

Statement of Carolyn W. Merritt
Chairman and Chief Executive Officer
U.S. Chemical Safety and Hazard Investigation Board
before the U.S. House of Representatives
Committee on Appropriations
Subcommittee on Veterans Affairs, HUD, and Independent Agencies
Washington, DC
March 24, 2004

Chairman Walsh, Ranking Member Mollohan, and members of the Committee: thank you for the opportunity to present the U.S. Chemical Safety Board's budget proposal for 2005. In the last twelve months, the Board has continued to advance its life-saving mission of preventing serious accidents at facilities that produce and use chemicals.

I would like to introduce Mr. Rixio Medina, whom President Bush appointed to the Board in December. Mr. Medina has had a distinguished career in process safety, most recently as Manager of Corporate Health, Safety, and Security for CITGO Petroleum in Tulsa. He has been a leading member of the American Society of Safety Engineers and of the safety committees of the American Petroleum Institute and the National Petrochemical and Refiners Association. Mr. Medina has been a tremendous addition to our agency.

With me also is Mr. Charles Jeffress, our Chief Operating Officer, together with fellow Board members and members of our staff.

Mr. Chairman, let me begin by thanking the committee for having provided the Board with increased resources for the current fiscal year. Our current budget of \$8.2 million with a \$447,000 emergency fund allows the Board to take on an unprecedented number of significant accident investigations and studies.

Mr. Chairman, the Committee's growing investments in this agency are paying off. Earlier this month, we achieved probably the most noteworthy success in the six-and-a-half year history of this agency. On September 30 of last year, meeting in New York City, the Board voted to recommend that New York City modernize the control of hazardous materials under its existing 86-year-old municipal fire code. The recommendation followed an 18-month Board investigation of a chemical accident in downtown Manhattan, where at least 36 people were injured when hazardous chemicals — improperly mixed in the basement of a commercial building — exploded and caused the building to partially collapse.

The Board's investigation showed how weaknesses in the antiquated fire code were handicapping New York City fire inspectors, preventing effective oversight and enforcement of good hazardous material safety practices in the city.

The Board's September public meeting received extensive public attention in the city, and within weeks legislation was introduced in the city council to begin the process of modernizing the fire code. The Board testified twice before the city council in support of our recommendation, and three weeks ago the city announced that it will be hiring a new staff to spend the next couple of years overhauling the entire city fire code. This process is expected to lead to city's adopting an accepted model code, like the International Fire Code, as other cities have done. At the end of this process, eight million New Yorkers will be considerably safer.

What is happening right now in New York City is a striking proof of the value of independent, non-regulatory, root-cause investigations of accidents. While society has a strong impulse to find fault and punish wrongdoing when accidents like this occur, our own small agency is dedicated to discovering the true root causes of these events and promoting real safety in the future.

Mr. Chairman, the Board's budget is modest in comparison with the cost of even a single large chemical accident. As you know, we are now engaged in two of the most complex and difficult investigations the CSB has ever undertaken. These are the investigations of last year's catastrophic dust explosions at West Pharmaceutical Services in Kinston, North Carolina, and CTA Acoustics in Corbin, Kentucky. These accidents took 13 lives and injured scores of workers. Two large industrial plants were idled, disrupting hundreds of jobs and undermining the fragile economies of two small towns. The overall cost from these two accidents alone will run to hundreds of millions of dollars.

The Board's independent investigations and recommendations help prevent costly disasters like those in North Carolina, Kentucky, and New York City. Today I appear before you to seek additional funds for the Board's work in fiscal year 2005. One of our main strategic challenges over the next several years is to gain greater awareness and acceptance of the safety improvements we have recommended, based on our accident investigations. Many of our specific safety recommendations are directed to individual companies that have experienced major accidents.

It is vitally important, however, that we transmit our lessons and recommendations to other audiences beyond the specific recommendation recipients. To make progress nationally, we need thousands of other companies to learn about the causes of accidents, study our findings, and make changes in their operations — before more accidents occur. Promoting those actions will fulfill an important part of our mission. That is why we have requested additional funding of \$450,000 for fiscal year 2005 — to disseminate our safety information in ways that lead to

new prevention initiatives. These funds will allow us to hire three new staff and establish a working program.

I offer several examples where the Board's safety findings — put into the right hands — can help prevent future accidents and save lives.

First, there may be hundreds of other plants around the country today that have hidden hazards from combustible dust — chemical dust that can explode as it recently did in North Carolina and Kentucky. Many engineers and managers remain unaware of this danger. Getting them the right information promptly is critically important. Despite the notoriety surrounding the major dust explosions early in 2003, dust explosions continue to occur with great frequency. We receive reports of smaller dust fires and explosions on virtually a weekly basis. On October 29, 2003, eight months after the explosion in Kentucky, the Board began investigating yet another fatal dust explosion, this time at an automotive parts factory near Fort Wayne, Indiana. Two men were burned severely; one of them later died. Clearly more needs to be done.

There are many other examples where the Board has potentially life-saving information that needs wider understanding, especially among small businesses that have limited resources and limited expertise in process safety, engineering, and risk assessment. Less than two weeks ago we held a public meeting in Representative Northup's district of Louisville, Kentucky, to approve our final report on a fatal explosion at a food additive plant there. People in the community were distressed to learn that straightforward, inexpensive safety equipment could have prevented the blast. As one plant neighbor lamented, "For the want of a safety valve, a man was killed." It sounds simple enough: providing a pressure relief system for any vessel exposed to dangerous internal pressure. Yet in seven of the 19 major accidents the Board has investigated since 1998, inadequate pressure relief was either a primary cause or a contributing factor. Once again, more needs to be done to get the word out.

As a former industrial manager, let me tell you that nothing motivates you to act — to make any investments, arrange any training, install any safety equipment — like the knowledge of what terrible disaster may happen if you fail to act. That is where the CSB, with its almost seven years of experience investigating the worst accident sites in the country, has unique credibility and value.

Investigations will continue to be the mainstay of our work, and you can see from the number of investigations begun and completed since 2002 that I have put the main emphasis in that area, consistent with the direction from this Committee. Our request seeks additional funding to continue to bolster the Board's investigative work. First, we ask your support to hire a new accident investigator with expertise in the area of human factors. As many of you know who follow aviation safety, the interface between fallible human beings and complex technological equipment is the source of many accidents. Adding a new specialist investigator

will allow the CSB to investigate the “human factors” that contribute to deadly chemical accidents in complex manufacturing plants.

Next, we also request funds to hire a new technical writer-editor. The CSB’s main products are lengthy written reports. To date, all these reports have been funneled through a single technical writer, creating a bottleneck to report production. Additional funds will support hiring a second individual to accelerate report production and maintain report quality. We also plan to further expand work to put our reports and findings into plain language, useful to workers, members of the public, and other non-technical users.

Over the past year, we have begun by publishing two-page plain-language Investigation Digests of our investigative reports. Seven digests have already been published and we are now planning to issue digests of each of our investigation reports, in both English and Spanish. These digests are receiving extremely positive feedback from trade associations, labor leaders, educators, and safety trainers. Recently, the PACE International Union requested 12,000 copies of one of our digests for training workers on how to maintain safety during process changes. I believe that we have just begun to tap the demand for this kind of plain-language product.

In keeping with our primary focus on investigations, I am also seeking an increase of \$400,000 to our new investigative emergency fund. As the Committee recognizes, major accident investigations — like our investigation in North Carolina where an entire plant was leveled — have significant and unforeseeable costs. Physical evidence and the recollections of eyewitnesses are short-lived, and when a major accident occurs the Board cannot realistically await a supplemental appropriation from Congress before beginning its work.

In this year’s budget, the Committee has created a \$447,000 emergency fund of “no-year money” — available until it is expended. The use of the money is restricted to extraordinary investigative expenses, and we have not as yet tapped any of the funds. In seeking an increase to this fund, we recognize that extraordinary expenses for testing and contractual support of a major investigation can easily run over the \$447,000 ceiling currently in place. For example, extraordinary expenses from our North Carolina and Kentucky dust explosion cases last year exceeded \$450,000. Therefore we are requesting an additional \$400,000 in no-year money for fiscal year 2005, to bring the total emergency fund to \$847,000. The Board is confident that this sum will be sufficient to initiate investigations of any major disasters that may occur.

Additional increases, detailed in our agency’s Budget Justification, will fund an expected January 2005 civilian pay increase and modestly increased contract costs associated with the Board’s investigations, public affairs, and information technology programs. Increased costs for the latter items are a direct result of the Board’s increased investigative workload.

Mr. Chairman, the past year has been one of significant achievement by the Chemical Safety Board. I believe that, with your strong support, the agency has become a powerful voice for the protection of workers, plants, and communities from deadly chemical hazards. I ask for your continued support so that the CSB may fulfill the full breadth of responsibilities that Congress has envisioned.

The remainder of my testimony provides additional details on the accomplishments of the past year and the work that lies ahead.

High Level of Mission Accomplishment

In fiscal year 2003, the Board initiated a total of twelve accident investigations, completed five accident investigations, a case study, and a safety bulletin. The investigation reports included a total of 90 new safety recommendations to government, industry, labor, and other organizations. A summary of the current and recently completed investigations follows.

Recently Completed Investigations

D.D. Williamson & Co. (Louisville, Kentucky). On the morning of April 11, 2003, one worker was killed at a food additive plant when a process vessel became over-pressurized and failed catastrophically. The explosion caused extensive damage to the plant and triggered a secondary release of 26,000 pounds of aqueous ammonia, requiring a community evacuation. The Board approved the final investigation report on March 12, 2004, at a public meeting in Louisville. Recommendations were issued to the company and also to the Commonwealth of Kentucky to increase awareness about existing regulations on the importation and inspection of used pressure vessels.

Catalyst Systems (Gnadenhutten, Ohio). On January 2, 2003, a vacuum dryer containing nearly 200 pounds of benzoyl peroxide exploded, injuring one worker. Employees were in the process of drying granular benzoyl peroxide, which is unstable at high concentrations, when the explosion occurred. The explosion and subsequent fire damaged the production facility. The Board approved a case study report on this investigation at a public meeting in Washington, DC, on October 29, 2003; the case study described good practices for safe handling of explosive peroxides, which are widely used in industry.

First Chemical Corp. (Pascagoula, Mississippi). On October 13, 2002, a violent explosion occurred in a nitrotoluene distillation tower sending heavy debris over a wide area. Although no one was seriously injured or killed in the incident, the control room was damaged and explosion debris narrowly missed a large storage tank that contained highly toxic anhydrous ammonia. A nitrotoluene storage tank at the site was punctured by debris, igniting a fire that burned for several

hours.

The final CSB report on this investigation was approved at a Board public meeting in Pascagoula on October 15, 2003. In addition to recommendations to the facility and its new owner, Dupont, the CSB recommended that Jackson County improve its emergency notification system to better protect and inform residents about chemical accidents. CSB also recommended that the American Chemistry Council improve its Responsible Care voluntary safety program to ensure that companies like First Chemical are fully analyzing process hazards.

Kaltech Industries (New York City). On April 25, 2002, an explosion occurred at a sign manufacturer in the Chelsea neighborhood of downtown Manhattan, injuring 36 people, including 14 members of the public. The sign company occupied the basement of a mixed-use commercial building. The CSB found that the accident resulted from mixing two incompatible waste chemicals, lacquer thinner and nitric acid, without following basic safety procedures.

In the course of the investigation, the Board held a public hearing on April 16, 2003, in New York City, where city officials and fire code experts discussed the adequacy of hazardous materials controls under New York City's 1918-era municipal fire code. On September 30, 2003, the full Board met again in New York City, approving its final report and citing the city's fire code as a contributing factor in the explosion. The Board called on the Mayor and City Council of New York to adopt a modern set of control measures for hazardous materials, such as those contained in the International Fire Code. On March 5, 2004, the city announced its decision to move forward with a complete revision of the code.

BLSR Operating Ltd. (Rosharon, Texas). On January 13, 2003, a vapor cloud deflagration and fire erupted at a small petroleum waste disposal facility in rural Texas south of Houston. The fire, which occurred during the unloading of flammable gasfield waste, killed three workers and injured four others. The CSB concluded that the fire could have been prevented if the companies involved had recognized the hazards of the materials being handled and transported; had safer procedures for handling flammable wastes; and if the companies and regulators had better oversight of the operations. On September 17, 2003, the Board made a series of safety recommendations to prevent a recurrence, calling on the Texas Railroad Commission to require all permitted drillers and producers in the state to furnish workers with appropriate hazard information.

DPC Enterprises (Festus, Missouri). On August 14, 2002, a chlorine transfer hose ruptured during a rail car unloading operation at a chlorine repackaging facility near St. Louis. Automatic emergency shutdown valves malfunctioned and the leak continued. Several hours elapsed before outside emergency responders in full protective gear were able to reach the rail car and contain the leak. By that time, 48,000 pounds of potentially deadly chlorine had been released to the atmosphere. Three workers and 63 residents sought medical treatment.

Investigators determined that the ruptured hose — although visually similar to a chlorine transfer hose — had the wrong materials of construction. On December 4, 2002, the CSB issued a safety advisory to all users of chlorine transfer hoses, urging them to verify their hoses were correctly constructed. On May 1, 2003, the Board approved its final report on the DPC Enterprises investigation at a public meeting in Festus. The CSB found that better equipment maintenance and quality assurance procedures would have prevented the release. In addition to recommending changes at DPC Enterprises, the Board called on Jefferson County to improve its community notification systems for chemical emergencies. The CSB also called on the chlorine industry and hose distributors to collaborate in making chlorine hoses more readily identifiable throughout the supply chain.

Current Investigations

DPC Enterprises (Glendale, Arizona). On November 17, 2003, there was a release of chlorine gas from a DPC Enterprises chlorine repackaging facility near Phoenix. Fourteen people, including ten police officers, required medical evaluation for possible chlorine exposure. More than 4,000 households and businesses were ordered to evacuate. The release occurred when excess chlorine vapors from a rail car unloading operation were diverted to a recapture system known as a scrubber. The scrubber malfunctioned, releasing the gas. This accident represents the Board's second investigation at a DPC Enterprises chlorine facility.

Hayes Lemmerz (Huntington, Indiana). On the evening of October 29, 2003, a series of explosions severely burned two workers, injured a third, and caused property damage to an automotive parts manufacturing plant in Huntington, Indiana, near Fort Wayne. One of the severely burned men subsequently died. The Hayes Lemmerz plant manufactures cast aluminum automotive wheels, and the explosions were fueled by accumulated aluminum dust, a flammable byproduct of the wheel production process. This accident is the third fatal dust explosion of 2003 that the CSB is currently investigating.

Isotec (Miamisburg, Ohio). On September 21, 2003, a violent explosion destroyed an underground distillation tower at the Isotec chemical manufacturing plant in Miamisburg, Ohio, injuring one worker. The explosion ruptured a carbon monoxide gas pipe and led to a precautionary overnight evacuation of about 2000 residents. The Isotec facility manufactures rare forms of oxygen and nitrogen, known as stable isotopes, which are used in research and medicine. CSB expects to issue a case study report on this incident in summer 2004.

Honeywell (Baton Rouge, Louisiana). On July 20, 2003, there was a release of chlorine gas from the Honeywell chemical plant in Baton Rouge, Louisiana. The accident resulted in the hospitalization of four plant workers and required residents within a half-mile radius to shelter in their homes. On July 29, 2003, a

worker was fatally injured by exposure to antimony pentachloride when a gas cylinder released its contents to the atmosphere. On August 13, 2003, two plant workers were hospitalized for exposure to hydrofluoric acid. The Honeywell Baton Rouge plant manufactures refrigerants using chlorine and other potentially hazardous materials.

CSB is investigating all three incidents and will convene a community meeting in Baton Rouge on March 30, 2004, to present its preliminary findings and receive comments from residents.

Avery Dennison Corp. (Mill Hall, Pennsylvania). On April 25, 2003, an uncontrolled heat-producing reaction occurred in a vessel used to manufacture adhesive polymers. As a result of the reaction, about 6,000 pounds of sticky polymer was expelled through a rupture disk into the surrounding area. More than 100 people were seen at community hospitals, but no serious injuries were reported. CSB expects to issue a case study report on this incident during 2004.

CTA Acoustics (Corbin, Kentucky). On February 20, 2003, an explosion and fire seriously damaged the CTA Acoustics manufacturing plant, fatally injuring seven workers. The facility produced fiberglass insulation for the automotive industry and used a combustible phenolic resin powder as a binder for the fiberglass. CSB investigators have found that the initial explosion and fire occurred on a production line that was partially shut down and being cleaned at the time of the incident. During the cleaning, a thick cloud of dust dispersed around the line. The dust was likely ignited by a fire that spread from the production line's oven, which had malfunctioned earlier and was being operated with its door open.

On July 8, 2003, the Board held a community meeting in Corbin attended by several hundred people. Board investigators presented their preliminary findings and fielded questions and comments from concerned residents and workers. The Board's investigation is now continuing with a detailed examination of components of the malfunctioning oven. Investigators are also examining why many CTA personnel were unaware of the catastrophic potential of resin dust that had accumulated on surfaces around the plant. The Board expects to issue its final report on this investigation in 2004.

Technic Inc. (Cranston, Rhode Island). On February 7, 2003, a worker was seriously injured in an explosion at a plant that manufactures precious metal processing chemicals. The explosion occurred during maintenance on a ventilation system connected to multiple chemical reactors, evidently due to an accumulation of reactive material inside. CSB plans to issue its final report on this investigation in mid-2004.

West Pharmaceutical Services (Kinston, North Carolina). On January 29, 2003, an explosion and fire destroyed the West Pharmaceutical Services plant causing six deaths, dozens of injuries, and hundreds of job losses. The facility

produced rubber stoppers and other products for medical use. CSB investigators have found that the fuel for the explosion was a fine plastic powder used in producing rubber goods. This combustible polyethylene dust accumulated above a suspended ceiling over a manufacturing area at the plant and provided the major energy for the blast.

On June 18, 2003, the Board held a community meeting in Kinston, attended by several hundred people. Board investigators presented their preliminary findings and took questions and comments from the audience. CSB's investigation is continuing, examining possible sources of ignition for the dust. The Board's final report is expected in 2004.

Hazard Studies and Bulletins

Dust Hazards. Prompted by the fatal dust explosions at West Pharmaceutical Services, CTA Acoustics, and Hayes Lemmerz in 2003, the CSB has now launched a systematic review of dust explosion incidents over the last several decades. Preliminary reviews point to a number of other tragic events in recent years, including major fires and explosions at the Malden Mills factory in Lawrence, Massachusetts (December 1995); the Ford Motor River Rouge plant in Dearborn, Michigan (February 1999); the Jahn Foundry in Springfield, Massachusetts (February 1999); and Rouse Polymerics International in Vicksburg, Mississippi (May 2002). These accidents caused numerous deaths and injuries as well as extensive property damage and economic losses.

A main purpose of the hazard study will be to assess the overall effectiveness of current codes and standards for preventing dust explosions. At present, the U.S. Occupational Safety and Health Administration (OSHA) does not have specific standards for controlling combustible dust hazards in many industrial facilities. National standards are in place for dust hazards in coal mines and grain handling facilities. The Board plans to examine whether current regulations are adequate and also how to improve awareness of dust hazards among industrial managers nationwide.

Sodium Hydrosulfide Handling. As an outgrowth of the Board's November 2002 Georgia Pacific investigation, CSB staff are conducting a review of other incidents involving sodium hydrosulfide, the chemical which reacted at a Georgia Pacific paper mill to release toxic hydrogen sulfide gas from a process sewer, killing two contract workers and injuring eight others. CSB expects to issue a safety bulletin highlighting good practices for handling sodium hydrosulfide in spring 2004.

Nitrogen Asphyxiation Hazards. In June 2003 the CSB completed a nationwide review of incidents similar to the March 1998 nitrogen asphyxiation incident at Union Carbide in Hahnville, Louisiana, which the CSB investigated.

The new CSB study identified a total of 85 incidents that occurred in the U.S. between 1992 and 2002 and involved exposure to dangerous nitrogen-enriched, oxygen-poor atmospheres. Together these incidents caused 80 deaths and 50 injuries. The CSB developed a safety bulletin on nitrogen asphyxiation hazards, highlighting a variety of good practices to avoid such incidents. The CSB also developed a short safety pamphlet and training slide presentation on nitrogen hazards.

Safety Recommendations Program

Recommendations are the CSB's principal tool for promoting chemical safety. Each recommendation has one or more specific recipients, who are the parties best able to carry out the recommended action to improve safety. Once the Board has issued a recommendation, CSB recommendations staff encourage adoption and track implementation activities. The Board aims for a cumulative 80 percent acceptance rate for our recommendations.

We have continued to receive excellent cooperation from recommendation recipients over the past year and have received numerous responses indicating positive actions underway or planned. In fiscal year 2003, the CSB successfully closed 10 outstanding safety recommendations. While these safety actions represent important progress that will help prevent accidents, the Board will continue to work for faster progress in this area. As we have increased our output of investigation reports and safety recommendations, our ability to track adoption of those recommendations has not kept pace.

As a result, the CSB will this year be doubling the amount of staff time allocated for closing recommendations. Also, the Board has recently established a special subcommittee of Board members, the Prevention Outreach Committee, with the main purpose of promoting faster adoption of major Board safety recommendations.

The recommendations program continues to deliver important safety improvements around the country. Earlier, I mentioned how the Board's recommendations have motivated New York City to modernize its 86-year-old fire code. Earlier, in March 2003, the Board completed an investigation of a catastrophic chemical fire in Brazoria County, Texas, south of Houston. The Board found that the county had no fire code for unincorporated areas, and as a result a facility that stored more than a million gallons of combustible petrochemicals lacked basic fire protection — such as smoke alarms, sprinklers, and fire walls. A small fire that started overnight spread to engulf and destroy the entire multi-acre facility, which had employed about 100 workers. Less than a week after receiving a safety recommendation from the CSB, Brazoria County supervisors voted to adopt the International Fire Code.

The Board continues to press for effective actions on the control of reactive hazards — the dangers associated with uncontrolled chemical reactions at industrial sites. The Board's 2002 hazard study, *Improving Reactive Hazard Management*, documented 167 serious reactive chemical accidents over the past two decades. Those accidents caused more than a hundred fatalities as well as numerous injuries and huge property losses. The CSB found that more than half the chemicals involved in these accidents are currently exempt from federal process safety regulations. In September 2002 the Board called on OSHA and EPA to revise those rules to broaden coverage of reactive hazards.

In June 2003, the Board organized and co-sponsored (with OSHA and EPA) a daylong stakeholder roundtable meeting in Washington, DC, to discuss possibilities for reforming the process safety rules. The Board was highly encouraged by statements from both industry and labor representatives at the meeting in favor of broader regulatory coverage for reactive chemicals. All parties recognized the seriousness of the problem and the need for more actions to prevent catastrophic accidents. In August 2003, two months after the meeting and less than a year after the Board's hazard study, New Jersey acted to add reactive chemicals to the state's list of regulated "extraordinarily hazardous substances" — an action that will result in additional safety controls among New Jersey chemical plants.

Although substantial progress was made at the roundtable meeting, in November 2003 OSHA Assistant Secretary John Henshaw announced that he was declining to initiate new federal rulemaking on reactive hazards. In his letter back to the Board, Secretary Henshaw detailed a series of new initiatives, including outreach, education, and increased enforcement of existing legal authorities. The Board found all these initiatives to be commendable and worthwhile and believes they will help strengthen reactive chemical safety. However, the moves fell short of the regulatory actions the Board continues to believe are necessary before most reactive chemical accidents are prevented. We will continue working with OSHA toward a mutually acceptable outcome on this issue.

CSB Expands Community and Web-Based Outreach

The CSB has found great value in conducting its public business in the communities that are directly impacted by chemical accidents. CSB public and community meetings have garnered hundreds of audience participants and received widespread news coverage among local and regional news media, reaching audiences that number in the millions. The CSB's objective, scientific investigations are proving to be one of the most important ways that community members can learn about the causes of chemical accidents and ways they can participate with companies to help prevent future occurrences.

Since our last appearance before the Committee, the Board has held public meetings, community meetings, and hearings in Louisville, Kentucky; Pascagoula,

Mississippi; Festus, Missouri; Kinston, North Carolina; Corbin, Kentucky; and twice in New York City. Next week the Board will be convening a similar meeting in Baton Rouge, Louisiana, a community that has been affected by a series of chemical accidents at a Honeywell plant there. The Board has continued to offer free webcasts of significant public meetings, which reach hundreds of additional viewers who are unable to attend the meetings in person.

In August 2003, the Board launched a completely revised version of its popular website, CSB.gov, with streamlined access to CSB accident reports, video webcasts, safety recommendations, and other information. Selected information is now being made available in the Spanish language as well as English, and we plan to increase this service in coming months. In December 2003 the Board launched a new live incident news service from CSB.gov, with updates from around the world every 15 minutes, a popular feature among safety professionals who track chemical accidents.

Inspector General Oversight

During fiscal year 2004, the CSB will be transitioning to a new Inspector General (IG) shared with the Environmental Protection Agency. In January 2004, the CSB received its last program audit report from its outgoing Inspector General, the IG of the Department of Homeland Security (formerly the IG of the Federal Emergency Management Agency). That study, *A Report on the Continuing Development of the U.S. Chemical Safety and Hazard Investigation Board (CSB)*, resulted in 11 new recommendations for improving agency operations. The CSB responded to all 11 recommendations and will be moving forward with implementation over the coming year.

While the report highlights some important areas for improvement, particularly in the tracking of chemical incidents and open safety recommendations, I was pleased by the generally positive conclusions of this final audit report. The Inspector General found, for example, that "... the CSB increased its productivity and stability under new management during the past year. The CSB is progressing toward meeting its statutory responsibilities and has increased the number of investigations it performs." (IG Report, p. 1)

Of note to the Committee will be the outgoing Inspector General's assessment that "the CSB lacks the resources to investigate all accidents within its purview." As a result of the IG recommendations, the Board will begin providing the Committee with an annual inventory of the chemical accidents evaluated by the Board for possible investigation. Over the next several months, we will seek discussions with the Committee on the additional statutory and resource issues raised by the IG report.

Homeland Security

In accordance with new Committee report language this year, the CSB has contacted the Department of Homeland Security (DHS) to begin discussions on a Memorandum of Understanding (MOU). This agreement will describe the respective roles of the two agencies in case of an act of terrorism against a chemical facility or a chemical release of uncertain origin. While we anticipate the Board's focus will continue to be on chemical accidents, the CSB remains fully ready to offer any chemical expertise to DHS in support of its important functions. The Board will report back to the Committee by June 2004 on its progress toward development of the MOU.

I also draw the Committee's attention to recent Board findings that have important ramifications for homeland protection. While the CSB's focus is accidental releases, our investigations typically include an examination of the adequacy of local emergency response to chemical accidents. Three of our recent investigations revealed a lack of sufficient local preparation for a major chemical event. I refer to Board investigations at First Chemical Corporation in Pascagoula, Mississippi; Isotec in Miamisburg, Ohio; and DPC Enterprises in Festus, Missouri.

While I believe all these communities are working aggressively to address the gaps that were uncovered, it is likely that other communities around the country may have similar shortcomings in their preparations to survive a terrorist attack on a chemical plant. Our investigations found that local authorities had difficulty notifying residents of a chemical release and informing them of the appropriate safety actions, such as evacuation or sheltering. In Missouri, lack of adequate planning beforehand prevented emergency responders from containing a serious chlorine release for several hours. If the wind had been blowing in a slightly different direction that day, the plume would have drifted over a residential area, with potentially grave consequences.

We communicated the Board's concerns in this area to Homeland Security oversight committee members in correspondence last year. We also anticipate discussing these concerns with DHS officials as we proceed with an interagency agreement. I thank the Committee for seeking the Board's assistance and cooperation on these vital homeland security issues. As the foregoing examples show, I believe this is an area where the Board can make a positive contribution.

Conclusion

The last 18 months mark a major turnaround for the Chemical Safety Board. Following several years of organizational challenges, the CSB is now producing considerable value for the taxpayers — issuing reports, studies, and recommendations that safeguard workers, plants, and the public from chemical

accident hazards. The Board is back on track as a strong, nimble federal agency that works closely with industries and communities that suffer deadly chemical disasters. The CSB's work helps to save lives and make plants and communities safer. I urge the Committee's support for modest budget increases that will allow the Board to be even more effective in the future.