ZUCKETT: First of all, I would 1 2 like to thank you for providing the public with forum today. Just couple 3 а а of 4 questions. Kanawha 5 At. Putnam emergency planning committee meeting discussing this 6 incident, the Charleston area medical center 7 safety director CW Sigmond confirmed that Bill 8 Oxley, the worker who was severely burned, was 9 10 not decontaminated prior to being transferred off-site. 11 Unfortunately, the first casualty, 12 13 Barry Withrow, had cyanide in his blood, according to the New York Times. I'm wondering 14 15 if this is going be taken under to 16 consideration in your investigation? Also, I would like to know if the 17 CSB will investigate all of the toxic Chemical 18 19 processes and storage at the Institute site, including MIC, just 20 not the part that exploded? Thank you. 21 22 MR. Thank you. BRESLAND: Mr. NEAL R. GROSS COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W.

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William Taylor? We'll pass. Donna Willis?

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MS. WILLIS: As resident of 2 а Institute for 54 years, I have been through 3 the blowing out of windows by Carbide and the 4 chlorine leak in Carbide and the numerous 5 other leaks of Carbide and Rhone Poulenc and 6 7 Aventis and Bayer and -- I just want to know how much chemicals can the human body take and 8 some physical effect that's 9 not show not 10 associated -- to cigarettes? Okay, because there is not a physician in the state of West 11 Virginia who has been certified by our board 12 13 who can stand up and say that we are suffering cancer, that we are suffering lung diseases, 14 15 suffering heart ailments that we are or 16 anything else all because of cigarettes and second-hand smoking. 17

Who is out here testing these drugs and these chemicals and what effect it will be on our bodies. I had a child who was lying in a bed, sleeping infant, when it happened that the MIC leak happened. What effect is that

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going to have on my child 30 years from now. Is he going to live to 40? I'm not going to make it 70. See,

4 my heart's gone at 41 years old. No rhyme, no 5 reason, no medical.

The concern that I have is that a 6 7 lot of people believe that they can put things in black communities and think that we're 8 nothing. I'm high maintenance. My whole family 9 10 is high maintenance. So if that's the idea that there's still working with today, there's 11 a rude awakening. Black people are no longer 12 the pit of the valley of America. 13

When hear intelligent people 14 Ι 15 trained in the field of engineering, chemical 16 engineering, stand up and say, well, there was a disconnect here, there was a wrong here. 17 There was mis-communication, la di da. Τf 18 19 anybody else had said that on their job, they would have been fired. 20

21 When economics, no matter what the 22 problem is in America -- I don't care about

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1 the money. I don't care about the money Bayer 2 can make. I don't care about the money they can pay their employees. I don't care because 3 human beings are God's gift to this earth and 4 when you diligently pick at them and tear them 5 apart in order to make a product, you have 6 7 scorned the reason why we exist as human beings. 8 For years, we have sat up here and 9 10 we have listened and we have watched people ignore Institute -- ignored the last three 11 days. If anybody was snubbed, raise your hand 12 because it's been all over. 13 And the excuses. I called to tell 14 15 them there's a huge smell of flowers over on my street. They send over a person who tells 16 me that I have a gas leak. I live on an all 17 electric facility. There is no gas. 18 19 So that kind of stuff really it 20 irritates us, but SO qood to see the representatives from the county commission 21 here because they know we've been through this 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W.

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the last 40 years. They never once spoke up 1 2 for us. It's good to see that, finally, that these people who have been working jobs to 3 4 help us in the fire and everything else, they are finally getting somebody to listen to them 5 to help us. 6 Personally, I think that Bayer can 7 have Institute. They can have the vegetables 8 we grow -- feed their families that mess. They 9 10 can breathe in the air that we breathe. They can live in the chemically-infused homes that 11 we live in. 12 13 Give us a ticket to anywhere and we will go because it is no use having this 14 15 happen to our community over and over again 16 for decades and our state doesn't acknowledge us, our county doesn't acknowledge us, and 17 President Carter, I am so glad to see you here 18 19 because now I know he cares about the college. BRESLAND: Thank you. The next 20 MR. Steve Irwin. Steve Irwin is 21 speaker is declining. Jesse Johnson? Jesse Johnson? Sue 22

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1 Davis? Sue Davis followed by Mike Harmon. MS. DAVIS: Can you hear me, I hope? 2 First of all, I'd like to just read something 3 4 that my daughter sent me today because it's interesting that I saw that the headlines in 5 the paper where it says that Bayer does not 6 7 like to be compared to Bhopal. They don't want it to be compared to us. 8 Yet, of all of the failures and all 9 of the things that were broken, either before 10 or after the incident, here's what I read --11 it was a National Geographic documentary. This 12 13 was supposedly what took the place the night before Bhopal occurred. 14 None of the plant safety systems 15 operation. Flare 16 were in power was disconnected. The vent gas scrubber was out of 17 undersized. caustic soda and The 18 water 19 curtains on the side, the pressure valve was run-off 20 not working. The tank already contained MIC. The mandatory refrigeration for 21 the MIC unit was turned off to save money. 22

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You know what? I asked one of the 1 2 former plant managers in a public meeting for community safety assessment -- I said, 3 end this question for me. Why do you have to store 4 such large amounts of MIC rather than to bring 5 it in as you need it or do it any other way? 6 7 He didn't say anything that any of said. said because it's you He 8 more economical. So in other words, they equate 9 10 money with my life and your life. I want to say one thing. First of 11 Dr. start with 12 all, Ι want to Carter's 13 welcome. You said that you talked about this being a laboratory of living relations. I'm a 14 I've been a lab rat for 60-some 15 lab rat. 16 years, starting when the first US government rubber plant was bought here. 17 How in the world did they find this 18 19 community when Institute was not on anybody's map? Someone had to look for some lab rats. It 20 has been that way ever since, ever since, and 21 it's only getting worse. 22

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1	You know what I think of being a
2	lab rat because when I look at a lot of the
3	MSDS sheets, they don't have any stats. They
4	say known to cause cancer in rats, and they're
5	talking about the ones that crawl on the
6	ground. But the long-term effects on humans,
7	not yet known not yet status. Those two
8	awful letters, capital N-E none
9	established, no permissible level exposure
10	established. So they're testing through us.
11	Dr. Carter, you said you were
12	training your students for their future roles.
13	I know one student of yours that will not have
14	a future woe because two or three days
14 15	a future woe because two or three days following the explosion, the young kid, a
15	following the explosion, the young kid, a
15 16	following the explosion, the young kid, a freshman, just beginning his life, went to the
15 16 17	following the explosion, the young kid, a freshman, just beginning his life, went to the hospital lived on this campus went to
15 16 17 18	following the explosion, the young kid, a freshman, just beginning his life, went to the hospital lived on this campus went to the hospital because he couldn't breather. He
15 16 17 18 19	following the explosion, the young kid, a freshman, just beginning his life, went to the hospital lived on this campus went to the hospital because he couldn't breather. He was having trouble, gets to the hospital, and

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back because he still can't breathe. He never
 returned to the campus.

You know what? When we had our 3 meeting here, People Concerned About MIC, I 4 in that hallway 5 stood out and Ι begged students to come in here. I said, please come 6 7 and learn something. We've invited the plant We've invited the official. qovernor. We 8 invited everybody. Come and learn something. I 9 10 said, there are things you need to know to protect yourself. I said, we don't want to see 11 you sent home to your parents in a box. And 12 13 four or five days later, that kid was sent home in a box. That breaks my heart. 14

15 breaks my heart, Mr. Crosby, Ιt 16 that your men die at that plant. A Chemical facility or a chemical tank -- it doesn't have 17 a brain. But the people who man those things 18 19 have the brains. That's where the problems come from. Nothing wrong with their brains, 20 but what are they doing? 21

And Mr. Crosby, you said -- and

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1 I'll turn to you if you want me to and I'll 2 try to end it -- but you said that you've done all that you can to assure that this kind of 3 thing will not happen again. I have heard that 4 for 40 years and it continues to happen. 5 MR. BRESLAND: Can we move on? 6 7 MS. DAVIS: Mr. Hendershot? You looked up the words in the dictionary that you 8 needed to know. I looked up some words too --9 10 I looked up one word and you know what it was? Terrorist. Terrorism. 11 And you know what? It relates to 12 13 people who instill fear in those around them. Who fits that description? 14 15 The Right to Know act is fine. The 16 problem is, when we call the plant to know something, they say it's nothing to know. The 17 former plant manager told me, in writing, and 18 19 I still have the letter that I plan to submit to you all with some other things -- he told 20 me, when I wrote him a letter -- and I had 21 asked him about an incident that we had -- and 22

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under FOIA, he told me that they're not subject to FOIA and they didn't have to tell me anything. They're private.

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don't understand that. 4 Ι They're private till it comes to sending their things 5 over here. I think that means that they're not 6 7 probably going to say one more thing. I was -and it's kind of like what Donna said -- when 8 I was pregnant with one of my children, my 9 10 youngest, in fact, and I worry about her to this day -- but when I was pregnant with her 11 and I stayed in a house on Lincoln Avenue and 12 13 I was upstairs and in the middle of the night, this awful smell had filled that house as it 14 15 does all the time in the same smell -- all the 16 time.

I was so sick, I couldn't walk. I couldn't turn. It was terrible. I somehow managed to contact the plant. I think that was probably one of my first calls to that plant. I asked them, I said what on earth do you have in the air? I said it is all in my house. I

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said I am pregnant. I don't know what to do. Is it going to harm my child? Do I need to get up and go to the doctor? He said I'll call you right back and I'm still waiting and she's 28 years old now.

I found out also that my brother
who lived in Dunbar had called at the same
time. They had problems in their house and
they never called him back. I could go on and
you all know I could go on. But I thank you.
Thank you so much for what you're doing. Thank
you for what you're doing.

I'm going to say one thing to you and I think I said it to you today and that is, it seems like -- to me, this is being turned into an MIC problem. MIC is going to wipe us all out fast, right? But if it doesn't leak, what about the problems that we're having to endure every single day.

I am sick half of the time. What about those problems? I don't care whether you close MIC down. That's not what I'm asking you

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1 to do. I'm asking you to pack Bayer up and 2 ship them out of here. Send them back to Germany. Send them back to Germany because 3 they're in this country, just like they're in 4 Institute because we are lab rats and we are 5 back. 6 They are in this country because 7 they know that our country will allow them to 8 do in this nation what their own government 9 10 will not let them do in their own nation. MR. BRESLAND: Ms. Davis, thank you 11 Mike 12 very much. Thank you. Harmon? Mr. 13 Harmon? HARMON: Hi. My name is Mike 14 MR. 15 I live in Saint Albans in the house Harmon. 16 that I grew up in. I've been there for 54 years. I can really identify with the lady 17 that just spoke who talked about living here 18 19 for 54 years.

20 And like Mya, I'm roughly a mile 21 from the plant here. So over the years, I've 22 certainly witnessed a number of incidents,

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including the one that happened last August
 here.

I want to personally thank Maya Nye for re-convening People Concerned About MIC. I was a member of People Concerned About MIC. I started attending the meetings in 1985 because of the leak that Maya described that sent over 100 people to emergency rooms here in the local area -- same plant, different owner.

When I looked at the newspaper this morning, this headline caught my eye. It says cutting MIC is doable, but costly. I looked at that and I thought, you know, this is a golden opportunity for a full employment program for the chemical industry here in the Valley.

In 1985 -- and I was happy to hear the questions that you folks raised tonight about air monitoring, which is obviously completely deficient here at this plant.

But in 1985, I made an urgent plea then that we implement a comprehensive air monitoring system here in the community so

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that the residents of Institute and other neighborhoods that are in close proximity to chemical plants would be able to know for certain what it is that they're breathing on a

Over the years, we've had a number 6 of meetings and discussions with chemical 7 plant people, union folks, environmental 8 protection people, public health officials and 9 10 so forth, and everybody has said, almost to the letter, that don't have enough 11 we information about chemical exposures here. 12

In other words, we don't know what 13 causes this or that illness. We don't know 14 15 whether certain emergency responders were 16 exposed to toxic chemicals. That's an issue struggling with 17 that you're in this investigation. We don't really know whether 18 19 residents should shelter in place because we don't get that information. 20

21 When Carl Beard, the former 22 director of the West Virginia Air Police

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daily basis.

Control 1 Commission retired, he spoke 2 passionately and eloquently to his commission about the need to do more air sampling here in 3 the Kanawha Valley because when we did do the 4 air sampling, we found chemicals in the air 5 that supposed to be there in 6 were not 7 concentrations that exceeded safe standards 8 for human exposure. talked about the 9 Anyway, SO we 10 headline in the paper. I do applaud Congress woman Capito's attendance at the hearings in 11 Washington and for her apparent concerns for 12 13 the safety of the employees and residents of the local area. 14 I urge her and this body to require 15 that Cropscience immediately 16 Bayer cease operations at the plant involving MIC until it 17 achieved the highest level of safety 18 has 19 achievable in this facility. call it 20 We could the Bayer Cropscience Stimulus Package Full 21 and

22 Employment Program. I would think that that

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1	would make all of us happy the union
2	members, the plant management, public
3	officials, and so forth. Thanks.
4	MR. BRESLAND: Thank you. I have one
5	final speaker, Mr. Bill DePaulo. He's making
6	his way up, and then, that's the end of the
7	list of speakers.
8	MR. DEPAULO: Hello. My name is Bill
9	DePaulo. I live in Charleston. I'm a lawyer.
10	I'm with the Sierra Club. We're frankly, at
11	the Sierra Club, we're Concerned that we've
12	neglected this whole topic and haven't done as
13	much as we should have.
14	I'm glad to see that you all have
15	taken a very serious interest in it. It's been
16	a massive information dump for those of us who
17	are not chemists and don't know as much about
18	it as you do. So that's a great public service
19	and we thank you for it sincerely.
20	I know I'm not here to kick
21	anybody around. I want to ask a few questions
22	that hopefully will move your analysis
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1 forward.

2	Ms. Sciallo I hope I'm
3	pronouncing that correctly
4	MR. BRESLAND: Excuse me. If you
5	have a question, please direct it to me and
6	then we can decide where to take it.
7	MR. DEPAULO: Okay, that's fine. I'm
8	not trying to cross examine her. She mentioned
9	the Risk Management Program, which had
10	complied a worst case scenario.
11	It was based, I believe, as was
12	explained here this evening on the assumption
13	of the rupture of the largest vessel, which
14	was a 200,000 gallon vessel, I believe, as it
15	was described.
16	There are other vessels on the
17	site, as I understand. The day vessel has a
18	26,000 gallon capacity, I believe. There are
19	multiple vessels there. Wouldn't the worst
20	case scenario assume the rupture of multiple
21	vessels. In fact, the worst case scenario, no
22	matter how improbable it is, would assume the

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1	rupture of all the vessels present. So isn't
2	that the way the question ought to be asked?
3	Secondly, the assumption that would
4	affect 300,912 people was based upon the
5	computer model, which was limited to 25 miles.
6	Is that a satisfactory assessment? In other
7	words, was it Cropscience's computer program
8	or the EPA's or some others?
9	It just seems to me that if that's
10	a limit on the computer program, that's not an
11	acceptable analysis of the worst case
12	scenario.
13	There's another component to this.
14	Although a whole range of adverse impacts on
15	individuals were described from difficulty
16	breathing to death, I've never seen these
17	kinds of analysis done where you didn't
18	actually have probabilities of outcomes. How
19	many people would have asthma? How many people
20	would get nauseated? How many people would
21	die? That's not a trivial and it's not
22	intended to be an inflammatory question.

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1 The information you gave us today was truly helpful, but you need to, if you 2 will, to truly let the chips fall where they 3 In other words, don't sugarcoat 4 may. the ending, the last chapter on this. 5 I'm certain that some computer 6 7 person somewhere has sat down with а probability study and said, okay, if we're 8 exposing 300,000 people to this, how many of 9 them are going to be dead? That's a number 10 that as a community, we're entitled to know 11 because we make the decision what risk, as a 12 13 community, are we willing to absorb to get whatever economic benefits Cropscience offers 14 us. We need to know the ratio. 15 16 It's relevant and all we're talking about perusing pesticides 17 is here _ _ а pesticide. We need to know what the pesticide 18 19 homicide ratio is if we're going to accept the risk. 20 Now, there's another item, which, I 21 know Mr. Chairman, you live in the state, but 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS

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you don't live in this area. There's a geological or a topographical fact that may be relevant.

4 There's a very, very significant steady wind that blows west to east through 5 6 this valley. The people who complained about 7 the impacts _ _ and local communities are certainly correct to make those observations -8 - but if there is a rupture or multiple tanks 9 10 with significantly more than 200,000 gallons, blown it's going be to the largest 11 to population center here, all the way back to 12 13 Charleston and beyond. That needs to be factored in to your analysis. That is not a 14 15 trivial part of the puzzle.

I know people who are considering locating wind turbines, not on the mountain ridges here, but down in the valley because the Venturi effect that's generated by the valley on the wind makes the wind blow through more powerfully. Thank you.

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MR. BRESLAND: Thank you very much.

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1	Could you state your name and spell it?
2	MS. JAMES: Yes, I will. My name is
3	Pam James. This is totally not planned, so I
4	promise to go under the three minute rule,
5	unlike everyone else.
6	I would also ask for respect in
7	what I say because I am on the other side of
8	the fence tonight. I'm a Bayer employee's
9	wife.
10	I am only here to support Nick
11	Crosby and the plant. My husband has a
12	chemical engineering degree. My husband is Rod
13	James and I think I can pretty much say he's
14	well respected in the plant by all employees
15	that know him.
16	I have sent my husband to this
17	plant for ten straight years. We're both born
18	and raised in West Virginia. He was a chemical
19	engineer. He was also on a nuclear-powered
20	submarine as an officer, and those aren't safe
21	either. There's lots of dangers in jobs.
22	But what I wanted to say tonight
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1 was I've also sent my daughter into the plant 2 numerous times on Take Your Daughter to Work Day. These men and women don't go into this 3 4 plant with unsafe environment. There are just kinds things that 5 all of can happen in numerous jobs. Teachers have gotten shot in 6 7 schools. There's things that happen.

I would also like to say that Barry 8 Withrow -- and many of you don't know Barry 9 it really hurt me tonight 10 Withrow and ___ everybody has their opinions. I'm here for 11 Bayer -- but it really hurt me to night to 12 hear the other side sit back here when Nick 13 Crosby was talking or things were being said 14 15 that went wrong that night. Things went wrong. Does everybody not agree? 16

Nick has admitted communication was a problem that night. What was so funny about that? Why do you take joy in lives that are lost? And that's how I took that sitting there. People laughing. Things went wrong. Let's move on. Let's learn from it.

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1 Barry Withrow was a personal friend 2 of ours. We went to church together. I sit in church Sunday afer Sunday watching his wife 3 cry. She misses him, but it could be a happy 4 song. She's looking forward to going to heaven 5 to meet Barry one day. 6 But this is what hurts me is that -7 - let's work together as a community. Let's be 8 adult about this. I lost a friend that night. 9 When I got up and was woken that there's been 10 an accident. I may not have a job to go to 11 tomorrow. That's what my husband told me. 12 13 I said what about Barry? That's the first thing I said when he said it might be 14 the larvin unit. He said no, I think Barry has 15 16 gone to a different unit. Well, Barry's wife was also at home thinking I might call Rob and 17 see if he knows anything. 18 19 So you people that are here for the other side didn't know Barry. I didn't know 20 Bill Oxley, but also know that my husband is 21 well-respected. 22 He's а smart man and he **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS

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1	wouldn't go into an environment that's unsafe.
2	So I would just ask I don't know
3	what the future holds for any of this, but I
4	wanted to speak on behalf of Bayer and my
5	husband because I trust my husband. I don't
6	think I know that he wouldn't hide things
7	and I would hope that he doesn't work for a
8	company that does.
9	I don't know all the technical
10	stuff about all this stuff that's gone on. I
11	don't understand it. He tries to explain it to
12	me, but again, I just wanted to say that lives
13	were lost that night. It was sad and it was
14	very disrespectful to me tonight to hear
15	people laugh and carry on about this kind of
16	stuff.
17	MR. BRESLAND: Thank you.
18	PASTOR LEWIS: Hello. My name is Jim
19	Lewis and I'm an Episcopal minister and this
20	is a real challenge to ask a preacher for
21	three minutes.
22	I'm going to really try and do it
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1 in less than that. I've got a statement and 2 I'll give it to you. The ending of the statement talks a little bit about something 3 been mentioned and that's 4 that's not the legislation that was just done here in West 5 minute rule. Virginia, the 15 Ιt was 10 6 7 minutes in Bhopal, the people were dead. We need something more than that, so I'll submit 8 that. 9 10 I'm here, really, as а pastor because I serve a church in which about 3/4 of

because I serve a church in which about 3/4 of the people in that church live in Institute, Dunbar, South Charleston, and in this region here, Dunbar. I also am a part of the group that Maya represents here, People Concerned About MIC.

I'm a pastor in that church and Margo Holt -- the name hasn't been mentioned here tonight -- is also in that church. I mention her name and I want to thank the Charleston Gazette for making the Freedom of Information Act really work for us because in

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their article using the Freedom of Information 1 2 Act, we were able to understand that this has been a public relations game with us. It's 3 really a public relations game. 4 That report opened up to us exactly 5 what's going on. Mr. Crosby, you said today or 6 7 Mr. Crosby said here this evening that he wants dialogue with the community. Well, if he 8 wants dialogue and his company wants dialogue 9 with the community from all of 10 us, every single one of us, then don't pit us against 11 one another. 12

To pit Margo Holt against Maya Nye is not right. You won't get to the truth. Mr. Hendershot said that management needs to hear bad news and welcome it. We all need to get together and find good news and be able to look at some of the bad news.

To pit Mildred Holt as a longtime person here who wouldn't get real active about this like Maya Nye has -- it's a younger woman here -- is just no way to create dialogue in

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1 this community.

2	A report that came through from the
3	Freedom of Information Act told us that the
4	company is trying to marginalize those of us
5	who are raising these difficult questions
6	Maya and People Concerned About MIC. There
7	will be no dialogue if we have that kind of
8	attitude. We will not be marginalized.
9	I want to thank Maya for the
10	inspiration and the work she's done for us. I
11	came back to live here in my community, West
12	Virginia, where I'd been away on 9-11.
13	When I came back here by the
14	way, having worked in the Dunbar peninsula
15	where Bayer was with antibiotics and chickens
16	and to come here and find them here and to
17	find the leadership that I find with Maya and
18	this group of people who have been working for
19	25 years around this problem is real
20	encouraging to me, an older guy.
21	Do not pit us against one another.
22	That's no way for dialogue interviews his
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1 community. I tell you, Mildred Holt, a member 2 of my parish, a black woman and Maya, a dear friend now, a new person -- a new person in my 3 life -- was here. Those two people seem to me 4 to have a great deal to contribute to this 5 discussion. Do not pit us against one another, 6 7 That's no way for dialogue. Thank you all for coming down here. 8 We really needed this kind of outside help to 9 10 come in here and listen to us and give us this presence here tonight. Thanks a lot. 11 MR. BRESLAND: Thank you very much. 12 13 Reverend Lewis. MR. FOOCE: One more person. 14 MR. BRESLAND: Please state 15 and spell your name. 16 MR. FOOCE: Kevin Fooce. 17 MR. BRESLAND: How do you spell your 18 19 name? MR. FOOCE: F-O-O-C-E. 20 MR. BRESLAND: Okay. 21 MR. phone 22 FOOCE: Ι was on а **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W. (202) 234-4433 WASHINGTON, D.C. 20005-3701 www.nealrgross.com

1 conference one night and I got asked about 2 this situation. Maya, I believe, was one of the ones asked. She didn't have any help. You 3 4 all, all of a sudden, come to help these people. 5 The next day, I called OSHA to get 6 7 the report for what happened. I say that Bayer 8 _ _ I've taken people to the hospital before in 9 10 these past two incidents. Bayer did not have protocols. They did not train their people. 11 They did not give them safety equipment. They 12 13 did not qive them training on safety equipment, and they had been cited before for 14 15 this problem. 16 This is the facts. This is what OSHA has cited for. Am I correct? This has not 17 been brought up tonight, but this needs to be 18

It is because somebody willingly did not write the protocols, willingly did not train their people, and they created an

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brought up.

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This accident could have 1 accident. been 2 prevented. It should have been prevented, and these two people should have gone home to 3 their families that night. 4 That is the whole point of this. 5 Thank you. 6 MR. BRESLAND: Thank you very much. 7 Please state your name and spelling. 8 MR. ANOPOLIS: Yes. My name is Doug 9 10 Anopolis. Ι lived on campus when this happened. I'm not here to point any fingers. I 11 don't know anything. I'm not that bright if a 12 13 human being really -- well, okay. all joking aside, what's 14 But 15 unfortunate to everybody here is you all 16 became the faces of something bad that's happened. It's not every -- you can't point 17 the fingers at person. It's 18 one not 19 everybody's fault. Yes, I don't want people to lose 20 jobs, but also, I don't want people to lose 21 lives. I'm only 23 years old. That's pretty 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W.

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young, at least last time I checked. I just want people to get together and go, maybe we should try a little harder. I think there's a famous song -- I can't remember who did it -but it goes this song is not about you.

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This song is not about you guys. 6 7 It's not about you quys. It's about us, students, workers, so please put petty things 8 aside, both of you. Let's 9 try to work 10 something out so I can be really proud to be American again and be in the state of West 11 Virginia. 12

That's all I ask. Thank you.

14 MR. BRESLAND: Thank you. Thank you 15 very much. Do we have anyone else who would 16 like to be part of the public comment period?

17If not, I Thank all of you very18much for your -- do we? Oh, here we go. Hold19on. State your name and spell it, please.

20 MS. JACKSON: My name is Gertrue 21 Jackson. G-E-R-T-R-U-E. I would just like to 22 state that the night of the accident -- I live

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at 110 Vernon Street, which is at the end of the golf course in the little community of Institute.

4 Ι parked my car and Ι walked Ι witnessed 5 towards the steps and the 6 explosion, the noise, and then what looked like a mushroom cloud. I was out and we were 7 trying to inquire whether or not it was any 8 chemical leaks that night. I was out for about 9 10 an hour close to the college campus.

told anything. 11 We weren't My 12 feelings there wasn't а larqe staff are 13 available to give us any answers. I saw that you had a time frame of 10:39 --was 14 that 15 correct? When it happened? actually Ιt 16 happened 10:24 or 10:25, not 10:39 -- not that it makes any difference. 17

My heart goes out to the family of the men that were killed. I'm really saddened by that. I retired in -- I love to work out in the yard. I love my flowers and when I'm out there, I have such peace of mind -- at least,

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1 I did.

2	But this frightens me. I'm like
3	this lady. I don't know if I want to live in
4	Institute anymore and I constantly smell
5	odors, constantly. So whatever it's worth, I
6	felt led to say that. And the explosion was
7	10:24 or 10:25, not 10:39.
8	CLOSING STATEMENT
9	MR. BRESLAND: Thank you very much.
10	Going once? I think we're all out of speakers,
11	so just let me make a few closing remarks.
12	I'd like to thank each of the board
13	members and the investigation team for their
14	participation. I'd like to thank the panel
15	members again for their participation.
16	All of us share a strong interest
17	in preventing these tragic explosions from
18	occurring. Our hope is to make sure that
19	workers, the community, and emergency response
20	personnel are not forced to experience an
21	instance similar to this one.
22	Our investigation is continuing and

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we expect to complete our final report with 1 2 safety recommendations by the end of the year. The CSB plans to return to Institute to 3 release its final report and recommendations. 4 Т would like to thank all of 5 6 today's participants. I'd like to thank the 7 audience. You've been very, very patient. It's been a long evening. I'd like to thank you 8 all, and you're now allowed to go home. Thank 9 10 you very much. (Whereupon, the hearing concluded 11 at 10:36 p.m.) 12 13 14 15 16 17 18 19 20 21 22 **NEAL R. GROSS** COURT REPORTERS AND TRANSCRIBERS 1323 RHODE ISLAND AVE., N.W. (202) 234-4433 WASHINGTON, D.C. 20005-3701 www.nealrgross.com

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