U.S. CHEMICAL SAFETY BOARD

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BUSINESS MEETING

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WEDNESDAY,
JULY 22, 2015

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U.S. CHEMICAL SAFETY BOARD MEMBERS PRESENT:

RICK ENGLER, Member, U.S. Chemical Safety Board
MANNY EHRLICH, JR., Member, U.S. Chemical Safety Board

STAFF PRESENT:

JOHNNIE BANKS, Team Lead, Investigator
DON HOLMSTROM, Director, Western Regional Office
MARK KASZNIAK, Senior Recommendations Specialist
KARA WENZEL, Acting General Counsel
CHERYL MACKENZIE, Team Lead, Investigator
DAN TILLEMA, Team Lead, Investigator
VERONICA TINNEY, Recommendations Specialist

This transcript produced from audio provided by the U.S. Chemical Safety Board.

T-A-B-L-E O-F C-O-N-T-E-N-T-S

P-R-O-C-E-E-D-I-N-G-S

(9:30 a.m.)

OPERATOR: Welcome to the CSB business meeting. My name is Chris and I will be your operator for today's call. At this time, all participants are in a listen-only mode.

Later we will conduct a question and answer session. Please note that this conference is being recorded. I will now turn the call over to Board Member Mr. Rick Engler. Mr. Engler, you may begin.

MEMBER ENGLER: Good morning and welcome to the CSB offices. My name is Rick Engler and I am the Board Member presiding over this meeting. I would also like to introduce my colleague on the Board, Manny Ehrlich. Also with us is Kara Wenzel, CSB's Acting General Counsel.

Since we don't have a huge group, could we quickly go around the room and just get a sense of who is here? Just name and affiliation starting with you.

MS. VASSALLI: Katie Vassalli, the International Liquid Terminals Association.

MS. PARASRAM: Vidisha Parasram, U.S. Chemical Safety Board.

MR. SUTTON: Ian Sutton, Sutton Technical Books.

MR. CRIMAUDO: Steve Crimaudo, API, American Petroleum Institute.

MS. TINNEY: I'm Veronica Tinney, also with the CSB.

MS. SANDLER: Carla Sandler, King Support (phonetic). I help companies that need to find buyers. So I write their solicitation.

MS. SWETT: Laura Swett, ASPM.

MS. HAASE: Karen Haase, American Chemistry Council.

MR. SHEPPARD: David Sheppard, ATF.

MR. HEENAN: Dan Heenan, ATF.

MS. MCFARLAND: Krista McFarland (phonetic), WilmerHale

MS. COBREN: Marcy Cobran (phonetic), O'Melveny and Myers.

MR. PRILLAMAN: Walter Prillaman, Dupont employee and also Local 900C Safety Officer.

MR. MORAWETZ: John Morawetz, International Chemical Workers Union.

MR. DOBBIN: Denny Dobbin, Society for Occupational and Environmental Health.

MR. FIORUCCI: Lou Fiorucci, Fiorucci Consulting.

MS. FLANAGAN: Susan Flanagan, Institute of Makers of Explosives.

MR. DUDZIG: Rob Dudzig, Debs-Jones-Douglass Institute.

MR. DRANEY: Ross Draney with RedGuard.

MS. FENDLEY: Anna Fendley, United Steelworkers.

MR. PAULSON: Glenn Paulson of George Washington University.

MS. MCCORMICK: Amy McCormick, CSB.

MR. GREEN: Lee Green (phonetic) with Katten.

MR. FARLEY: Mark Farley with Katten.

MEMBER ENGLER: Thank you. Since a quorum of the Board given the current Board makeup is two members, we have a quorum today. Today's gathering constitutes a public meeting of the Board under the Sunshine Act rules and was duly announced in the Federal Register.

Before we get started, I would like to address some housekeeping items first. In the event of an emergency, please exit out the front entrance and down the stairs to the lobby. Our gathering point is on the corner of Pennsylvania and 22nd Street.

The restrooms are in the hallway on this floor. There are sign up sheets outside this room if you would like to make a comment. Cell phones, please mute them. For those calling in to the meeting, please mute your phone.

During the comment sessions, we will give those on the phone an opportunity to speak. Please limit your verbal comments to three minutes. You can of course submit additional

written comments.

Today's meeting focuses on core mission work of the CSB. I assume everyone has picked up a copy of the agenda that's been out on the table. We will hear reports on some of our important investigations and recommendations, vote for plans at this time on the three items noted on the written agenda that you should all have.

I want to give you all a heads up that there will be a motion at the end of the meeting in case you're not staying until the end, to alter the meeting date and also a time change for future meetings.

There are three opportunities for public comment. The first two are focused on the items that we will have discussed immediately prior. The last opportunity for public comment at the end of the meeting is for any other comments that the public may wish to make.

I'd also like to point out to any of the media representatives on the telephone that

the Dupont La Porte update prepared by Dan Tillema and our Denver office is now on the website and you can view it there.

So the first item on the agenda for today's meeting is an investigation update. First I'd like to introduce Don Holmstrom, Director of the Western Regional Office. I'm sorry, Manny I apologize, I'm rushing along. Manny, do you have an opening statement?

MEMBER EHRLICH: I do. Good morning and thank you all for coming. I was informed that some of the members of the families from La Porte, Texas were going to be here, the Tisnados and Lynette Soto. And it doesn't, I haven't heard them or seen them. On behalf of myself and the Board, I want to extend our sincerest condolences to them and their families. I'll have further thoughts about that later on in the meeting.

I appreciate the efforts by the CSB staff to prepare for today's business meeting and I appreciate everyone's attendance. This is my

first public meeting since returning from medical leave in June and since the departure from the Board of former member Griffon. I'm happy to be back and to be in much better health, I can walk.

There is much important business before the agency. We have a draft report on the Caribbean Petroleum explosion that occurred in Puerto Rico in 2009. Since releasing the draft last month, we received some significant stakeholder comments which I look forward to reviewing today.

It was important that this report be completed and include realistic safety recommendations that can be applied by industry. The catastrophic incident in Puerto Rico in a 2005 explosion at the Buncefield terminal and the U.K. underscored the dangers from large gasoline release and vapor cloud emission.

I hope all companies in the sector are already taking the opportunity to study the draft report and the video that was released last month and are reviewing the safety of their gasoline

storage tanks.

It is no secret that the CSB is facing a very challenging governance situation currently with only two sitting members, three Board vacant seats, and no confirmed Chair. I pledge to the agency and to you, I stand ready to work cooperatively with Board Member Engler to navigate this difficult situation.

We offered a power sharing agreement under which Mr. Engler and I would share responsibility for day to day operations. My background running chemical plants and my practical management experience is certainly needed here.

Earlier this year, I toured the DuPont pesticide plant in La Porte, Texas. That plant was the site of a large release of toxic methyl mercaptan November 14th, an incident that took four lives.

During my visit to La Porte, I received a detailed briefing from the investigative team and was able to observe the

building where the workers died during a maintenance operation on the process vent system. You'll hear more on this issue today.

I believe the team has important findings about why this tragic incident occurred and has also prepared certain possible recommendations to improve the safety of the facility and to protect workers when production is resumed.

I would like these draft findings and recommendations to receive prompt consideration by the Board and to be available to the workforce and the public. Thank you and I look forward to today's meeting.

MEMBER ENGLER: Thank you Member Ehrlich. Apologies for rushing ahead.

MEMBER EHRLICH: Not a problem.

MEMBER ENGLER: With that, I'd like to introduce a panel to give a CSB investigations update beginning with Don Holmstrom.

MR. HOLMSTROM: Thank you Board Member Ehrlich, appreciate that. There are actually

three statements from the Western Regional Office that we'll be discussing today. I'll be talking about the ExxonMobil investigation and Torrance refinery in California.

The lead investigator, Cheryl MacKenzie will shortly be talking about the final two volumes of the Macondo investigation. And Dan Tillema, also from the WRO, will be talking about preliminary findings and analysis from the DuPont La Porte, Texas investigation.

On February 18, 2015, there was an explosion in the fluidized catalytic cracker, also referred to as the FCC at the ExxonMobil refinery in Torrance, California. The explosion occurred in a piece of equipment called the ElectroStatic Precipitator or ESP.

The blast released FCC catalyst into the surrounding Torrance residential area, exposing numerous members of the community to the catalyst dust. At least four refinery workers were injured in the explosion and subsequent evacuation.

Debris from the exploding ESP damaged nearby process units causing several leaks and fires. The FCC unit converts long chain hydrocarbon such gas oils into shorter hydrocarbons that are blended into gasoline products. ESP is a pollution control device that, at that refinery, was installed in 1999, excuse me, 2009 to remove fine catalyst dust from the FCC process.

The high voltages present in the FCC during normal operation generate ignition sources. The ESP is not designed to handle flammable atmospheres. ESPs are commonly used to remove particulate dust, pollution control, and various processes.

Soon after the incident, the CSB deployed and an investigation team was sent to the refinery. The investigation team has carried out multiple investigative activities including a number of interviews of operators, management, emergency responders, eye witnesses to the incident, as well as receiving thousands of

documents that have been reviewed thus far.

We have taken part in multiple catalyst and hydrocarbon sample collection and testing activities. We met with community members offsite. We've hired contractors to assist us in some of the technical analysis and post incident review of equipment and some modeling of what occurred.

We are generating, editing multiple protocols to test equipment and the integrity of various parts of the FCC unit including valves, control systems, and analyzers.

The CSB investigation determined that the explosion likely occurred when flammable hydrocarbons within the FCC mixed with oxygen and reached the electrostatic precipitator which served as an ignition source.

ExxonMobil had numerous safety systems in place to ensure that both flammables would not reach the ESP and if flammables did reach the ESP, it would be turned off automatically. All of the safety systems put in place failed and

allowed the incident to occur.

These included failures to mechanical integrity, hazard analysis, non-routine work procedures, among others. The CSB investigation team has identified a number of key issues that are similar to issues identified in previous CSB refinery investigations including the Chevron investigation in Richmond, California.

As the investigation moved forward, key issues such as the ones listed below have continued to be analyzed. These include failure to assess the effectiveness of safeguards during a PHA as well as general failure to identify and mitigate hazards. Work force involvement and empowerment about safety concerns, a reluctance to shut down units despite severe process upsets and equipment failure, and mechanical integrity, failure of equipment due to known damage mechanisms.

The incident progress currently is, we're undergoing a scoping process to identify what key issues we're going to be undertaking in

the investigation, what type of product. A full investigation report or some other product will be generated from this investigation and that's currently under internal review. That concludes my presentation on ExxonMobil, thank you.

MEMBER ENGLER: Thank you. Next we'll turn to Johnnie Banks, Supervisory Investigator to discuss West Fertilizer and the Freedom Industries investigation status. Johnnie?

MR. BANKS: Thank you Board Member Engler and good morning everyone. I'll be providing a real brief overview of the West and Freedom investigations.

The West case initiated on April 17, 2013 with a tragic detonation of ammonium nitrate at an ammonium nitrate storage facility where there 15 fatalities. Twelve of those were emergency responders, three from the public. There were hundreds of injuries and significant damage to homes, nursing homes, residences, and the infrastructure.

Currently we are in the midst of

submitting the report for technical expert review. We anticipate getting comments back from that on or about July 25th of this year. And we will resolve any comments that the experts provide.

We're preparing to send the report to counsel for West for confidential business information review and comment. That process would take about another week or so. The team is continuing to work on the draft of the full report with input from these previously mentioned reviewers.

We're working to complete the report and prepare for Board review and comment late fiscal year '15 which would be September 30th of this year or early fiscal year 2016, October 1st.

Prior to that, we'll be preparing recommendations. We'll meet with the recipients of these recommendations to ensure that they are, the appropriate parties receive those recommendations and that the recommendations are

appropriate. And then we'll also issue the report for factual accuracy review from both parties that would have the knowledge of whether the facts that they didn't report are accurate.

The next case that I'll be providing overview for is the Freedom Industries incident which occurred on January 9, 2014. That was where there was a failure of a tank that contained methylcyclohexanemethanol or MCHM. The release of this went to the river and affected the water for 300,015 Charleston, West Virginia area.

The team has been involved with this investigation since January 13th of that year and we're making progress on drafting the report. We recently traveled to Charleston to conduct interviews, follow up interviews and initial interviews with parties that we had not interviewed to date.

We toured the site and met with local agencies that we've had contact with from the very outset. We hope to initiate the Board

review for the full report in early fiscal year 2016 which would be October 1st. That includes the report and obviously the eco-report, we're here to encourage the passage of that as well.

MEMBER ENGLER: Thank you very much. Next on the Macondo investigation, Cheryl Mackenzie, the team lead who has been working diligently on that.

MS. MACKENZIE: Thank you. A status update, the final two volumes of the Macondo investigation report are drafted and are in the middle of our internal CSB review process. These volumes are on the human organizational factors that contributed to the incident as well as our regulatory analysis.

The team received comments back from the technical editor on Volume 3 this week and we're incorporating any of those such edits. We'll be getting Volume 3 to the Board this Friday. Volume 4 is with the technical editor now and will be going to the Board the following Friday, the 31st.

After that, we have a number of additional reviews which is what Investigator Banks mentioned regarding stakeholder reviews, recommendation recipients, et cetera. And we're completing, the completion date for both volumes is currently projected to be October 12th of this year. We hope to release those volumes together at a public meeting around that time.

MEMBER ENGLER: Great, thank you. Member Ehrlich, do you have any questions for folks concerning what was just reported on the status of our investigations?

MEMBER EHRLICH: I do not, thank you very much.

MEMBER ENGLER: Okay. We know you're all working diligently on them and we look forward to, as Board members, to having an opportunity to review the latest drafts, provide comments, and move forward on them. Thank you for your work and of course for all the staff that you work with that contribute to the core mission of working on these critical reports.

Next on the agenda is discussion of the Caribbean Petroleum investigation and I would like to make an opening statement concerning that.

The staff of the Chemical Safety Board has finalized its report, which we will vote on today, on the October 23, 2009 overfill incident at the Caribbean Petroleum refinery in Bayamon, Puerto Rico where a five million gallon capacity above-ground storage tank overfilled while fuel was being transferred from a tanker ship.

I thank the staff and particularly Vidisha Parasram for her long and hard work on this report. Thank you Vidisha. During the overfill, gasoline spray from the tank aerosolized forming a vapor cloud which pooled in the secondary containment area where it leaked through an open dike valve to the wastewater treatment area and ignited.

The vapor cloud explosion led to multiple tank fires that burned for two days. Local community members were forced to evacuate

in the middle of the night. The explosion and fires damaged 17 of 48 tanks at the facility, caused three offsite injuries, and damaged or destroyed approximately 300 homes nearby. The magnitude of the incident caused President Obama to declare a state of emergency.

The CSB found that lack of a robust overfill prevention system with more than one layer of protection as an independent or redundant level alarm can lead to catastrophic incidents. And that current safeguards applicable to above-ground storage tanks do not adequately protect the public from catastrophic incidents that are using NFPA 704 Class 3 flammable liquids such as petroleum products.

Preventing future catastrophes necessitates regulatory safeguards and industry and consensus standards that require tank terminal facilities to implement additional layers of overflow protection, conduct a risk assessment considering the proximity of communities, and follow good engineering

practices.

The findings of the CAPECO investigation led CSB to recommend that EPA and OSHA determine the best regulatory standards to require bulk above-ground storage facilities to conduct risk assessments considering existing populations in sensitive environments, the complexity of site operations, the reliability of the tank gauging system, and the rigor of gauging operations.

To further minimize the potential of catastrophic incidents such as CAPECO, in our report being proposed today, the CSB asks the EPA and OSHA to ensure that a tank's automatic overflow prevention system be separate and independent from the tank level control system and follow good engineering practices.

In addition, the CSB recommends that OSHA implement elements of this process safety management standard that includes a mechanical integrity program into the flammable and combustible liquids standard. CSB investigative

findings identify the regulatory deficiencies that contribute to this incident.

Thus, these recommendations for safeguards were issued with the hope of preventing future incidents such as Caribbean Petroleum from occurring. I again thank the staff for all their hard work in producing this important report.

Through a written notation vote process, I voted for this report and the recommendations concerning this incident. The notation item 2015-41 on July 6, 2015. On July 13, 2015 Member Ehrlich calendared this matter for discussion at a public meeting.

And I just note that calendar items now have to be brought up for discussion at public meetings. They cannot be swept under the rug anymore. This is something that's in our new regulations that are now effective. That basically makes the calendar motion an opportunity for public discussion, debate, transparency, et cetera. So it's perfectly

appropriate that the item was calendared for discussion at this meeting today.

So I now make the following motions, the Board hereby votes to adopt and release the proposed final investigation report including the proposed recommendations as the Board's report and recommendations on the Caribbean Petroleum incident as well as the accompanying video. I now ask if there is a second for that motion.

FEMALE PARTICIPANT: Is it possible for --

MEMBER ENGLER: No. Just to back up for a second, there's been extensive public input into this report. We had a public meeting on it. We extended the comment deadline. So at this point, we're focusing on actually taking action on the report.

Of course, if you have additional comments to submit at this point, you can always submit a statement to the public record. We have an open public record process here so we're always open to hearing comments on draft reports,

final reports, et cetera.

Do I hear a second?

Hearing no second, the motion failed. Do you have statements that you would to --

MEMBER EHRLICH: Yes I do. I wish to have it known at the outset that the CAPECO investigation team produced an excellent report with important factual findings and did so with very limited staffing and resources. For this they are to be strongly commended.

I also commend the CSB Public Affairs staff for another outstanding safety video describing the causes of the CAPECO incident which will greatly benefit the investigative community.

I agree with the report's premise that overfilling gasoline storage tanks is a serious hazard that deserves a high level of attention from industry. Both the 2009 CAPECO incident in Puerto Rico and the 2005 Buncefield incident in the U.K. demonstrate the potentially severe consequences from gasoline vapor cloud

explosions.

Thankfully, gasoline tank incidents since the 19 -- I'm sorry. Thankfully, gasoline overfill incidents have been rare in the U.S. and the report noted only a handful of (inaudible) incidents since the 1970's. Fortunately, the explosion in Puerto Rico caused no serious injuries and it has been many years since a gasoline tank overfill incident caused a fatality in the U.S.

My vote was based on fundamental philosophical disagreement with several of the key recommendations in the draft report. Specifically the recommendation for extensive new regulations directed to the United States Environmental Protection Agency and the United States Occupational Safety and Health Administration.

I believe these recommendations would be burdensome for industry, would not reflect the stated priorities of already overstretched regulatory agencies, and do little to reduce the

risk to the public for any facilities like CAPECO that fall far short of complying with existing regulatory standards.

Their not having followed the existing regulations would call into question the issue of how they would adhere to stricter regulations. I also believe that given the difficulty of getting new federal regulations adopted, the CSB should only recommend such regulations when absolutely necessary. Doing otherwise simply dilutes our very limited resources for recommendations advocacy.

In suggesting that the EPA expand its risk management program to encompass thousands of terminals storing flammable liquids, NFPA Class 3, like gasoline, the draft report would greatly expand a regulatory program that already lacks sufficient staffing and resources to do effective inspections and enforcement at major refining and chemical manufacturing sites.

I am unique among the current members and staff at the agency in having run industrial

chemical plants. And at one time I ran a petroleum terminal in New Jersey that handled products similar to CAPECO. There, however, the similarity ended. At the terminal I ran, we were extremely vigilant about the danger of an overfill event.

And our standards and safeguards and alarms received extensive and regular scrutiny from regulatory agencies including the EPA, the NJDP, the New Jersey Department of Environmental Protection, and the United States Coast Guard. Using the existing the rule book, that terminal facility was held to an extremely high standard.

The draft report does an excellent job documenting the fact that CAPECO, at the behest of EPA and based on current regulations, previously installed an electronic level control system for its gasoline storage tanks. But then unfortunately, allowed that system to fall into serious disrepair.

CAPECO management continued operating the facility right until the night of the

incident without a functioning tank level control system that would meet existing EPA regulations. As the EPA noted in its comments on the report, the company also did not comply with existing regulations to properly supervise the containment dike valves to prevent the spread of any spilled petroleum.

On the night of the incident, open valves allowed the spread of the spilled gasoline over a wide area and greatly increased the incident severity. The lack of adherence to current EPA regulations was a direct cause of this incident. Had EPA regulations required additional layers of protection on that gasoline storage tank as suggested by the draft report, there's no assurance that CAPECO would have maintained these systems any more diligently.

As the EPA and others have pointed out in public comments on the draft report, current provisions of the Spill Prevention Control and Countermeasures, SPCC rule, already require companies to have continuous or fast response

tank level monitoring to prevent overfilling. And to ensure the existence or design according to good engineering practices and they are regularly tested to ensure proper operation.

The EPA might best assist the regulated community by providing additional interpretation or values concerning the good engineering practice a company should implement to prevent overfills including references to the appropriate and up to date NFPA, National Fire Protection Association, and API, American Petroleum Institute, consensus standards.

In light of the situation at CAPECO, it would also be beneficial for the EPA to apply additional resources to enforcing its existing SPCC regulations, requirements, and to educating the regulative community on effective implementation. However, layering an additional conflicting or duplicative regulations concerning tank overfill prevention through the EPA risk management program and/or the OSHA flammable liquids standards, 29CFR1910106, it will simply

add cost and confusion to an already complex system with little safety benefits.

It would also run contrary to the approach directed by President Obama in several Executive Orders that encourage agencies to streamline and simplify regulatory approaches and specify performance objectives rather than specific compliance strategies.

My position in no way should be construed to be a criticism of the staff that prepared this report. They did an excellent job, Vidisha and Adel (phonetic). I simply have different life experiences and differing perspective on how to address hazards like those found at CAPECO. Thank you.

MEMBER ENGLER: Thank you for that statement Mr. Ehrlich. I would like to respond. First of all, the CSB is fundamentally a non-regulatory agency. We don't propose regulations. But if we think that regulations should be considered, we have a duty and obligation to put them forward for consideration, for further

debate, to go through the long process that involves many, many steps before regulations actually are adopted.

And not to propose where there are clearly defined, non-duplicative, non-conflicting safeguards, I see as a fundamental problem in an approach to the way this agency should move forward. We are not here to reflect other agency's priorities frankly. If you look at the statutes that establish the CSB, we're supposed to look critically at OSHA, at EPA, and at other entities and make recommendations about policies that should be considered.

It doesn't say in our statues, in our enabling statute or the legislative history which I've read numerous times, P.S. consider other agency priorities. Of course, that doesn't mean we can't interact with them and we do interact with them.

We send our recommendations in advance, as part of the draft and consultation process, to agencies to get their feedback. To

find out, are we off base? Can we make alterations? Can we improve them? That process was, in my view, thoroughly done with this particular report.

Obviously, if we suggest things that make no sense to an agency whatsoever, the chances of them seriously considering such a proposal are much reduced. But not to make a proposal based on another agency's priorities is frankly, would be a dereliction of duty for this agency.

The argument that the proposal would do little to reduce risks to the public is fundamentally flawed. And the logical conclusion of that is simply not to have safeguards because after all, if there is one bad actor out there who won't adhere to them and since it won't work, we simply don't need such protections. It makes no sense whatsoever to me.

It would actually be an argument for abolishing existing regulatory protections because some outlier didn't follow them. So I

find it deeply disturbing about what it portends for the future reports that we have before us.

In cases such as West, where it's my understanding that the State of Texas has, Mr. Banks you can correct me if I'm stating it incorrectly here, a new law that says ammonium nitrate can't be stored within 30 feet of a combustible or flammable area.

Now it seems to me that that may be somehow inadequate as a preventive measure for this problem. Does that mean that because there is a philosophy of opposing regulatory protections, that we should not as a Board discuss the particular vaccuum of safeguards for workers and communities? Not only in Texas, but across the country. I think not. I'm deeply disturbed by this vote today which means that the report and the video will not be released in final form.

And I intend to bring this up at a subsequent Board meeting for further consideration as soon as possible with the hope

that the Senate promptly, as soon as possible, can confirm the additional Board members that have been nominated who bring a commitment to preventive measures, public health, worker safety, and the core mission of this agency.

So I would like to move on, unless there's any other comments from Mr. Ehrlich, to the next agenda item. The next agenda items is -- just to note for the record that again, the motion that I made failed for lack of a second in terms of the official record. Next on our agenda is the BP Incident Reporting System recommendation with a presentation by Mark Kaszniak, our Senior Recommendations Specialist.

MR. KASZNIAK: Thank you Mr. Engler. This recommendation was issued as a result of the CSB BP Texas City refinery explosion in 2005 which was one of three recommendations issued to BP corporate Board of Directors in the final report that was released on March 20, 2007 at the conclusion of that investigation at the public meeting that was held in Texas City, Texas.

The CSB found in the report that the BP lacked a sufficient reporting and learning culture in its refinery and its organization. If you would consult further details, you should look at Section 10 of that report which is posted on our website.

It briefly, the key elements that CSB noted in this recommendation is that reporting bad news in the BP organization was not encouraged. That BP Texas City managers did not effectively investigate accidents and take appropriate correction action when those accidents occured.

And that a corporate audit conducted the year prior to the BP Texas City explosion throughout the BP corporate structure revealed that there were insufficient mechanisms for disseminating information from previous incidents in the BP organization in 35 of BP's group business units.

So based on that recommendation, based on those findings, the CSB issued the following

recommendation which I will read in its entirety here. Is that to ensure and monitor that senior executives implement an incident reporting program throughout the refinery organization that A, encourages the reporting of incidents without fear of retaliation.

B, requires prompt corrective actions based on incident reports and recommendations and tracks closure of action items at the refinery where the incident occurred and at other affected facilities. And C, requires communication of key lessons learned to management and hourly employees as a result as well as to industry.

This recommendation is also tangentially related to the next recommendation that was issued to BP, R13, this was R12 by the way. That it also required BP to ensure and monitor through its senior executives, both leading and lagging process safety indicators indicating measures to strengthen safety performance at its refineries.

CSB had numerous communications with

the BP organization from 2007 with regarding to how these recommendations were being implemented. In September of 2012, BP finally provided us sufficient information for both B12 and B13 for the Board, for the recommendations partner to evaluate to them to determine if their standards changed, or those recommendations that we could submit to the Board.

At that time, there was an evaluation of the responses by the staff and the Office of Recommendations and at that time, they were recommended to be both closed as acceptable action. The rationale for this particular recommendation that prompted that recommendation by the CSB staff was that in regard to Bullet A of the recommendation, that BP had developed a revised code of conduct in June of 2005 which required prompt incident reporting by all of their employees of any particular incident that occurred in BP operations which was widely communicated throughout its organization when it was launched.

And that there is an annual certification by BP team leader that is followed to ensure that this new standard of conduct is being met in the organization. This annual certification is passed on up through the BP line of command to the Chief Executive Officer to assure that this particular provision is being followed throughout the BP organization.

BP also developed a BP open talk, 24/7 multilingual help line where people could call anonymously and voice concerns about incidents within the BP organization. Those incidents, the hotline is actually monitored by an outside party.

And then that information is taken and then referred again, back into the internal part of the BP organization in an area where that particular area of the plant that's being, the incident was alleged, somebody can investigate who is not part of that line organization. To assess whether or not that particular incident has been looked at or not and how BP is examining

that particular incident that was being alleged at the hotline.

In addition, BP had modified its group practices in the refining sector to require incident investigations for both documented incidents and near misses which include developing of investigation teams, conducting investigations using root cause analysis techniques, determining causes, establishing remedial actions, and then reporting the finding of those investigations.

Once those investigations findings were developed, they were placed into an internal system at BP called their Traction system which is designed to follow up all those recommendations until they get successful closure.

Those items in the BP tracking system are also incorporated into the company's leading and lagging indicators and are monitored on a quarterly basis to ensure that traction items are being dealt with. Particularly with regard to

incident investigations that aren't being closed out on a prompt basis.

Finally, regarding dissemination of lessons learned, BP has developed various mechanisms both within and outside of its organization to post information about these incidents which include posting intranet results of these investigations internally for the benefit of their employees.

They also have email blasts available when investigations get completed where people can be informed of the results of investigations. They produce quarterly bulletins that highlight incident investigations that have occurred in the organization.

And that BP, with regard to outside participation, participates amongst various industrial associations like the American Petroleum Institute and also makes presentations at other health safety and environmental related national conferences and international conferences that are convened throughout the

year.

With these many examples that were provided with the BP documentation, all of that could be verified. The only thing that the staff could not verify at the time of this recommendation was being prompted for closure, was actually how the BP employees felt about the implementation of these efforts.

Our organization is a very small department, we only have three people in our department to be able to follow up on over 170 recommendations. It is impossible for us to survey the BP community to find out. We did extend our outreach at the time to the recognized bargaining units at the facilities.

And we basically got informal information back that some things were working and some things weren't working. But no formalized information at the time. So that led the staff to conclude this should be proposed to the Board for an open, acceptable action.

As such, it was prepared for notation

Board vote and went before the Board, both R12 and R13 at the same time. R13, which involved leading and lagging indicators at the BP refineries was closed as acceptable by the Board. However, R12 was calendared by Board Member Griffon on April 19th of 2003 so that this issue could be discussed in a public meeting and that all affected parties would have an opportunity to provide input to the Board.

MEMBER ENGLER: Point of information, excuse me. 2013?

MR. KASZNIAK: Yes, 2013. And it has been calendared up until then, until the recent new Board provisions require it to be discussed at an open public meeting which is being held today.

So the public discussion on this issue has long been overdue. However, now that several years have passed since BP has revised its incident reporting system, we at the CSB are looking forward to hearing both from the public and in particular from the company and the

workers about how it's performing. And whether or not it is effective to this day.

MEMBER ENGLER: Thank you. With that, I think I'd like to open the floor for any comments from the public through the Board on the report that Mr. Kaszniak just presented concerning the issue.

We have none by the way, no one signed up on the sign up sheet that was in the hall but perhaps some folks missed it. Or if there's anyone on the telephone that would like to comment.

OPERATOR: We will now begin the first public comment session. If you have a comment, please press star then 1 from your touchtone phone. If you wish to be removed from the queue, please press the pound sign or the hash 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 comment, please press star then 1 from your touchtone

phone. It looks like we have a comment from Ashlee Dunham from Barton Law Firm. Your line is open, please go ahead. Ashlee, if you're on mute, please unmute yourself. And at this time Ashlee, I have no audio, I'll be releasing you back in the call. At this time we have no further comments.

MEMBER ENGLER: We have received a written submission from the United Steelworkers Health Safety and Environment Department. We're looking forward to reaching out to BP. Again, it's our understanding that if BP is represented in the room that they have chosen not to make comments at this time.

We will make additional efforts to reach out both to the United Steelworkers which represents workers at BP facilities as well as BP Board of Directors to see if there's any comment that they would like to make before reconsidering this.

Again, this is an example, by the way, even though there's no comment, it's an example

of something, as Mr. Kaszniak pointed out, that we actually have to do. The way our procedures have worked, calendaring, my understanding was originally intended so that issues would come to public meetings and they wouldn't disappear. So that's why this is on the public agenda for today.

But given that there's no comments and yet we seek further input, I'd like to make a motion to table this item to the next, to a subsequent CSB public business meeting. Do I have a second?

MEMBER EHRLICH: I'll second the motion.

MS. MCCORMICK: Okay I'll call the roll. So on the motion to table this item for discussion, Mr. Ehrlich?

MEMBER EHRLICH: Aye.

MS. MCCORMICK: Mr. Engler?

MEMBER ENGLER: Aye.

MS. MCCORMICK: Motion passes.

MEMBER ENGLER: Thank you. At this

point, because we're actually running a bit ahead of schedule I think we will not have a long break. Amy, do you know if Dan is ready to --

MS. MCCORMICK: I'll go get him. He's upstairs with the families.

MEMBER ENGLER: Oh they are here, okay. So why don't we just take a very short break until Dan Tillema, our investigator who will be presenting the next update on the DuPont La Porte, Texas investigation is able to come down.

I think, according to Amy McCormick, he'll be accompanied by some family members of the victims in that tragedy. So we'll just take a couple minutes so if people need to take a very quick break, please do so but we'll be reconvening very shortly.

(Whereupon, the above-entitled matter briefly went off the record.)

MEMBER ENGLER: Okay thank you all. A number of folks have joined us since this brief break. Could I request that those who have just

joined us in the room stand and just introduce themselves, who you are, where you're from?

CLAY DUGAS: I'm Clay Dugas from Beaumont, Texas.

JANE LEGER: I'm Jane Leger, I'm from Beaumont, Texas as well.

MR. DELAUNE: I'm Justin DeLaune from Baton Rouge, Louisiana.

LYNETTE SOTO: Lynette Soto from Pasadena, Texas.

MICHELLE TISNADO: Michelle Tisnado from La Porte, Texas.

GILBERT TISNADO: Gilbert Tisnado, from Pasadena, Texas.

MR. TILEMMA: Dan Tillema from the Western Regional Office.

MEMBER ENGLER: Thank you all for joining us. Just briefly to introduce this part of the agenda, some remarks. On November 14, 2015 after a release of methyl mercaptan at the DuPont facility in La Porte, Texas, four employees died in what clearly appeared to be a

preventable incident.

They were Crystal Wise, age 53, Robert Tisnado, age 39, Gilbert Tisnado, age 48, and Wade Baker, age 60. Before we hear a report from CSB's Dan Tillema on the status of this investigation, I would like to recognize the family members who have joined us today. They are, they just introduced themselves, Gilbert Tisnado, Robert and Gilbert's father. Michelle Tisnado, Gilbert Tisnado's spouse. Lynette Soto, Robert and Gilbert's sister.

On behalf of the Board, we offer our condolences on your terrible losses. We pledge to make every effort to help prevent such tragic chemical incidents from happening in the future. To recognize the seriousness of this incident, I would ask that we all stand for a moment of silence in recognition and memory.

(Moment of silence.)

MEMBER ENGLER: Thank you. So Mr. Tilemma could you proceed with your report?

MR. TILLEMA: Yes, thank you. I'm Dan

Tillema. I'm the Lead Investigator for the CSB's investigation on the DuPont La Porte incident. My presentation today will cover the CSB's history with the clients and some of the factors that the Board weighed in making a deployment decision to the La Porte incident, the basic incident and investigation facts, and conclude with a discussion of some serious hazards at DuPont and our draft proposed recommendations for the Board's consideration.

I should probably clarify one item before we go further. It's an item that's caused confusion with many people that we've talked to throughout the investigation. Our investigation and the findings that we are discussing today are only focused on the crop protection unit where the insecticide manufacturing is done at La Porte. The herbicides unit and the hydrochloric acid unit are not presently part of the focus of our investigation.

In 2010, the CSB investigated three serious incidents over a two day period at the

DuPont Belle facility. One of these incidents resulted in a fatality. Then later in 2010, the CSB investigated another fatality incident at the DuPont Yerkes facility. And finally, just over eight months ago, the CSB began its investigation of the DuPont La Porte accident that tragically claimed the lives of four workers.

Listed on this slide is our recollection of important factors that weighed in the Board's decision to deploy to those four incidents. Factoring heavily was the seriousness of this incident along with the fact that this is the third fatality incident at three different La Porte facilities. We believe this is a first in CSB history.

The CSB was also concerned about DuPont's process safety performance. And while DuPont's personal safety performance has been good, these incidents reflect poor process safety performance. It's important to know and understand that the CSB has been advocating for companies to have a separate focus on process

safety since the 2005 BP Texas City incident.

This slide just lists some of the key facts about the investigation. As we stated already, it was November 15, 2014 the four employees were killed. There was 24,000 pounds of highly toxic methyl mercaptan released on and off site. The releasing occurred inside an enclosed building which is an important factor. All four employees were inside the building. Two of the four fatalities occurred during rescue.

To give people an idea of the size of the La Porte facility, we listed that there's 300 personnel at this site at the time the incident occurred, employed at the site at the time the incident occurred.

Then just some brief comments on the investigation progress. Our initial deployment started on November 16th and concluded on June 12th. We are not finished with the investigation. We concluded our initial deployment in order to develop and promote proposed recommendations that we're discussing

today.

During the investigation, we identified serious process safety concerns. We routinely communicated these to DuPont. Our concerns were not kept a secret, they were well known. However, on June 11th, DuPont management communicated their dismissal of some key actions we believe are needed in order to prevent future similar major accidents. These serious hazards are the focus of the proposed recommendations.

Next I'll cover subjects that are relevant to the proposed recommendations and we're going to cover these at a fairly high level. The proposed recommendation document provides much more specific detail on each of these topics.

First, I'll discuss inherently safer design. Following the Bhopal tragedy in 1984, DuPont modified its methyl isocyanate process using inherently safer design. DuPont's new design included the use of an open building structure and installing equipment directly to an

incinerator for destruction of highly toxic chemicals.

The snippet at the bottom of this slide is an important excerpt from DuPont's actual design document clearly showing the inherently safer design principles they applied. However, DuPont did not effectively apply similar inherently safer design to other highly toxic chemicals at La Porte such as methyl mercaptan and chlorine.

Since the November 2014 incident took place inside the enclosed and unventilated building, not effectively applying inherently safer design more broadly following Bhopal played a significant role.

The next topic is enclosed building hazards. The area of the process where the incident took place is inside an enclosed building. At this point, we know of no documented reason or design purpose that requires this equipment to be located inside a building.

However, locating this equipment

inside the enclosed building introduced significant hazards to workers that DuPont has not effectively identified or controlled. The building itself is not what companies would consider a containment building. Companies in the industry have made choices at times to enclose highly toxic chemical manufacturing equipment inside containment buildings.

The general idea with the containment building is that if a significant leak were to occur, the leak would be contained in the building and then the vapors would be routed to a destruction device such as an incinerator or a scrubber system. Industry has recognized that when containment buildings are used, there is a benefit to the community because it is less likely that the release will travel offsite to impact the community.

However, industry has also recognized that enclosing a leak within the building creates a increased work risk to workers. The building at La Porte is not considered a containment

building. Doors are routinely kept open, piping penetrations are not sealed leaving large air drafts in the building. And the ventilation fan is discharged directly to the atmosphere rather than an incinerator or a scrubber system.

So because of the building's design, the building at DuPont has all the negative increased risk to workers without any of the benefits of decreased risks to the community.

Next topic I'll address is building ventilation hazards. First, the ventilation fans were classified as PSM critical equipment by DuPont and yet neither fan was in operation at the time of the incident. However, even if both fans had been operating, the rate of the methyl mercaptan release was just too large and the fans would have not been able to prevent a lethal atmosphere inside the building.

The ventilation fan for the area of the unit where the methyl mercaptan release occurred had not been operating since October 20th despite an urgent work order being written

to repair it. Also, DuPont did not add any additional safety precautions such as worker access restrictions, or require workers to have any additional personal protective equipment to access the building when the ventilation fans were not operating.

The stairs located inside the building are the primary means to access the various levels and equipment inside the building. These stairs are designed for fire escape and DuPont has not effectively evaluated entry or escape hazards for toxic or inert gas atmospheres.

The building stairways are designed to be totally enclosed and they are not ventilated. However, the internal doors between the stairway and the inner portion of the building where the manufacturing equipment containing hazardous chemicals is located, do not provide an effective barrier to keep hazardous gases from entering into the stairway.

Our next topic is that DuPont's gas detectors, and their response to these gas

detectors, is not effective. Overall, the design of the detectors for methyl mercaptan do not effectively warn workers or protect the public.

The detector alarm point is 25 parts per million for methyl mercaptan. This is well above the OSHA 0.5 part per million recommended limit. In addition, the response to detector alarms is not sufficient to protect the public and I'll get this more on the next slide.

In the hours prior to the incident, multiple highly toxic methyl mercaptan detectors sounded but DuPont's emergency response team was not notified and the area was not cleared of personnel. In addition, our investigation identified methyl mercaptan releases on November 13th and November 14th, so the day and two days before this incident.

These highly toxic chemical releases resulted in detector alarms but were never reported as releases nor investigated as serious process safety incidents.

Our next topic is DuPont's process

hazard analysis. We found that process hazard analyses did not consider key events that took place during this incident. Valves connecting the liquid methyl mercaptan feed line to the vapor waste gas vent header were open at the time of the incident.

However, the process hazard analysis never considered the hazard that the line could create. PHAs, which is the acronym for process hazard analysis, at DuPont are broken into sections. Most companies do something very similar. OSHA and EPA require these PHAs to be re-validated every five years.

To spread the work load out over the five year period, companies do a portion of these PHAs each year so that at the end of the five year period, each PHA has been reviewed. DuPont has broken its PHAs into 15 sections. So essentially there are 15 different PHAs done over that five year period.

Following the incident, DuPont conducted a new process hazard analysis on two of

these 15 sections. To their credit, DuPont applied a much more robust technique to these two PHAs that requires far more time and considers more potential scenarios than their previous PHAs had done.

This effort resulted in their PHA teams identifying hundreds of new action items. However, DuPont management stated to us back in June that they were not going to apply this approach to the other 13 PHAs prior to their plan start up in August.

Our next topic is ventilation evaluation. In short, the building air dilution ventilation system has never been evaluated by a PHA or engineering study. Even before this incident, DuPont had scheduled such a review for 2017.

No evaluation of the ventilation flow rate or effective distribution of ventilation air had ever been conducted on the area of the building where the release took place. Even with the relevance of the suspicion of ventilation air

to the November incident, DuPont did not intend to conduct this review prior to the August 2015 start up.

Our next topic is building safeguards. I've been told by at least one person that this slide is confusing. I think the supporting information, the full 42 page proposed recommendation document does a much better job of what we are trying to say here.

But the message we want to convey is that DuPont's very small process analyzer buildings are equipped with sensors to verify there is adequate oxygen concentration. These sensors alarm and a green light at the door to the building turns off to warn workers of potential hazardous conditions so they don't enter the building.

We think this is good and we are pointing out that the workers who approached the door to the much larger manufacturing building where the incident took place have no similar protections. There are no detectors inside those

doorways to monitor the atmosphere and warn workers if it is not safe to enter.

The last topic I'm going to cover is pressure release systems. We found pressure release systems at DuPont that are improperly designed and have not been evaluated to ensure they relieve to a safe location as required by industry codes and standards. We provided some very specific details in the 42 page proposed recommendation document.

So the proposed draft recommendations for the DuPont crop protection unit are as follows. These are just a high level summary of the recommendations. The full text of each recommendation is much more detailed, typically 100 words per recommendation.

So recommendation one, conduct and implement a comprehensive inherently safer design review. Recommendation two is to conduct a PHA and engineering evaluation of the building's design and its ventilation system. Recommendation three is to perform a site wide

pressure release study to ensure compliance with codes and standards. And recommendation four is to develop an expedited schedule for robust, more detailed PHAs like DuPont completed after the incident for those two sections.

The last two slides reflect our current status. We communicated to DuPont on June 11th that we were going to pursue these recommendations. After DuPont was provided with a draft of these recommendations, they told us that they would suspend the August start up to address our concerns.

We also expect to receive some type of written plan to address these proposed recommendations by the end of this month. Although DuPont has stated a willingness to address these items, the investigation team is still recommending that the Board formally adopt and approve the issuance of these proposed recommendations.

This is the CSB's formal program to allow the Board to effectively track and evaluate

DuPont's mitigation of these serious hazards. And it provides an opportunity for the public to be informed of the implementation status.

MEMBER ENGLER: Thank you Mr. Tillema. We very much appreciate the time and effort that you have spent in Texas, far away from Denver, for a long time working to discover the underlying causes of this incident. Member Ehrlich, do you have any questions?

MEMBER EHRLICH: Yes, I do. First of all Dan, outstanding job. Read all the documents you've written and Don, my same opinion goes to you. You referenced the 42 page document. Is that material the same as the 40 page document that was issued on July the 13th?

MR. TILLEMA: It is. There's been a couple of updates to it which extended the length. But it is essentially the same document that you saw.

MEMBER EHRLICH: Okay. And these have been reviewed by DuPont to determine that there's no confidential business information contained

within it?

MR. TILLEMA: It went through both confidential business information review at DuPont as well as factual review and we've implemented their comments.

MEMBER EHRLICH: Okay so did they find anything factually incomplete or incorrect? Or has that been changed?

MR. TILLEMA: In general, we have a very good working relationship with DuPont on these type of activities. You know, there's areas where I as an engineer choose a word that I think means something and they suggest that it might mean something else. And so we make those kind of modifications. But there were no material objections to the findings itself.

MEMBER EHRLICH: Okay, great. And the reason you call them urgent recommendations, is that because of an imminent hazard of danger?

MR. TILLEMA: Good question. From the investigation team's perspective when we paused on June 11th, they were imminent hazards. And

our process for addressing imminent hazards per Board Order 22 which is publicly available on the website. If you Google search CSB Board Order 22, you'll see our process for recommendations. For imminent hazards, the only appropriate recommendation is an urgent recommendation.

MEMBER EHRLICH: So at this point, what stands between getting these recommendations to the Board for final approval? Are they not ready?

MR. TILLEMA: That might be a great question for Don Holmstrom.

MR. HOLMSTROM: Currently given the fact that we have met with DuPont and received some information about the fact that there's now an indefinite delay in starting up the building, we are reviewing the document internally through a staff review process and anticipate within, I think, a relatively short period of time.

As Dan indicated, the document is fairly mature, to be able to, once the document has gone through that staff review for it go to

the Board for comment which ultimately, you at the Board as the deciders of the recommendation.

MEMBER ENGLER: When do you think that will happen?

MR. HOLMSTROM: Well we hope to have it happen relatively soon. And I think that, you know, we're setting up meetings, you know, attempting to set up meetings even this week to try to further the discussion. So I believe relatively soon.

MR. TILLEMA: I would add that the investigation team has been working with the folks who make our video animation essentially since the investigation started. The complexity of the incident at DuPont really lends itself well to an animation.

It's very difficult to just stand up here and describe all the nuances of how the piping is interconnected and people come away with a good understanding of how that happened. That animation is nearly complete. Our view was to release them at the same time.

MEMBER EHRLICH: Okay. I'm, again, you guys have done an outstanding job. I visited the site as well, you know. And I spent 50 years in the chemical industry even though I'm only 35-years-old. I have to say these guys have done a tremendous job in terms of finding out what happened and made recommendations to see to it that it doesn't happen again. Thank you both.

MEMBER ENGLER: Thank you Member Ehrlich. Dan, what would you say the next steps, if you want to comment as well Don, what are the next steps moving forward in the investigation? These are essentially interim recommendations, preliminary to the development of a broader final report. Where do you see going after this stage?

MR. TILLEMA: As I mentioned, we paused the investigation at this point in order to develop this document and issue these recommendations. So we are still far from being complete at La Porte.

So we need to finish our full causal analysis and get a complete understanding of the

causes, to the best of our ability, at La Porte. And then I think we need to start looking at what the corporate oversight role was that allowed these problems to exist for so long.

That would be our next focus, trying to understand at a corporate level the various things that are supposed to prevent these types of accidents from happening and have significant process safety management gaps at a site such as corporate audit.

MR. HOLMSTROM: Board Member Engler, I mentioned that for the ExxonMobil investigation we have a Board order on scoping. And so we are implementing a scoping process for the DuPont investigation which is, we think a key way to have the Board's input into what kind of product we're going to produce, full investigation report, what sort of issues we're going to examine and have full input to that.

We currently have a draft that, again, is both ExxonMobil and DuPont are recent investigations. So at this point, the work plan

and everything else is dependent upon, is it a narrow scope? Is it a broad scope? Currently we're engaging in the scoping process.

But as Dan indicated, given the fact that we've had three, actually four previous incidents at two separate facilities and two reports from the CSB in addition to this incident, that we're going to be potentially looking for linkages and issues related to those investigations and potentially other issues. And how that impacts, looking more broadly than at just La Porte, Texas.

MEMBER ENGLER: Thank you. At this point, I would like to open the floor for public comment. On the public comment sheet, we have three people who have signed up so far. First I'd like to recognize Lynette Soto.

MR. TILLEMA: They weren't here earlier. Are you having them come up here for the comments or just staying where they're at?

MEMBER ENGLER: I think it would be great if people came up to the podium, if people

are comfortable doing that. Thank you.

LYNETTE SOTO: Good morning. I apologize in advance, I am very emotional. I want to speak from my heart and tell you how I feel. I'm here for two main reasons, the main reason is to give voice to my brothers. I'm the sister of Robert and Gilbert Tisnado.

They are just not a casualty or a statistic of DuPont, they were my brothers. My family is devastated, heartbroken. There is no measuring the amount of pain and suffering we are going through by losing these two people.

My brothers loved their job, loved their job. A month prior to the incident, I applied for a job at Valero where my oldest brother Gibby's two boys work. I wasn't sure about working there so when Gibby brought me over these tests, I said, I don't know Gib, I'm kind of worried about it.

He said Nette, there's a lot of dangerous chemicals. He's like, but there's so many safety precautions that you don't have to

worry about it. And my brother truly believed that his environment that he worked in was safe. And he was wrong. I mean he was wrong - this was not an accident.

I live in this area. La Porte, Pasadena, Deer Park, 90 percent of the people that live there are related to or know somebody personally who lives in those plants. There are all those people are know well aware of the safety hazards. The majority of my friend's husbands do not come up or comment or say anything because financially, they are paid well.

Just because you're paid well doesn't mean you should have your life in jeopardy. You're playing Russian Roulette with their lives. This wasn't an accident, this was gross negligence.

These issues at this plant had been there for years. If it was an accident, we would not be here talking to you right now because of course, living in that environment, there are accidents. This wasn't an accident, this was

deliberate neglect, letting it go for so many years. And unfortunately, my brothers were two of those casualties.

But I won't let them go without being heard their voices. They should have never died. My brothers were such wonderful people. I'm not saying that because I'm related to them. I'm saying it because it's genuine and it's true.

They were hard working men. My youngest brother had a one-year-old, a three-year-old who will never know what a bright piece of sunshine that little boy was. He was the baby of the family, let me tell you. He lived that to the T. He was a pain, I understand that. But he was a breath of fresh air.

And my oldest brother, he was my go-to guy. For anything, going through a divorce, personal, whatever it may be, Gibby had my back. They worked both nights and so when he was over there doing the panels, I would speak to him about it.

I'm here to beg and plead for these

recommendations and this report to go through. Nobody should have to go through this anymore. I Googled the heck out of DuPont and their safety records and I read that between 2007 and now, there's been over 34 different leaks. There's been 12 people, 12 deaths. I don't understand what we're doing here. They need to fix it.

I know that the unit that my brother's in is the money maker. It made over $1 million a year. And you know what, the money that they make, it goes through our community. And we have better schools and stuff because, yes, all these chemical plants are near us. And I know this.

My daughter's a teacher at Deer Park. I have grandchildren who live near there. But it needs to be safe. Make your money. Maybe I Google too much, I know that CEO, the Forbes, the CEO of DuPont is Number 26. So that means she is way up there and they can do what they want.

How many times do people have to lie and cut corners and stuff so financially it's better for them? If you have this facility and

it's making you all this kind of money, then wouldn't it be smart to invest in it and make sure it's safe? So you can make all the money you want. But I'll be danged if you should be able to kill people and use them as a casualty or just, oh well we lost two today, no big deal.

But to the family, it was a big deal. They are vital people that worked from the heart, they loved their job, they loved the people there. They didn't deserve to die for a profit and that's what it is. I mean DuPont's got more money than you can shake a stick at, I'll be the one to tell you. And that's fine and dandy. I'm not envy of that.

What I'm mad about is you have no right to take my brothers. They were my life. I can't describe to you the heartache, I can't put into words but it's wrong. They need to fix it. It's been a problem apparently, that building has been here since World War Two. It never should have been there.

I read his report. I've heard Dan and

I appreciate you coming to my house and explaining it to my family. And not only that, explain it to me like I was a five-year-old because I don't get all that. I'm not into all this stuff.

But I know that my brothers died in vain and they shouldn't. DuPont has gotten away with a lot of stuff and they cut these corners. But when is enough? When are you going to say, hey we do these recommendations and people keep dying? When is there point where you say, hey maybe they have a problem, maybe we should make them be accountable and fix it?

Somebody, somewhere, I'm begging you. Somebody's got to be accountable. I mean they've gotten away with it for so long. Not with my brothers, I mean, there's nothing we can do about my brothers. No matter what I pray and I beg, my brothers won't come back.

But nobody else should have to lose their brothers, their sons, their spouses, nobody for something like that. You work hard and these

people give their life for DuPont. And for what? For you to think they're just disposable. We're not disposable.

The people that work there, that have been there 23 years, give their whole life. Mr. Baker had been there 40 years. He deserved better than that. He should have been able to retire. He couldn't. That unit was horrible. They knew I'm sure, Gibby told me that the ventilation system had been broke. You see the work orders.

I'm sure there's probably more that disappeared somehow, magically disappeared. That place is horrible. The ventilation system, the pipes, I don't even know how to, whatever you want to call it, that little thing who rigged that little pipe in there, should have never done that. And they should have never been able to do that but they did.

Not just in La Porte and DuPont and yet, that's my main objective because I live there. But what about those plants in all those

places? I heard all kinds of stuff, I read so much stuff. I mean when is there a stopping point when we say that they need to be held accountable?

They have the money. You make all the money you want but make sure you're doing it safely and not jeopardizing people that I love and the community that I love. So that's all I have to say, thank you.

MEMBER ENGLER: Thank you very much. Next will be Walter Prillaman from the International Chemical Workers Union.

MR. PRILLAMAN: Good morning. I'm Walter Prillaman Jr. I'm a second generation DuPonter with 36 plus years service. Sorry that touched me. I know those boys, they're good boys. I guess you could say that I'm just (inaudible).

I'd like to thank the Chemical Safety Board for the opportunity to be here. I'd also like to thank OSHA, DuPont, International Chemical Workers Local 900C which I'm the Safety

Officer. Thank you to the investigation team for the hard work that ya'll have done. It was definitely evident in the interim report and how deep that you dug through this incident.

Their report along with OSHA's NEP report has already started to have impact on safety. With four new safety items started just this week so thank you for that. In my opinion, these recommendations, without these recommendations, these changes would not have started to happen.

We need to be held accountable. It is important that this report be made public. This information will identify and help make corrections. The community that surrounds our plant and the lives of the workers are too important. Thank you.

MEMBER ENGLER: Thank you Mr. Prillaman. Next will be Justin DeLaune, do I have the pronunciation correct?

MR. DELAUNE: Yes sir.

MEMBER ENGLER: From the Smith Law

Firm.

MR. DELAUNE: Good morning ladies and gentleman. My name is Justin DeLaune and I'm an attorney from Baton Rouge, Louisiana with the Smith Law Firm. I represent a whistleblower federal False Claims Act against DuPont arising out of toxic gas leaks at DuPont's Darrow, Louisiana facility, also known as the Burnside site.

The suit alleges that DuPont withheld leak information from the EPA to avoid paying fines. A two week trial jury commenced and DuPont prevailed following an eight hour jury deliberation. However, following this verdict, it was discovered that DuPont withheld material information from this trial.

On June 25, 2015 a federal judge set aside the jury verdict that was in favor of DuPont. The court found that DuPont had engaged in misconduct that impacted the integrity of the trial process by withholding information regarding gas leak calculations and withholding

information regarding OSHA violations similar to those in La Porte, Texas. I have a copy of this ruling available for the Board along with several other things.

The evidence in our case includes an audio recording of a meeting led by Tom Miller, the plant manager at the Darrow Burnside facility since February of 2011. This meeting was regarding anonymous leak reports by employees to outside agencies.

This audio recording was accepted into evidence in our case. I have a copy of the recording available for the Board and also have a transcript of the recording prepared by a certified court reporter so that the Board may follow along in the recording at a later time. I will now read an excerpt for you beginning at Page 7 of the transcript and continuing to Page 9.

Tom Miller, the plant manager is the main speaker in this excerpt. I want to have a quick inaudible -- it's a meeting, but I got

here, the points that was written Friday I guess. About 3:00 the fire department came to the plant, Alan (phonetic) was working. He called me, they were responding to a gas cloud above the Burnside plant.

I guess that's what the complaint was. I can call the fire department and find out what exactly happened but I don't know if you guys know that this is the third complaint that we've gotten from an outside entity. One from, it says MBQ but it should be DEQ, one from OSHA, and there's one here like in the last month.

And you know, I know there are folks who are unhappy with the gas leak. I am too. I guess that's what's prompting all of this but, you know, of course these all have been complaints. I don't know who is calling them in but if this is coming from inside the plant, I'm very disappointed.

You know, we've got to be in the position where these things are talked about and discussed. There have been a lot of people

working on these things, we've had two shutdowns, and we've had a bunch of people up here doing all these things to try to contain this thing and nobody believes that.

Then go ask the folks that have been doing it. But, you know, there was an unidentified speaker, why would somebody in the plant call? Tom Miller responds, I don't know but I don't know why somebody would call OSHA from outside the plant but who knows.

But the point is that whenever a third party gets called, it never works out for the two parties that are involved on the receiving end of that. It never does. And whoever thinks it does is nuts. And we've seen it time and time again, both within the company and outside.

So you know my request is that if you guys know of anybody doing this or if you're doing it yourselves, then I'm telling this to everybody. So I'm not picking on any one person but you know, come forward with it and talk about it instead of calling agencies and stuff. That's

my point.

If you know somebody doing that, then tell them to stop doing it as well. We don't need this kind of help. DuPont will shut plants down for this. I mean, there's no doubt about it, they'll shut them down for good. I've seen it happen before.

You know, it just takes one, one iota of information. Next thing you know, it grows up to this big problem and you can get a lot of people wrapped up in looking into it. And it just becomes a big cluster. And you know, I kind of want this plant to keep running. I'm sure you guys do too because we all get paid, right?

I'll skip to his next comment. But you know, I think for us to be sitting looking at the outside and saying man, I wish we could have done something back when, you know, when this stuff originally happened instead of waiting for DuPont to come and shut this plant down because we're not, you know, not a safe operation.

That was a transcript of actual audio

recording from the plant manager himself. We had several pieces of evidence like this in our case. The evidence in our case also includes video footage that depicts disturbing amounts of toxic gas leaking from the Darrow Burnside facility shortly after a shut down that was taken to repair leaking equipment.

These videos clearly show that repair efforts failed. This footage was accepted into evidence in our case and no witness seriously challenged these videos that depict what former and current operators identify as toxic SO3 gas leak. There are several videos that I have made available to the Board including footage from cameras inside the Burnside facility.

There should be no further concealment of information involving DuPont, they do that enough. I ask the Board to be swift and thorough in how it evaluates the making public of this information the Board obtained from DuPont. This information is key to enable the industry to progress beyond the current state of the industry

and to progress beyond incidents like La Porte. Thank you.

MEMBER ENGLER: Thank you very much. Are there any other comments from within the room here today?

MEMBER EHRLICH: There are two other people, the Tisnados. The wife of Gilbert Tisnado and the father of Gilbert and Robert Tisnado.

(Telephonic interference.)

MICHELLE TISNADO: -- before making vital changes to ensure the safety of the workers as well as the public would not only be a mistake, but would also be saying that the four lives that were lost including my husband Gilbert and my brother-in-law Robert, didn't matter.

I'm concerned not only for the workers but their families as well. I do not want other families to have to go through what our families have gone through and are continuing to go through. It is unbelievable and sickening to see DuPont's disregard for the four lives that were

lost on that dreadful Saturday, November 15, 2014 at approximately 3:30 a.m.

DuPont claims it's motto is safety first, but it is obvious that DuPont is putting collection first since they are trying to reopen the unit without making the necessary changes to make it safer for the workers.

The changes that should take place should have been made a long time prior to the fatal incident that occurred due to gross negligence which would have prevented these tragic deaths that DuPont is now refusing to make to prevent future loss.

The investigators with the Chemical Safety Board and the other agencies investigating the accident have worked diligently to find recommendations that would ensure the safety of workers as well as the public which I wholeheartedly appreciate. It appears that DuPont is trying to bypass these recommendations in order to reopen the unit and start production back up.

It appears to me that DuPont has not learned anything from this tragedy and only cares about profit. I sincerely hope that you will deny DuPont's request to reopen the (inaudible) unit before the required safety measures and changes are implemented. Please allow the report to be released and approve the urgent recommendations as soon as possible. Thank you for your time.

MEMBER ENGLER: Thank you very much. Is there anyone on the phone who would like to make a comment?

OPERATOR: Once again, if you have a comment, please press star then 1 from your touchtone phone. It looks like Brent Coon from USW is on line with a question. Your line is open, please go ahead.

BRENT COON: Good morning ladies and gentlemen. Thank you ma'am. Yeah, our firm and just for clarification, we are speaking on behalf of not the USB, the USW they have their own counsel, but we are designated counsel in several

states including Texas. I think a number of you guys with the CSB know of the work our firm has done in the petrochemical industry, most notably in Texas City where we were lead counsel.

Real briefly, Don for you and the others, I was not aware that the meetings this morning would include commentary on some of the recommendations with respect to the reporting systems at BP. We are intimately familiar with a lot of the tracking devices, traction systems, and MOTs there.

We would like to weigh in further on that matter at a later date if we can be steered to the actual report that Mark and others may have generated on that. Going specifically, and just real briefly for background gentlemen, we represent clients in the DuPont incident, the Exxon matter, many of the BP Texas City, and are the major stakeholder in the Macondo incident with about 10,000 clients.

I want to first very briefly comment on some early criticism on the meeting this

morning regarding the CSB and their agenda. I was disappointed that the West final report is at least for the time being going to be suppressed.

My firm has been intimately involved in the petrochemical industry for 30 years. We work very closely --

MEMBER ENGLER: For a point of information, could you clarify that comment again?

BRENT COON: Yes. We're disappointed that there were some early technical criticism of the CSB investigators and some of the reported, what I read to be from Flint (phonetic) on their activities. We've always found the CSB to be --

MEMBER ENGLER: I'm sorry, in which investigation? We're talking about DuPont.

BRENT COON: I think that was just a comment generally as we were going through the West report.

MEMBER ENGLER: First of all, just to clarify, I'm not aware of any such information. Secondly, comments in this part of the comments

section are restricted and focused on the DuPont situation. At the end of the meeting, there will be an opportunity for any other comments about any issues that the public wishes to raise.

BRENT COON: Okay, thank you. What we would like to specifically address with DuPont at this time is there's a parallel investigation by a number of attorneys on behalf of claimants, some of whom spoke this morning, regarding our investigation through the civil system which sometimes provides supplemental information regarding the incidents.

But we rarely get up to speed on the cases as quickly as the CSB due to the slow process that it takes for the litigation in the civil arena to move forward. As a consequence, it's very beneficial for us in our parallel investigations to have access to investigations that are already being committed to by OSHA and CSB.

We appreciate very much that Mr. Tillema and others have engaged the victims and

counsel on some briefings. But we would like to have better access to the actual documentation. Most particularly this would include, for instance, the 40 page report or urgent recommendations to DuPont.

We had, in discussions with CSB investigators, thought that this would be accessible to the victims and counsel. There appears to be some questions with respect to whether or not that type of information can be disseminated to them. So we would like some clarification of that.

And to the extent there is uncertainty, we would request that the CSB resolve that in favor of the liberal construction of the dissemination of those types of communiques to the victims as part of an extension of the victims interaction program.

Other than that, we concur wholeheartedly with all of the findings that have been made to date. They're very consistent with what we have found in our independent

investigations. And we look forward to continuing to work with the CSB and other investigative agencies moving forward.

As others have said, they do an excellent job at root cause analysis. And frankly, we think that they tend to give too much benefit of the doubt to the industry regarding the lessons learned which really is just, in our opinion, renewed reminders.

We concur with the sentiments of some of the victims earlier that most of these process safety management failures throughout the industry are things that the industry is well aware of. And they put their cost benefit analysis and ROI factors in, which put everyone at additional risk.

So we would like to see the CSB be more proactive and to have more enforcement capabilities. Because frankly, the industry self regulates and OSHA, EPA, and CSB do not really have the staffing and resources enforcement that we would like all of them to see. Thank you.

MEMBER ENGLER: Thank you for those comments. I'd now like to recognize Gilbert Tisnado. Thank you for your patience here.

GILBERT TISNADO: I'd like to give thanks to my sons. This is my youngest, my baby. This is my eldest my firstborn. I haven't gotten (inaudible). I know that accidents will happen especially in plants.

But to me, the CSB Board was like doctors coming to check out a sick plant. They went through that sick plant, they found the problems, they looked at them, they made recommendations. I believe that, I don't think anything should happen until their recommendations are taken care of, until the plant is 100 percent safe for everyone.

I mean life and limb is the most important thing. I know money is important. It's so sad for a man to go to work in the morning and not make it home that evening. That's all I want to say, is that we need to make this public, let it go and let people see, learn.

If you've got a problem, fix it. Not try to sweep it anywhere, not try and cover anything. Just make it open, confront it, and go with it.

MEMBER ENGLER: Thank you. Can I ask, are these your personal photos that you're taking back to Texas with you?

GILBERT TISNADO: Yes. They're my daughter-in-law's.

MEMBER ENGLER: One thing that I remember from the recent, well the leadership at OSHA took over is that they changed I believe their conference room. Some of you may have been in it. And the conference room, I forget what they had before, but the conference room at OSHA now has photographs of people who lost their lives in preventable industrial incidents.

I wonder, even though we feature people, family members, victims in our videos, whether we shouldn't have photos in this office. I frankly, to be perfectly blunt, have gotten caught up in a lot of the difficulties,

challenges, intrigue here. I think it would help me to have photos to see every day of why we do this work and of why CSB is in existence.

So I don't know if this is the best way to do it -- sure and we will certainly post them to remind us all. Thank you again. Other comments from those on the telephone? I'm sorry, did I say I'd come back to you? I did I think. Go ahead sir.

MR. SUTTON: My name is Ian Sutton. I have two technical questions about the interpretation. Of the 300 employees, how many were contract workers and how many were DuPont employees?

The second question, you say the PHA techniques were the before and after. What were those techniques? What were they doing and what did they change to?

MEMBER ENGLER: Normally, to be frank, this is not a question and answer opportunity. But since you raised it through the Chair, I will bounce them from myself. Dan, if you would like

to respond to that.

MR. TILLEMA: Sure. So the first question was the employees, those are DuPont employees. There are other contractors on site but that's not included in that number. Off the top of my head, I do not have the number of contractors on the site.

The initial PHAs were what if checklist PHAs done with large notes and methodology. The new PHAs is a DuPont technique called a structured what if. They've published at least one paper that I'm aware of on that methodology.

MEMBER ENGLER: Are there any other comments from those joining us on the telephone or in the audience?

OPERATOR: At this time, we have no audio questions or comments.

MEMBER ENGLER: Okay. I shall note for the record that DuPont has indicated that they will submit written comments. Member Ehrlich, do you have any further comment?

MEMBER EHRLICH: No I don't at this time.

MEMBER ENGLER: I would just like briefly to say the following. This situation is deeply troubling. Not only do we have this incident but as Mr. Tillema talked about, there have been prior incidents that CSB has investigated.

We're now looking at a situation where DuPont is thinning off and splitting up. That certainly raises questions about what happens when you have management subdividing and how you deal with a situation like that within one, essentially one standard facility around the fence line.

We're looking carefully at the two sets of citations that federal OSHA issued. Including the fact that OSHA put DuPont into the severe violators program. This is a very serious situation.

So the question arises, what are the opportunities for CSB? What can we do? Just to

clarify again, we are not a regulatory agency. We have no statutory authority to say, before the facility or a section of the facility can resume production, the following steps must be taken.

With that said, we do have a rather important, I guess the phrase might be bully pulpit, to highlight problems, to suggest solutions, and to vigorously advocate for safety and prevention. I'm encouraged that DuPont has indicated that they're not starting up the facility on the original date that they had suggested which was the August 15th date, correct?

We don't know when they do plan to start up again. I think that the findings suggest that there needs to be a very, very serious and prompt response by DuPont management to what the staff of the CSB have found so far. And there needs to be a very, very serious dialogue about ensuring that preventive measures are taken within a short period of time so that the possibility of this type of tragedy repeating

itself at that facility, or frankly, in terms of impact at other DuPont facilities is taken very, very seriously.

I think I can pledge on behalf of Member Ehrlich and myself that we're deeply concerned about this. But that the proof of the direction will not be just in written statements or press releases but actual changes and implementation of safety precautions, preventive measures, assurance of whistleblower protection at DuPont facilities.

So with that, unless there's any closing comments by the investigators in this case, I would like to close that part of the discussion on DuPont. And to assure the family members that we will be taking this very seriously and following up.

By the way, I would like to meet with the family members at the conclusion, if I could, for a few minutes just to talk informally for a couple of minutes. And with that, it's now 11:30. Why don't we take a 10 minute break and

resume at 11:40. So we'll resume promptly at 11:40.

(Whereupon, the above-entitled matter briefly went off the record.)

MEMBER ENGLER: Thank you all. At this point we will reconvene.

MS. MCCORMICK: Chris, we're going to get started again.

OPERATOR: Okay, your line is open.

MEMBER ENGLER: Next on our agenda is a presentation by both Veronica Tinney from our Recommendations Office and Don Holmstrom on the status of California Process Safety Management Recommendations.

MS. TINNEY: All right, thank you. So first I'm going to start with talking about our overall recommendations that are currently under Board vote. The Board is currently reviewing the status change of 16 of our recommendations and that's outlined on a handout that is actually out in the hall. So you can review all of the ones that are currently under Board vote.

This vote is taking place by notation item which just means it's done by a paper vote. And that voting period takes place from July 14th to July 28th. These recommendations include six recommendations from the Chevron investigation, four from the AL Solutions investigation, and one each from the Texas Tech University MSG (inaudible) carbide and (inaudible).

The six Chevron recommendations include one to the Governor and State Legislature, two to Contra Costa County, and three to the City of Richmond. These recommendations have been suggested by staff to the Board on open discussible or alternate actions which just indicates that the recipient has made progress towards implementing the CSB's recommendations.

Additionally, the recommendations under review also include one potential closed acceptable alternative action to the American Petroleum Institute as a result of the Valero Refinery fire in 2007.

So I'm going to talk a little bit more about those specific Chevron investigation recommendations that I just mentioned that are up for Board vote. As a result of the Chevron investigation which occurred on August 6, 2012 in Richmond, California and caused 50,000 people in the surrounding communities to seek medical treatment, the CSB makes recommendations at both the local level to the city of Richmond and Contra Costa County and to the State of California to improve its process safety management program.

Like I mentioned, there's six that are currently in open acceptable or alternate action as recommended to the Board that they're voting on right now. Several of these include efforts made by the City of Richmond and Contra Costa County to revise industrial safety ordinances or ISOs to improve process safety.

So those are the ordinances that deal with process safety in those two jurisdictions. For example, both ISOs added language regarding

reducing risk to the greatest extent feasible, adding language relating to inherently safer systems analysis, and additional safeguards or process hazard analyses.

The CSB commends the City of Richmond and Contra Costa for initiating changes to its ISOs to address the CSB recommendations and looks forward to working with both to ensure that the intent of these recommendations is fully met. And now Mr. Holmstrom is going to talk about the recommendations that we made to California regarding its process safety management.

MR. HOLMSTROM: Thank you Veronica Tinney and I appreciate all the great work that you've done by our recommendations group on these California PSM recommendations and the great cooperation we had working together to further these recommendations. Thank you for your hard work.

Also out of the Chevron investigation, the CSB issued three reports, two of which contained recommendations to the State of

California to make specific improvements to their process safety management regulations. The State of California in part in reaction to the incident itself as well as to CSB recommendations initiated changes to their general industry safety order. And promulgated a draft, over time several drafts, a document entitled Process Safety Management for Refineries.

So this is specific process safety changes that apply to petroleum refineries in the State of California. In September and October of 2014 and May of 2015, the California Department of Industrial Relations released these drafts of the proposed rule for public comment, Versions 1, 2, and 4.5, respectively.

The CSB provided oral and written comment on the June 22, 2015, on that date to the California Department of Industrial Relations or DIR, 4.5, which is the latest version dated May 26, 2015. These comments are available under the open government portion of our website and will be briefly summarized as follows.

The CSB has previously reviewed Versions 1 and 2 of the draft regulation and expressed that it was greatly encouraged by the DIR and Cal/OSHA's leadership in advancing process safety management protections for workers and communities. The CSB has also stated that California can be a model.

We know that there's obviously currently the executive branch is reviewing reforms in terms of process safety management. That California can be a model for reforms that are being considered at the federal level by the Executive Order 13650.

However, the CSB finds that Version 4.5, in our view based on the recommendations that the Board adopted both in our first report and second report to the State of California, does not go far enough to require real risk reduction to prevent major accidents.

Without risk reduction measures for refineries to work towards, and with no clear role for the regulator, it is unclear how the

draft proposed rule is an improvement upon PSM regulations that are currently in place. Some of the major concerns that the CSB has are as follows.

The first is a concern that the majority of the language that's requiring risk reduction be implemented to the greatest extent feasible has been removed between Draft 2 and 4.5. So the current draft has most of that language removed. And as we had pointed out, some of that language, the way it's phrased, it's not clear that it would apply to remedial actions or recommendations or corrective actions.

The remaining performance measures are inconsistent, with the CSB counting ten different performance goals referenced in the draft proposed rule. Removing the central feature returns PSM to a list of required activities that lack real goal setting attributes of risk reduction.

Our concern is that PSM standard is intended to be a goal setting standard but lacks

real effective goals that are established with the standards. Without clear performance measures, the CSB is concerned that refineries will satisfy the intent of the regulation by submitting the required process documentation but without actually reducing risk of major incidents.

Preventative role of the regulator, there's very little language in 4.5 that relates to the role of the regulator in helping to prevent potentially catastrophic chemical incidents. Version 2 allowed the division, that's the earlier version, to review submitted hazard control analysis, HCAs.

In addition, where the division identifies deficiencies, the division can require the employer to submit further information, perform a real analysis, and submit a revised HCA and modify the HCA to incorporate changes proposed to for example, inherent safety measures.

Version 4.5 eliminated this language,

removing the ability of the regulator to ensure that the employer has properly controlled hazards prior to a potential catastrophic incident. And we want to emphasize that the process safety management standard is intended to focus on major accidents, on preventing potentially catastrophic incidents occurring.

The inspection strategy that focuses on response to incidents, complaints, and referrals is not an effective strategy for potentially catastrophic incidents. It's not acceptable for a catastrophic incident to occur and expect change to happen in response to an investigation of that incident solely. There has to be preventative inspections, preventative actions by the regulators.

And that certainly was the intent of the original compliance directive that OSHA issued in response to the PSM standard back in 1992. The CSB believes that the regulator can play a critical preventative role in reducing risks of accidents through inspections and audits

to ensure that refineries are adequately reducing risk.

Pursuant to its recommendations, the CSB believes language should be included that outlines the role of the regulator. Conclusions, the CSB appreciates the substantial effort involved in the development of the draft proposed rule in implementing our recommendations.

However, the CSB is concerned that the current draft, if finalized without the recommended changes, will not be effective in reducing risk of incidents at refineries. The CSB urges the DIR to make the previously mentioned changes prior to finalizing the proposed rule in addition to those described in our written comments submitted at the June 22nd meeting available on our website.

The CSB welcomes any additional conversation on how to improve the draft proposed rule and looks forward to further dialogue on how to improve refinery safety in California. Thank you.

MEMBER ENGLER: Thank you. Member Ehrlich, do you have any questions?

MEMBER EHRLICH: I do not, thank you.

MEMBER ENGLER: I have a question. Is California the leading state, in a sense, doing this? Are there efforts in other states? Or is California really the one path that's being gone down, that's being explored? Is there anything else going on in other states where this is really critical?

MR. HOLMSTROM: I apologize, I meant to say Member Ehrlich a minute ago, I mean Member Engler.

MEMBER ENGLER: Well we both begin with E.

MR. HOLMSTROM: Member Engler, California I think, because they put out a draft and they are pursuing these reforms, I think California is leading, as we've said, is leading the country in trying to improve PSM. As we know, as we've said in several reports, the PSM standard has not be substantively changed.

There have been some minor changes relative to, you know, hazard communication. But it has not been substantively changed since it was promulgated in the early '90s. So we think California is, as we said in the reports that have been issued by the Board, we think that the PSM standard needs to be strengthened based on the number of incidents occurring, particularly in oil refineries.

California is certainly taking the initiative of being proactive and moving that. There are other arenas. Veronica mentioned Contra Costa County in California which is also in California. But also the State of Washington, we understand has been meeting with the State of California to try to understand their process because we made similar recommendations to the State of Washington.

So there's also activity in the State of Washington pursuant to the recommendations we made in the Tesoro and Anacortes investigation that was issued about a year and a half ago.

MEMBER ENGLER: Okay, thank you. And thank you both for your work.

MEMBER EHRLICH: Can I change my mind?

MEMBER ENGLER: Sure.

MEMBER EHRLICH: Did they not, in California put on a whole group of inspectors to follow up and enhance the inspection program? What, they put on 13, was it?

MR. HOLMSTROM: Right. In response to, again CSB recommendations as well as the incident itself that occurred at the Chevron refinery, the State of California has undertaken several actions to improve process safety including the hiring of a number of additional, not only inspectors inspecting for TSM, but who have more technical qualifications.

A number of them, I think a majority of them are engineers. So the CSB, in our reports, have noted that it's important that the technical qualifications of the people who inspect highly technical process plants, they have equivalent technical backgrounds and

experience of those operating the plant so they can understand and play a preventative role in that process.

Much like, for example, the Nuclear Regulatory Commission hired, $1 billion budget entity that's hired really hundreds of nuclear engineers to do, to look at those highly technical issues there.

MEMBER EHRLICH: Are you familiar with the SBREFA efforts? Have you heard about that? It's coming out of small business and the Executive Order. Rather than ask you if you've heard of it, I was in a meeting where the fellow that runs it commented on it.

He says that the two big players in there are OSHA and EPA, and he thinks they're going to have legislation or formal documentation in no greater than 120 days to address a lot of these issues. Veronica, you shake like you've heard of it.

MS. TINNEY: Yes, and you can correct me, but OSHA is currently conducting its SBREFA

panel on PSM, further additions to PSM.

MEMBER EHRLICH: SBREFA, just for those any of who you are not familiar with it, is a process by the Small Business Administration to basically, structure panels of business, small, medium, and perhaps larger as well to review the impact and the cost and benefits of particular regulations.

It's an extensive and lengthy process that has been used to identify issues but in my view, frankly, has been also used to slow down the needed adoption of safeguards. So it has its benefits, but it also has its challenges to deal with.

MEMBER ENGLER: Thank you. If there's any public comments, we'll defer public comments on this presentation because we do have another public comment period coming up. Veronica, you're up again on Laboratory Safety Guideline Recommendations to the American Chemical Society.

MS. TINNEY: Sure. So one of the one recommendations from that that we would like to

highlight is the recommendation to the American Chemical Society who is here with us today. So I look forward to their comments.

This was made out of a result of the Texas Tech University laboratory explosion which in 2010, severely injured a graduate student there. As part of the investigation, the CSB found that a comprehensive hazard evaluation guidance for laboratories did not exist. And as a result, the Board recommended that ACS develop guidance for assessing and controlling hazards in research laboratories.

The full text of the recommendation which is Number 2010-05-I-PX-R2 reads, develop good practice guidance that identifies and describes methodologies to assess and control hazards that can be used successfully in a research laboratory.

So in terms of any CSB actions, the CSB issued this recommendation in October 2011 and the ACS responded in December 2011 indicating that they would not only create the guidance

documents that we recommended, but that they would also initiate a task force on safety culture and draft a document to aid institutions on establishing a safety culture at research institutions.

As a result of that, the Board voted to designated it as open acceptable action in May of 2012. The ACS published its first report which was entitled Creating Safety Cultures in Academic Institutions, A Report of the Safety Culture Task Force of the ACS Committee on Chemical Safety in December of 2012.

Then in September 2013, ACS completed the draft of its guidelines which is entitled Identifying and Evaluating Hazards in Research Laboratories, Guidelines Developed by the Hazards Identification and Evaluation Task Force of the American Chemical Society's Committee on Chemical Safety.

Even though, at that time, we decided that generally the document met the intent of the recommendation, we did not put it up for Board

vote until the document was finalized which happened on May 28, 2015. While those documents that were created are consistent with the recommendations, we're just going to focus on the second document which pertains more to our actual recommendations.

So a little bit about the document, the guidance document. The scope says that it's supposed to apply and provide guidance for laboratory researches including all levels of the institution, undergraduate students, graduate students, post-docs, instructors, clinical investigators, technicians, and chairs.

The document identifies and describes five different methodologies for identification, analysis, and selection and control of hazards. The document discusses the strengths, limitations, and potential applications of five of those methodologies which include chemical safety, levels of control banding, job hazards analysis, what if analysis, checklists, and structured development of standard operating

procedures.

The document also addresses the variable nature of work conducted in research laboratories and states that change should be evaluated against the current hazard analysis to determine if the hazard now continues to be sufficient.

It also provides practical examples of changes that might require that type of analysis and factors the effect recognition such as an individual perception of risk. And provides organizational strategies for ensuring the recognition and appropriate response to changes in the research laboratory.

Consistent with the CSB's case study, the document also emphasizes the importance of near misses and close calls and discussing those incidents. The ACS publication also emphasizes the importance of striving for continuous improvement and using lessons learned to inform future hazard analysis.

The document also references the first

publication which was the Creating Safety Cultures in Academic Institutions. So our conclusion and what we recommended to the Board, we decided that this should be a CE recommendation where the call for ACS to develop good practice guidance was met.

As evidenced by the various aspects that I just talked about, the ACS guidance finalized this year is not only extremely thorough but we believe that it actually goes above and beyond what we actually recommended. Further, ACS communicated to us that following the release of this, they will create an online portal.

It's a very lengthy document so they intend to make it more user friendly and searchable. For this reason, we have, like I said, recommended that it be closed exceeds recommended actions. We are very pleased that this report and recommendation has been implemented and that there now exists a comprehensive guidance to help evaluate and

control hazards. And that concludes our staff recommendation.

MEMBER ENGLER: Thank you. Member Ehrlich, any questions?

MEMBER EHRLICH: No, I don't have any questions. Nice job, thank you.

MEMBER ENGLER: I'm very pleased to hear that a recommendation is proposed, that we're potentially commending the American Chemical Society for exceeding what we recommended which is a nice thing to happen. Just to be clear, we're not doing all of our business in public.

This is one issue that's currently pending in a set of notation votes that we do through reviewing documents and indicating whether we support them, oppose them, calendar them for a public meeting, or not vote. That process is currently pending. I'm optimistic that my vote on this last matter will be affirmative. So thank you very much for that.

Before public comment, we have one

other item of business. And this is a proposal to remove the September business meeting from the schedule and change the time. On May 6th, the Board voted on a schedule of upcoming public business meetings. The next meeting was scheduled for September 16th and the following meeting was scheduled for October 21st.

However, because the Interim Chair, in his brilliance, figured out that the office was moving during that precise time, and that things like the IT system and the hook ups to remote commenting by people on the phone, would be difficult if not impossible. And we had a subsequent meeting in October that basically, it added up to, based on staff recommendations, that we would like to remove the September 16th public business meeting from the schedule.

I should note that under our new rules where we said we have to have four public business meetings annually in Washington D.C., we're meeting that requirement through the meetings we've had per quarter. We will still

meet that requirement by an October meeting.

Additionally, folks on the west coast and I apologize for being so New Jersey centric, all this Washington, national stuff is new to me. They pointed out that getting up at 6:30 in the morning for a CSB meeting was not the funnest thing.

So this motion will basically says that our September 16th business meeting is cancelled and that we will change the start time of future meetings to 1:00 p.m. Eastern Time. I make that as a motion. Do I have a second?

MEMBER EHRLICH: Second.

MS. MCCORMICK: I'll call the role. On the motion to remove the September 16th public business meeting from the schedule and change the time of future meetings to 1:00 p.m. Eastern, Member Ehrlich?

MEMBER EHRLICH: Aye.

MS. MCCORMICK: Member Engler?

MEMBER ENGLER: Aye.

MS. MCCORMICK: Motion passes.

MEMBER ENGLER: As our second to final agenda item, this is an opportunity for public comment on any issues that we've addressed today, other concerns that the public may have. Comments are, of course, very much encouraged. Please do not make negative comments about specific individuals inside or outside the CSB. Please try to keep remarks to approximately three minutes.

The floor is open for comments. We do have a comment sign up list from five people who are here. I'll start with David Sheppard from ATF. Is David Sheppard on the phone by any chance? Walking down the street on his cell phone? No, okay.

Dan Heenan from also ATF. Is he here? No, okay. Katie Vassalli from ILTA.

MS. VASSALLI: Good afternoon. I am Katie Vassalli, the Manager of Member Education Services for the International Liquid Terminals Association. ILTA represents owners and operators of above-ground storage tank facilities

that store petroleum products, chemicals, and other liquids.

Our members operate in all 50 states and in 39 countries. I thank the Board for the opportunity to speak today regarding the agency's report on the October 2009 CAPECO incident. My comments reflect those previously provided by ILTA and serve to support the conclusions expressed by Board Member Ehrlich earlier this morning.

CAPECO is not an ILTA member. And ILTA supports the findings concluded in the draft report. The agency's findings clearly laid out the case that the CAPECO facility was poorly managed and had a long and troubled history of compliance violations.

Yet, rather than addressing the problems inherent with a known repeat offender, the draft report's recommendations call for an expansion of OSHA's and EPA's regulatory authority. Thereby indicting an entire industry that, as Member Ehrlich's remarks reflect, have

routinely demonstrated flawless safety record while complying with existing regulatory requirements and industry standards.

In fact, there is nothing in the draft recommendation to tackle how to drive compliance among repeat violators. In light of the fact the report was not finalized today, ILTA encourages the CSB to use this as an opportunity to revise the recommendations so that they can effectively address the root causes of the incident.

As outlined in our June 17 comment letter to the Board, ILTA offered three substitute recommendations. One, recognize the role that industry standards have in fostering compliance with existing regulations.

Two, promote the use of management systems as a tool for improving operational integrity. And three, prompt the regulatory agencies to assess the effectiveness of their compliance verification activities. Thank you again for the opportunity to provide comment today and for your further consideration in this

matter.

MEMBER ENGLER: Thank you for your comments. Next will be Stephen Crimaudo from the American Petroleum Institute.

MEMBER EHRLICH: I think he left too.

MEMBER ENGLER: Okay. Next on, do we have anyone on the phone, on the telephone line?

OPERATOR: Once again, if you have a comment, please press star then 1 from your touchtone phone. And currently we have no comments pending. Pardon me, I'm sorry, it looks like we just got a comment. Celeste Monforton from the Safety Board is on line with a comment. Your line is open, please go ahead.

CELESTE MONFORTON: Hello, this is Celeste Monforton. Can you all hear me?

MEMBER ENGLER: Yes.

CELESTE MONFORTON: Okay, great. Thank you so much. I am a public health and worker safety consultant. I live in San Marcos, Texas. I had two comments. The first was I was really pleased to hear Board Member Engler

discuss having photos of workplace fatality victims posted at the Chemical Safety Board's headquarters.

I want to give credit to an organization called United Support and Memorial for Workplace Fatalities. They are the organization that provided the photos to OSHA which appear inside of their conference room which is what Board Member Engler was referring to.

Just briefly, I was troubled, I was extremely troubled to hear the statement from Board Member Ehrlich regarding the CAPECO recommendations. And specifically his opposition to those calling for new OSHA and EPA regulations.

I took some time over the last couple weeks to look at previous recommendations by the Chemical Safety Board, I counted more than 700. Less than 40 of them, only about 5 percent, were actually calling for regulations at the local, state, and federal agencies.

I see it as, if anything the CSB has been missing its opportunity to use its authority to identify and make recommendations on gaps in worker safety regulations. I'm speaking from my own experience as someone who was an investigator of the Sago Mine disaster in 2006 which killed 12 coal miners. And the 2010 Upper Big Branch explosion which killed 29 coal miners.

Our investigation team was appointed by the Governor of West Virginia. We were charged with identifying the factors that caused the disasters and to make recommendations so it didn't happen again.

Some of our recommendations were directed to the industry, you know, outreach activities and training, and to research institutions. But we did identify inadequate and outdated mine safety regulations that needed to be addressed. And it would have been a dereliction of our duty and an abandonment of our duty had we scrapped those regulatory recommendations.

Board Member Ehrlich talked about, you know, recommendations that might, regulations that might be burdensome to the industry or because our agencies were overstretched. Well that's not an appropriate to not make those recommendations. And it's not for the Chemical Safety Board to make those determinations.

It's for the Chemical Safety Board to make those recommendations and then for those agencies to go through the process and determine whether it's too burdensome or whether it's unnecessary. So that's what I wanted to say.

I think that this is something that definitely deserves more attention and discussion by the Chemical Safety Board and the staff and other stakeholders.

MEMBER ENGLER: Thank you very much for your comments. United Memorial folks were here for our June 10th stakeholders meeting which we much appreciated their input. We should follow up with them for some of the photos that may overlap with some of the CSB investigations.

MEMBER EHRLICH: Thank you for your input.

MEMBER ENGLER: Anyone else on the phone, on the telephone?

OPERATOR: At this time, we have no further comments.

MEMBER ENGLER: Okay. The last speaker at this moment, I will call for any other speakers after that in case someone is suddenly moved to say a few words, is John Morawetz from the International Chemical Workers Union.

MR. MORAWETZ: Firstly, I support what Celeste just mentioned. I think that the CSB has done an excellent job of looking for the findings as to what happened in that incident, what are the root cause analysis, and made recommendations. Where the facts go, and the recommendations lead to organizations like the American Chemistry Council, the education that you've just voted on.

Whether it means other voluntary associations, whether it means regulations, we

just have to look where the facts go and follow up on them. I think that's what the CSB has done an admirable job on.

I'd like to also say that I wrote a letter after the original meeting about CAPECO. And I think that, in particular, the community around that area deserves to have a report for people to hear what happened. Further, I think that it's good to see an incident that I believe there any weren't any fatalities in that situation.

But that the aim is to avoid them. And I think that's exactly what the CSB is doing an excellent job. Thank you for doing that as well as having these public meetings. In particular for the chemical workers, having the opportunity for some of the family members from DuPont to come to talk, to see the preliminary report.

It's a similar vein of seeing preliminary findings, being able to use them, take them back to the community, it's a very

useful function. And thank you for doing the regular meetings. Thank you.

MEMBER ENGLER: Thank you. Anyone else in the audience or on the phone?

KERI MOSS: Hi my name is Keri Moss and I'm delighted to be here on behalf of the American Chemical Society. We are grateful for the CSB staff recognition of our work on the report Identifying and Evaluating Hazards in Research Laboratories.

On behalf of the Chemical Safety members or the ACS members who work in chemical safety, we would like to say we really appreciated this collaboration and this opportunity to collaborate. Our members are eager and available to work with the CSB, collaborate with the CSB on any future projects.

Our chemical safety members would also like to say that we have utmost respect for your investigative team and the level of technical competence that you demonstrate in your investigations.

We hope that throughout this time of transition, that CSB, that you will continue to maintain the same admirable level of technical standards in your reports. Thank you very much.

MEMBER ENGLER: Thank you very much. With that, I'm going to close the public comment period of the meeting. We're approaching the closure of the meeting overall.

I want to remind people that the next public business meetings of the CSB will take place on October 21st, January 20th, and April 20th. All of those meetings will be noted through the Federal Register. We'll include the topics that will be discussed at the meeting in the register. We'll endeavor to get advance materials where we can on the CSB website.

I would also suggest that, starting in October people not show up here because we will have moved. And the new address will be 1750 Pennsylvania NW which is actually an adjunct of the White House.

Because of the size of our agency and

its influence, those in the Executive Branch decided that they wanted us much closer so we could far better coordinate our expectations for chemical safety moving forward. So it's 1750 Pennsylvania Avenue.

We also anticipate with the release of reports that we will be holding meetings in the communities affected by the incidents. Those meetings are incredibly important to engage with the local communities.

At the point in the future, if we approve the CAPECO report of course, I think there are some important outreach to be done in Puerto Rico. I've already talked to Vidisha about developing a potential, and I have to underline potential because it's pending a re-vote on that issue, plan to get out the video that in fact is completed but not approved to the local community.

And take other steps to assure that those who were affected by that incident and the fact that there's a continuing operation of the

facility there, will have as much information as they can to prevent future incidents.

With that I am going to close the meeting. Thank you all for attending. Thank you to the staff for their very important contributions to this meeting today and of course, stakeholders.

OPERATOR: Thank you ladies and gentlemen, this concludes today's conference. Thank you for participating.

MEMBER ENGLER: No it doesn't, stop a second.

MEMBER EHRLICH: First of all, I want to thank our staff both here and from the Denver office for what they've done. I know that there's been some disagreement. I certainly appreciate the work you've done and we'll get through that. For everyone that made the time and effort to come here, thank you very much.

Again, I want to make sure the record reflects that the condolences go out to the family members here and their family for the

tragedy that occurred in La Porte. So with that, thank you all very much.

MEMBER ENGLER: And with that, the meeting is closed. Thank you again for attending.

OPERATOR: Thank you ladies and gentlemen, this concludes today's conference. Thank you for participating. You may now disconnect.

(Whereupon, the above-entitled matter went off the record.)

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C E R T I F I C A T E

MATTER: Business Meeting

DATE: 07-22-15

I hereby certify that the attached transcription of page 1 to 159 inclusive are to the best of my professional ability a true, accurate, and complete record of the above referenced proceedings as contained on the provided audio recording; further that I am neither counsel for, nor related to, nor employed by any of the parties to this action in which this proceeding has taken place; and further that I am not financially nor otherwise interested in the outcome of the action.

Neal R Gross

ATTACHMENT A:
STAKEHOLDER COMMENTS

AGRICULTURAL
RETAILERS
ASSOCIATION

1156 15TH Street, NW · Suite 500 · Washington, DC 20005
T 202.457.0825 · F 202.457.0864 · *www.aradc.org*

July 21, 2015

The Honorable Manuel Ehrlich and Rick Engler
Board Members
U.S. Chemical Safety Board
2175 K Street, NW
Washington, D.C. 20037

RE: DRAFT FINAL INVESTIGATION REPORT; CARIBBEAN PETROLEM TANK TERMINAL EXPLOSION AND MULTIPLE TANK FIRES; REPORT NO. 2010.02.I.PR

Dear Mr. Ehrlich and Mr. Engler,

On behalf of the Agricultural Retailers Association (ARA), I am writing in response to the Chemical Safety Board's (CSB) Draft Final Investigation Report on the Caribbean Petroleum Corporation (CAPECO) Tank Terminal Explosion and Multiple Tanks Fires (Report No. 2010.02.I.PR) released to the public on June 11, 2015. ARA is a not-for-profit trade association that represents the nation's agricultural retailers and distributors. ARA members provide goods and services to farmers and ranchers which include: fertilizer, crop protection chemicals, fuel, seed, crop scouting, soil testing, custom application of pesticides and fertilizers, and development of comprehensive nutrient management plans. Retail and distribution facilities are scattered throughout all 50 states and range in size from small family-held businesses or farmer cooperatives to large companies with multiple outlets.

CSB Investigation Findings Do Not Warrant Expanded Regulations and Stricter Standards
ARA appreciates the opportunity to provide constructive input regarding the CSB's thorough investigation of the CAPECO terminal explosion and multiple tank fires. ARA is in general agreement with the CSB as to basic facts that led up to this accident. It is very clear from this investigation that CAPECO repeatedly failed to comply with existing federal regulations, especially as it relates to the Occupational Safety and Health Administration's (OSHA) Process Safety Management (PSM) standards and the U.S. Environmental Protection Agency's (EPA) Spill Prevention, Control, and Countermeasure (SPCC) plan requirements. For example, CSB notes that EPA cited CAPECO in 1993 and 1996 for poor housekeeping, including oil in tank berm areas and inadequate control of vegetation in the secondary containment areas as well as not employing engineering controls to prevent a spill. CAPECO subsequently complied with these EPA recommendations by 2001 but cited again in following the October 23, 2009 incident for not having "fail safe engineering."

The history of this CAPECO facility clearly show repeated violations of existing federal regulations and industry standards due to operational and compliance problems. ARA has worked closely with EPA's Office of Solid Waste and Emergency Response (OSWER) on extensive outreach efforts with

ARA members and the agricultural industry to educate facilities on the compliance requirements of the SPCC regulations, including webinars, mailings, and multiple presentations by EPA officials at industry events such as the National Agronomic Environmental Health & Safety School (NAEHSS) - a non-profit organization of dedicated industry and government volunteers whose mission is to provide industry personnel with training and information that will aid them in meeting state and federal regulations. The unfortunate accident at the CAPECO facility is clearly as case of failing to comply with existing regulations, rather than a lack of robust

regulations to prevent oil from reaching navigable waters and adjoining shorelines, and to contain discharges of oil.

The CSB notes the lack of resources for EPA to inspect all covered facilities. Today the nation faces an ever growing U.S. national debt, currently over $18.3 trillion dollars as a result of annual federal budget deficits over $500 billion. It is puzzling how the CBS believes expanding regulations will increase compliance among industry since both federal agencies and industry already struggle with the significant financial and man-power costs to follow existing regulations and standards. Now more than ever it is important for increased outreach efforts between federal agencies and industry to educate facilities of their federal regulatory requirements.

ResponsibleAg

ARA and The Fertilizer Institute (TFI) in 2014 launched a stand-alone program called ResponsibleAg (RA), a non-profit organization founded to promote the public welfare by assisting agribusinesses as they seek to comply with federal environmental, health, safety and security rules regarding the safe handling and storage of fertilizer products. ResponsibleAg provides participating businesses a federal regulatory compliance audit relating to the safe storage and handling of fertilizers, recommendations for corrective action where needed and a robust suite of resources to assist in this regard. The program has compiled a checklist of federal regulatory requirements applicable to the storage and handling of fertilizer. The checklist, developed by a technical committee comprised of industry regulatory professionals, contains more than 320 questions. Auditors credentialed under the ResponsibleAg Certification Program will use this checklist to assess compliance with federal regulations at each participating facility. ARA believe this type of pro-active, voluntary industry program is the best approach to address the lack of regulatory compliance with facilities such as CAPECO, rather than piling on additional regulations that only create more costs, confusion, and decrease the ability of U.S. agribusinesses to compete in a global marketplace. For more information, go to www.responsibleag.org.

ARA agrees with the Targeted Recommendations Proposed by the International Liquid Terminal Association (ILTA)

ARA in general agrees with the targeted recommendations provided to the CSB by the International Liquid Terminal Association (ILTA) in their June 17, 2015 letter in response to the CSB CAPECO Draft Final Investigation Report. Rather than expand the current regulations, the agencies should work with industry to promote regulatory compliance and the adoption of industry standards as an effective means to promote safety and prevent unnecessary spills, fires, or explosions.

Conclusion

ARA believes the CSB investigation clearly shows a facility that did not follow existing regulations or its own internal procedures. We request CSB encourage federal agencies such as EPA and OSHA to work more closely with industry on compliance outreach efforts, co-branding of educational materials, as well as support for voluntary, industry compliance assistance programs such as ResponsibleAg. Thank you for your review and consideration of our comments. Feel free to contact me at 202-595-1699 or richard@aradc.org if you have any questions.

Sincerely,

Richard D. Gupton

Richard D. Gupton
Senior Vice President, Public Policy & Counsel

DuPont Statement
U.S. Chemical Safety Board Public Business Meeting
July 22, 2015

DuPont appreciates the opportunity to submit this statement to the U.S. Chemical Safety Board (CSB) regarding the incident that resulted in four employee fatalities in the La Porte facility's Insecticide Business Unit (IBU) on November 15, 2014. Our deepest concern and sympathies remain with the families and friends of our four co-workers who lost their lives.

From the time that the CSB first deployed to the site in the days after the incident, DuPont has cooperated completely with the agency. Throughout the course of the investigation, we have facilitated the interviews of numerous employees, coordinated laboratory tests and field visits, and produced over 100,000 pages of information and data. We value the CSB's perspective, and we remain committed to cooperating with the agency throughout its investigation.

After the incident, DuPont immediately convened its own investigative team comprised of experts who have extensive technical experience and a proven commitment to safety. These experts have conducted a systematic and rigorous analysis of the complex circumstances associated with the incident, and have developed recommendations that will address the causal factors to help ensure that such an incident never happens again. We have already started to implement corrective actions based on the investigation team's analysis.

DuPont representatives recently met at the CSB's Western Regional Office on July 7, 2015 to understand the CSB's concerns. At this meeting, DuPont made clear that the La Porte IBU will not resume operations until we are certain that we can restart and operate safely. We also explained that we are developing a comprehensive and integrated plan for the resumption of operations that would address issues identified by all of the government agencies, as well as recommendations identified by DuPont's incident investigation team. DuPont agreed it would share this integrated plan with the CSB and solicit the agency's input.

We will continue to cooperate and communicate with the CSB. As part of our commitment to process safety improvement, we take seriously any recommendations resulting from the agency's investigation. We will learn from this incident, share the critical lessons, and do all that is necessary to ensure that such an event never happens again.

Comments to CSB board regarding Recommendation 2005-4-1-TX-R12

The United Steelworkers (USW) represent the workers at two (Whiting, IN and Toledo OH) of three remaining BP owned refineries in the US as well as workers on the Alaska North Slope.

Neither of the BP refinery locals were able to send a representative to this meeting nor was the North Slope group. They did send comments and the USW International Union has compiled the responses and is passing them along in this communication.

Although the recommendation specifically references the refineries, the operation of BP facilities whether production, pipeline or refining were all a concern to the represented employees and the recommendation was pursued at all locations.

In addition, with the sale of BP properties that were once under this recommendation; do they now get a free pass because the employer has changed? Much of the problem is still at the site. In the case of the former BP Texas City refinery where the explosion that killed 15 workers triggered the CSB investigation, programs that BP had implemented to help address some of these issues are now being dismantled by the new employer, claiming that was BP not us, but the members see the same problems remaining in the facility. There should be an audit to see if they were/are complying with the recommendation and if not the same hazards exist and somehow need to be addressed.

The locals have been less than enthusiastic about progress and report they are seeing a move back to blame the worker and behavior programs. This personal injury focus was blamed as a driver for the lack of attention to process safety concerns in the BP Texas City accident.

The North Slope group has tried to use the Ombudsman set up for confidential reporting (reporting of incidents without fear of retaliation) but he has been in ill health for some time and is of no help. The deputy who employees assume has been handling the role is not an independent anonymous resource that it was promoted to be.

There is a longstanding list of safety issues that have not been addressed claim workers. Employees are still required to be in non-blast proof zones with lack of egress from upper floors in manifold buildings. Valve maintenance is not at the level it should be including access to wells for water/mud injection to kill runaway or burning wells. To the company's credit, there has been an emergency valve maintenance program initiated.

The workers are concerned that once federal oversight and prohibitions are removed, BP will revert back to its old ways; they expect things to be as they were before.

The most important safety concern for the workers is the failure to address structural, mechanical and operational integrity. With oil prices being down, budget concerns are an issue at all locations. Capital jobs are being assessed and reassessed to determine whether they are still needed. Some of the fire and safety systems are old and not being well maintained, there is concern whether they will work when needed.

Incident reporting was improved at one location, but there were not productive actions being taken as a result of the reporting. At another facility, workers said incident reporting has not been encouraged and operators still feel the fear of retaliation, often with discipline involved, for reporting incidents.

In the lower 48 the anonymous outside reporting is said to be a feel good exercise without much happening; it is not functional.

The workers have stop work authority but it is not easy to implement and make work.

There is a concern about staffing levels that echoes through all three locations.

These are the latest responses in regard to this recommendation (this year) below are responses to the same question asked in 2013:

a. encourages the reporting of incidents without fear of retaliation

b. requires prompt corrective actions based on incident reports and recommendations, and tracks closure of action items at the refinery where the incident occurred and other affected facilities; and

c. requires communication of key lessons learned to management and hourly employees as well as to the industry.

Response from the BP locals is that the company has not fully filled this recommendation in their opinion. Some examples given to support this follow.

Site 1: One incident with an amine release on a process unit caused four H2S alarms to go off and a unit was evacuated. There was some discipline given but no investigation of the event was conducted.

Some of the events are being tracked in a system and there is limited sharing of some of the incidents, but the overall quality is low. There is a feeling of going through the motion and not much opportunity for feedback or review.

The events can be technically claimed as done because there is encouraging of reporting and some incidents are shared with the industry, but it has a feeling of just checking off the box.

Site 2: (a) Fear and reality of retaliation for reporting is clear at this site.

(b) No, far from prompt corrective actions, taken over 1½ years to address one issue with a loading rack. Only a call to OSHA has been able to move this item.

(c) Yes, they are good at making it look like they are doing a good job by a large paper trail to shift blame to the employees.

Site 3: (a) Issued a 'stop unsafe work' card to every employee

(b) Have a tracking system in place which assigns and tracks to completion all action items that arise from incident investigations and reports.

(c) Communication of lessons learned occurs through mandatory meetings; weekly 'Tailgates', monthly stand downs, monthly unit safety committees, monthly learning forum which reviews industry accidents and lessons learned. They are happening, but not effective.

As you can see, not much has changed from the original response. The workers feel that the only reason they are seeing any action on the items in the recommendation are due to the scrutiny of federal agencies (CSB and OSHA) and are fearful that if this recommendation is seen as acceptable and closed, the company will quickly revert back to where it was before the BP Texas City report was issued and no one will pay any attention.

The locals feel that there is still a lot of work to be done and would appreciate some follow up to judge what level of the recommendation has been completed and what work is left to be done to meet this recommendation.

Thank you for your consideration of these responses in regard to the disposition of Recommendation 2005-4-1-TX-R12.

Submitted by

Kim Nibarger

USW HSE Department

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