

U.S. Chemical Safety and Hazard Investigations Board

Business Meeting

April 20, 2016

CSB Headquarters Office - Washington, DC

U.S. CHEMICAL SAFETY BOARD MEMBERS PRESENT:

VANESSA ALLEN SUTHERLAND, CHAIR

MANNY EHRLICH, MEMBER

RICK ENGLER, MEMBER

KRISTEN KULINOWSKI, MEMBER

STAFF PRESENT:

KARA WENZEL, ACTING GENERAL COUNSEL

OPERATOR: Welcome to the business meeting conference call. My name is Ashley and I'll be your operator for today's call. At this time, all participants are in a listen only mode. Please note that this conference is being recorded. I'll now turn the call over to Chairperson Vanessa Allen Sutherland. Vanessa, you may begin.

VANESSA ALLEN SUTHERLAND: Thank you. Good afternoon and welcome to the business meeting for the U.S. Chemical Safety Board or we'll be using CSB today. Today we meet in open session as required by the government and the Sunshine Act to discuss the operations and agencies activities since our last meeting. I'm Vanessa Allen Sutherland, Chairperson of the Board, and joining me today are Members Kristen Kulinowski, Manny Ehrlich, and Rick Engler. Also joining us is our Acting General Counsel, Kara Wenzel, and members of our staff.

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

which are designed to prevent similar accidents in the future and/or mitigate their consequences.

I will now walk you through today's agenda and highlight how we will proceed. First the board will give an update on any current investigations, studies, recommendations, or deployments. We will then provide updates on ongoing IG, Inspector General, activities, our finance and budget updates, and any organizational initiatives. Next, we will provide an update on the CSB's action plan. This will be followed by discussion and Board vote on Calendared notation items from the CSB's *Improving Reactive Hazards Management* study which we mentioned at our last public meeting. This will be followed by a public comments section on our agenda and on the recommendations and will close with a general public comment opportunity.

If you are in the room and wish to make a comment, please sign up using the yellow forms that were right outside of the glass doors to my left, your right. If you are on the phone, you may submit public comments by e-mailing them during the meeting to meeting@csb.gov, to be included in the official record.

Before we begin, I'd like to point out very brief safety information so that we can all note where the exits are and also silence our phones. If you were to go out of the back entrance of

the room or the door immediately next to our panel and out the glass doors, there are stairwell exits to the left and right. The restrooms are in the same location. And I do please ask if you have not already muted or silenced your phones, please put them on vibrate so that the proceedings are not disturbed.

Last week the Board released its draft report into the Deepwater Horizon rig explosion and oil spill. We also call that Macondo for short. But it was at the Macondo well in the Gulf of Mexico. 11 workers died and many others were injured. But I am pleased to say that as of today, all CSB Board members have approved the final two volumes of reports, Volume 3 and 4, and an executive summary that outlined the critical issues in those volumes.

The CSB's report found that the offshore regulations in the U.S. have been moving gradually toward a performance-based approach. But in order for the changes to be effective, there are key regulatory attributes that the Bureau of Safety & Environmental Enforcement or BSEE needs to pursue. This includes an adaptable oversight approach that continuously strives to reduce risk, proactive tools to evaluate and monitor safety performance, and meaningful worker participation. Successful safety and risk management will take a tripartite effort among industry, BSEE, and

the workforce. Preventing the next major accident is not an easy task but certainly communication and collaboration can go a long way in preventing that.

So release of the CSB's final report into that 2010 accident is truly an accomplishment for everyone at the CSB. I first want to applaud the staff, some of whom are in the room, some of whom have already heard that we really appreciated their very strenuous efforts to get both volumes to the finish line. It was really no small task and it does offer an opportunity for the CSB, not only to implement those recommendations, but also for the Board to redouble its outreach and advocacy efforts by continuing to conduct the work and amplify it in other public settings.

This is the third full investigation that has been closed since I have been the Chair. We have very passionate, very active Board members. So they don't usually get the thanks, but I would like to thank all three of them, too, for reading these, commenting, and taking the mission and the work very seriously. I'm pleased to say that together we really are trying to work towards being one of the most high-functioning, efficient agencies in the federal government and doing work that really belies our size.

I hope that the CSB will continue to see staff and Board members work together in action and in words to achieve operational excellence, execution of our important mission, and communication, transparency, and trust.

So with that, I would like to open it up to my fellow Board members if they have any additional comments or thoughts before we discuss our open investigations. I'll start to the right and rotate. Member Kulinowski?

MEMBER KULINOWSKI: Thank you, Chair Sutherland. I just want to reiterate the praise for the staff in getting Volumes 3, 4, and the second summary of Macondo out, and thank my fellow Board members for allowing us to announce that the vote is final on the six-year anniversary, a very momentous occasion. This is a herculean undertaking by the staff. Required [inaudible] persistence over the years. That's too many Greek metaphors.

VANESSA ALLEN SUTHERLAND: We like the mythological.

MEMBER KULINOWSKI: My daughter's really into it, so I'm reading a lot of Greek mythology. I appreciate the staff's efforts to close this out and think that the recommendations and the reports themselves will stand as some of the most significant work CSB has done. Thank you.

VANESSA ALLEN SUTHERLAND: Member Ehrlich?

MEMBER EHRLICH: Thank you, Madam Chairperson. Good afternoon. I want to start off by saying that this effort and what went on in Macondo has been going on now for six years, longer than I've been going on, on CSB. When I sit down to think about what's been accomplished and what this team did, it's absolutely a herculean effort. And I might agree with Board Member Kulinowski's other Greek mythology except I don't know who the hell it is.

MEMBER KULINOWSKI: Pushing rocks up hill.

MEMBER EHRLICH: I've been pushing rocks up hill for 70 years so I ought to be used to that. I've attached a rather lengthy statement to my notation in which I did...I voted favorably to accept the report. But I wanted to read a brief statement at the meeting. First of all... First and most importantly, I wish to extend my personal and professional thanks and congratulations to the team who performed the herculean task of completing this report. Unless you sit down and read all 1,200 pages of it, you really don't have a good idea of what it's all about. I've never seen a volume like that in my experience, in my career. I've personally learned a lot in this. It's been a very learning, growing experience. And I made several commitments to myself and several commitments I will make to the agency going forward based on what I learned. I've learned a great deal and going forward will apply those lessons

learned to maintaining a collegial environment with the team. Extremely important. Very, very important. To demonstrate recognition of their efforts, in recognition of the efforts involved in the process, and most importantly to forego my personal and political agendas for the good of the agency and the team, I will continue to ask questions but not from an attack mode. And again, I want to thank everybody in the agency that had a hand in bringing this to fruition. Thank you.

VANESSA ALLEN SUTHERLAND: Thank you. Member Engler?

MEMBER ENGLER: Well, I would echo the comments of other Board members. I would also like to just add that I think that the Macondo volumes are a very useful and important contribution to an ongoing debate about ensuring safety in the Gulf of Mexico. I think there are recommendations there that will prove much broader for a continuing discussion, dialogue, and lively debate, including the extent to which we have in fact supported safety [inaudible], to the extent that we have supported new approaches to worker participation that should be further debated, contribution around human factors in particular, which was the basis for the original request from Congress to investigate the Macondo incident, are some things that I think are addressed in the report.

And, as much as any report tries to ask...answer questions, they also raise new ones at the same time. So now I look forward to our participation in the ongoing dialogue and also commend the staff for their efforts to take this lengthy project to fruition.

VANESSA ALLEN SUTHERLAND: Thank you. At this time, the Board will provide an update on ongoing investigations. I will now ask Member Kulinowski to provide an update on the Williams Olefins investigation.

MEMBER KULINOWSKI: Thank you, Chair Sutherland. As a reminder, there was a CSB investigation into the boiler rupture and fire at the Williams Geismar Olefins plant in Geismar, Louisiana. Currently under internal review. It's already gone through a number of stages of review. The Board has seen the draft report and it's currently taking the form of a case study. The team is responding to comments from the Board and some other reviewers. The draft investigation report is currently in our external stakeholder review phase and is still on track for completion in this Fiscal Year 2016.

VANESSA ALLEN SUTHERLAND: Great, thank you. Member Ehrlich, can you please provide an update on Freedom Industries?

MEMBER EHRLICH: Sure. Thank you, Madam Chairperson. To date all fieldwork has been completed and the investigative team is

developing a full report with recommendations. I'm sure you'll recall this is the event where methylcyclohexane methanol got into the river in Charleston, West Virginia, and contaminated their water supply. The report as expected will be circulated through internal and external reviews. The team will complete and attach recommendations prior to submitting the report for Board final review and consideration of the completed report by the end of Fiscal Year '16.

VANESSA ALLEN SUTHERLAND: Do you also have an update on Tesoro Martinez?

MEMBER EHRLICH: I do, thank you. Very limited. A draft investigation report is in the external stakeholder review phase and it's still on track for completion in Fiscal Year 2016.

VANESSA ALLEN SUTHERLAND: Thank you. Member Engler, can you provide an update on Exxon Mobil [inaudible]?

MEMBER ENGLER: Yes. In February 2015, an explosion occurred in the electrostatic precipitator or ESP at the Exxon Mobil refinery south of Los Angeles in Torrance. The explosion injured four workers, caused significant property damage to multiple processing units within the refinery, and resulted in an offsite accidental leak of catalyst dust. Debris from the ESP fell onto neighboring units within the refinery, including the alkylation

unit. Multiple pieces of equipment in the platinum reforming unit were also impacted by debris and failed.

During the ESP explosion there was also a near-miss release of hydrofluoric acid—I think this is one of the most significant aspects of this investigation—when a large piece of ESP debris fell within feet of a storage vessel storing thousands of gallons of modified HF. If the storage vessel had failed due to impact following the explosion, hydrofluoric acid would have been released. Based on the release characteristics of HF, potentially hundreds of thousands of workers and community members could have been exposed to HF with the possibility of serious injuries and fatalities.

The investigation team is in the process of developing and editing the investigation report and continues to work with the Department of Justice to enforce subpoenas to Exxon so that a full all-cause investigation can be conducted. After the investigation report rough draft is generated, the team will circulate it internally and externally for review before issues findings and recommendations.

If I can just emphasize, as I did in a recent presentation to the Center for Chemical Process Safety, that it is really unacceptable for Exxon not to cooperate in this investigation. The

fact that this is such a clear example of a near miss would suggest that Exxon would have their interest in cooperating actively with the ongoing investigation in the way that they apparently are when you move a few feet away to the catalytic cracker unit on the FCC unit. But they're not. So this is something that's a continue frustration and we're pursuing all that we can do through legal channels.

VANESSA ALLEN SUTHERLAND: Thank you. I will now discuss Dupont LaPorte and the Delaware City Refining Company.

First, Dupont. On November 15, 2014, nearly 24,000 pounds of methyl mercaptan was released in the Dupont pesticide manufacturing facility where the highly toxic chemical release resulted in the death of three operators and the shift supervisor inside the enclosed manufacturing building. Additionally, three other workers were injured from their exposure to methyl mercaptan and at least three more workers experienced methyl mercaptan exposure symptoms.

Earlier this month, Dupont announced its decision to not restart the LaPorte insecticide manufacturing facility. That has been shut down, as a matter of fact, since the November 2014 incident, about 17 months ago. The CSB's investigation into the causes of the incident will continue, however, and we are still

planning to complete our investigative report and share the lessons learned from that incident.

For Delaware City Refining Company in Delaware City, Delaware, on Sunday, November 29th, 2015, a flash fire occurred at DCRC while operations personnel were preparing equipment for maintenance. As a result of this incident, an operator at the facility supporting this activity suffered second- and third-degree burns to the face and neck areas. Two other previous incidents had occurred at that same facility on August 21st and August 28th, 2015, and coupled with the November 29th incident formed the basis for the decision to dispatch a small investigative team to that location to investigate the most recent event.

The status update is that our investigation team is developing a safety bulletin which will feature lessons learned and they are preparing a draft for internal and external review. Once the internal review is completed, the bulletin will be finalized and submitted for CSB Board vote and approval.

Under studies, we mentioned very briefly following West and at our last public business meeting that we were determining whether a land use study might be useful or of benefit. Member Kulinowski, at that meeting, did a really great job outlining the findings from West and how that falls into the CSB evaluating whether or not

there was more to learn from our investigations in a land use study.

We want the land use study to be focused and based on the work that we've done and highlight where we have seen land use issues contribute to or exacerbate the consequences of an accident. We'll be using our own data to summarize [inaudible] information in an effort to make data already in our possession more accessible. We will continue to update you as that develops more and hopefully we'll have Board members champion that as Member Kulinowski identified last meeting and have the staff help us define the scope.

So the update is simply that we have moved a little bit further analyzing how we might proceed but still need to communicate what the final scope and timeline will be for that study.

For recommendations, the CSB currently has a ratio of 76%. There's 575 recommendations that have been closed, while 24% or 186 remain open. The status of all of our investigations can be found on our website at www.csb.gov/recommendations. The recommendations that have been recently voted on can be found on the recommendations page under the Recent Recommendation Status Updates

link and each of the recommendations has a status sheet summary that describes the rationale for the Board vote.

Recommendation closures so far in Fiscal Year 2016 have been 24 recommendations closed, 18 of those were closed acceptably, 1 was closed unacceptably, and 2 were closed reconsidered or superseded. In addition this year, in Fiscal Year 2016, the Board has voted to move 17 recommendations to the status Open Acceptable and has voted on the status of 38 recommendations which include 11 from the Chevron Refinery fire investigation, 7 from the Dupont LaPorte investigation, 4 from the US Ink investigation, 4 from the Reactive Hazard Study, and 2 from MFG, and 2 from BP Texas City.

There's 1 each from Honeywell, Hoeganaes, West Fertilizer, [inaudible], Kleen Energy, and Valero McKee and combustible dust investigations that have also had an update to their status.

One recommendation related to the Reactive Hazard study was calendared by Board Member Engler and will be discussed by the Board in more detail later at today's public meeting.

We have a few ongoing projects that we provided an update for in January and that is the Recommendations Department is currently working to update the 2016-2017 Most Wanted List program so that the Board may determine what, if any, additional items or safety concerns should be added to that list for highlights and

amplification of additional outreach. We will continue to provide updates on CSB's decisions to deploy to chemical incidents and will continue working on other important work that's being conducted by our Board Members and staff.

Three of those that I will highlight very quickly before we progress to our calendared items are IG updates, our finance update, and an organizational update.

First, on the IG update, as of April 19th, the CSB is currently working with the Office of the Inspector General on four audits, which is down from six. So thank you [inaudible], Office of Inspector General, for working with us, turning around our documents very quickly, providing comments, to close the two that were recently closed. The status of the audits are as follows. We have a FISMA audit for FY2015 open, a CSB governance project open, the audit of CSB's purchase card, and an FY2016 proposed management challenges and internal control and weaknesses document. All of those, except for the first one, are with the OIG. They are working on draft reports. The first, which is the FISMA.. For those of you who are not into the technical government acronyms, it's the Federal Information Security and Modernization Act. And there were a total of seven recommendations in that document. We are actually working on addressing several security and IT

programming recommendations. We anticipate closing all of those recommendations by May 31st of this year.

On the finance updates, like all other agencies, we're awaiting our FY17 budget. So no news, no new news anyway there. The CSB has sufficient funding to complete FY2016 so we are in great shape to complete the work that we have currently slated for our action plan.

And lastly, on the organizational update, I mentioned at the last meeting that we would update you on our strategic planning process. In May, this upcoming May, the first or second week roughly, several of our staff will meet to begin discussing and laying an outline for the 2016 to 2020 strategic plan. Our expires this year so we will be working on the new four-year plan. It's going to be a very important team effort and we will make sure that we keep our interested stakeholders and participants... Many of you come regularly and we will make sure that we do not only this outreach but broader outreach as we begin to share what our strategic planning efforts will be for the next four years. That will define our action plan. We continue to update our current action plan as we start the third quarter of FY2016. So more to come on the strategic plan.

I do not have any additional old business. Member Kulinowski?
Member Ehrlich? Member Engler? Okay.

We do have some new business. But before we discuss the notation item that was calendared, the Board is involved with many investigational and operational activities that are keeping us extremely busy which is great. At this time, I'd like to open the floor up to my fellow Board members for any comments before we discuss any business. We are going to, obviously, in detail discuss our notation items and share with you all how we deliberate on this particular item. But I open it up for any comments or any pre-comments on the notation item before we start. Member Engler?

MEMBER ENGLER: Pre-comments?

VANESSA ALLEN SUTHERLAND: Do you have any comments about...
Anything you'd like to say before we discuss the notation?

MEMBER ENGLER: I think that [inaudible] introduce the notation item and then I will make comments.

VANESSA ALLEN SUTHERLAND: Anything? Manny?

MEMBER EHRLICH: Yes, thank you, Madam Chairperson. I just want to say that we talked about the notation item a number of months ago and I think the Chair pointed out at that Board member, and I must say I don't remember which one it was, that what... We have way too many but that's neither here nor there. I think what

we've done with this particular notation item is allowed you to get an insight into how the agency works. And I think that's important. I think that the agency's worked very hard on taking care to establish a position of transparency and I think it's something we all feel grateful for.

VANESSA ALLEN SUTHERLAND: I thank you for that. I didn't give you \$5 or anything for saying that.

MEMBER EHRLICH: \$10?

VANESSA ALLEN SUTHERLAND: Don't push your luck. I think all of us have an interest in showing how we do business and that's why these meetings have been more regular. There shouldn't be any secret or mystery how we get to a decision or how we reach a conclusion. There shouldn't be mixed messaging. We're trying to do this in a way that this particular notation item allows us to actually have really good internal debate about how the ultimate resolution of this notation item should be addressed. And so, with any luck, for those of you who are new to how we do business and haven't been following the CSB for a while, will see what are the kinds of questions we ask the staff and we ask of ourselves, that we analyze before we actually put a checkmark or an X next to a vote.

I will commence with the general counsel's comments, just to provide an overview of what we will be discussing today and how we will do that. So Kara.

KARA WENZEL: Thank you. Just because the procedure is a little bit unusual, I wanted to give you a bit of an overview about what's about to happen. This Board can vote on issues in one of two ways. The first is at a public meeting like this one and the second way is by a notation item which is [inaudible] for a paper vote. And the procedure for voting on paper by a notation item is explained in the Board's governing documents; Board Order 1 is the specific one. All of those are public on our website if you want to take a look.

So in a nutshell, it says that the members can approve, disapprove, or calendar an item, a notation item, for consideration at a future meeting, giving public notice in the Federal Register within 90 days of that initial vote. Depending on the substance of the matter before them, they can hear comments from the public, while they deliberate, before or after.

And as they mentioned in our last public meeting that was February 23rd, Member Ehrlich, a notation item had become before the Board about a week prior to that and the substance was about changing the status of a couple recommendations. One member

calendared it and so we mentioned at the meeting a vote would occur today, our next public meeting.

So instead of recording their votes on paper, which was the original [inaudible] the act of calendaring just simply stopped the process, delayed it until today. So the members are now going to deliberate this item, discuss it, give their views, and then when we're done, they have to vote to either approve or disapprove, one or the other.

VANESSA ALLEN SUTHERLAND: So, as background about the notation item, after a series of high consequence events that involved runaway chemical accidents, the CSB undertook a comprehensive study, the one I mentioned before, entitled *Improving Reactive Hazards Management*, which was issued in 2002. During the investigation, the CSB identified 167 serious accidents in the United States between 1980 and 2001. 48 of those incidents resulted in a 108 fatalities. More than half of these incidents involved chemicals not currently covered by existing OSHA, Occupational Safety & Health Administration, or Environmental Protection Agency standards. Both recommendations made to EPA and OSHA are currently in the status open, unacceptable actions. However, they may be addressed in future revisions to OSHA's Process Safety Management Standards and EPA's Risk Management Plan

[inaudible] many of you are currently in their own various rule making and update [inaudible].

As part of the CSB's study, four recommendations were made to the American Chemistry Council, 2001-01-H-48, 2001-01-H-R9, 2001-01-H-R10, and 2001-01-H-R11. Both Recommendations R8 and R11 have been closed for acceptable actions taken by ACC. The two remaining recommendations are the subject of today's calendar vote are R9 and R10, which read as follows.

R9, develop and implement a program for reporting reactive incidents that include the sharing of relevant safety knowledge and lessons learned with your membership, the public, and government to improve safety system performance and prevent future incidents.

R10, work with NIST in developing and implementing a publicly available database for reactive hazard test information. Promote submissions of data by your membership.

CSB's recommendation rationale. In the study, the CSB noted that the American Chemistry Council's ACC Process Safety Code Management System, abbreviated PSCMS, contains data on the type of incident, number of injuries, and other data for 1,500 facilities but no data on the causes of accidents or lessons learned. PSCMS, which was created in 1996, is primarily designed as a metric for tracking industry performance on process safety incidents. It is

not intended to be a lessons-learned database. However, the CSB found that if expanded to include causes and lessons learned and was more widely distributed, the data could be used in preventing similar accidents.

Further, the CSB found that there's no publicly-available database for sharing lessons learned from reactive incidents or to share reactive chemical test information. Consequently, the CSB issued recommendations, R9 and R10, but in this particularly instance, with focus on R9, which was to develop and implement a program for reporting and sharing of reactive [inaudible].

ACC's recommendation response on February 3rd, 2015, the CSB staff recommended to the Board that the recommendation should be given the status closed, acceptable, alternative action, based on actions taken by ACC. ACC stated it believed as a trade organization they are not the optimum venue for selecting, vetting, or disseminating a large volume of information that would be generated by this recommendation.

ACC does have an internal system to annually collect a summary of process safety incidents data from its members which includes events that may involve reactive chemicals with an exclusive tag in the system to note any reportable incidents that involve a reactive chemical. However, ACC does not provide any of this information to

the public or the government due to unresolved questions regarding legal protection needed to make this information available. ACC also noted that the Center for Chemical Process Safety, or CCPS, the National Oceanography & Atmospheric Administration, and the Organization for Economic Cooperation and Development have developed publicly-available reactive chemical [inaudible] software and databases that ACC believes satisfies the intent of the CSB's recommendation.

As ACC has developed and implemented an internal system for reporting and sharing reactive incidents for its member companies and has given a rationale for not making the information available to the public or the government, CSB staff recommended to the Board that the Board vote to give the recommendation status closed, acceptable alternative action.

So for any of you who read this in preparation, I just read what was already in the publicly available notation item. But I read it for anyone who is in the meeting and you don't have the R9 or the R10 handy. Both R9 and R10 were included on the same notation item for Board vote. Member Engler calendared recommendation R9, they're packaged together, for a public meeting. However, R10 was included in the same notation item. Action has not been taken on either recommendation prior to this public

meeting. We will, however, as Acting General Counsel Wenzel mentioned, be voting on that today.

So at this time I would like to invite Member Engler to read his calendaring statement and then we'll open up the discussion to other Board members for their comments as well.

MEMBER ENGLER: This information was on the desk outside. I'm not sure everyone got it. Does everyone have this information before I read the statement? [inaudible] violates the rule of giving out material to an audience when someone's about to speak because it determines that no one will listen to you and everybody will read but it is important that you have this.

So I would like to explain... I will speak louder since I know I just handed out the paper to distract you from the reading material. I would like to explain why I calendared this notation item on February 16th of this year. Again, I'd like to make it clear that this statement applies to recommendation 9, not to recommendation 10, which I am prepared [inaudible].

As part of my deliberation in coming to this decision, the only CSB staff status change recommendation I have calendared to a public meeting since my term began in February, 2015, I reviewed the extensive material provided to the Board members by CSB staff, the 252-page transcript of the 2002 CSB public hearing on reactive

hazards, the 2002 CSB report entitled *Improving Reactive Hazards Management*, which Chairwoman Sutherland referred to, materials from the Center for Chemical Process Safety, and the ACC's Responsible Care website.

I have four central reasons for calendaring this notation and opposing the proposed change to close acceptable, alternative action, specifically for recommendation 9. First, incidents involving reactive hazards continue. Second, the ACC has not implemented the clear CSB recommendation language contained within R9. Third, the public has a right to know about chemical hazards and incidents. And fourth, the ACC should advance the intent of its Responsible Care program to share what it has learned about the acts of chemical incidents.

So first, incidents continue. For example, here are just four recent examples in 2016 that were obtained largely from public sources compiled by CSB. Dow Chemical, [inaudible], North Andover, MA, January 7th. Four workers were injured, three critically, during a routine process of transferring trimethylaluminum from one cylinder to another in a laboratory at the facility. PeroxyChem Bayport Plant, Pasadena, TX, January 16th. One contractor was fatally injured and another injured at this facility when a valve on a vacuum truck failed during routine transport operations in a

hydrogen peroxide process. Contractors from Evergreen were injured when over-pressurization led to the valve on the vacuum truck to fail, hitting one contractor.

Texas A&M Food Protein Lab explosion, College Station, TX, March 9th of this year. A visiting scholar received second-degree burns to his hands in an explosion while processing some liquid samples containing hexane, an insect protein, in a container hooked up to a vacuum. Texas Tech University, Lubbock, TX, March 10th. A student experienced injuries during a precipitation reaction when the glass housing the experimental products exploded.

By the way, the first two incidents that I just cited were at ACC member companies, Dow and PeroxyChem.

And, of course, in April 2013, in West, TX, an ammonium nitrate explosion at the West Fertilizer Company killed 15 people. That was a reactive chemical accident, as well as the subject of [inaudible].

Clearly, the impact on workers and the public from reactive chemical incidents continue to this day, 14 years after CSB issued its report on the Morton Chemical explosion and fire in 1998 in Patterson, NJ, in which nine employees were injured and hazardous chemicals were released into the community. As the CSB concluded in a 2007 update to our report, *Improving Reactive Hazards*

Management, although the available data are lacking in important respects, they strongly suggest that the reactive incidents continue to result in fatalities, injuries, property damage, and public impact.

That update further concluded that, "It is impossible to reach any firm conclusion about trends since the publication of that report, however, because of the continuing limitations in data."

The second reason for my action was that the ACC has not implemented the crystal clear recommendation language. I commend the ACC for their actions to address reactive hazards and for developing an internal system to annually collect a summary of process safety incident data from their members and to flag incidents that may involve a reactive chemical. However, our recommendations also say, and I quote, and of course Chairwoman Sutherland indicated this before, the recommendations also says that ACC should, "Ensure that they develop and implement a program for reporting reactive incidents that include the sharing of relevant safety knowledge and lessons learned with your membership, the public, and government, to improve safety system performance and prevent future incidents."

In our recommendation response evaluation, our staff finds that ACC remains unwilling to make the information available to the

public or the government due to "unresolved questions regarding legal protection" needed to make this information available. Fourteen years after the CSB recommendation was made, this rationale remains inadequate.

Third, the public has a right to know about chemical hazards and incidents. Workers in a wide range of industries need to know what they can be exposed to every day on the job. Firefighters, EMTs, and police officers need to know about the hazards they can face before they respond to an incident. Neighbors need to know what they may be exposed to, including those substances that may cause fires and explosions nearby their homes and businesses. And policymakers need to know so they can assess gaps in regulations and to take necessary steps to protect all of us. All of us have the right to know so we can take steps to protect our own health, safety, families, and livelihoods. The right to know about chemical hazards is a recognized public right and a fundamental premise of many widely accepted public policies. These include the OSHA Hazard Communication and Process Safety Management Standards, the Emergency Planning and Community Right to Know Act, Clean Air Act Section 112(r) which created the EPA Risk Management Program and created the Chemical Safety Board. Today, the EPA is moving to

expand the public right to know in its recent proposal to update its Risk Management rules.

While these laws are a major advance from where we were in the early 1980s, they are not perfect. For example, they do not include requiring a national government agency to develop a chemical incident database to share lessons learned.

Finally, the fourth reason is that the ACC should advance the intent of its Responsible Care program to share what it has learned about the act of chemical incidents. The absence of a federally-mandated chemical incident database is incumbent upon ACC, which includes about 2,000 facilities, to help ensure that workers and the public are protected. This appears to be the intent of the ACC's Responsible Care program, created in 1988.

The 1990 Responsible Care guiding principles included to make health, safety, and the environment critical considerations for all new and existing products and processes, to provide information on health or environmental risks, and to pursue protective measures for employees, the public, and other key stakeholders.

In 2005, the Technical Specifications of Responsible Care included to "provide information on health, safety, security, and environmental risks and pursue protective measures for employees, the public, and other key stakeholders." Responsible Care

stakeholders are defined to include employees, neighbors, emergency responders, other industries, competitors, public at large, and regulators.

Part of the Responsible Care Process Safety Code covering each ACC member firm requires information sharing and says that experience from process safety reviews, inspections, audits, and incidents and near miss investigations should be shared with stakeholders.

This week I examined the ACC website. Current Responsible Care Guiding Principles include to communicate process risks to stakeholders and to openly report health, safety, environmental, and security performance. While the website reports that Responsible Care companies have reduced process safety incidents by 53% over the past 20 years, there is no public reporting that I can find of specific chemical incidents or lessons learned. Thus, the ACC, as documented by the CSB staff, has not shared this information with the public or government.

Therefore, a CSB decision to change the status of this recommendation to closed, acceptable alternative action is unjustified and I will vote no. If circumstances change in the future, including the presentation of new information or steps to

address this issue or other mitigating circumstances, I will revisit the status of this recommendation.

Finally, this is a highly consequential vote for CSB. The outcome speaks to the critical role of our agency in helping to safeguard the public through transparency of information. I urge my fellow Board members to move forward, not back, and to vote no.

VANESSA ALLEN SUTHERLAND: Member Kulinowski?

MEMBER KULINOWSKI: Thank you. Are we going to have a separate discussion or should we do it [inaudible]? Thank you, Chair Sutherland. First of all, I'd like to commend the staff for continuing to promote the adoption of our recommendations generally. I appreciate the work they did and the specific example of encouraging the American Chemistry Council over a period of 15 years to adopt two of the outstanding recommendations for reactive hazards setting.

In doing a second review since the notation item was calendared, I remain persuaded by our team's case to close R10, in which we recommend the ACC work with NIST to create a database of reactive hazard test information. A compelling argument was made that the ACC carefully considered the recommendation, convened a workshop to discuss the issues, and considered in detail what such a database would look like and how it would be populated. Serious

issues of potential liability to data contributors from misuse of the test data emerged during those discussions and remain unresolved, which ultimately derailed this effort.

We have closed a related recommendation to NIST and I believe it is appropriate to close this recommendation as well, as we consider what superseded.

R9, however, is a different case. R9 asked the ACC to create a database of reactive hazards incidents and to make it available to public and government. The careful thought given to R10 does not seem to have been applied to R9. Rather, the two databases—test data in the case of R10 and incidents in the case of R9—appear to have been conflated in the analysis presented in our evaluation. No evidence was provided in our notation item of any workshop or multi-stakeholder discussion dedicated to considering how best to make the reactive incidents public. The ACC's arguments that Member Engler articulated are that as a trade association it is not the optimum venue for creating and curating an incident database and that other organizations do this. Particularly they call out the CCPS's Process Safety Incident Database but this database is not publicly available. One has to be a member of CCPS to even access it. The CCPS Process Safety Beacon is also mentioned in the ACC's response but that's a series of incident vignettes provided

in narrative form which is not the same as a database. Information sharing at the Global Congress on Process Safety and other professional society and trade association meetings, while undoubtedly valuable, also is not a substitute for a database.

The ACC is quoted in our recommendation's response evaluation as referring to "unresolved questions regarding legal protections" to make this information public but it is not clear from the evaluation whether this refers to R9 or to R10 or supporting information regarding the legal liability was documented fully. Without such supporting information in our own evaluation on R9, I am left to consider that the two databases were conflated into a single issue and I see them as separate.

The ACC has stated that it has now created its own internal database for use by its members in which they specifically flag reportable incidents that involve a reactive chemical. This is an advance in chemical safety for which the ACC should be recognized and I do so today. But as with the CCPS database, the ACC's database is not available to the public or to government. In fact, the CSB has not itself examined the database.

So in responding to our recommendation, ACC has fallen short of the mark, public and governmental access, established for it in the recommendation by a prior Board. Now, whether or not the

original recommendation was well crafted or delivered to the appropriate recipient is not at issue today. We must vote on what was presented to us in the notation item. For that reason, I will vote not to approve this item and I do request that going forward two new notation items be drafted that consider the status changes of R9 and R10 as separate items. Thank you.

VANESSA ALLEN SUTHERLAND: Thank you, Member Kulinowski. Member Ehrlich, any comments or thoughts?

MEMBER EHRLICH: Just a few, Madam Chairwoman. Thank you very much. I'm not going to go into all the details. I have a question as to how this was crafted in the first place and I do think that's relevant. And I have... I've worked around this issue for a long time in my mind. And by virtue of the fact that I have, I'm going to vote in favor of this notation item.

VANESSA ALLEN SUTHERLAND: I've been talking for the majority of the meeting so I'm going to give my [inaudible]. I'm simply going to share my analysis because I think the recommendation's applicability or issuance to a recipient and whether it's well crafted, I actually do think is at the heart of the Board's responsibility. Our Board orders say that it is the Board's responsibility based on the staff's analysis, evaluation, interaction, and engagement with the recommendation recipient to

make a wide variety of conclusions. That could be closed, unacceptable; closed, acceptable; closed, alternative response; or closed, superseded/reconsidered, which by, in and of itself, I think one could infer that we are in fact allowed to take a look at how well the original recommendation was crafted, whether it was to the right recipient and whether or not it should be reconsidered given subsequent information, changes in the status of industry, changes in the status of technology, or a whole host of other factors that are [inaudible] expertise based on our investigation can inform us.

After 14 or 15 years, my analysis was, was the CSB recommendation and change status presented to the Board a reasonable recommendation? I originally voted yes although that is in contention because of a variety of factors. Starting with the analysis I just gave you, I reread R9 and said, it is to develop and implement a program for reporting reactive incidents that includes sharing of relevant safety knowledge and lessons learned with membership, the public, and the government. Rather than R10, which was more myopically tailored to appropriately available database.

In looking at R9 and what that meant, I certainly had to then look at the history of the investigation, the recommendations for

the recipient, and included that while I absolutely and fundamentally agree it was transparency and public access, that is handled through [unintelligible] which is not our area of expertise and not the core of our mission. Protecting the workers who are in chemical industry and in harm's way in chemical accidents is critical, but our mission is to investigate chemical accidents at fixed facilities in order to protect people and the environment by identifying root causes and then developing a naturally logical outgrowth of recommendations that will further prevent accidents and mitigate their consequences. And the team made a very compelling case to me the first go-round before it was calendared as to why the knowledge among those who control the risk management and process safety, etc., meaning member companies, if they're hopefully sharing those lessons learned and safety knowledge, although I concede we should look at and should have looked at what that program and sharing mechanism is. But to the extent those people, as in very well discussed typical Center for Process Safety mantra would be, is the way that people get lessons learned and hopefully prevent accidents and mitigate some of the consequences.

The fact that a recommendation could be written, whether we in hindsight think it is written well, slightly well, or poor, the fact that it might be of issue...might have been issued to the wrong

person and may have been a herculean effort and may not ultimately progress chemical safety or prevent it in the way that we seek, is relevant to me. Making a bad recommendation and not writing it well 15 years, 20 years, 30 years ago doesn't mean I'm not beholden to it. I can use logic. I can use analysis of the team. And I can look at who are the right recipients who bear the majority of the burden for ultimately addressing this issue? I have been at a company and I have been at a regulator. I now get the luxury of being at neither. So I can say in a more, let's say, removed context that if EPA and OSHA are not willing to put reactive at the forefront of their regulatory agenda, investigate them, develop their own database, call upon those whom they regulate to share this information in a formalized program—and they've had 15 years to do it also—if they are not developing their own database and/or reports and related information, it does make me wonder will they be using this information in the fruitful way we had envisioned 15 years ago.

Moreover, I think that it is...there's not a titanium link between a reporting program to the public and prevention. It is hard for me to then conclude that without the... By the way, the rest of this recommendation is to improve safety performance and prevent future incident. It is not to provide knowledge to the

public. It is not [inaudible] related. It is not to assure that people are aware or public awareness. It is to drive down future incidents. So when I look at how it was drafted, I certainly don't want to be a Monday morning quarterback and say I would have done it this way, I would have done it that way. But I think the better alternative is to look at where our advocacy and knowledge may be better served in keeping a recommendation open for another 15 years when the recipient has said, "This is what we are doing. We think that that meets the intent." Our staff has said, "We think this is going to meet the intent and further a safety objective." And the other government recommendation recipients, which we tailored this to, thinking it would benefit them, haven't been raising their hand and screaming for it in the interim, in any [inaudible] from a regulatory database or other mechanism. It seems to me to be enough for us to say maybe we have served our purpose. We've raised awareness. We've set in motion several activities that have been conducted by ACC and others over the last 15 years. And I don't want to diminish the work that was done there, both in R9 and R10. But the majority of my comments, obviously, are related to R9.

The last thing I would say, because then part of our Sunshine Act is we never get to go into each other's offices, all four of

us, and have kind of a really fun debate and try to persuade each other because it would be a quorum and it would [inaudible] the Sunshine Act. So I am actually looking forward to, now that we've had our introductory remarks, for us to sort of probe and prod each other because eventually we'll have to call it to a close and vote. That is a requirement based not only on our regulations but on our Board orders. So we are going to vote either up or down for this today. But that does not [inaudible] statements of talking to each other which is part of the reason I wanted to share this. This is what we go through on a day-to-day basis for a variety of notation items. So I think it's only fair for you all to see how we get to the conclusion and that we are in fact giving a lot of these topics very, very deep thought and we are in no way minimizing the work that our team, stakeholders, and others put into it. But we do bring to it a variety of perspectives that I think brings good solutions ultimately to the end result.

So I would still vote to approve the recommendation as presented to me by the staff, although I would concede that going forward I would be giving a lot of scrutiny to how these recommendations are crafted and when you make a general recommendation is it really the right thing to do to say this single recommendation is going to be available to this group, this

group, this group, and this group? There might be more nuance and bifurcation that will help us get more crisp analysis of what we are trying to achieve and whether that recommendation recipient is the right party and whether the person we are trying to benefit really needs what it is that we are describing as the ultimate fix. That's a broader conversation for another day.

With that, I welcome the four of us to discuss before Kara holds us to a count and vote or a call for a...

MEMBER KULINOWSKI: Thank you for that, Chair Sutherland. I do think this recommendation should be closed because it is 15 years and there has been very little movement in any forward direction on the recommendation and I know that our staff spends a lot of time following up on open recommendations and this is one of our oldest open recommendations. I'll be voting today to withhold approval for this part of the notation item because I'm not sure that closed acceptable, alternative action has been met in my...that the bar has been met for that, in my opinion.

We have a number of other ways that we can close the recommendation. We can close it unacceptable. We can close it as we are proposing to close R10, which is reconsidered or superseded. So if, in our estimation, we find that another recipient would have been a better place for this recommendation to go or it was written

in a way that is not now implementable, that might be a...that's an alternative that we could explore in a future notation item.

VANESSA ALLEN SUTHERLAND: I certainly could be moved to close it unacceptable as opposed to closed, alternative response, for all the reasons that you just described, which is, yes, there was a subset of the work that was done for members but not for the public and government. I still have fundamental questions about whether the public and government should have even been in the recommendation line item. So for me, having to get over the hurdle of... I think it needs to be closed because there was action taken that does evidence that the recommendation recipient took the recommendation seriously and tried to strive to do something, even if it doesn't fully meet the end that the original recommendation strived for.

So I could be moved to close it unacceptable rather than closed acceptable alternative. But that obviously would have to be done as a new notation item which we can't consider today. I hear your point and I think that's a legitimate one, that we wouldn't have to [inaudible].

MEMBER EHRLICH: Thank you, Madam Chairperson. I guess I have a fundamental issue about something that's been hanging around for 15 years, except for me, of course. I've been affiliated in some

way, off and on, with ACC, CMA, and all of its predecessor organizations since 1980s. I would suspect there's probably nobody around anymore that even remembers this. I don't know if that's correct or not here. I just don't see any utility in not moving forward and at least in some level cleaning the decks, clearing the decks. And if the issue presents itself in another way, we'll have a much more modern approach to it and hopefully much more forward-thinking about how we can address it and go from there.

VANESSA ALLEN SUTHERLAND: Just quickly. I want to make sure for [inaudible] we include that, but one of the things that was a stumbling block for me in thinking about that was what will the public gain or lose by not having the program as described in R9? Are there any serious deficiencies and at greater or exponentially greater safety risks by not having a program in place to tell them about lessons learned for all collected reactive incidents?

That made me think because the point of R9 was to develop the program in order to prevent future accidents. In safety for me, there's always a concern that I have about anesthetizing the public. You all remember, I remember, this is just the three of you, right after 9-11, every time there was a red alert, like, "Ah, red alert, yellow alert, orange alert. Can't go outside. Don't want to drive." And then after like six months of that, it was

like when the [inaudible]. Red alert, okay, well, I have a meeting at 9:00 and I've got to get there or whatever. I don't want to speak for the majority of people but it makes you numb. We had this conversation with specifically PHMSA, the Pipeline and Hazardous Material Safety Administration, which is why their national pipeline mapping system is tailored to the public who has a need to know, when they need to know it, and what they need to know. You can always put in your zip code and then that comes up. But it wasn't like everyone needs to know about everything outside of their community in every other state in order to do something with it.

That might be a different analysis for the government because the government is making policy decisions and regulatory decisions. But I don't have the answer to share with people here. I simply say that that was a musing of mine when I looked at that recommendation and I thought, so if this program existed would the public knowledge directly contribute to the improvement of industry safety performance or prevent accidents? And I don't know. Would it help the members know? Yep, for sure. Would it help if they acted on it? Yep, for sure. Is there a direct link between the public knowing and us being able to extrapolate that that knowledge will lead to fewer accidents?

So, again, I agree that the recommendation, it does need to be moved forward [inaudible] we can be mindful about how to craft them in the future. But I definitely am at the point where I can agree with the three of you. Closure is good. What I think we will end up having to discuss is how it's closed, whether it's unacceptable, alternative, reconsidered, or something else in the next notation item.

What do you have?

MEMBER ENGLER: I think it's one of the presuppositions or premises of a democratic society that we have an informed public and that we cannot prejudge what people will do or will not do and that people, whether they come to a conclusion or proposed action, one would hope it would be based on a sufficient degree of information that in fact is available. When I walked the streets of Lodi after the Napp explosion and looked at the cracked windows downtown and talked to people, when I talked to Jim Gannon, who I was almost going to quote but I decided it would take too long, from our transcript, about what happened in his life... He testified in 2002 at the CSB hearing in Patterson. It was obviously a very hard experience for him to do that. But the whole reason he did that was to add his experience but also to provide information about what happened in that very specific incident that killed five

workers. I think there was a recognition that Jim Gannon had that unless we have adequate information and data, that it's very hard for the citizenry, for policymakers to make informed decisions.

And so that underlies my work here at the Board. I think EPCRA is key to it, inadequate as it is, because it is in many ways limited in scope. But the Federal Community Right to Know Act is a core part of our toolbox as an agency that I am quite sure staff refer to all the time. One of the issues in the West investigation was whether local emergency planning committees were fulfilling their function. Those were created by EPCRA.

So I think where there's a question of whether there should be information provided to the public, I'm going to come down on the side of information being public every time. That said, I do believe that there could be circumstances in the future that would lead me to take a different approach on a specific resolution. I'm certainly open to closure in other ways. And I realize that it makes sense not to have open recommendation on the books going forward forever.

Some of those mitigating factors could include submission by ACC of a report on the experience of their internal database and what the lessons learned were. That might influence me because if there's a collective...if all this incident data hasn't been tracked,

maybe there's something to learn from it that still would be valuable, even if there were not specific company identifiers on it. Seems to me that would be a positive contribution.

Another positive contribution could be reviewing the issue of coverage of reactive chemicals under the RMP program and under the OSHA PSM standards and taking a step back to the trade association to think about maybe it should reconsider its opposition to changes within those two regulatory protocols.

Those would be examples. I'm sure there's others of steps that could be taken that could be considered a basis for circumstances have changed, facts...new facts warrant a new review essentially to look at changing my vote.

VANESSA ALLEN SUTHERLAND: Rick, as a follow-up to that, do you see...in that line item, the trio of members, public, and government, do you see them as different, having different standards? You said, "I'll come down on the public each time," if some were for members. What's your assessment...are you putting that together with public? Public being broadly government agencies and citizens?

MEMBER ENGLER: I think there may be some narrowly tailored situations [inaudible] where the government has an interest in looking at some security issues. I'll just explain what the

example is. Right now you can go on federal databases to look at risk management plans. But you can't see offsite consequence information but you can go to the Federal Reading Room and look at that information. So there might be a government interest in doing something slightly different. We have access as a federal agency to all of that information. I don't necessarily agree with it the way it the way the whole scheme is set up. But I see that there could be a tailoring in that way.

But in terms of an incident database where a lot but not all of the incidents are in the public domain, where the public and the communities that surround the facilities are aware roughly of what happens, where some but certainly not all of the information, and not lessons learned is communicated. I would think that the public and government agencies would have a very similar kind of interest. And they also have elected representatives. After the Napp and Morton incidents, both Senators Lautenberg and Courson testified in the CSB hearing because they were very concerned about this. I'm not sure whether they're members of the government in that capacity or members of the public or both, but they were seeking information in order to sort out what type of policy response they wanted to make.

MEMBER KULINOWSKI: I wanted to go back to something Member Ehrlich said about clearing the decks on old recommendations. As a newer Board member, I certainly feel the weight of longstanding, open investigations and longstanding, open recommendations that all were guided under a different Board and think carefully about what my role is in evaluating the existing body of work, the decisions made by former Board members in my role as a current Board member. So I appreciate the desire for the staff certainly to clear the decks.

I guess I'm a little bit concerned about the potential, unwitting as it may be, for us to set a precedent in closing old recommendations just because we've given up hope that they're ever going to get adopted. I wonder whether it could lead some recommendation recipients to potentially just try to wait us out. We can wait for a new Board. We can wait 16 years. Whatever they determine is the optimal amount of time. We'll just wait them out. So there's no consequence, really, other than public discussion for not implementing our recommendations.

So that's one of the reasons why I think we have to consider carefully whether we just close a recommendation just because it's old and we're not getting anywhere. To have a rationale that either says times have changed, we've found a new way of doing this

that meets the same objective, a new recipient to direct it to potentially, or there's new thinking on the subject matter, which would lend itself, perhaps, to a reconsidered or superseded closure rather than an acceptable alternative. So I think that we should consider that as we move forward, that we may be setting a precedent that we don't want to set.

MEMBER EHRLICH: Thank you, Madam Chairperson. I don't disagree with that. But 15 years is a long time to sit around and think about what consequences are, how much has or has or has not been done. And I don't know who's responsible for that. Maybe I should say shame on us, shame on the Board for not pushing this a long time ago, okay. I don't know. I wasn't here. But I think the sooner that these things can be acted on and we don't dwell on something that most of us don't even remember how it got to be 15 years ago, I think the better off we'll be. And I cite that specifically with regard to West, where they've just come out with an NPRM, Notice of Proposed Rule Making, from the EPA as a result of Executive Order in the formation of [inaudible] and that was all based on the West explosion. And I was [inaudible] to go through that NPRM and find anything that talks about ammonium nitrate. It's not there. So where are we going to be 15 years from now? Talking

about ammonium nitrate. I just don't know. If I did, I'd bet on the lottery tonight.

VANESSA ALLEN SUTHERLAND: So I won't say I'm an eternal optimist but a fair weather optimist. And I don't think that age can be at the top of our list for reasoning to close recommendations. Some of them take a long time.

MEMBER EHRLICH: Yep.

VANESSA ALLEN SUTHERLAND: They take a lot of money. You have to evaluate cost, efficacy. Rule making can be...well, that [inaudible] an entirely different context. That can take a long time. So really what resonates with me is when I say it's been 14 years, it's the fact that in that time people haven't come up with an alternative mechanism. There's been some movement as it relates to lessons learned and sharing, but time in and of itself does not a decision make.

And so I think it's a good point to make sure that we're [inaudible] items. Maybe we'll break them out, R9 and R10. But certainly time alone... And I'm not sure that a database is the mechanism. R9 says develop and implement a program. That could be a brochure. It could be a database. It could be a training. I don't know what it looks like. It seems to me there's a lot of flexibility in there. So if there wasn't a nationwide, accessible

database or government access portal created in that time, I don't see that as a flagrant failure because of the way that we wrote it. That's a long time ago, and that's not a negative. Just the way it was crafted.

So I'll go down once and see if there are any final comments. I'll go this way this time. Member Engler, any final comments before we close the discussion?

MEMBER ENGLER: No.

VANESSA ALLEN SUTHERLAND: [inaudible]

MEMBER EHRLICH: Well, I'll just say I certainly agree with your comments about age. It's not a prevailing factor. But...

VANESSA ALLEN SUTHERLAND: It's a consideration.

MEMBER EHRLICH: It's a consideration. And as time goes on, you tend to forget what your original emphasis was. 9-11 is a perfect example of that [inaudible].

VANESSA ALLEN SUTHERLAND: Member Kulinowski?

MEMBER KULINOWSKI: I'd just like to say that I've enjoyed the conversation and welcomed the opportunities to talk to all three of you at once about this, instead of going one by one. And to have the kind of dialogue that you've said you wanted to have in the public where we get to discuss and debate without acrimony. So thank you.

MEMBER ENGLER: Yes, thank you as well.

VANESSA ALLEN SUTHERLAND: You're welcome. Kara?

KARA WENZEL: I think it's motion time.

VANESSA ALLEN SUTHERLAND: Are there any motions related..

[multiple voices] Any motions related to Recommendation 2001-01-H-RO and 2001-01-H-R10 to the American Chemical Council from *Improving Reactive Hazards Management*? Member Engler?

MEMBER ENGLER: I move to consider notation item 2016-27, which I calendared on February 16, 2016. The item designates the status of recommendation to the American Chemistry Council 2001-01-H-R9 and R10 from the *Improving Reactive Hazards Management* investigation as closed, acceptable alternate action for R9 and closed, reconsidered/superseded for R10. Currently both recommendations have the status of open, awaiting response or evaluation.

VANESSA ALLEN SUTHERLAND: Is there a second?

MEMBER KULINOWSKI: I second.

VANESSA ALLEN SUTHERLAND: Having been moved and seconded, we have a motion related to recommendation 2001-01-H-R9 and 2001-01-H-R10. Last call. Is there any further debate? Seeing none, I hear none. If not, the question is on the closure of R9 and R10 as closed, acceptable alternative as presented to the Board by the CSB

staff. Our acting general counsel will now call the roll call. As Ms. Wenzel reads your name, please vote. She will give you instructions about your options for voting.

KARA WENZEL: Remember, because this is a calendared notation item vote, you have option to approve or disapprove it [inaudible]. Member Ehrlich?

MEMBER EHRLICH: Approved.

KARA WENZEL: Member Engler?

MEMBER ENGLER: No.

KARA WENZEL: Member Kulinowski?

MEMBER KULINOWSKI: Disapprove.

KARA WENZEL: Chairperson and Member Sutherland?

VANESSA ALLEN SUTHERLAND: Approve.

KARA WENZEL: Okay, that is a tying vote, with a 2-2, so that results in no action.

VANESSA ALLEN SUTHERLAND: But we can do a new notation item.

KARA WENZEL: Correct.

VANESSA ALLEN SUTHERLAND: For the item. Because I heard some interest in [inaudible] which I heard interest in today.

KARA WENZEL: [inaudible] no action.

VANESSA ALLEN SUTHERLAND: So thank you to my Board members. We really never get a chance to do that because of the quorum

requirement. At the time, I'd like to open the floor to the public for any comment related to the CSB's recommendation to the American Chemistry Council. We're going to ask that people limit their comments to three minutes or under. And actually that is true for anyone on the phone as well. You can open the phone line if anyone has a comment on the recommendations that we just discussed.

OPERATOR: Thank you. If you have a question or comment please press * then 1 on your touchtone phone. If you wish to be removed from the queue please press the # sign or the # key. If you are using a speaker phone you may need to pick up the handset first before pressing the numbers. Once again, if you have a question or a comment, please press * then 1 on your touchtone phone.

VANESSA ALLEN SUTHERLAND: As [inaudible] the callers are getting into the queue, I'm going to start with requests in the room. So for the Reactive Hazards recommendations, we have John Morawetz to make a public comment or statement.

JOHN MORAWETZ: Yes, I would say first that it's very interesting, the initial discussion about having the discussion of the four of you. And I think in terms of Sunshine Act, I'm glad you're having these meetings. Given the limitations, it would be really interesting to have a meeting devoted more time only to a

single issue where you can speak, we can hear from the staff as well as the public on a clear issue and have a discussion. Because you are so limited by the Sunshine Act. So I'd take that into consideration. You can't do many of them. Limited time and resources. But on key subjects, I'd recommend you doing it.

In a nutshell, I would say that the original recommendation as acceptable term of action, I don't think it was clearly an acceptable term of action. I'm only going to speak to R9. R10 is fine. And R9 clearly is not... It is not... Whenever it was crafted, it was not acceptable term of action that there was not a program for reporting to, yes, the membership of ACC but not the public or the government, meaning OSHA, EPA, or CSB. And I [inaudible] you to say not just prevent future incidents but also improve safety [inaudible] performance. If you don't have the data, how can you make decisions?

Which leads me more to my more fundamental point which is we live in a democracy. And to be in a democracy, you have to have information. How can you make judgments if you don't have information? So you can look at it as do I live, one of the tens of hundreds of thousands of people, near a facility that has reactives? You also look at it collectively where we vote on [inaudible] representatives and do we have the information? If

it's an issue, whether it's HF, methyl mercaptan we're concerned with, reactive chemicals in New Jersey, you need to have that information.

And in particular, I'd like to share my personal experience where I worked in a wire and cable factory before the Right to Know for workers [inaudible] existed. I did not know what the chemicals were I was working around. It was called Agent X. And then Hazard Communication was passed and then there had to be a label and workers knew.

Second experience, working at NIOSH. There was a question of right to know for workers when there was a study that NIOSH did. Did the workers have a right to know the results of that study? And I was equally dumbfounded in both cases where you have to prove the affirmative, that the knowledge can prevent accidents. That's not the question. It should be the reverse, like with terrorism. You have to prove that people should not have the information. The default is always people have a right in a democracy to know what's going on. And clearly this recommendation didn't go that way. I'm not sure whether you should say leave it open. There's a question for logistics. Or whether you should say it's closed, unacceptable and maybe you should move on. As long as it's clear you don't have the data. You don't have that information yet. That's all.

VANESSA ALLEN SUTHERLAND: Thank you. Any other comments in the room?

KAREN HAASE: Hi, I'm Karen Haase with the American Chemistry Council. I had not intended to say anything originally but some of your comments prompted a few remarks. One is that I think that ACC has taken seriously any recommendations it has gotten from the CSB and considered them carefully. And while you've mentioned the amount of time that the staff has spent on this over the 14 years, I don't know if you have seen there have been communications via letter since 2002 between CSB and ACC. So it has been going on for some time. There have been records that I've found of four meetings between CSB staff and ACC staff, including the most recent was a voluminous amount in 2014, trying to get this. So it's not a matter of sitting and waiting for it to disappear. There are still legal issues related to the kind of request that's in this and I do think that whether the recommendation was phrased properly, given to the proper organization is still something that you, as Board members today, have a responsibility to look at. And there are a lot of other organizations out there that are or can collect the same types of data and most of it is still protected by the membership. So I hope that, one, you will separate the two notation items. But I hope that you will reconsider your feelings

on this first one. And the ACC would be more than willing to sit down again, for a fifth time, and have a conversation about that.

PAUL ORUM: I'm Paul Orum. I was not also planning...also not planning to speak but I would like to reflect on a couple of things that were said here today. I've worked for about a quarter century in government information policy on hazardous materials, including well before this recommendation. I don't want to address this recommendation, just urge you to think, when you think of public information, don't think of public as just Mr. and Mrs. Jones at home in their castle. Think of technology vendors, insurers, academic researchers, emergency responders, industry not affiliated with ACC in this particular case, other government agencies to a certain degree.

For example, an insurer might look at a facility and say, "We saw what happened at this facility over here which we learned about through this ACC database. We're not going to insure you unless you show us certain capacity to manage this hazard." That's public information. I also urge you to recall that EPCRA is information generally about hazards, not about incidents and also not about alternatives, not about solutions, not about safeguards. All of which could be very important outcomes from this sort of exercise. Thank you.

VANESSA ALLEN SUTHERLAND: Thank you very much. Ashley, do you have any callers in the queue?

OPERATOR: Yes, we do. First up, we have Jerry Poje from George Washington University.

VANESSA ALLEN SUTHERLAND: Hello?

JERRY POJE: Hi, this is Jerry Poje. I can quote Mark Twain, "News of my demise is greatly exaggerated." I'm a former Board member of the Chemical Safety Board. Was front and present in generating, reviewing, implementing, and accepting the recommendations from staff in 2002 for *Improving Reactive Hazards*. So I just would urge the current Board. I'm not an unknown entity. I'm available to consult with on various matters associated with your past actions. Not all the people who did that are dead. They can still be consulted with and perhaps give you some information about how to act.

A couple of things I want to say. I support Eric Frumin's comments. I'm presuming he will come in shortly. He's the Health & Safety Director for Change To Win. I think he's done a good and thorough review of history. He... I can only speak for the intent of the Board in 2002 for improving the management of reactive hazards. It really was clear. It was for industry, government, and public to coordinate closely to make abundant use of the

tragedies of ongoing reactive hazards to prevent them from recurring.

My recent review, just similar to other Board members, currently standing Board members, of the ACC website indicates no data on reactive hazard incidents. Not even a pathway for members at various staff levels to get into the internal access of the database. And so there's also no access for the public or government to access either.

Currently ongoing we have an EPA RMP proposal for a regulation that does not accept the CSB longstanding recommendation on adding reactive hazards to RMP. One state, the State of New Jersey, has accepted that recommendation. So CSB, in its longer history, has been effective. But the fact that that recommendation has yet to be acted upon, nor is it currently instituted within the proposal from EPA, speaks deeply about the need for publicly accessible data post the 2002 data from CSB. CSB, as far as I know, has not done any further analysis on reactive hazards except that it's been involved in major reactive hazard incidents that are indicative within their recommendations program.

So I would urge you to recognize that this situation is front and center. If we had better data on reactive incidents the larger public, the CSB, EPA, and OSHA, might have been persuaded to

require greater incident histories to be gathered into the next generation of a regulatory reform.

There are two other matters that I wanted to just highlight. One is I want to have you recognize the inadequacy of public notification process via the Federal Register notice about the substance and the intent of the change in this status. I have to await private contact from Eric Frumin and that's not a useful way for the members of the public to be alerted to the substantive matters in front of this matter. You can do quite a bit to engender greater public engagement and outreach on this. I work closely, as others in attendance in the room, with over 100 different organizations on a coalition to prevent chemical disasters. Many of them, if they knew of this specificity of change in status, would want to have been participants today. So general counsel and Board members, please seek to be transparent on the matters before your Board.

And then finally, I know you congratulated yourselves and your staff for the arduous work to complete the Macondo well investigation. I think the best we can say six years after the incident is that this is the best cautionary tale for the current CSB and for future CSBs that would say we have to avoid waiting six years to complete our investigation. The President's commission on

the BP blowout in the Gulf Coast was completed in less than a year. And you have to ask yourselves seriously what value added after six years has the CSB contributed to this important work. I hope there is some but I fear that the signal waned after six years and your ability to leverage recommendations is much weaker than it would have been if you completed work within a much shorter period of time.

Thank you so much for the opportunity to comment.

VANESSA ALLEN SUTHERLAND: Thank you and we're happy to hear you're alive and vibrant. I will note that we completed Macondo only seven months after I joined the Board. [laughter] Ashley, are there any other callers in the queue?

OPERATOR: Yes, up next we have Michael Wright from Steel Workers.

MICHAEL WRIGHT: Hi, can you hear me?

VANESSA ALLEN SUTHERLAND: Yes.

MICHAEL WRIGHT: Hi. This is Michael Wright from the Steel Workers, as has been said. And I think most of you know that although we're called the Steel Workers, our true name is much longer and we are the predominant union in...or the largest union in both the chemical industry and the oil industry. So we have a pretty big stake in this issue.

I want to say something about the process. This is, I think, the first time I've been in a public meeting where the public is asked to comment only after the vote is taken. I know that's the way your rules work but I hope you will reconsider that. It's a little like Alice in Wonderland where at one point I believe it's the queen who says, "First the sentence, then the verdict." This is first the decision and then the discussion, at least among members of the public. I hope as this goes forward we'll have a chance to comment in some way, either written or verbal, on how this matter should be disposed of.

Just a couple of things. I'm glad this is still an open issue because I think there are some things that can still be done.

First, I think that unlike what some people have said, I think the recommendation did go to the proper place and I should say, in the interest of full disclosure, I was a member of the Responsible Care public advisory panel for three years. At that point, CNA—it became ACC later on—was very clear that Responsible Care was meant as a way of defending the public and the environment and workers from serious chemical incidents. And it was very clear that Responsible Care was entirely a creature of then the CNA and now the ACC. So I'm not sure where a recommendation to industry would have gone except to the ACC.

Second, on a couple of the issues that were raised. First, I find the ACC's argument about legal problems unconvincing. It seems to be equivalent to saying, "We don't want to share critical safety information with you because we're afraid you will do something with it." The whole point is to do something with it.

Second, on sort of the other side of that coin, the question about whether the public actually will use this information. I understand there's a lot of public information the public, or at least a lot of members of it, don't use. We all...people ignore information about the risks of smoking. People ignore information that they currently get or at least have the power to get about various environmental matters. But in this case we, at least, will use this. We investigate about 30 fatalities a year. We publish lessons learned on our website. We think those are absolutely critical. We will use information about reactive chemical hazards. We can get some of that from our own employers. But in the chemical industry, we only represent about 15% of the plants in that industry. So even though we can get information about accidents that happen among our employers, we can't get information about accidents that happen in plants where we don't represent the workers. And we would use that information.

The problem isn't so much the big accidents because the things that become publicly known because they spread outside the workplace or because they seriously injure workers, it's possible by following the OSHA investigation, for example, to get reasonably good information about those. The problem is all of the little ones, all of the near misses, all of the places where a reactive event has taken place but where there has been few injuries or minor injuries. Those are going to be known only to the company where it happened. And some of those could be warnings about much, much larger events that could take place if we don't heed the lessons. We can't heed the lessons unless we know them. So this kind of information is absolutely critical and I promise we will make use of it. Thanks.

VANESSA ALLEN SUTHERLAND: Thank you. Ashley, is there someone else in the queue?

OPERATOR: Yes, we have Eric Frumin from Change To Win.

VANESSA ALLEN SUTHERLAND: Hello?

ERIC FRUMIN: Yeah, hi. Can you hear me okay?

VANESSA ALLEN SUTHERLAND: Yes.

ERIC FRUMIN: Great. Thank you for letting me speak. My name is Eric Frumin and I'm with [inaudible] federation Change To Win.

I submitted a written comment. I'll just summarize that very briefly.

First were [inaudible] that the recommendation was not closed as acceptable. In 1995, as Rick Engler has alluded, a horrible incident at the Napp Company in New Jersey demonstrated the glaring weakness in the PSM Standards exemptions for reactive chemicals. And multiple trade unions, some of them who are on the phone here today, petitioned OSHA then and we've refiled that petition following the Board's 2002 report. And it was all to no avail. At least finally until the West, Texas incident demonstrated the need for strong leadership and the President responded and we're now seeing the evidence that the agencies are moving forward.

So, to Chairman Sutherland's comments about the question of whether the agencies themselves should have acted faster, yes. We would certainly agree they should have. My testimony discusses some of the horrific obstruction that prevented efforts by the agencies to do that, including some of which was politically motivated and completely inappropriate. But it's... I would think it would be wrong to say that industry is not responsible for doing its share just because the industry at the same time has successfully lobbied for the White House and the Congress to stop the agencies from acting.

The Napp incident, I should just remind everyone, was instrumental in the creation of the Board itself. And in our comments we provide some of the press coverage around the time the Board was funded in 1997 by President Clinton in response to the study by OSHA and EPA to adequately investigate the NAPP incident.

With regard to the role of the ACC, and its often by the National Association of Chemical Distributors, they have consistently opposed closing the loophole in the PSM standard but interestingly they said, when the recommendations came out in 2002, that they supported the sharing of information with the government and they said academia, but with the public. So it's kind of ironic that they never pursued it and that they would now be interested in being essentially let off the hook for that.

So I think it's vital that OSHA move ahead. It would be great if OSHA long ago had set up the kind of reporting system that Chairman Sutherland mentioned where we have a publicly-administered database with industry contributions mandated by regulation. We don't have it. We still need it. And hopefully the Board will continue its vigilant oversight of the agencies themselves to make sure that they follow through on their commitment to close this loophole and the other loopholes in the PSM standards that urgently need to be closed in order to protect workers, chemical facilities,

the environment, and communities from hazards like reactive chemicals.

So thank you very much for considering this issue today and for your vigilance and we hope you'll continue to pursue the recommendations in the 2000 report and the West, Texas incident until this exemption in the PSM and RMP is closed. Thank you very much.

VANESSA ALLEN SUTHERLAND: Thank you. Ashley, you can queue up the next caller.

OPERATOR: We have Richard Rusarra from Ressayay EHS Service.

RICHARD RUSARRA: Hello. I just have a couple of comments. One is on the Board itself. I note that there's a two to two tie and that obviously there's a highlight that we're still short one Board member. I heard no movement recently concerning nomination of a Board member to fill the vacancy. And I suspect that maybe in the current political environment, even if one is nominated, there's no guarantee that he or she would be approved.

Secondly, I note that all of your terms are expiring in 2020 which is also an election year. So my comment is that we could be headed toward more turmoil in 2020 concerning the continuing operation of the Board given the current state of affairs politically.

Finally, I have a question related to the Torrance Refinery. I note that recently the refinery was given the go ahead to restart their operation and that this restart seems to be tied in with the sale of the refinery by Exxon Mobil. So my question is do you foresee that this may affect your investigation going forward and your legal actions with respect to requesting information from Exxon Mobil or the successor to Exxon Mobil?

Thank you.

VANESSA ALLEN SUTHERLAND: Thank you. So very different at a high level proceedings over an investigation than [inaudible] open legal issues. Irrespective of the change in ownership [inaudible] is successful in consummating its acquisition of Torrance, we're going to continue moving forward with our investigation of Exxon. We'll continue following up on the subpoenas to collect data and as we get more information and we make progress, we'll come back and we'll report on both of those topics.

RICHARD RUSARRA: Okay.

VANESSA ALLEN SUTHERLAND: Thank you. Ashley, do we have other callers in the queue?

OPERATOR: We have one final comment from Rick Hind.

VANESSA ALLEN SUTHERLAND: Hello?

RICK HIND: Yes. Hi, I'm Rick Hind with Greenpeace. I just wanted to thank you. I'd like to associate ourselves with the comments of those folks from labor today and Paul Orum and others. I think that the credibility of the CSB would be tested or could be tested in the long run. I understand that there could be fatigue with a recommendation being ignored for so long but you aren't the only entity involved and I think having that out there allows others, Paul Orum gave some examples. Things change. Political occurrences change and so forth. And the recommendations may have been...have gained and will gain more currency if the industry feels the pressure for it.

As others have mentioned, the EPA is now in the process of an RMP rulemaking in which the industry is pushing for the least amount of regulatory progress and here again the CSB following its statutory duty has made a number of recommendations that are not yet in the proposed rule but could be. And so I assume and would encourage the Board to submit comprehensive comments to the EPA on the RMP, in particular that the EPA not simply stop with a requirement to conduct safer technology and alternative assessments for three [inaudible] codes, about 13% of the RMP, but that that extend to all of them and that they be required to submit that to the agency. It seems to be somewhat of a fool's errand to have

them do an assessment and have it sit in plant somewhere or a computer somewhere. It could easily be integrated into RMP reports or other means in the modern day.

In addition, the CSB has rightly recommended the implementation of these safer alternatives. Not that the agency would have to dictate those things, but to actually take the lessons learned from root cause analysis and other kinds of past learnings to make sure that a new and safer process is used. And in fact, I would remind the Board and everyone that this industry has a legal obligation to design and operate their facilities to prevent catastrophic releases and the consequences on the public. And that has been weakly implemented, that legal obligation or duty. And the regulation would allow for the elegance of regulation to account for specific stakeholder concerns that are legitimate while also ensuring that the safest alternative technologies available and appropriate for that facility begin to be implemented as the earliest point possible.

And that then gets back to the original recommendation you had, which is that if the Board was in fact created to investigate accidents in order to learn how to prevent them, the...it seems to me to be central to the mission of the Board that you not relinquish these things. I think that someone's comment that the industry

would simply wait you out is absolutely the case. Half of what the industry does and this rulemaking, for example, with the EPA is trying to draw the process out and run the clock out basically on the current presidential administration, in the hopes that it won't be carried by the next administration.

So I think that kind of stalling and foot dragging should be seen for what it is, ignored, and you could reissue your recommendation with any additional concerns to address alleged legal concerns or liability concerns. But I think reissuing it with some updated information might also help in terms of engendering better practices with the industry. Liability is supposed to be the free market regulator of risk. And ironically the ACC was grilling the EPA in April on the list of accidents they disclosed in their RMP process.

So I think, once again, Sunshine is the best disinfectant of [inaudible] and stalling on needed and long overdue safety measures.

Thanks for letting me have some moments here today.

VANESSA ALLEN SUTHERLAND: Thank you. So, for process, we have about ten minutes. I want to thank everybody on the phone and in the room for your comments. Two things. It's just in my nature not to leave things unanswered so even though it was a comment

period, I feel compelled to share, just from a couple of the comments.

The first is we have just recently talked, actually, about the Federal Register notice. We have a regulation that says our public business meetings are going to be at least four times a year. We've been doing a lot more than that, honestly. But we know what months they're in so we have actually put the dates on our calendar to make it easier for people internally to plan and then we will back up. We've all made a commitment internally to make sure that knowing that the dates are fixed on the calendar, we will set the agenda, we will do our part to get the Federal Register notice out sooner and have it be in print as to what we're going to cover and in what level of detail and specificity.

So we actually are very focused on being transparent and having people engaged in our conversation, whether that's webcast, telephone, email. And I think we are and continue to be very committed to doing that kind of outreach. So if we're still not doing enough, you guys tell us. We'll have a public meeting every month and you guys can come on down. We'll try to have a snack though because this...

On the other point about some of the things we should consider, I think, as you heard, we certainly are going to need to

do a new notation item. My personal belief, which many of you have heard, is that safety is not just regulators and just industry and just fill in the blank. It's everyone. And it has to be a shared responsibility because everyone has a piece of the puzzle that they control and all of those pieces have to be communicating, collaborating, and working together in order to keep all of us safe and our families and our friends and our neighbors.

So to the extent we focus on a particular recommendation, investigation, study topic in any of these public meetings, it is not to imply, I think, that we hold any one group more or less accountable. We have recommendation recipients that are in industry, insurance, regulators, you name it. So I want to make sure that if we are not... If we are in a meeting and we're talking about one discrete topic, give us that feedback, but know that the concept is that we, in a root cause investigation, are very willing to make recommendations to any group, not highlighting one over the other but those who we think will actually be able to promote not just site-specific but more broad scale change.

And then I do feel the need to engage help from my counsel on a very legitimate comment which was taking comments and feedback after a vote because I don't know that we communicated, as I think General Counsel Wenzel did a good job explaining, that this was

simply to display how we work. And I do not want to leave any of our stakeholder groups feeling like we pulled the rug out from under you. I am very open. I go out and I probably have racked up more frequent flyer miles than a salesperson doing Amway. But I like it and I am very receptive to hearing what people want to know from us and how we can be helpful and communicating what we expect. But every item that we have...we don't have a Board Order mechanism to have public comment tell us how to do a recommendation. That's not in our... It's not in our process. So for the Board members on the phone and in the room, you know of what I speak. But that doesn't foreclose us from hearing how our recommendations can be improved or interpreted, can be overseen. But I will let you, Kara, discuss that at a higher level.

KARA WENZEL: Sure, I think most of the people in the room have been to CSB public meetings before. Typically they're focused on ongoing or investigations that are about to close. And you will always see a public comment period within those meetings. Typically that happens before a vote. That is [inaudible] in the statute in all of our authority. We welcome that and value it very much so.

The item that they considered today is a little bit different. It's a recommendation status change for which we have an internal

procedure that we have to follow. The Board has its own order, again on our website if you want to take a look at it. It's Number 22. They use a specific mechanism to communicate with the recipient and document changes in status with the Board would then consider. So you heard that portion today.

I think that one commenter made a suggestion that we can have public meetings on topics of interest and receive comments and deliberate. I think that's actually a great suggestion. So we'll definitely consider that. All of your stuff today is heard. Everything you've told us is recorded. We can make a transcript and we can review those and [inaudible] on our website as well.

Because this particular item results in no action, we will definitely take a look at those options and consider what you've heard. In the future, I think you may well see that we decide to have future...

VANESSA ALLEN SUTHERLAND: [inaudible].

KARA WENZEL: Yeah, on more specific topics. In which case, we will make very clear in the Federal Register and on our website that we welcome anyone who has anything to say on those topics.

VANESSA ALLEN SUTHERLAND: And definitely any apologies if...when we suggested at the February meeting and in the recent Federal Register notice if the language that we had was ambiguous

that it was going to be more of a feedback that would determine our vote. We were constrained in doing that. But heard the suggestion. Think it's a good suggestion. We hear a lot of great feedback. Several points that I took down. I'm sure my fellow Board members did as well. So we appreciate that, those comments.

So I do know that we're ending at 3:00. I want to thank the staff, all of our participants, everyone who is on the phone, my fellow Board members today for a really good discussion. And we really are still focused on a shared vision and a shared interest in trying to figure out ways to prevent chemical accidents through our investigations and through our resulting recommendations.

We have...any of the comments that you submitted, as General Counsel Wenzel mentioned, these will be part of our transcript which will be posted on the website.

Our next public business meeting is in June. We will be sensing out the specific date shortly and you can also check our website, which is the CSB.gov address I gave earlier, for additional details. Thank you to everyone on the phone for your attendance. Thank you to everyone in the room. And our meeting is adjourned.

OPERATOR: Thank you, ladies and gentlemen. That concludes today conference.