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A Brief Overview of the Chemical Safety Board

Learning from Experience

P2SAC Spring 2023 Conference

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Purdue University, West Lafayette, IN

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CSB History

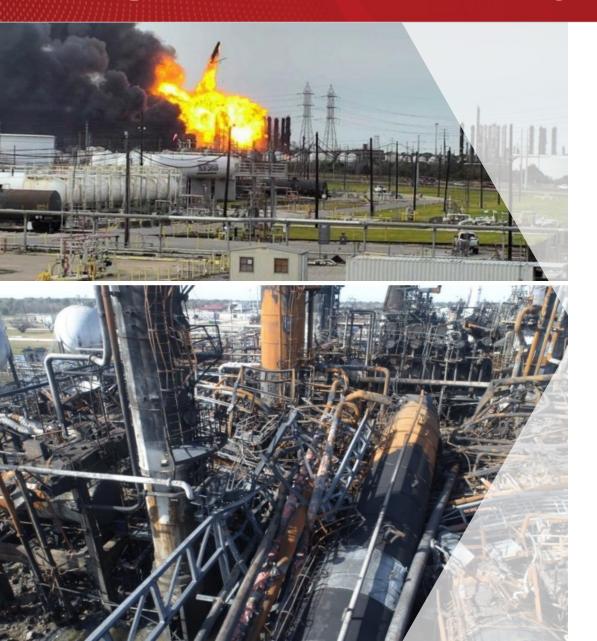




- Independent Federal Agency
- Established in 1990 Clean Air Act Amendments
- First funded in November 1997
- Did not begin operations until January 1998
- 5-member Board (including Chairperson)

Legislative Authority 42 USC§7412(r)(6)





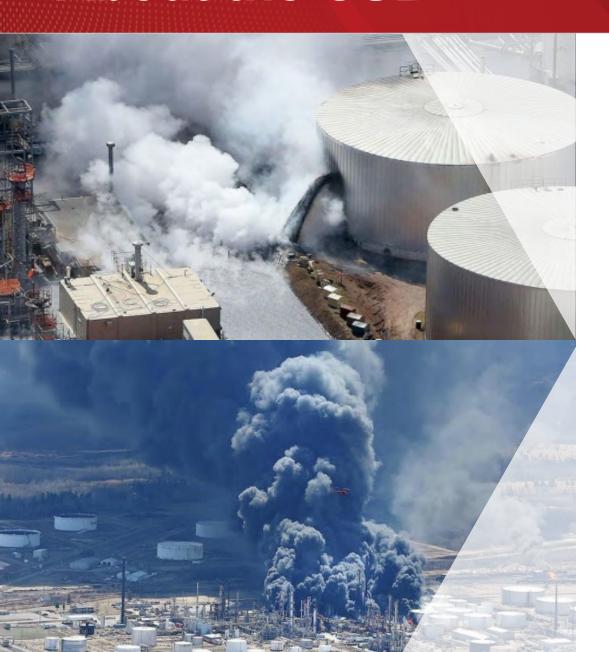
- 1. Investigate
- 2. Determine and report to the public in writing the facts, circumstances, and conditions
- 3. Determine (probable) cause

Of any accidental release resulting in a fatality, serious injury or substantial property damage.

- Scope is for "stationary sources"
- Not an enforcement agency

About the CSB





- Mission Drive chemical safety excellence through independent investigations to protect communities, workers, and the environment.
- 25th anniversary this year
- CSB has deployed to over 130 incidents and issued over 900 recommendations
- CSB Reporting Rule 253 incidents which resulted in fatalities at 37 facilities, serious injuries at 140 facilities, and substantial damage to 118 facilities nationwide since March 2020.

2023 Investigations Closure Plan



	INCIDENT NAME	INCIDENT LOCATION	INCIDENT DATE
First Half of 2023	Intercontinental Terminals Company (ITC)	Deer Park, TX	3/17/2019
	Watson Manufacturing and Grinding	Houston, TX	1/24/2020
	Bio-Lab	Lake Charles, LA	8/27/2020
	Optima-Belle LLC	Belle, WV	12/9/2020
	Wacker Polysilicon North America	Charleston, TN	11/13/2020
	LyondellBasell	LaPorte, TX	7/27/2021
Second Half of 2023	KMCO	Crosby, TX	4/2/2019
	Yenkin-Majestic	Columbus, OH	4/8/2021
	Wendland 1H Well	Burleson County, TX	1/29/2020
	Didion Milling	Cambria, WI	5/31/2017
	Foundation Food Group	Gainesville, GA	1/28/2021

Published



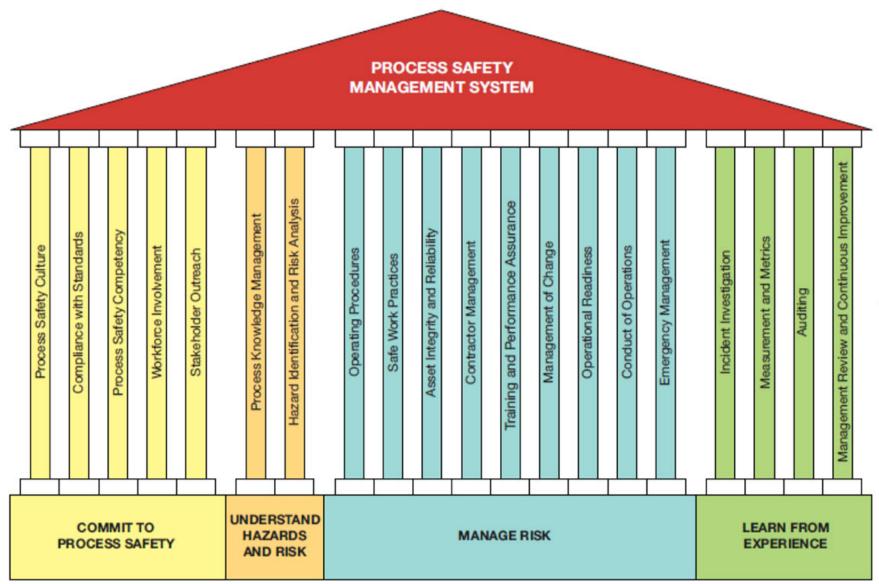


Learning from Experience



The Four Pillars of Risk Based Process Safety





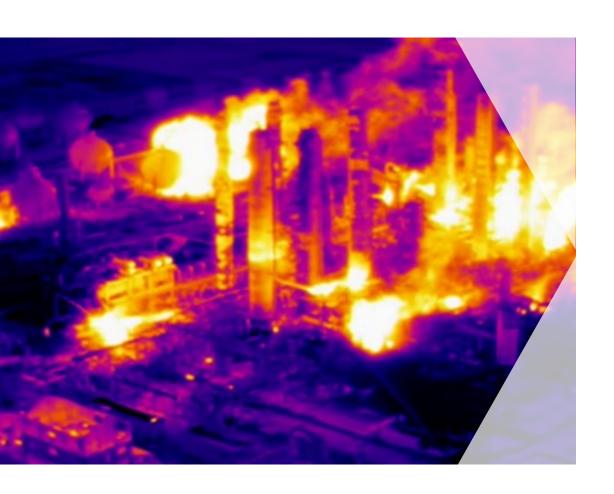
Source: Center for Chemical Process Safety (CCPS)

Trevor Kletz



Important Themes





- Near misses are a gift
- Expect Human Error to occur and design accordingly
- Incident investigation management system should account for the above
- How to deal with "organizational memory"

What are some strategies you have seen?

Near Misses and Warning Signs – Some Previous Examples



• Imperial Sugar – 2008

Previous smaller combustible dust fires

Loy-Lange Box Company –
2017

Previous leaks, history of corrosion before BLEVE

Kuraray America – 2018

Previous relief device releases, VCEs predicted

 AB Specialty Silicones – 2019 Previous drum explosion due to mixing incompatibles

• TPC Group – 2019

Excessive popcorn polymer for months

Case Study: Kuraray America







Background

- Pasadena, TX
- May 19, 2018
- 23 Injured
- Ethylene release, fire, explosion
- Starting up morning of incident
- Reactor 2 had lower design pressure than the others, with no visual reminder of this to Operators (740 psig vs 1150 psig)
- Concern over flare permit limits caused limited venting to flare
- Liquid in reactor
- Operator turnover during startup





Case Study: Kuraray America



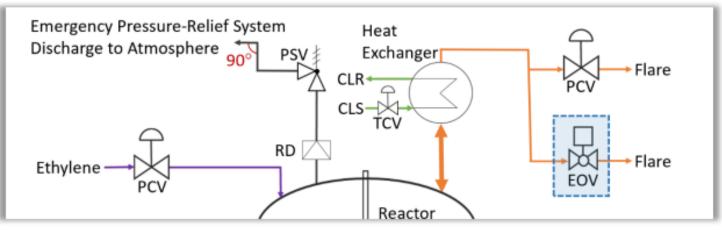


Figure 13. Emergency Open Valve to Flare. (Credit: CSB)

- Previous near miss in 1980s, but cloud did not ignite.
 Organizational memory?
- 2015 PHA team did not recognize liquid in reactors as a hazard, but did recognize reliefs to unsafe locations
- How do you know relief is venting to a safe location?

Published industry studies have shown that flammable gases can be discharged into the air safely by following the design guidelines in API 521. Among other considerations, emergency pressure-relief system outlet piping should direct a release of flammable vapor **vertically** upward to satisfy these design guidelines [79, p. 12].



You can learn from others' experiences too...



U.S. Chemical Safety and Hazard Investigation Board

www.csb.gov youtube.com/USCSB