July 21, 2013 Written Comments for the
U.S Chemical Safety Board Sunshine Act Meeting
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My comments address the recommendation to the U.S. Occupational Safety and Health Administration (OSHA) 2005-04-1-TX-R9, revision of the process safety management standard (29 CFR 1910.119) to require management of change (MOC), reviews for certain organizational changes. As you know, this recommendation is a result of the Chemical Safety Board's (CSB), investigation of the March 23, 2005 explosion at the former British Petroleum (BP), Texas City refinery that killed 15 workers and injured over 180 others.

I offer a highly personal perspective of the need to address this recommendation. My father, Ray Gonzalez, was killed at that very same refinery in an incident 6 months before that fatal explosion in 2005 on September 2, 2004. His death was reviewed by the CSB and cited in its final report issued March 20, 2007 (Board, 2007). Referred to in the report as the Ultraformer #3 Incident, my father along with two of his co-workers and friends received 2nd and 3rd degree burns to the majority of their bodies from exposure to 500 degree water and steam during the opening of a pipe flange. The check valve they were working on had stored hazardous energy. It was determined that the absence of a bleed valve did not allow them to verify for certain that the pipe was safe to open. It also states in the report that the incident was process safety related and "revealed a serious decline in process safety and management system performance at the BP Texas City refinery." (Board, 2007)

My father had burns to 80% of his body and endured multiple skin graft surgeries and painful daily cleaning of his skin. He endured 2 ½ months in the hospital before losing his life on November 12, 2004. The torture inflicted upon my father and his two friends, and the lingering grief of my family, should be a compelling call for better safety standards.

OSHA investigated my father's incident and cited BP Products, North America $102,500 for 7 serious and 1 willful violation. The willful violation was for failure to control hazardous energy. In truth, $102,500 is not a very persuasive motivator for large corporations.

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I support the recommendation to amend the OSHA process safety management standard (29 CFR 1910.119) to require that MOC review be conducted for organizational changes that may impact process safety including major organizational changes such as mergers and acquisitions, personnel changes, and policy changes such as budget cutting.

The CSB's investigation of the former BP Texas City refinery's March 23, 2005 explosion concluded that all these items --poorly managed corporate mergers, leadership and organizational changes and budget cuts-- increased the risk of accidents. (Board, 2007) The independent panel headed by James Baker, III reviewed the company's corporate safety culture, safety management systems and corporate safety oversight at its U.S. refineries. That report stated that "BP's corporate structure has been complex for many years. In the last two years, BP has made significant changes to its corporate and refining organizations, creating new positions, changing various job responsibilities, and establishing several new reporting lines. In many instances, the contours of these new lines and relationships remain undefined." (Panel, 2007) If MOC was a requirement by the OSHA process safety standard (29 CFR 1910.119), these new lines would have been required to be reviewed, subsequently possibly preventing incidents like my father's and the March 23rd explosion.

OSHA's response to the recommendation was a policy memorandum to all Regional Administrators to clarify the MOC policy with regard to the coverage of organizational changes under the process safety management's MOC requirements. I acknowledge and appreciate that the memorandum is a step in the right direction to covering the MOC policy. My fear is that the memorandum is not a strong enough declaration to prevent another fatal incident that takes the life of another worker.

In 1998 BP acquired AMOCO, which included the Texas City site. (Steffy, 2011) Even after the acquisition, and a MOC requirement by OSHA, and a reminder safety bulletin by the CSB in 2001, (Board, Safety Bulletin-Managment of Change, 2001) it was determined that the former BP Texas City site had insufficient training for process hazard analysis leaders in the use of MOC policy, a lack of identified responsibility for the refinery's turnaround organization and lack of review of the MOCs which all prevented the MOC policy in place from being implemented as was intended. (Board, Investigation Report: Refinery Explosion and Fire, 2007) The Baker panel concluded that BP does not have a list of specific qualifications it expects a new refinery plant manager to possess. BP has, however, recently

adopted a formal MOC process for considering a change in certain positions. Previously, BP used a formal MOC analysis for engineering, technical and procedural changes and not for personnel changes. (Panel, 2007) If BP had considered personnel changes as part of the MOC process, it is possible that fatality incidents may not have occurred at the Texas City site.

Earlier this year, the BP Texas City site was acquired by Marathon Petroleum. (Reuters, 2013) This is yet another major organizational change and brings with it all the problems already cited. The former BP Texas City site, now Marathon site had 22 worker fatalities in five years (2004-2009), an astonishing and disturbing number that demonstrates that gentle prods do no generate change. (Steffy, 2011) A recommendation from the Baker Panel review was to utilize an effective MOC process for organizational and personnel changes at all levels. This is only a recommendation and not a requirement. How many incidents that result in worker injuries and deaths could be prevented if this requirement was in place? How many more workers need to lose their lives before we improve process safety standards?

I am encouraged to see that OSHA's spring 2013 regulatory agenda indicates that the agency is considering expanding the scope of its process safety management standard (29 CFR 1910.119) to "require greater organizational MOC from employers." I also acknowledge that changing the standard is a long cumbersome rulemaking process.

I cannot help but wonder though, if changing the standard prevents another event like what happened in Texas City, isn't that worth all of our efforts?

Our family members who die on the job are not incidents or statistics. They are our sons, daughters, sisters, brothers, husbands and fathers. My father spent his 35th wedding anniversary in the hospital. My kids will only hear our stories about him. I miss my father very much, that pain will never go away.

I am asking the board to vote to designate recommendation 2005-04-1-TX-R9 with the status "Open-Unacceptable Response" to demonstrate respect for life through job safety so that no other family has to endure the pain and grief that mine has.

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