U. S. Chemical Safety and Hazard Investigation Board
RECOMMENDATIONS STATUS CHANGE SUMMARY

Report:	**DuPont Corporation Toxic Chemical Releases**
Recommendation Numbers:	**2010-8-I-WV-R5**
Date Issued:	**October 17, 2011**
Recipient:	**DuPont Belle Plant**
New Status:	**Closed – Acceptable Action**
Date of Status Change:	**February 14, 2013**

Recommendations Text:

Revise the near-miss reporting and investigation policy and implement a program that includes the following at a minimum:

- *Ensures employee participation in reporting, investigating, analyzing, and recommending corrective actions as appropriate for all near-misses and disruptions of normal operations.*
- *Develops and encourages use of an anonymous electronic and/or hard copy near-miss reporting process for all DuPont Belle site employees.*
- *Establishes roles and responsibilities for ownership, management, execution, and resolution of recommendations from incident or near-miss investigations at the DuPont Belle facility.*
- *Ensures that the near-miss investigation program requires prompt investigations, as appropriate, and that results are promptly circulated to well-suited recipients throughout the DuPont Corp.*
- *Ensures that this program is operational at all times (e.g. nights, weekends, and holiday shifts).*

Board Status Change Decision:

A. Rationale for Recommendation

This recommendation was issued after the investigation of an incident that occurred at the DuPont Corporation's Belle, West Virginia, chemical manufacturing plant on January 23, 2010. A release of highly toxic phosgene gas from a ruptured hose exposed a worker who died at a hospital the following evening. The investigation concluded that operators had discovered a physical defect on a phosgene hose in another area of the system shortly before the fatal incident, and maintenance staff had replaced the hose before it leaked or ruptured. The operators were concerned about their finding, but only planned to tell the supervisors about the discovery on Monday morning, about 48 hours later, because supervisory staff did not work on weekends. Operators said that they expected that the supervisors would conduct a full investigation. However, the defect in the hose was not investigated before the fatal incident, because it occurred during the weekend. Had there been a system in place for operators to report near-miss incidents on weekends, a near-miss investigation could have been promptly initiated, and its findings may have prevented the subsequent fatal release.

B. Response to the Recommendation

The DuPont Belle site reported to the CSB that it revised its incident investigation program and conducted a series of safety meetings to discuss lessons learned from the June 2010 incident.

The revised program allows employees to submit a preliminary near miss or incident report into the site's electronic system at any time. The reports are routed to a plant shift supervisor, a new management position that is now staffed 24 hours a day, seven days a week, and has the authority to initiate an investigation. The program also established a new safety and work improvement suggestion system to capture anonymous inputs from employees that are checked by the plant shift supervisor every day.

C. Board Analysis and Decision

The Board reviewed DuPont's response and documentation and concluded that DuPont's recently revised site incident investigation program and supplemental training efforts were consistent with the intent of the CSB's recommendation. Therefore, the Board voted to designate recommendation 2010-8-I-WV-R5 with the status of "Closed- Acceptable Action."