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SECRECY IN THE RESPONSE TO BAYER'S CHEMICAL PLANT EXPLOSION

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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CONTENTS

	Page
Hon. Bart Stupak, a Representative in Congress from the State of Michigan, opening statement	2
Hon. Greg Walden, a Representative in Congress from the State of Oregon, opening statement	4
Hon. Henry A. Waxman, a Representative in Congress from the State of California, opening statement	6
Hon. Betty Sutton, a Representative in Congress from the State of Ohio, opening statement	8
Hon. Bruce L. Braley, a Representative in Congress from the State of Iowa, opening statement	9
Hon. Donna M. Christensen, a Representative in Congress from the State of Virgin Islands, opening statement	9
Hon. Edward J. Markey, a Representative in Congress from the Commonwealth of Massachusetts, opening statement	10
Hon. John D. Dingell, a Representative in Congress from the State of Michigan, prepared statement	148
Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, prepared statement	150

WITNESSES

John Bresland, Chairman, U.S. Chemical Safety and Hazard Investigation Board	12
Prepared statement	14
Answers to submitted questions	152
Michael Dorsey, Chief of Homeland Security and Emergency Response, West Virginia Department of Environmental Security	33
Prepared statement	35
Kent Carper, President, Kanawha County Commission	38
Prepared statement	40
Joseph Crawford, Chief of Police, City of St. Albans, West Virginia	56
Prepared statement	60
Pamela Nixon, environmental advocate with the West Virginia Department of Environmental Protection	65
Prepared statement	68
James Watson, Director of Prevention Policy for Marine Safety, Security and Stewardship, U.S. Coast Guard	89
Prepared statement	91
William Buckner, President and CEO, Bayer CropScience LP; Nick Crosby, Vice President, Institute Site Operations, Bayer CropScience	95
Prepared statement	97

SUBMITTED MATERIAL

Hearing memorandum	124

SECRECY IN THE RESPONSE TO BAYER'S CHEMICAL PLANT EXPLOSION

TUESDAY, APRIL 21, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 12 p.m., in Room 2322, Rayburn House Office Building, Hon. Bart Stupak [chairman of the subcommittee] presiding.

Present: Representatives Stupak, Braley, Markey, Christensen, Sutton, Waxman [ex officio], Walden, and Burgess.

Also Present: Representative Capito.

Staff Present: Karen Lightfoot, Communications Director, Senior Policy Advisor; David Rapallo, General Counsel; Theodore Chuang, Chief Oversight Counsel; Mike Gordon, Deputy Chief Investigative Counsel; Dave Leviss, Deputy Chief Investigative Counsel; Scott Schloegel, Investigator, Oversight and Investigations; Stacia Cardille, Counsel; Daniel Davis, Professional Staff Member; Jennifer Owens, Special Assistant; Jennifer Berenholz, Deputy Clerk; Caren Auchman, Communications Associate; Lindsay Vidal, Special Assistant; Julia Elam, Fellow, Kenneth Marty, Detailee ICE; Allison Cassady, Professional Staff Member; Andrew Su, Professional Staff Member; Byron Gwinn, Staff Assistant; Alan Slobodin, Minority Chief Counsel; Karen Christian, Minority Counsel; Peter Kielty, Minority Senior Legislative Analyst; Peter Spencer, Minority Professional Staff Member; and Jerry Couri, Minority Professional Staff Member.

Mr. STUPAK. This meeting will come to order. Today we have a hearing titled "Secrecy in the Response to Bayer's Chemical Plant Explosion."

Before we begin with opening statements, I ask unanimous consent that the contents of our document binder be entered into the record, provided that the committee staff may redact any information that is business proprietary, relates to privacy concerns or is law enforcement sensitive. Without objection, the documents will be entered into the record.

[The information was unavailable at the time of printing.]

Mr. STUPAK. I ask unanimous consent that the supplemental memo prepared by the majority staff be entered into the record. Without objection, the documents will be entered into the record.

[The information appears at the conclusion of the hearing.]

OPENING STATEMENT OF HON. BART STUPAK

Mr. STUPAK. Now the Chairman, Ranking Member and Chairman Emeritus will be recognized for 5 minutes for opening statements. Other members of the subcommittee will be recognized for 3 minutes for their opening statements. I will begin.

On August 28, 2008 a tank exploded at the Bayer CropScience Chemical Plant in Institute, West Virginia. The explosion sent a fireball hundreds of feet into the air and was felt 10 miles away.

I have here photographs of the accident and its aftermath. The explosion captured from a distance, the destruction at the plant—do you want to flip that over one—and then a pair of safety goggles encased in chemical residue.

Before I go any further I would like to express on behalf of the entire subcommittee our condolences to the families of the two employees, Barry Withrow and Bill Oxley, who were killed as a result of the explosion. We acknowledge the tremendous personal sacrifices and pain these people and their families have been put through as a result of this tragic incident.

We also thank the emergency first responders who protected the public that night, especially the six volunteer firefighters who suffer from nausea, intestinal and respiratory disturbances as a result of the exposure that night. We are tremendously grateful for their service and the service of all our public safety personnel.

Today the committee is examining not only what actually happened but what could have happened. About 80 feet from the blast site was a day tank that can store nearly 40,000 pounds of methyl isocyanate or MIC. MIC is the chemical that killed thousands of people and sickened tens of thousands in 1984 after release of the toxic chemical at Bhopal, India.

The explosion at the Bayer plant in West Virginia caused a 2½-ton steel vessel containing methomyl to rupture and to be violently propelled in a northeasterly direction, leaving a path of destruction. Had the projectile headed south and struck the MIC tank, the subcommittee today might be examining a catastrophe rivaling the Bhopal disaster. As it happened, the explosion caused shrapnel to damage the protective blast blanket around the MIC day tank.

Immediately after the explosion, local emergency responders tried to obtain crucial information from Bayer representatives, information that was essential to determine how best to protect the public and their own personnel from possible chemical contamination.

For example, the emergency responders were trying to determine whether to order the community to shelter-in-place, which is to stay in their homes with doors and windows closed. A shelter-in-place order must be announced soon after a chemical release in order to be effective.

The fire department in Nitro, West Virginia reported, "We have a cloud of some type that is dark, it is moving towards Nitro. Can you please try to get some information so you can tell us what it is?" Bayer rebuffed the emergency responder's effort to obtain information about the explosion. When the 911 dispatcher asked the company to confirm whether the explosion took place in the Larvin Unit, which contains toxic chemicals, Bayer responded, "No, that's

all. I'm only allowed to tell you that we have an emergency in the plant."

At least six State and local emergency responders were denied entry to the plant to investigate the explosion. As Kent Carper, the president of Kanawha County Commission wrote to Bayer a week after the explosion, METRO911 repeatedly asked for information and was refused. This was a complete abdication of Bayer's responsibility to your neighbors and to our first responders who were sent, uninformed, to an explosion because no one was allowed to inform us. We will hear testimony today from Mr. Carper as well as from other officials and representatives of the local community.

The United States Chemical Safety and Hazard Investigation Board, CSB, an independent Federal agency, is conducting an investigation with the goal of reporting to the public on the cause of the accident and recommending changes to prevent future accidents like this one. We will hear today from the chairman of the CSB on the board's preliminary findings.

For the first time during a CSB investigation, a company sought to limit CSB's use of documents and information by labeling it sensitive security information, SSI, under the Maritime Transportation Security Act. Although the law is supposed to prevent the public release of information that might compromise national security, Bayer has now admitted that it began using this SSI label in part to prevent negative publicity and stymie public debate about the safety of its processes.

William Buckner, the president and CEO of Bayer CropScience, says in his written testimony for today's hearing that Bayer invoked SSI out of "a desire to limit negative publicity, generally, about the company or the Institute facility to avoid public pressure to reduce the volume of MIC that is produced and stored at the Institute by changing to alternative technologies."

One document Bayer produced to the subcommittee, company counsel instructed that the assertion of sensitive security information should be liberal and should strike any references to any piece of equipment, piping or document involving MIC or chlorine, a process that resulted in the marking of thousands of pages of documents.

Finally, the committee's investigation has uncovered several troubling facts that further raise concerns about an orchestrated effort by Bayer to shroud the explosion in secrecy. Bayer removed and destroyed the blast blanket that surrounded the MIC tank, pictured here with the visible damage. There's the photo up in the top part. The whereabouts of this important piece of evidence is unknown.

Air monitoring devices designed to determine whether MIC has been released into the air were not operational on the night of the explosion. Video cameras positioned to capture the site of explosion did not record the time period of explosion because they had been disconnected from the recording unit.

Bayer's pattern of secrecy raises questions, not just about Bayer, but also about whether the law adequately protects the public's right to have information about potential dangers in their communities and what their communities face and how those dangers might be minimized.

Today we will ask whether the security sensitive information designation system is susceptible to abuse, given the committee's investigation has revealed that a private chemical company—which has the most to lose—invoked SSI in part out of business motive of limiting public discussion of the fact that it continues to be the only company in America that still stores large quantities of methyl isocyanate, or MIC, on site. We will also explore ways for companies to employ safer technology to protect their communities so tragedies like this do not happen again.

Next, I turn to Mr. Walden from Oregon for his opening statement, please.

OPENING STATEMENT OF HON. GREG WALDEN

Mr. WALDEN. Thank you very much, Mr. Chairman. Before I start, I want to recognize our colleague Shelley Moore Capito who has joined us today. While I appreciate your allowing her to join us on the dais even though she is not a member of this committee and therefore is not allowed to participate in the process, we do appreciate her involvement in this issue, since it is in her district, and I think maybe even in her hometown. And she has been very helpful in providing background information to me and probably others on the committee.

I join you, Mr. Chairman, also in expressing our condolences to those who lost their lives, and our praise for public safety officials who rose to the challenge on a very difficult night in that part of West Virginia. The subject of this hearing revolves around communications and information provided by Bayer CropScience during and after the fatal explosion and fire in its Riverside Chemical Plant outside of Charleston.

Our bipartisan investigation leading up to this hearing focused on the concerns this single troubling incident has raised among first responders, the surrounding community and Federal safety investigators.

For more than 21 years my wife and I were small business owners out in Oregon. We are in the radio business, and therefore have been very closely involved with emergency communication, alerting the communities, trying to get information in a timely manner. And so as I've read some of the background here, obviously there are some enormous lessons to be learned about what didn't work right on that evening. And I will tell you, if I were in that community I would share the frustration that's been shared already by many in that community for the lack of knowledge.

The hearing today will examine these concerns closely, I'm sure, and hopefully shed some light on a broader tension between the public safety information and sensitive security obligations of chemical and other industrial facilities following this accident.

Given the Energy and Commerce Committee's primary jurisdiction over public health and safety, it is incumbent upon us to confront this tension so that we can identify whether additional congressional action or guidance is necessary.

To the people and first responders along the Kanawha River, the explosion on the night of August 28th didn't really involve Federal rules and regulation about safety and security. They were immediately concerned about what was engulfed in that fireball and es-

caping in a cloud of smoke and mist blowing in the wind down river from the facility. That's what worried them.

The police and firemen along the river—from Nitro, St. Albans, Dunbar, South Charleston, Jefferson, Kanawha County—knew that many very dangerous chemicals were used at the Bayer plant. In fact, some of them were employees of the plant, others had relatives who worked there. They had been on site, they had friends or family who worked there, they knew about phosgene and chlorine, and they knew about methyl isocyanate, or MIC, the toxic chemical notorious for killing and sickening thousands of people in India.

What they did not know, and what Bayer would not confirm with any specific information for nearly 3 hours, was what chemicals were associated with that fire and whether anything toxic risked being released into the community. They could not even get confirmation where the fire was for nearly an hour and a half. Bayer wouldn't let them into the facility. The county sheriff had to get fire information through a deputy's family contact in the plant. Frankly, folks, that's unacceptable.

What Bayer would say in its main communications to the county METRO911 and emergency operations center was, "Our response team is responding to our emergency." And sometimes would add, "Alert the public." This went on all night. Alert the public about what? Having been—not in a chemical situation—but having been, again, in the radio business, when things break loose the public wants more information and the media can actually be helpful in calming the fears or helping people do the right things.

We will learn today that Bayer CropScience has a very capable fire brigade. It managed to control the fire largely on its own, but this does not absolve the company of its obligations to the community.

As County Commission president Kent Carper, a witness today, noted a few days later, Kanawha County emergency officials were given no information during this critical time to make proper decisions to ensure the safety of its citizens. Fortunately, the fire did not result in a major toxic release, but emergency responders, lacking information, had to notify some 40,000 residents to take shelter in their homes. Imagine the concerns that generated.

We'll take testimony on what Bayer and first responders have done to resolve communications issues which reportedly have been addressed. Yet as we moved from the communications during the incident to the ensuing Federal safety investigation, we find continuing problems. Chief among these is the ability of the Federal Chemical Safety Board, the CSB, to investigate, examine and report, unhindered, full and necessary information about the causes of the explosion.

Similar to the Federal investigations following airplane crashes, the CSB reports result and makes recommendation that can improve safety throughout the industry. This is a critical function for enhancing public safety. Security sensitive information about chemical plants does need to be protected against terrorists. But Bayer CropScience admits using the Federal law and such information to frankly restrict legitimate public discussion by CSB about critical

safety processes for certain chemicals at the site and prevent public debate.

At least initially the U.S. Coast Guard, the arbiter of security designations, and CSB both had to take company assertions at face value, in part due to a lack of familiarity with and clarity in the regulations as they applied to chemical facilities. This is a policy matter beyond the Bayer case that may require congressional attention. Allowing inappropriate use of sensitive security information designations to hide inconvenient facts is simply not acceptable and undermines public safety.

Moving forward, we have to ensure the rules are clear and that CSB and the U.S. Coast Guard can work out bureaucratic differences so the public safety can be addressed effectively and with our security needs.

I welcome the witness and I think you, Mr. Chairman, for this hearing.

Mr. STUPAK. Thank you Mr. Walden.

The Chairman of the full committee, Mr. Waxman, for an opening statement, please.

OPENING STATEMENT OF HON. HENRY A. WAXMAN

Mr. WAXMAN. Thank you very much, Mr. Chairman. Today's hearing is important not only for the residents of West Virginia, but for people across the country who live near chemical plants and may be concerned about their safety.

This morning I would like to do two things. First, I would like to provide some historical context for today's hearing. And secondly, I would like to describe some of the specific findings of the committee's investigation into the Bayer explosion.

I've been working on the issues relating to chemical security for several decades. On December 14, 1984, when I was chair of the committee's health subcommittee, we held a field hearing in West Virginia to examine the safety record of the very same plant we are discussing today. Back then, the plant was owned by Union Carbide. We called that hearing because earlier that month the company's sister plant in Bhopal, India released 25 to 45 tons of an extremely toxic chemical called methyl isocyanate, killing approximately 4,000 people and injuring tens of thousands of others. We wanted to make sure that we never had a similar incident here.

As a result of the committee's work on this issue, we passed legislation in 1990 to create the Chemical Safety and Hazard Investigation Board. Congress gave the Board broad investigative powers, authorized it to identify measures to reduce the likelihood of the consequences of an accidental release, and charged it with recommending ways to make chemical production, processing, handling and storage as safe and free from risk of injury as is possible.

The Board is investigating the recent Bayer explosion, and we are pleased to have Chairman John Bresland with us today to present his preliminary findings.

In my opinion, the most significant problem we face today is that we are examining the same chemical plant in West Virginia, although it is now owned by Bayer, and the same toxic chemical, MIC. Although other chemical companies like Dupont have invested in safer technologies to eliminate their MIC stockpiles, Bay-

er's facility in West Virginia is the only site in the United States that continues to produce and store large amounts of methyl isocyanate.

Twenty-five years after the catastrophe in India, I think it is finally time to ask whether it makes sense to allow Bayer to continue producing and storing such massive amounts of this highly toxic chemical. I know the Chemical Safety Board is considering how to address this issue. So I want to make absolutely clear that Congress will look to the Board for specific and concrete recommendations on how Bayer can reduce its MIC stockpile and change its procedures to inherently safer technologies. This is not an easy task, but it is essential and time has occurred for us to get on with this job already.

Now let me turn to the findings of our investigation. We have a detailed memo that was compiled by our committee staff and it sets forth the result of our investigation. The committee reviewed more than 200,000 pages of documents, as well as audio and video recordings obtained from Bayer, the Coast Guard, Environmental Protection Agency and the Chemical Safety Board.

Committee staff also inspected the Bayer's plant in West Virginia and interviewed more than 20 Bayer employees, first responders, elected officials and concerned residents. Based on this evidence, our overall conclusion is that Bayer engaged in a campaign of secrecy by withholding critical information from local county and State emergency responders by restricting the use of information provided to Federal investigators, by attempting to marginalize news outlets and citizen groups concerned about the dangers posed by Bayer's activities and by providing inaccurate and misleading information to the public.

We have three specific findings:

First, on the night of the explosion, Bayer failed to provide emergency responders with critical information about the scope of the explosion, the potential chemical hazards involved, or the action needed to safeguard the surrounding communities.

Second, there are serious questions about the vulnerabilities of Bayer's inventory of MIC and about MIC monitoring systems that were out of service at the time of the explosion.

And third, Bayer is now attempting to conceal information about the explosion by invoking, and in some cases misusing, a statute governing maritime transportation security to designate unprecedented amounts of material as "sensitive security information."

The memo goes into greater detail about the evidence that forms the basis of these findings. Mr. Chairman, I ask unanimous consent that the memo and the documents it refers to be made part of the official hearing record.

Mr. STUPAK. Without objection, I think it has previous been entered.

Mr. WAXMAN. Thank you.

Finally, I would like to extend special thanks to the local, county and State emergency responders and other officials from West Virginia who worked with our staff on this investigation and traveled here today to answer the committee's questions.

Mr. Chairman, I want to thank you very much for holding this hearing and doing this investigation.

Mr. STUPAK. Thank you, Mr. Chairman.

Next, Ms. Sutton from Ohio for an opening statement.

OPENING STATEMENT OF HON. BETTY SUTTON

Ms. SUTTON. Thank you, Chairman Stupak, and thank you for holding today's important hearing on the secrecy in the response to Bayer's fatal chemical plant explosion. And to the families of those who lost their lives as a result of this explosion, I am deeply sorry. There is nothing quite like the fear of the unknown. Musicians have written songs and Hollywood has made countless movies about this fear.

On August 28, 2008, families and rescue workers throughout the community of Institute, West Virginia lived through this fear. They knew some information. They knew that an explosion shot a fireball more than 100 feet into the sky. They knew that a fire was raging inside Bayer's facility, the only facility in the United States that continues to store MIC. This is the same highly toxic chemical that killed thousands of people in an industrial disaster in India in 1984.

According to Dale Petry, the director of the Office of Emergency Services for Kanawha County in West Virginia—and I quote—"We didn't know what to do. We want to protect the community and we need more information to do that." That is not an acceptable place to leave our first responders.

He said, we didn't know what to do. Without the proper information, actions cannot be taken in a timely fashion to inform and protect the public. And without the proper information, those charged with protecting the public are left to plan for the absolute worst case instead of an actual situation, which can waste a lot of time and resources.

For the sake of our safety, our firefighters and other first responders face dangers every day throughout my district and communities across the country. And increasingly they are called to do so under cash-strapped conditions and understaffing. They can't afford to waste resources and they certainly cannot afford to operate in a crisis, without knowledge, all the knowledge that we can give them to safely do their jobs and protect their communities. And our constituents deserve a system that works, a system that keeps them safe.

I take my responsibility to ensure the safety of Americans very seriously. Congress, through this committee's hard work, created the Chemical Safety and Hazard Investigation Board in 1990 as an independent agency to investigate chemical accidents and provide public recommendations in findings to help prevent future accidents. After 9/11, additional laws, such as the Maritime Transportation Security Act, were passed, aimed at protecting the public from potential terrorist attacks. But we now find ourselves in a situation where two laws, both aimed at protecting the public, failed to get the job done. And I think that the laws had some help.

The accident and the actions taken and not taken in the aftermath of the accident caused grave harm. We owe it to the families of those who lost their lives, we owe it to the first responders who were on the scene, we owe it to the community in West Virginia, and we owe it to communities throughout this country to get to the

bottom of what has happened and take the actions that are necessary to make sure if it ever should happen again, which we hope to prevent, that things will be handled differently and more effectively. And I yield back.

Mr. STUPAK. Thank you.

Mr. Braley for an opening statement, 3 minutes.

OPENING STATEMENT OF HON. BRUCE L. BRALEY

Mr. BRALEY. Thank you, Mr. Chairman and Ranking Member Walden, for holding this hearing. You know, we talk a lot about accountability on this committee and we talk a lot about transparency. But what I thought about as I was reviewing the materials for this hearing is a public relations course that I took when I was a college student at Iowa State University, where Bayer has a huge presence. And the number one thing that you are taught in a public relations course in response to a disaster of this magnitude, the first thing you do is own up to your responsibility, accept responsibility for it, and communicate to the public your plan to make sure that it never happens again.

If Bayer had been graded on their project based upon the response they made to this disaster, they would have gotten an F. That's the bottom line of why we are here today. Our job is to get to the bottom of what went wrong, to get answers to the people in this community who are entitled to answers, and to get a commitment from this corporation about what they are going to do to change their corporate behavior and start to put a better image forward of corporate responsibility.

This is not an isolated incident that happens in one community in West Virginia. It is the type of risk that U.S. citizens are exposed to every day. In light of what's going on on Wall Street and other parts of the economic sector, it is time for American companies to realize that the best way for them to generate profits for their shareholders is by being frank and forthright when they do something wrong; to accept responsibility for it, and to look into the eyes of the people they have harmed and say, we will make this better, we will make sure this doesn't happen again.

And that's what I hope happens as a result of this hearing and I yield back.

Mr. STUPAK. Mrs. Christensen for an opening statement.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and thank you, Chairman Stupak, for holding this hearing on chemical plant security, both for this Energy and Commerce Committee and my previous committee.

Mr. STUPAK. Is your mike on?

OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN

Mrs. CHRISTENSEN. Homeland Security. If we can fix what went wrong during the incident of August of 2008, it would not only ensure the safety and reassure people living in the areas adjacent to Bayer CropScience, but it will do so and be reassuring for people all over our country who live near chemical, nuclear and other plants that house and store hazardous material.

As a former emergency services coordinator, I have been responsible for health during two of the worst hurricanes that hit any

part of the United States at that time. I find the lack of information-sharing and failure of coordination of response at the time of the incident shocking and totally unacceptable.

I am very concerned about the withholding of vital information the community needed to have, but also about the lack of a clear incident command process that would have linked the plan to those responsible for the safety of the community.

And I am especially concerned, since I have an oil refinery and several other smaller chemical plants on a small 82-square-mile island that has less people than live in the area surrounding Bayer CropScience. And all of the plants are on the water and come under the Coast Guard and the MTSA. The entire island of St. Croix, 60,000 people, including my daughter and grandchildren, would be in grave danger if there was an accident and the response was not quick and appropriate.

I also have a long and excellent relationship with the Coast Guard and admire and applaud their history of service and readiness to serve and protect lives under every circumstance, and it pains me to see them drawn into this situation, especially on an issue of possibly withholding information the public is entitled to have. And I trust that this will be cleared up during the hearing. I am sure we will examine this and other areas of concern, and so I look forward to the testimonies, and thank everyone for coming here to share information with us this afternoon. I yield back.

Mr. STUPAK. Thank you.

That concludes the opening statement by all members of the committee—almost concludes. Mr. Markey, recognized for an opening statement.

OPENING STATEMENT OF HON. EDWARD J. MARKEY

Mr. MARKEY. Thank you, Mr. Chairman, very much, I appreciate your recognizing me.

On December 3rd, 1984, an accident at a Union Carbide pesticide plant in Bhopal, India released 42 tons of toxic methyl isocyanate—or MIC—gas, killing thousands of people and injuring many more. Reports regarding the accident's cause indicated that in addition to questions surrounding the maintenance of the plant, other factors also contributed to the catastrophe. Union Carbide was using toxic MIC, even though a safer substitute that could have reduced the consequences of the accident was available. Union Carbide was storing the toxic MIC in large tanks instead of smaller ones, the use of which could have reduced the consequences of the accident.

Last summer when a chemical tank exploded at a Bayer facility in West Virginia, sending a fireball into the sky and killing two employees, that facility was, just like the facility in Bhopal, storing large quantities of the same chemical and, just like the facility in Bhopal, the Bayer facility could have chosen to use safer processes that eliminated or greatly reduced the need for the toxic chemicals in the first place.

But unlike the Bhopal catastrophe, the people of West Virginia were relatively lucky because, quite by chance, the explosion that caused the two tragic deaths did not result in the release of large quantities of MIC gas that could have killed thousands more. That is because when the 8-by-10-foot steel vessel became a violent pro-

jectile missile as a result of the explosion, it happened to travel in the opposite direction, away from the MIC tank.

Although the accident ultimately caused two fatalities and the demolition of the area within the facility, the most catastrophic consequence, the release of almost 7 tons of MIC gas, did not occur. The explosion at the Bayer plant highlights the need for all facilities storing large quantities of dangerous chemicals to assess if there are safer ways to do business and to use these technologies when possible.

Today's hearing is about an accident. Another chilling scenario: that would-be terrorists who target these facilities could cause a catastrophic accident. I am committed to ensure that the use of safer technologies and processes be part of the legislation which we ultimately pass.

I thank my colleagues for all of their hard work on this legislation and I thank you, Mr. Chairman, for recognizing me.

Mr. STUPAK. Thank you, Mr. Markey.

That now concludes the statement of members of the subcommittee.

I want to recognize our colleague, as the Ranking Member said, Ms. Capito, Shelly Moore Capito, who represents and lives near Institute, West Virginia. Ms. Capito, you are welcome to sit through this hearing and observe. And I understand you have an opening statement or written statement for the record.

I ask unanimous consent that Ms. Capito's statement be entered into the record. Without objection, so be it.

[The information was unavailable at the time of printing.]

Mr. STUPAK. Also Senator Rockefeller from West Virginia has also submitted an opening statement that will be made a part of the record. Hearing no objection, it will also be made a part of the record.

[The information was unavailable at the time of printing.]

Mr. STUPAK. I now call our first panel of witness.

On our first panel we have Mr. John Bresland, who is chairman of the U.S. Chemical Safety and Hazard Investigation Board, CSB; Mr. Joseph Crawford, who is chief of police for the City of St. Albans, West Virginia; Mr. Michael Dorsey, who is the chief of Homeland Security and Emergency Response for the West Virginia Department of Environmental Protection; Mr. Kent Carper, who is the president of the Kanawha County Commission in Kanawha County, West Virginia; and Ms. Pamela Nixon, who is an environmental advocate with the West Virginia Department of Environmental Protection. Welcome to all of our witnesses.

It is the policy of this subcommittee to take all testimony under oath. Please be advised that you have the right under the rules of the House to be advised by counsel during your testimony. Do you wish to be represented by counsel?

Mr. STUPAK. They are shaking their heads "no." So then I will ask you to please rise and raise your right and to take the oath.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect that witnesses have reapplied in the affirmative. You are now under oath and that includes your opening statement.

We will now hear an opening statement from each of you. If you have a longer statement we will submit it for the record, but please try to keep your comments to 5 minutes.

TESTIMONY OF JOHN BRESLAND, CHAIRMAN, U.S. CHEMICAL SAFETY AND HAZARD INVESTIGATION BOARD; MICHAEL DORSEY, CHIEF OF HOMELAND SECURITY AND EMERGENCY RESPONSE, WEST VIRGINIA DEPARTMENT OF ENVIRONMENTAL SECURITY; KENT CARPER, PRESIDENT, KANAWHA COUNTY COMMISSION; AND JOSEPH CRAWFORD, CHIEF OF POLICE, CITY OF ST. ALBANS, WEST VIRGINIA

Mr. STUPAK. We will start with you Mr. Bresland, if you don't mind, for an opening statement. You might have to press that button on that mike there. There you go. I can hear you.

TESTIMONY OF JOHN BRESLAND

Mr. BRESLAND. I have pressed it. I thank Chairman Stupak, Ranking Member Walden, and also Chairman Waxman for attending today. I'd also like to thank Congresswoman Capito for attending. I am one of her constituents living in West Virginia, but not in the area where the accident took place.

Also I thank all the other distinguished members of the panel or of the committee who are here today.

I am speaking today on my own behalf as CSB Chairman, not necessarily for the other board members. The Chemical Safety Board is an independent Federal agency that investigates major chemical accidents at fixed facilities. Our public reports, recommendations and safety videos are used worldwide to help save lives, protect the environment and promote safer industrial operations.

Mr. Chairman, the explosion at Bayer CropScience was a very serious and tragic event and it had potential for additional grave consequences. The explosion occurred during the restarting of the plant's methomyl production unit while highly toxic and reactive methomyl waste was overloaded into a residue treater vessel. A violent runaway reaction ruptured the 5,000-pound vessel and sent it careening through the production unit, breaking pipes and equipment, leaving a 50-long-foot swath—if I'm pronouncing that word correctly—of destruction.

The explosion and resulting chemical release and fire fatally injured two employees, six volunteer firefighters, and two others showed likely symptoms of chemical exposure. The blast waste damaged businesses thousands of feet away.

Mr. Chairman, our investigation has revealed that significant lapses in process safety management set the stage for this accident. Plant operators had received inadequate training on a new computer control system which was being used for the first time. Written operating procedures were outdated and could not be followed during start-ups due to longstanding equipment problems. The heater for the residue treater was known to be undersized. This regularly forced operators to defeat three critically important safety interlocks during start-ups, increasing the chance of dangerously overloading the treater with methomyl. This longstanding practice was known to Bayer management prior to the explosion.

I am also troubled by Bayer's delays in providing county 911 officials and the National Response Center with accurate information about the nature of the ongoing emergency and the hazardous chemicals involved.

In addition, there is the question that many of the public are concerned about: What else could have happened? The Bayer plant manufactures and stores very large quantities of some of the deadliest substances used in industry including phosgene gas, and methyl isocyanate, or MIC.

Following Bhopal, other companies moved to inherently safer technologies that largely eliminate MIC storage. Bayer is the last company that still stores large quantities of MIC.

Approximately 80 feet to the southwest of the methomyl residue treater there is a 30,000-pound vessel capacity MIC storage tank which contained almost seven tons of MIC on the night of the accident.

During the explosion, metal projectiles weighing up to 100 pounds flew in all directions. Some landed near the MIC tank. If the MIC tank had been damaged by a powerful projectile or the residue treater itself, which had a great deal of energy, there might have been a catastrophic impact on workers, responders and the public.

Finally I am concerned about Bayer's recent secrecy claims which surfaced in February, right after we told the company we were planning a public hearing on our preliminary findings. Bayer now contends that around 2,000 pages of previously submitted investigative documents should be treated as sensitive security information, or SSI, under the Maritime Transportation Security Act.

Simply understanding which of these SSI markings are proper or not is a daunting task for all of the agencies involved, including the Chemical Safety Board and the Coast Guard. In close consultation with the Coast Guard and with DHS, we decided to proceed with the CSB public meeting, which will now occur this Thursday in Institute, West Virginia. I still have significant concerns about how these information protection rules may negatively impact this and future CSB investigations.

I am asking Congress to consider the following:

Companies should not be able to claim OSHA and EPA safety compliance documents or routine business records as secret. The information protection rules for chemical plants should be harmonized across the different branches of DHS. Finally, the CSB and other public safety agencies should not be subject to potential sanctions when conducting their congressionally mandated job of reporting to the public on the causes of accidents. We should not be threatened with losing our job or being fined as a result of doing our job properly here in Washington.

I call for a reaffirmation of the public's right to know so we at the CSB can continue to fulfill our mission of saving lives of workers and the public from chemical accidents.

I thank you for this opportunity to testify today.

Mr. STUPAK. Thank you, Mr. Bresland.

[The prepared statement of Mr. Bresland follows:]

Testimony of John S. Bresland
Chairman and Chief Executive Officer
U.S. Chemical Safety Board
Before the U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
April 21, 2009

Chairman Stupak, Ranking Member Walden, and distinguished members of the Committee: I am John Bresland, Chairman and Chief Executive Officer of the U.S. Chemical Safety Board, the CSB.

My testimony today is on my own behalf and not necessarily for my colleagues, the other three sitting board members.

I thank you for convening this important hearing. The explosion at Bayer CropScience[1] was a very serious accident. Furthermore, the security-related issues that have been raised in the aftermath of the accident can have major ramifications for future investigations by the CSB – and for the public's right-to-know about chemical accidents.

Mission of the Chemical Safety Board

The CSB is an independent federal agency that Congress established to investigate major chemical accidents at fixed facilities. We have only limited regulatory authority,[2] and our primary power is to recommend and to motivate positive changes in chemical process safety performance to save lives and better protect communities.

This we have done quite successfully over the past ten years. Our accomplishments include major recommendations on preventing fires and explosions involving combustible dust and reactive chemicals. We have successfully pushed for the modernization of the New York City fire code, and we have advocated the expansion of workplace safety protections for millions of public employees.

Our investigation of the tragic explosion that occurred at BP Texas City in 2005 – which was examined in this subcommittee two years ago – has led to significant changes in oil refinery safety and regulatory enforcement. The CSB's reports and especially our safety videos, which are based on actual investigations, are studied and used to educate operators, engineers, and managers throughout the world.

In West Virginia, our investigation of a deadly propane explosion in 2007 is paying tangible benefits for the safety of emergency responders, workers, and businesses. Following the blast that killed two firefighters and two propane technicians, we

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[1] Referred to as "Bayer" throughout the testimony.
[2] The Board was directed under the Clean Air Act to develop a regulation on the reporting of accidental releases.

recommended regular hazardous materials training for West Virginia firefighters, training and certification for propane technicians, and improved 9-1-1 call procedures. We are very pleased with the progress on these recommendations, including recent proposals in the state legislature to require mandatory propane safety training.

Mr. Chairman, the only real tool we have to achieve this progress is the concern and interest of the American public, the Congress, and other stakeholders. We have no other power to order any business to improve its practices. That is why we take so seriously any effort that would potentially diminish our ability to make public the facts and circumstances concerning the major accidents we investigate.

Preliminary Findings of the CSB Investigation

Two days from now we will hold a hearing in Institute, West Virginia, to present to the public our preliminary findings on the explosion at Bayer, following seven months of the ongoing investigation.

Our investigative team spent more than a month at the accident site, interviewing dozens of witnesses and collecting many thousands of pages of evidence, all of which we have shared with the committee at your request.

Mr. Chairman, the explosion at Bayer was a very serious and very tragic event that could have had additional grave consequences.

Let me summarize what our investigative team has learned to date, and what we plan to discuss with the public on Thursday.

The Bayer plant in Institute is a large chemical complex of more than 400 acres that was first constructed in the 1940s. For four decades – until 1986 – it was owned by Union Carbide, which produced carbamate pesticides at the site. Bayer acquired the complex in 2002 and has more than 500 employees at the site.

The facility stands in a populated area along the Kanawha River, about 10 miles to the west of Charleston (see Figure 1). Chemical safety has been a major issue in the Kanawha Valley for decades, fueled in part by concerns about the number of major chemical plants, the density of settlement, the local geography, and the potential difficulty of evacuating the area in case of a chemical emergency.

The Bayer plant manufactures and handles very large quantities of some of the most toxic substances that are used in industry, including phosgene, a gas once used as a chemical warfare agent, and methyl isocyanate (MIC), the chemical that killed thousands of civilians in Bhopal, India, in 1984.

Explosion Occurred During Methomyl Unit Startup

On August 28, 2008, a powerful explosion occurred within the Methomyl/Larvin unit at the Bayer plant. The explosion occurred during the restart of the Methomyl section of the unit. The startup followed an extended maintenance shutdown of the entire unit. On the night of August 28, a vessel known as a residue treater experienced a runaway chemical reaction, which produced tremendous internal heat and pressure.

The residue treater was an eight-by-ten foot cylindrical steel pressure vessel with a capacity of about 4,500 gallons. When empty, it weighed more than 5,000 pounds. It stood vertically on steel supports, and it had just been replaced during the maintenance shutdown, although we do not believe that contributed to the accident.

About ten minutes prior to the explosion, two unit operators – Barry Withrow and Bill Oxley – were asked to go and check on the residue treater because of abnormally high pressure readings. They were in the vicinity of the treater at 10:35 p.m., when the emergency pressure relief valves opened.

However, the pressure relief system was not sized or designed for a runaway reaction involving large amounts of Methomyl, and pressure continued to build inside the vessel. Moments later, the vessel suddenly ruptured. The entire vessel was violently propelled in a northeasterly direction into the production unit – demolishing process equipment, twisting steel beams, and breaking pipes and conduits. The vessel finally came to rest about 50 feet away, grossly deformed and flattened. In its wake, it left a continuous swath of destruction.

Mr. Withrow and Mr. Oxley were caught by the explosion, chemical release, and fire and were both fatally injured. Mr. Withrow died at the scene; Mr. Oxley died after 41 days in a hospital burn center in Pittsburgh.

A blast wave propagated outward from the epicenter of the explosion, causing damage in the control room hundreds of feet away, breaking windows and cracking walls and ceilings at homes and businesses up to several miles away.

I will now discuss more details about why the explosion occurred.

Runaway Reaction of Toxic Methomyl Pesticide

Methomyl is a highly toxic substance that is sold as a pesticide and is also used as a feedstock to produce the pesticide Larvin. Methomyl can be highly reactive. When heated in solution, Methomyl breaks down chemically, producing heat. The residue treater was designed to decompose Methomyl at a concentration of less than 1% in solution. However, during the startup on August 28, the Methomyl concentration in the treater vessel reached a very high concentration, potentially as high as 20% or more.

In the production process, Methomyl is synthesized from MIC and other chemicals and then crystallized from a solvent solution. The solid Methomyl is separated out using centrifuges, leaving behind liquid residue that still contains some Methomyl. Most of the solvent is then recovered by distillation and reused, leaving behind a concentrated liquid waste stream that contains as much as 40% Methomyl. This liquid waste stream was sent to the residue treater, which was intended to decompose most of the Methomyl prior to incineration in a boiler.

The fact that high concentrations of Methomyl could cause a violent reaction or explosion in the residue treater was known to plant managers and operators and was described in the unit operating procedures. Bayer's process hazard analysis and the operating procedures for the unit warned against exceeding a Methomyl concentration of 0.5% in the residue treater, due to the danger of an explosion.

Significant Process Safety Deficiencies Set the Stage

Why then did the explosion occur? Our investigation has revealed significant lapses in process safety management that likely contributed to causing this accident.

Bayer had recently upgraded the computer control system for the unit, replacing an older Honeywell system with a more modern system purchased from Siemens. The control screens and commands were completely different with the new Siemens system; yet our investigation found that the unit operators received inadequate training on the new system. Furthermore, the written operating procedures for the unit were significantly out of date – still describing the use of the Honeywell control system – and were in some cases incorrect.

As early as October 2007 – ten months prior to the accident – Bayer assigned priority action items to correct deficiencies in the unit operating procedures, but the action items remained incomplete by the time of the explosion. The incorrect and inaccurate operating procedures are one example of a number of priority action items left undone by Bayer. In fact, Bayer's own process hazard analysis for the unit, which was prepared in 2004 to comply with OSHA process safety standards, contained some 25 action items that still remained open in August 2008, four years later.

In addition, we found that the steam heater used to heat the contents of the residue treater during startup was deficient: it was undersized and could not produce a sufficient amount of heat. As a result, it was simply impossible for operators to start up the residue treater in the way prescribed by the written operating procedures. The heater could not heat the solvent in the treater to the minimum temperature needed to ensure controlled decomposition of the Methomyl. Since the temperature always fell about 10 degrees Centigrade below the required value, a safety interlock would block the flow of Methomyl into the residue treater, making it impossible for operators to complete the startup of the unit.

Known Heater Deficiency Forced Routine Bypassing of Critical Safety Interlocks

The heater deficiency was a longstanding problem, was known to management, and had persisted throughout a number of previous startups. As a result of the heater problem, operators regularly performed a work-around to start up the residue treater. This involved defeating three safety interlocks controlling the operation of the Methomyl feed valve.[3]

Defeating the feed valve interlocks allowed Methomyl to be pumped into the vessel during the startup sequence even though the minimum operating temperature had not been reached. The Methomyl would begin to decompose and release heat, bringing the temperature up into the required range and allowing the startup to proceed, and thereby compensating for the known problem with the undersized heater.

The practice of bypassing the safety interlocks was longstanding and was known to Bayer managers and engineers. But bypassing the safety interlocks made it much more likely to overcharge the vessel with Methomyl, which could lead to a catastrophic runaway reaction.

On the night of the accident, not only were the three safety interlocks bypassed, but the residue treater was not properly filled with solvent and preheated to the maximum achievable temperature.

As the result of these multiple actions and omissions, the residue treater received hundreds or possibly thousands of pounds of excess Methomyl, which decomposed in a sudden and violent runaway reaction.

We also learned that a valve was missing from equipment related to the residue treater feed stream, causing abnormal conditions in a solvent distillation column. This and other column operational control issues diverted the attention of unit personnel, potentially making it more likely to inadvertently overcharge the residue treater with Methomyl.

The heater deficiency, routine procedural deviations, and routine bypassing of safety interlocks were never subjected to formal management-of-change reviews to assess their impact on safety – a key requirement of the OSHA process safety management standard.

These deviations likely contributed to the runaway reaction and the resulting explosion.

Understanding why all these factors came together on August 28 remains a focus of our investigation. We learned that unit operators had very high overtime levels during the three months prior to the accident, averaging almost 20 hours a week of overtime. Operators worked 12-hour shifts for many consecutive days, with few days off, and

[3] The three safety interlocks were activated by the minimum temperature, minimum pressure, and recirculation flow in the residue treater. If any of these were outside predetermined limits, the interlocks would cut off the flow of Methomyl solution into the residue treater.

sometimes worked up to 18 hours in a row. So we are concerned about the potential for fatigue, which can of course be an important factor in major accidents.[4]

Shortcomings in Emergency Response, Communications, and Reporting

When the explosion occurred at 10:35 p.m. on the night of August 28, the flammable and toxic contents of the residue treater, amounting to about 2,500 gallons, were suddenly ejected and a major fire erupted in the unit (see Figure 2). Chemical pipes and venting systems were broken open and their contents released to the atmosphere. Projectiles were hurled in all directions.

CSB investigators have examined the emergency response to the accident and interviewed many of the participants. At our public meeting on Thursday, we will present a detailed, minute-by-minute chronology of the emergency response.

I am very troubled by our observations of the inadequacy of Bayer's emergency response and emergency communications. For example, the county's 9-1-1 call center was told, fifteen minutes into the response, that no dangerous chemicals had been released. That information came from Bayer's incident commander and was relayed by the Institute volunteer fire chief, who was also a Bayer employee.

That statement is clearly incorrect, since Methomyl is toxic, and its uncontrolled decomposition may release highly toxic byproducts. According to publicly available material safety data sheets for Methomyl, those decomposition products may include highly toxic chemicals such as methyl isocyanate, hydrogen cyanide, acetonitrile, carbon monoxide, dimethyl disulfide, nitrogen and sulfur oxides, and methyl thiocyanate.

In addition, it is likely that hazardous substances were released from the broken chemical pipes and vent systems.

It was more than half an hour later that Bayer recommended to the 9-1-1 center to issue a shelter-in-place advisory for surrounding communities. This was actually some minutes after local authorities had already decided on a shelter-in-place order, after observing what they feared might be a hazardous chemical haze drifting from the plant.

It was more than two hours before Bayer reported the accident to the National Response Center, and that notification erroneously omitted the fatality and the critical injury. The report did state that "hazardous materials" exceeding the reportable quantities were likely released and noted that a shelter-in-place action was underway.

[4] In March 2007, the CSB's final report on the explosion at the BP Texas City refinery recommended new industry-labor consensus standards to prevent operator fatigue at petrochemical plants. The recommendation remains open.

Responders and Workers Exhibited Symptoms of Chemical Exposure

Of particular concern is the fact that apart from the two fatally injured workers, eight other people reported symptoms of chemical exposure following the accident. These include six outside volunteer firefighters and two rail contractors, who were on-site the night of the accident. Their symptoms included nausea, aches, and intestinal and respiratory disturbances.

The firefighters who reported those symptoms had approached the fire without full personal protective equipment – specifically self-contained breathing apparatus – apparently relying upon the fact that Bayer personnel at the scene were not using such equipment.

Finally, there were well-publicized problems with the content of Bayer's communications relayed by a front gate guard to the 9-1-1 center. For a period, the guard – evidently following instructions from Bayer – declined to identify to 9-1-1 officials even where in the 400-acre facility the explosion, release, and fire had occurred.

All of these observations point to serious deficiencies in internal communications, coordination, and emergency response planning on the part of Bayer.

Up to 18 Tons of MIC Stored Close to Explosion Site

As I have described, when the residue treater ruptured it was hurled with tremendous force in a northeasterly direction. This trajectory took the vessel through a highly congested section of process equipment, where it left a wide, long swath of destruction (see Figure 3).

As far as we can determine, the direction the residue treater traveled was a matter of random chance. The violent rupture of the vessel might have propelled it horizontally in any direction or upward on an arc-like trajectory.

Approximately 80 feet to the southwest of the location of the residue treater, there is a 37,000-pound capacity tank of methyl isocyanate (see Figures 4 and 5). This tank provides MIC feedstock to the Methomyl unit and to another pesticide unit located at the complex, a unit that is owned by FMC Corporation.

During normal production, this tank is filled once a day via pipeline with product from the MIC production unit, which is located several thousand feet away. The tank is actually a refrigerated pressure vessel that stands 19 feet tall and 8 feet in diameter.

At the time of the explosion on August 28, the tank was about 30% full, containing a total of 13,800 pounds of MIC.

In 1982, prior to the Bhopal disaster, then-owner Union Carbide equipped the tank with what the facility refers to as a "blast blanket." The blast blanket is a steel mesh that hangs from a steel framework and was presumably installed to try to protect the MIC tank from accidental process-related explosions (see Figure 6). In 1994, then-owner Rhone-Poulenc installed a second section of the blast blanket above the top of the MIC tank.[5]

On the night of August 28, 2008, the rupture of the residue treater sent metal projectiles in all directions. Some of these projectiles weighed up to a hundred pounds. When our investigators arrived at the site, they observed explosion debris near the base of the MIC blast blanket (see Figure 7).

We are still awaiting from Bayer any written documentation to indicate the design basis of the blast blanket, the standards to which it was constructed, and the scenarios it may be designed to withstand. Without that information, it is difficult to draw any conclusion about how much danger the tank might have been exposed to on August 28.

Subsequent to the August explosion, Bayer removed the blast blanket from the tank and installed a new blanket constructed from heavier steel cable.

MIC Tank's Existence and Siting Cause Concern

Although the MIC tank and the blast mat escaped serious damage on August 28, there is reason for concern. This was potentially a serious near miss, the results of which might have been catastrophic for workers, responders, and the public.

MIC is considered "immediately dangerous to life and health" (IDLH) at the extremely low concentration of three parts per million in air. At ordinary temperatures, MIC is a liquid but it evaporates very rapidly to form a heavier-than-air vapor cloud, which is obviously very dangerous.

Bayer's plant in Institute is the only manufacturing site in the United States that continues to produce and store more than 10,000 pounds of MIC, which is the EPA threshold under the Risk Management Program (RMP) rule.

There are hypothetical scenarios where the MIC storage tank could have been compromised during the August 28 explosion, either by powerful projectiles or by a collision with the residue treater vessel, had it traveled in that direction. Any release of MIC into the atmosphere is cause for great concern, even if it is far smaller than the 200,000-pound RMP worst-case scenario reported by Bayer to the EPA.

Speaking more broadly, there is the issue of whether it is necessary to keep large inventories of MIC in order to produce pesticides like Methomyl. Following the Bhopal

[5] In 1993, a serious process-related explosion occurred in the Methomyl/Larvin unit, fatally injuring two operators.

tragedy, DuPont and other companies moved promptly to eliminate the storage of MIC and develop manufacturing processes where this highly toxic intermediate is consumed as soon as it is made. In this manner, the maximum release is limited to the contents of a short length of pipe, instead of the thousands of gallons contained in a large storage tank. As Professor Trevor Kletz and other leading process safety authorities have frequently pointed out, "what you don't have, can't leak."

Mr. Chairman, the Chemical Safety Board will undertake a variety of steps to further the understanding of these issues. We have requested, or will request, from Bayer:

- the engineering design bases of the MIC tank and the blast blanket
- analyses of the appropriateness of siting of an MIC tank so close to a unit that has experienced two significant explosions since 1993
- any studies by Bayer or its predecessors of the feasibility and costs of eliminating MIC from the process or reducing its storage at the Institute site

The CSB will closely evaluate the suitability of the location of the MIC tank near a hazardous operating unit; the likelihood that the MIC tank could have been compromised on August 28; and the potential impact of such a release on workers, responders, and the public.

Our goal is that the community and workforce be as safe as possible from the risk of death or injury from a chemical release.

Impact of Security Regulations on CSB Investigations

Mr. Chairman, my testimony above describes what the CSB learned about this accident after about half a year of investigating. In January, we began planning for a public hearing in West Virginia to update the public and our stakeholders on our preliminary findings. We advised Bayer of our plans and the expected date of the public meeting, which was March 19.

In early February, Bayer officials and attorneys requested a meeting with the CSB to discuss concerns about the public meeting. That meeting occurred on February 12 at the CSB's headquarters in Washington. At the meeting, Bayer contended that a large number of documents they had already submitted to the CSB investigation should be treated as "sensitive security information" (SSI) under the Maritime Transportation Security Act (MTSA) of 2002. As a facility that operates a barge terminal, the security of the Bayer Institute complex is regulated under MTSA rather than under the Chemical Facility Anti-Terrorism Standards (CFATS), a program established by the Department of Homeland Security following Congressional action in 2006.

As a result, Bayer claimed that certain information should not be discussed or disclosed to the public. Bayer specifically cited documents relating to MIC use, storage, and process safeguards as potentially being SSI.

Following that meeting, I decided to postpone the CSB public meeting in order to evaluate Bayer's claims.[6] Following discussions with the Coast Guard and the Transportation Security Administration (TSA), we decided to proceed with the public meeting and to review our presentation in advance with the Coast Guard. The Coast Guard reviewed a draft of our presentation (in the form of a PowerPoint slide show), and determined that apart from one or two narrow issues, it did not contain any potential SSI.

On that basis, we are proceeding with our public meeting on Thursday.

Mr. Chairman, I would like to emphasize that the CSB and the United States Coast Guard have been cooperating, and both agencies are, in my opinion, working to protect what they believe to be the public interest, in accordance with their various mandates from Congress.

With that said, I have significant concerns about how current information protection rules may negatively impact this and future CSB investigations.

In response to recent requests from the CSB, Bayer has resubmitted all of its previously provided documents, marking those portions that Bayer believes to be SSI under the company's interpretation of current MTSA regulations. According to our initial estimates, Bayer has marked approximately two thousand pages of investigative information as containing SSI – a number that is likely to increase significantly as our investigation continues.

In addition, we have no real way of knowing whether the thousands of pages of interview transcripts, notes, and photographs generated in our investigation may later also be claimed to contain SSI.[7]

Bayer has provided us with a "protection log," which is merely a list of document titles that the company claims contain SSI. This log itself runs to 24 pages in length. It includes such items as process hazard analyses and standard operating procedures for the Methomyl/Larvin unit, surveillance videos that may depict the accident, insurance audits, and even a map of the facility.

As Bayer attorneys told me on February 12, the company believes that even documents that were originally prepared in order to comply with various OSHA and EPA safety regulations can be now protected from public disclosure or discussion, if those

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[6] Disclosure of SSI by federal employees carries potentially heavy civil penalties.

[7] On March 13, 2009, Bayer requested access to the CSB's full investigation file, including investigators' notes, photographs, and interview transcripts to mark information as SSI. To preserve the integrity of the CSB's ongoing investigation and to protect the information provided by witnesses, the CSB denied the request.

documents are merely referenced in the facility's MTSA-required security vulnerability assessment.

Mr. Chairman, it requires little imagination to see the potential for misuse if such an interpretation prevails. In the future, companies may be able to delay our investigations for years while complex claims and counterclaims under MTSA or CFATS are painstakingly resolved between the CSB and various homeland security agencies. Public confidence in the independence, thoroughness, and efficiency of our critical life-saving work may be undermined.

For these reasons, I believe it is vital that Congress work with the CSB, the Coast Guard, the Department of Homeland Security, and other affected agencies to develop an efficient system for conducting public safety investigations while protecting legitimate security interests. The starting point for such a system should be a reaffirmation of the public's fundamental right to know about major accidents and about the safety of the communities in which we all live and work.

The security precautions at chemical plants are beyond the scope of the CSB's mission. We don't investigate how many guards a site has, how personnel access is controlled, or what type of fencing is used. We defer those and other more complex security issues to the experts at DHS.

We do, however, conduct critical investigations of process safety issues that are essential to saving the lives of workers and the public from chemical disasters. I ask your support, Mr. Chairman and members of the subcommittee, to preserve and strengthen that authority.[8]

Under the Clean Air Act, the mission of the Chemical Safety Board is, quite simply, to "investigate ... determine and report to the public in writing the facts, conditions, and circumstances and the cause or probable cause of any accidental release resulting in a fatality, serious injury or substantial property damages."

In response to your request, Mr. Chairman, we recently submitted to the committee a list of such serious accidents since 2004 – a list that includes hundreds of accidents. As an agency with fewer than 40 employees and an annual budget of $10 million, we are hard pressed to perform in-depth investigations of even a fraction of these accidents.

Extensive secrecy claims from companies – which I believe are destined to occur unless the current issues are constructively resolved – have the potential to undermine the CSB's effectiveness as a public safety agency.

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[8] The CSB authorizing statute has not been reviewed or changed since the enactment of the Clean Air Act Amendments of 1990. As my predecessor testified to the Senate in 2007 – and as I reiterated during my confirmation proceedings in 2008 – Congress should review the adequacy of the CSB's authorities to promptly access incident sites; to preserve and test evidence; and to obtain relevant records from regulatory agencies.

In taking up new chemical security legislation this year, I would ask Congress to consider three basic principles related to the security of information. I am offering these suggestions in my capacity as chairman of the Chemical Safety Board and not necessarily for my colleagues, the other three sitting board members.

First, requirements under both MTSA and CFATS should be clarified to ensure that federal safety compliance documents and other routine business records cannot be claimed as secret – particularly by companies that are under investigation due to major process-related accidents. Without this protection, companies will simply include every document they can within their vulnerability assessments as a shield against possible future investigations or litigation.

Second, the disparate information security requirements under MTSA and CFATS should be harmonized. I believe that industry as well as the CSB and other safety agencies will benefit from a single, coherent set of rules that provides clear guidance to companies and preserves the public's right-to-know about chemical hazards.

Third, in discharging its official, statutory responsibility to report on accidents, the CSB should not be subject to potential penalties and sanctions from homeland security agencies. We stand ready to work cooperatively with DHS, the Coast Guard, and other sister agencies to protect legitimate security information, as we already have. However, the prospect of sanctions against individual employees and board members has an unavoidable chilling effect.

If these principles are implemented, I believe that safety agencies like the CSB and homeland security agencies can and will continue to coordinate effectively to protect the well-being of the American public, a goal we all share.

Thank you for the opportunity to testify today.

Figure 1: The Bayer chemical manufacturing complex in Institute, West Virginia, indicating the location of the Methomyl/Larvin unit, site of the explosion.

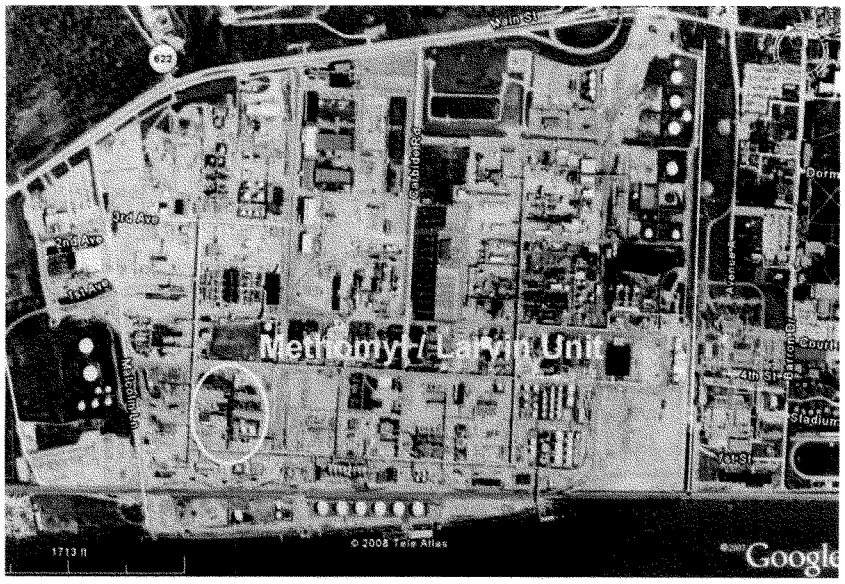


Figure 2: Fire in the Methomyl/Larvin unit following the explosion of the Methomyl residue treater on the night of August 28, 2008 (photo courtesy of Tom Hindman, The Charleston Daily Mail).

Figure 3: Equipment destruction along the trajectory of the residue treater vessel; the deformed shell of the vessel is visible at the center of the photograph.

Figure 4. Overhead view showing the proximity of the 37,000-pound MIC storage tank (day tank) to the Methomyl residue treater, which exploded.

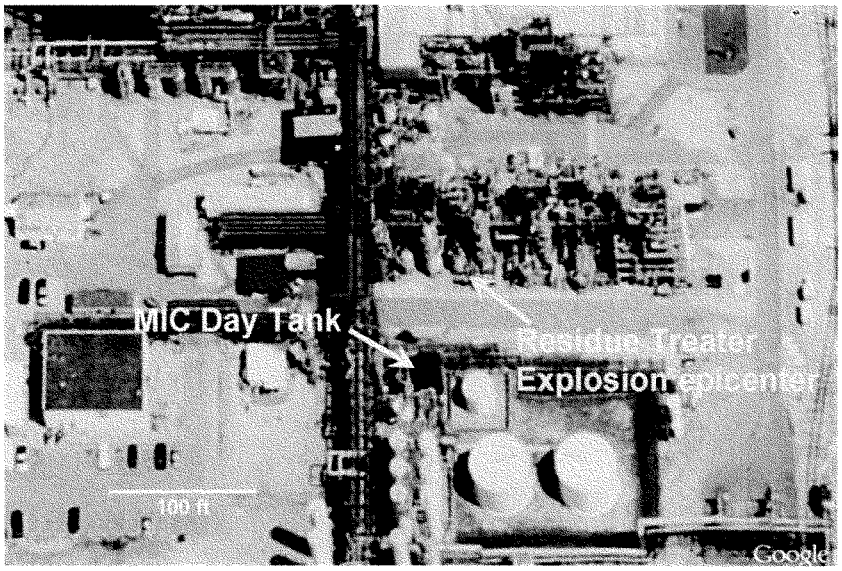


Figure 5: Ground-level view showing the proximity of the residue treater to the MIC storage tank, approximately 80 feet away across a roadway.

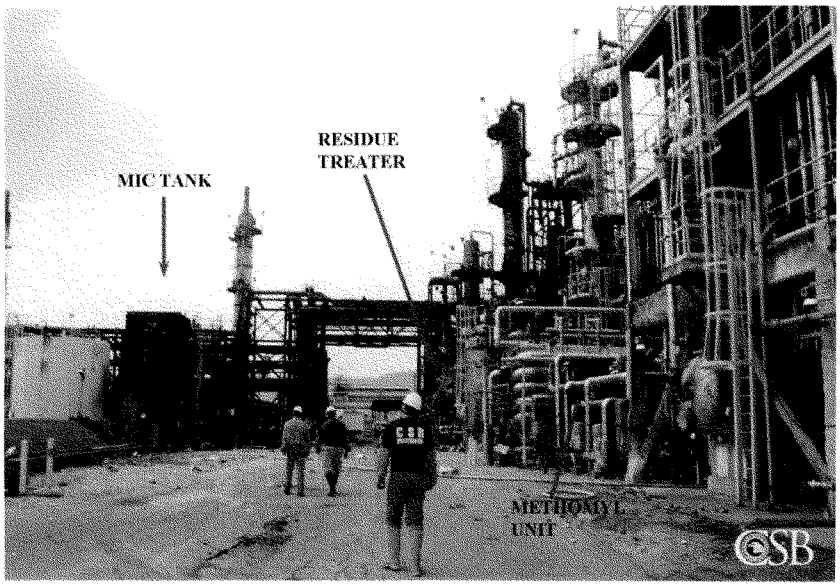
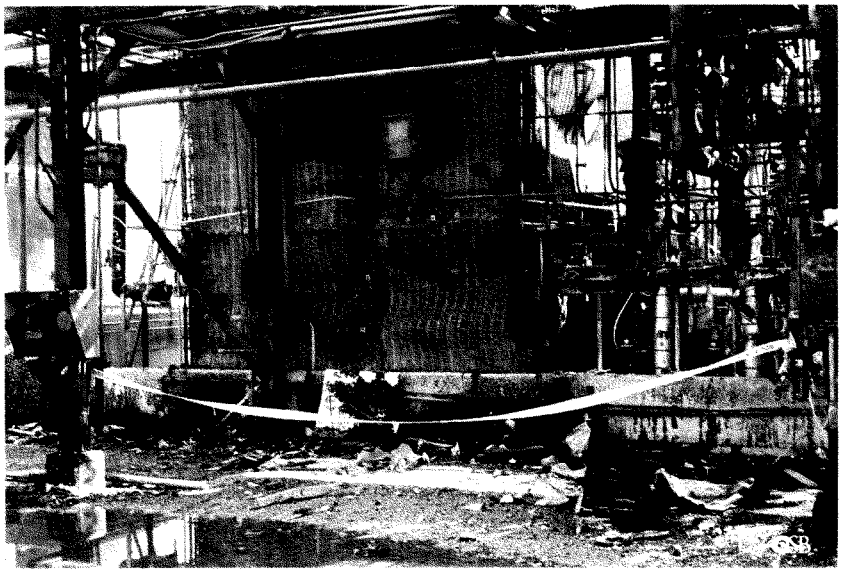


Figure 6: View of the MIC storage tank in the Methomyl/Larvin unit showing the blast blanket first installed in 1982 and then extended upward in 1994.

Figure 7: Explosion debris observed by CSB investigators at the base of the blast blanket surrounding the MIC tank.



Mr. STUPAK. Mr. Dorsey, your statement please.

TESTIMONY OF MICHAEL DORSEY

Mr. DORSEY. Thank you Mr. Chairman. Chairman Stupak, Ranking Member Walden, Congresswoman Capito, and ladies and gentlemen. Thank you for the opportunity to be here today. My name is Mike Dorsey.

The explosion at the Institute, West Virginia, Bayer facility which shook the entire area and eventually claimed the lives of two workers was a tragic accident, the effects of which, were compounded by a lack of communication about the conditions inside the plant by the onsite command team and a nearly complete failure of the instant command system as a result of that failure.

Perhaps of greater consequence, Bayer's attempts to stifle the report of the Chemical Safety Board by citing the Marine Transportation Security Act's provisions regarding port security plans, which in and of itself is a greater communication failure.

The Maritime Transportation Security Act of 2002, or MTSA, is legislation which seeks to improve security in America's ports through a number of measures, but the requirement pertinent to this investigation is that which mandates the preparation of maritime transportation security plans. This requirement has become an issue in this instance because in all States, "Information developed under this chapter is not required to be disclosed to the public."

It is under this language that Bayer sought to block the findings of the Chemical Safety Board. Bayer is able to make this assertion because the broad definition of "facility" in the act, which includes—and I'm quoting again—"any facility of any kind" on waters subject to the jurisdiction of that law.

The relevant definition does not present a problem when normal port facilities which deal only with the loading and unloading of various cargos are considered. When facilities such as chemical plants or other manufacturing facilities, whose major emphasis is the manufacturing of goods rather than the shipping of goods are included wholesale under this definition, vast areas under which the Coast Guard has no expertise or experience are suddenly covered by a protective veil which other concerned agencies as well as the public are prohibited from lifting.

Manufacturing processes, chemical storage transfer methods and many other physical and administration functions which have nothing at all to do with the shipping or the port portion of the facility are now potentially under the purview of an agency which, through no fault of its own, is now expected to make decisions far outside of its mission.

Bayer CropScience uses many dangerous chemicals such as chlorine, phosgene, methyl isocyanate and others in its processes. In fact, most large manufacturing facilities use dangerous materials and equipment.

Nearly all major Institute industries in West Virginia are on navigable waterways that are under the jurisdiction of the MTSA. Conceivably, all such chemicals and processes can be concealed using MTSA.

I do believe that the Coast Guard made a wise decision in the case at hand, allowing all information except the times when the MIC tank is to be filled to be disclosed. But I would argue that in spite of their skills, they are not the proper agency to make decisions regarding chemical processes or other activities far removed from the port setting.

As a member of the State Emergency Response Commission with the responsibility for implementing the Emergency Planing and Community Right To Know Act, or EPCRA, I believe that allowing the MTSA to be read as Bayer proposes will cripple provisions of this act. EPCRA mandates that local emergency planning committees write plans to address all potential emergency situations at chemical plants and that critical information be provided by the facility to the emergency response committee.

This information would not be available if Bayer's reading of the Maritime Transportation Security Act is validated; nor information required by other acts, such as the Resource Conservation Action, Clean Water Act, and others would be available.

A final, but critical note on the MTSA is language that Bayer used to attempt to prevent the CSB's finds from being revealed to the public is not prohibitive at all; it was permissive. The act states that facility plans—and I am quoting again, "are not required to be disclosed." It does not prohibit such disclosure.

In other words, even if the definition of the facility is broadly interpreted and the entire plan is covered, Bayer can still release the information developed under MTSA if it wanted to in this instance. The choice of whether or not to be a good corporate citizen in this case is Bayer's.

Ladies and gentlemen, I have other written testimony. I will now cease my comments.

Mr. STUPAK. Thank you Mr. Dorsey.

[The prepared statement of Mr. Dorsey follows:]

Bayer CropScience Explosion – August 28, 2008

Institute, West Virginia

Failure to Communicate

West Virginia Department of Environmental Protection
Homeland Security and Emergency Response

H. Michael Dorsey, Chief

The explosion at the Institute, West Virginia Bayer facility which shook the entire area and eventually claimed two lives was a tragic accident the effects of which were compounded by lack of communication about the conditions inside the plant by the on-site command team and a nearly complete failure of the Incident Command System (ICS) as a result of that failure. Perhaps of greater consequence is the later attempt to stifle the report of the Chemical Safety Board by citing the Maritime Transportation Security Act's provisions regarding port security plans which, in and of itself, is yet another communication failure.

The Maritime Transportation Security Act of 2002 (MTSA) is legislation which seeks to improve security at America's ports through a number of measures but the requirement pertinent to this investigation is that which the mandates the preparation of maritime transportation security plans. This requirement has become an issue in this instance because the law states that "information developed under this chapter is not required to be disclosed to the public." It is under this language that Bayer has sought to block the findings of the Chemical Safety Board. Bayer is able to make this assertion because of the broad definition of facility in the act which includes "any facility of any kind" on waters subject to the jurisdiction of the law.

The relevant definition does not present a problem when normal port facilities which deal only with the loading and unloading of various cargos are considered. When facilities such as chemical plants or other manufacturing facilities whose major emphasis is the manufacturing of goods rather than the shipping of goods are included wholesale under this definition, vast areas over which the Coast Guard has no expertise or experience are suddenly covered by a protective veil which other concerned agencies as well as the public are prohibited from lifting. Manufacturing processes, chemical storage and transfer methods and many other physical and administrative functions which have nothing at all to do with the shipping or the port portion of the facility are now potentially under the purview of an agency which, through no fault of its own, is now expected to make decisions in areas far outside of its mission.

The Bayer CropScience facility uses many dangerous chemicals such as chlorine, phosgene and methyl isocyanate in many of its processes. In fact, most large manufacturing facilities use some

dangerous material or equipment. Nearly all major industries in West Virginia are on navigable waterways that are under the jurisdiction of the MTSA. Conceivably, all such chemicals and processes could be concealed using the MTSA. I do believe that the Coast Guard made a wise decision in the case at hand in allowing all information except the times when the methyl isocyanate tank is filled to be disclosed; but I will argue that, in spite of their skills, they are not the proper agency to be making decisions regarding chemical processes or other activities far removed from the port setting.

As a member of the State Emergency Response Commission (SERC) with the responsibility for implementing the Emergency Planning and Community Right-to-Know Act (EPCRA), I believe that allowing the MTSA to be read as Bayer proposes would cripple provisions of this act. EPCRA mandates that local emergency planning committees write plans to address all potential emergency situations at chemical plants and that critical information be provided by the facility to the emergency response committee. This information would not be available if the Bayer's reading of the Maritime Transportation Security Act is validated.

A final but critical note on the MTSA is that the language that Bayer has used to attempt to prevent the CSB's findings to be revealed to the public is that the language is not prohibitive at all but instead is permissive. The act states that facilities "are not required to be disclosed"; it does not prohibit such disclosure. In other words, even if the definition of facility is broadly interpreted and the entire plant is covered, Bayer could still release the information developed under the MTSA if it wanted to. The choice of whether or not to be a good corporate citizen is Bayer's.

ICS is a federally mandated management system for dealing with the response to emergency situations. It is designed to be flexible and scalable so that incidents of any size from traffic accidents to terror attacks can be managed by the same system. And it works when used appropriately. A lack of critical information from the facility to the responders caused the system to fail and highlighted a flaw in the system that needs to be recognized and addressed by the response community.

Initial notification of the explosion and also later communications were handled by guards at the front gate who were given a minimum of information. More than an hour after the explosion, responders were still trying to find out what unit(s) was involved. Repeated calls to the plant were answered by the guards who refused to divulge additional information. A command post was set up inside the plant the was comprised only of Bayer employees (although later a single county representative was admitted). When the local volunteer fire department arrived, their fire chief, also a Bayer employee, set up a second command center at the main gate to the facility. A third command center was set up nearby at a local park where the rest of the responders including police agencies, transportation officials ambulance authority members, my agency and others were located. Although a Bayer employee was sent to the third command center mentioned above, this person professed ignorance of what was going on in the plant.

Due to the lack of reliable information coming from the in-plant command center, responders resorted to calling friends and relatives who were working in the plant on their cell phones to try to get accurate information on the status of the incident. It wasn't until after 1:00 a.m. on the morning of August 29th, 2009 that plant officials came to the third command center to officially brief responders on the situation in the plant. During the three hour since the explosion, responders were left guessing about what steps they should be taking to protect both themselves and the public. Reassurances from within the plant that all was going well rang hollow when a giant fire could be seen raging. The result was panic in the local community, confusion in the ranks of responders and a well-earned distrust of the facility.

It wasn't until after 3:00 a.m. on the 29th that state officials, myself included, were granted admittance to the plant and even then, only after a confrontation and then not to the actual command center. It wasn't until nearly 5:00a.m. that we were able to visit the stricken unit and make our own determinations about the safety of the general public; more than six and one-half hour after the explosion.

This situation could have been avoided. Competent implementation of the ICS would have avoided the majority of the problems encountered during this emergency. All emergency responders are trained to a greater or lesser degree depending upon their role. Depending upon the type and size of an incident, the system provides for multiple subsidiary command locations, public information officers, health and safety divisions and other well-known, well-trained components that needed to be implemented but weren't. Information needed to be flowing from the command center but wasn't. Resources needed to be marshaled but weren't.

Where does the blame lie? Squarely on the shoulders of Bayer CropScience. Failure to provide adequate, accurate information to responders was a problem from the onset of the incident until several hours into it. Failure to provide access to the facility command center prolonged community and responder concerns about the welfare of the community at large. Failure to competently implement the ICS resulted in three separate "command centers"; none of which had al the right resources to correctly address the problem. All of the resources needed to respond competently to such an accident were present at one of the command centers yrt there was no attempt to cooridinate or even use these resources.

The explosion at the Bayer CropScience facility was a terrible accident. Whether or not it could have been avoided is grist for another mill. What is indisputable is that the response to the accident was unacceptable and that the company is responsible for that failure.

Mr. STUPAK. Mr. Carper, your opening statement, please, sir.

TESTIMONY OF KENT CARPER

Mr. CARPER. First time someone had to push a microphone in my face.

Chairman Stupak, Ranking Member Walden, and members of the O&I Subcommittee, and particularly my Congresswoman Capito, I want to thank you for your interest and I also want to thank you for what I know is your absolute sincere concern about our two lost family members in the State of West Virginia. I want to thank you.

And I do have some written comments, I want to skip through part of it. But when I heard about your interest in passing communications and knowing we run a 911 center for about 600,000 calls a year—small enough for a peninsula, but pretty big for us—but I am familiar, Chairman, with your record on interoperable communications and how you fought for that, like our Congresswoman Capito.

And I've heard the comments about the lack of the command system. You can't dispatch someone if nobody will tell you where to send them to, what's going on and the nature of the emergency. And with all due respect, it is not a question of whether it happened or not, we supplied you—your staff has done an excellent job by the way, I want to commend them as well—we supplied them with our tapes.

One thing about our 911 center, when we do something right, we know it; and when we do something wrong, we know it and it is all documented. And I'm not saying the dispatch was perfect, but it was pretty darn good considering what we had, number one.

And our first responders were heroic. And it was practically a miracle that one of the other vessels didn't rupture. And that was our problem as we continuously sought to find out what was going on so we could tell police officers, firefighters and paramedics in the community what they needed to know. And they needed to know, and they didn't know.

I'm the former police chief of the city of Charleston. I have not the law enforcement background like the Chairman has, but a little bit. And this gentleman next to me has an extensive law enforcement background, and our elected sheriff and chief deputy on the scene, they did all they could do, but they knew so little.

As you look through this, we had an event that occurred in December the previous year. We were assured that this wouldn't happen again.

With me today is our executive director of our 911 center, our former fire chief of the city of Charleston. These folks have extensive experience in managing an emergency. But they were simply there, waiting to make decisions, waiting to work. The word "waiting" is what happened. And as my testimony—Mr. Chairman, you have it—we have the time line. This went on not for minutes, it went on for hours. And eventually the 911 people, in conjunction with our decision makers made a decision in the blind, in the dark, to go ahead and issue a shelter-in-place decision. I helped participate in that to some extent. I am proud of them for doing that. That was exactly what they needed to do.

As you know, the State of West Virginia, our Governor, Governor Manchin, has issued legislation now—which is in my written testimony—where we've changed the rules. The legislature simply won't allow this to happen. Our 911 center also changed the rules.

I think at the end of the day, there are two things that concern me. And frankly I agree 100 percent with CSB's recommendation. I hope Congress will take a look at that. You actually have two issues before you as O&I—whether or not you're going to issue stringent requirements on how they are going to handle that. But the more troubling aspect is the veil of secrecy as you all have described it. It is a veil of secrecy. And with all due respect to Bayer, I will go on record saying they have changed things since then. They are doing certain things. I am sure they will testify to that. I looked at it, and I believe they had good faith in those efforts.

However, we will have a public meeting in Institute, West Virginia, this Thursday at 6:30 I believe. What kind of a meeting is that going to be when certain information is still being withheld from the public? And even if they have complied in part after they drug the Coast Guard into this—I mean, Mr. Chairman, this is West Virginia, this isn't Upper Peninsula; we don't have 1,600 miles of coastline. It is a small State. And the idea that the Coast Guard is going to stop the people in Institute, which by the way is a heavy minority community, we have over 500 college students at West Virginia State University, right in the footprint of this chemical plant. Right now, even if everything seems to go good at this hearing, the people there will believe that critical information is being withheld from them simply because of this insertion of Homeland Security.

It is above my pay grade. I don't claim to be an expert on Homeland Security, the Patriot Act, or anything else. But I cannot imagine this Congress had that intent when they passed the law not to let the people know, who are sitting as a next-door neighbor to one of the most dangerous chemicals—I can't pronounce it either, I just call it M–I–C—but I know enough about it to know that it is a very dangerous chemical. And the more you store, the more dangerous it is. And if you're going to store a lot of it, you ought to tell your neighbors what you are doing.

And with that, I do again, Chairman, want to thank you for your sincere reflection on our loss and your interest in a very, very serious matter. Thank you very much.

Mr. STUPAK. Thank you Mr. Carper.

[The prepared statement of Mr. Carper follows:]

KANAWHA COUNTY COMMISSION

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Henry C. Shores
Commissioner

W. Kent Carper
Commissioner

David J. "Dave" Hardy
Commissioner

TESTIMONY OF: W. Kent Carper
President, Kanawha County Commission
President, Metro 911 of Kanawha County

DATE: Tuesday, April 21, 2009 - 12:00 Noon

BEFORE: United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

REGARDING: Investigation of the explosion and fire at the Bayer CropScience Facility located in Institute, Kanawha County, West Virginia, on August 28, 2008.

INTRODUCTION

I want to thank the Chairman and distinguished members of the House of Representatives' Committee on Energy and Commerce and its Subcommittee on Oversight and Investigations for inviting me to speak today. I am appearing before the Committee in my capacity as the President of the Kanawha County Commission, Kanawha County, West Virginia, and President of the Governing Board of the Ned Chilton Metro 911 Center. In addition, I am Kanawha County's Board representative to the Kanawha County Emergency Ambulance Authority and previously served as an Assistant Prosecuting Attorney of Kanawha County, the Public Safety Director, Chief of Police for the City of Charleston, West Virginia.

My primary purpose for testifying today is to make clear the aberration of a response by Bayer CropScience regarding the explosion and fire that occurred at its facility located in Institute, Kanawha County, West Virginia, on August 28, 2008. In my judgment, lives in the community were placed in grave risk and such risk was unnecessary and avoidable had Bayer CropScience followed protocols currently in place.

The lack of quality and timely information from Bayer CropScience placed first responders unnecessarily in harm's way and placed thousands of citizens at risk. Now that the incident is being investigated, I am concerned with the manner in which Bayer CropScience is attempting to utilize the Homeland Security laws passed by this Congress to avoid sensible disclosure of events surrounding this incident.

Accompanying me today are Carolyn Karr Charnock, Executive Director, Kanawha County Ned Chilton Metro 911 Center; David Erwin, Emergency Operations Center Coordinator, Kanawha County Ned Chilton Metro 911 Center; Dale Petry, Kanawha County Emergency Services Director; David Armstrong, Kanawha County Emergency Services Deputy Director; Grant Gunnoe, City of Charleston, West Virginia, Emergency Services Director; Chief Joe Crawford, St. Albans, West Virginia, Police Department; and David Sweeney, Region I Planner, West Virginia Department of Military Affairs & Public Safety.

Ms. Charnock, Mr. Petry, Mr. Erwin, and Mr. Gunnoe were present in the Emergency Operations Center located in the Ned Chilton Metro 911 Center throughout the incident. Mr. Armstrong reported to the front gate of the Bayer CropScience

facilities, where he was initially denied access, and finally was admitted into the on-site Command Center. Chief Crawford was deployed with his officers in the City of St. Albans which is directly across the Kanawha River from the Bayer CropScience facilities. Mr. Sweeney participated in all of the post event debriefings.

EXECUTIVE SUMMARY

Late in the evening of August 28, 2008, at approximately 10:30 P.M a thunderous explosion occurred in western Kanawha County near Institute, West Virginia which shook homes throughout a 20 mile radius. The Institute area, approximately 20 miles from Charleston, West Virginia, the State Capitol, is home to a significant minority population, elderly, and West Virginia State University, a historically African-American land-grant university, which has evolved into a fully accessible, racially diverse, and multi-generational institution. Currently West Virginia State University has a total enrollment of 5,000 students with approximately 475 students live on campus immediately adjacent to the Bayer CropScience facilities.

Within minutes the Kanawha County Ned Chilton Metro 911 Center began receiving radio and telephone reports of the explosion from emergency responders and concerned citizens. At 10:36 P.M. Kanawha County activated the Emergency Operations Center (EOC) located in the Ned Chilton Metro 911 Center and EOC personnel began assessing the situation based on extremely limited information as to the cause and origin of the explosion. Based upon the initial reports and lack of definitive information, Metro 911 dispatched the wrong fire department to a location on the wrong side of the Kanawha River.

As reports continued to be received by Metro 911, it was determined the explosion may have happened at the Bayer CropScience (Bayer) facilities located in Institute, West Virginia. At 10:39 P.M. Metro 911's personnel took it upon themselves to call Bayer and inquired if there had been an explosion at the facility. The Metro 911 Supervisor could only reach a security guard who answered the phone at the front gate of Bayer's facility and said he could not give out any information. Bayer had assured Kanawha County emergency officials in 2008 they would provide a Supervisor, authorized and informed, to provide information to Metro 911. Bayer made such a

promise due to their inability to provide timely information after a vapor release in the same Larvin unit in December, 2007.

EOC personnel were operating under the assumption that information regarding the explosion would be forthcoming any moment due to the protocol established after the December , 2007, incident. At 10:42 P.M. the Bayer Security Guard called Metro 911 requesting an ambulance be sent to the main gate of the facility. When questioned further about the explosion, the Bayer Security Guard once again stated he could not provide any information.

During this timeframe, Metro 911 received information from an off-duty Bayer employee, via the Kanawha County Sheriff, who had been paged to report to the plant because there had been an explosion in the Larvin unit. At 11:15 P.M., 45 minutes after the explosion, the Bayer security guard called Metro 911 stating there was an "emergency at the plant" and to "alert the public." When questioned if there had been an explosion in the Larvin unit, the Bayer security guard stated he was allowed to advise only of an emergency at the facility and would not confirm there had been an explosion in the facility. At 11:34 P.M. the Bayer security guard called Metro 911 to inform the EOC that the facility was "responding to our emergency" and to "keep the community on alert."

Kanawha County has had an Emergency Plan specific to chemical emergencies for decades. This plan was ascribed to by all the chemical plants in Kanawha County. The plan provides for protocols for redundant means of communications including separate radio frequencies for use in emergency situations should phone communications fail. Bayer failed to follow any of the required protocols and left Kanawha County emergency personnel completely uninformed as to any potential danger to the public, as well as, emergency responders on the scene.

The Kanawha County Emergency Plan does not provide for any protocols to deal with an "emergency at the plant" and "alert the public." This total lack of information resulted in a series of protective actions in the absence of an effective plan. Therefore, rather than continue to wait for a response from Bayer for vital information and to protect the public, at 11:42 P.M. the EOC ordered an immediate shelter-in-place for the affected area.

During this entire time period, Kanawha County emergency personnel and the West Virginia State Fire Marshal tried to enter Bayer's facility and were held at the front gate for a prolonged period of time. Once admitted to the facility's Command Center, they were sequestered in a separate room and refused access to any information about the emergency.

Normally, during an event of this nature, I would have reported to the EOC, but I was out of town during this incident. At approximately 12:00 midnight, I called into the EOC to obtain first-hand knowledge of the situation and to offer my assistance and remained in command with the EOC until the incident deescalated. I was informed of the total lack of information from Bayer, which I found to be totally unacceptable. A Bayer representative, Mike Curry, reported to the EOC, and I immediately questioned him as to the nature and location of the explosion in the facility. Knowing the extremely dangerous chemical MIC was produced and stored in this facility, I inquired as to what products were involved and whether lives were in danger. Mr. Curry offered no more information than what the EOC currently had, which was woefully inadequate.

With Mr. Curry present, I contacted the Fire Chief on scene, Chief Andre' Higginbotham of the Institute Volunteer Fire Department, to discuss the situation. It was confirmed at this time, more than two (2) hours after the initial blast, there had been an explosion in the Larvin unit of the Bayer facility, fire crews were fighting the fire and at least one person had been injured and transported to a local hospital. Learning this, we still did not know (1) if any product had been released, although a significant haze hung over the valley, and (2) whether there was a danger to the public and responders in the area.

In addition to talking with Chief Higginbotham, I was also in communication with David Armstrong, Kanawha County Emergency Services Deputy Director, who had finally been admitted into Bayer's Command Center. Mr. Armstrong could only offer opinions as to what was happening as Bayer was unwilling to share any information with Mr. Armstrong. At this time I discussed with our EOC team whether or not an evacuation was in order. The rationale for considering an evacuation was based on: (1) the number of elderly citizens and West Virginia State University students in the area who do not have transportation, (2) the unknown nature of the product(s) involved, (3) the size of the explosion of material still unknown, (4) whether the integrity of other vessels

were a concern, and (5) whether any other products, including MIC, was at risk due to the impact of the explosion. I would have been remiss not to have grave concern if this group had been treated differently than a more affluent area of the county.

At 5:50 A.M. on August 29, 2008, the Bayer security guard called Metro 911 to report an "all clear" for the facility with the exception of the Larvin unit which was still under watch. Throughout this entire incident, I found it difficult to believe our primary point of contact with Bayer was a security guard at the front gate. Furthermore, the reluctance by Bayer to provide information was totally unacceptable. One should ask were the West Virginia State University students, as well as, area residents treated differently than those who live in more affluent areas. Simply put, lives were at risk, and information was withheld!

POST SCRIPT

What have we learned from this event? Critical information needs to be shared and shared immediately. To address this concern, I had emergency officials implement a protocol providing steps should a chemical plant fail to provide within 15 minutes to the Ned Chilton Metro 911 Center all required information during an emergency, including the effect on the public, the EOC will immediately call for a shelter-in-place in the affected area. I even had clocks placed in the 911 Call Center and EOC to track the time elapsed during such an event.

Furthermore, with the leadership of Governor Joe Manchin III, the State of West Virginia Legislature just passed legislation that provides for reporting requirements for industrial accidents. This legislation creates two timeframes:

1. Timeframe Number 1: within 15 minutes of the industrial facility ascertaining the occurrence of an emergency event at an industrial facility, the industrial facility shall contact the Mine and Industrial Accident Emergency Operations Center by telephone OR shall contact a local emergency telephone system (Metro 911).
2. Timeframe Number 2: starts AFTER the Mine and Industrial Accident Emergency Operations Center or a local emergency telephone system (Metro 911) has been contacted. Within 30 minutes of obtaining information that affects the public health, safety and welfare, state AND local officials shall notify the public of any hazardous materials or events that may affect the area.

This legislation also stipulates another reporting requirement for the local emergency telephone system (Metro 911): In the event that an industrial facility contacts a local emergency telephone system (Metro 911) to report an emergency event, the local emergency telephone system (Metro 911) shall immediately forward all information received to the Mine and Industrial Accident Emergency Operations Center.

Ironically, the Chemical Safety Board has a public hearing scheduled to be held at West Virginia State University just two day from now on Thursday, April 23, 2009. Much to my dismay, it is my understanding Bayer intends to hide behind Homeland Security legislation and wants to prevent testimony and the sharing of information at the Chemical Safety Board's public hearing. I truly do not believe it was the intent of Congress to allow for chemical plants to use Homeland Security legislation as a smokescreen to prevent providing the public information regarding their safety and well being. If this is the case, I would respectfully request this Congress to change the law to provide for the access to information vital to the public's safety and well being. Emergency responders and the community in general do not know the total extent of the dangers area chemical plants pose. Citizens have every right to know. Bayer CropScience needs to be forthcoming with total cooperation at the upcoming Chemical Safety Board public hearing.

Once again, thank you for inviting me to testify before this Committee. Respectfully submitted:

W. Kent Carper
President, Kanawha County Commission
President, Metro 911 of Kanawha County

Name:	W. Kent Carper
Residence:	Charleston, West Virginia, Kanawha County
Information about family:	Married to the former Debbie Mitchell of Charleston, Kanawha County, West Virginia; 3 children: Traci; Bryan; and Virginia; 4 grandsons: William, Andrew, Michael, and Carson
Educational background:	Stonewall Jackson, 1970; Honor Graduate West Virginia State College, 1975. Law Graduate Ohio Northern University, 1978.
Occupational History:	Present: County Commissioner, President, County of Kanawha; Attorney at Law. Former: Administrative Assistant Legal Division State of West Virginia Department of Highways; State of West Virginia Deputy Securities Commissioner; Kanawha County Assistant Prosecutor; Public Safety Director/Police Chief, City of Charleston, West Virginia.
Prior/Current Public Office(s):	State of West Virginia Deputy Securities Commissioner; Assistant Kanawha County Prosecutor; Police Chief/Public Safety Director, City of Charleston, West Virginia; Member of the Kanawha County Emergency Ambulance Authority Board of Directors and Executive Committee for 19 years; President, Ned Chilton Metro 911 Board of Directors for 10 years.

INCIDENT TIMELINE

Bayer CropScience Explosion/Fire
28 August 2008

2233	First notification to Metro 911 from a deputy in St. Albans reporting a loud explosion, unknown location.
2234	Radio report from an off-duty trooper, reporting an explosion and flames showing in the Jefferson area.
2234	STA 19 dispatched to the area of 6318 MacCorkle Ave to investigate. This is roughly across the river from the incident.
2235	First 911 call. This is from a citizen reporting explosion and fire in the area of the plant. Metro 911 starts receiving multiple 911 calls reporting the same.
2236	Dale Petry orders activation of the EOC
2237	STA 24 units confirming explosion and fire in the area of the plant. Metro dispatches STA 23/24
2239	Metro on-duty supervisor makes phone contact with 'Steve', the guard at the main gate, who says he can't give out any information.
2240	Fire dispatcher tells Chief 24 that Metro is unable to contact the plant.
2242	Sheriff's Department is beginning to close roads in the area of the plant, requests assistance from neighboring police departments. Rt 25 and I-64 are eventually closed.
2242	Call from Steve at the plant requesting an ambulance at the main gate for a burn patient. Caller refuses to give further information when probed by the calltaker.
2243	(Discussions occuring on various radio frequencies about a haze or cloud around the plant and in the St. Albans area. St. Albans fire considers a shelter-in-place for their community.)
2253	COMMAND radios Metro and requests Petry to respond to the scene and also requests KC1. KC1 is eventually told by COMMAND to report to the front gate but moves back to Shawnee Park after a few minutes on advice from the EOC (hazard unknown).
2246	CF 24 on scene as COMMAND
2300	Sheriff tells Metro that a deputy has made contact with an off-duty plant employee who reports that he has information that an incident has occurred in the Larvin unit and that the situation is serious. No further information.
2301	Metro contacts Chief 24 (COMMAND) to ask about the substance involved and the need for a shelter-in-place order. COMMAND advises he is trying to get information at the scene.
2308	Metro contacts Chief 24 again to ask about issuing a shelter-in-place. Metro is told "negative".
2315	Steve calls again from Bayer and says that a supervisor has told him to advise Metro that there is an emergency at the plant and to "alert the public". He will not provide further information except that the supervisor's name is Mike Cox. Specifically, he is asked to confirm that the emergency involves the Larvin unit. Steve replies that he is only allowed to advise that their is an emergency in the plant.
2320	State Fire Marshall radios Metro to explain that he can't get any information from his location on the scene as to what the incident involves. Wants to know what Metro has learned. Also advises that he is placing a Regional Response Unit on standby.
2334	Steve called gain from Bayer CropScience calls again to repeat that the plant has an emergency and to "keep the community on the alert". "We are responding to our emergency", he says. Metro's supervisor tells him that a shelter-in-place is being issued for certain areas and that Petry wants someone from the plant to respond to the EOC. Steve tells him Tom Dover's name (as a "spokesperson", but says he doesn't know when Tom will be available to talk.

2342	Metro announces that the Director of Emergency Management has ordered a shelter-in-place for all areas west of the city of Charleston.
0006	Steve calls again from Bayer with the same information as previously related. Also advises that Mike Curry is enroute to the EOC.
0035	COMMAND on the radio advises still a working fire, unknown what chemicals are involved.
0040	Steve calls again with the same information as previously related. No further information.
0112	Steve calls again from Bayer with the same information as previously related. No further information.
0143	Steve from Bayer with the same information as previously related.
0301	Steve from Bayer calls to say that the situation is now under control but they're "still in an alarm state.
0333	Steve from Bayer calls again to repeat that they are "still under an alarm".
0550	Steve from Bayer calls to report "All Clear" except for the Larvin unit.
0200	Interstate is reopened in both directions. Both railroads may resume normal track operations.
0428	Call cleared... all units in service. EOC opertions secured.

Yellow highlight indicates communication between Bayer and Metro 911

Red highlight indicates communication with Institute Fire Chief

September 11, 2008
Bayer Critique Notes

Dale Petry, Kanawha County Emergency Manager began the meeting by discussing his involvement in the incident of the night of August 28, 2008 at the Bayer CropScience Plant. Mr. Petry went over the timeline of when he was notified, to include his actions regarding requesting Metro 911 to continue to contact the plant and obtain information. Mr. Petry discussed his reasons for issuing the shelter-in-place at 11:19 p.m. and discussed the Emergency Operations Plan and the protocol for issuing the shelter-in-place.

Joe Crawford, Chief of Police, City of St. Albans stated that he had four officers on the Eastern End of the County during the explosion and they started reporting information. They knew there had been an explosion, fire and a release from the plant from what they could see and hear. They immediately started determining which way the plume would be traveling to assess what to do in their city. Chief Crawford's concern was that it took 1 hour from the start of the event for the shelter-in-place to be issued, which created issues for his officers who were trying to direct traffic. Chief Crawford felt that the plant should have immediately notified Metro of the location and content of the explosion so that Law Enforcement and Firefighters could position their response.

Roger Wolfe, Mayor, City of Dunbar, stated that he felt that Metro 911 did a great job and passed on the information to the responders that they had. He was concerned over the chemical that was involved. Dunbar could not get information from the plant. Mayor Wolfe addressed the Bayer Representative and said that he was disappointed that no information was given to Metro from the Plant. Mayor Wolfe stated that the Chief of Police of Dunbar immediately started preparing for an evacuation for the city. He called all fire, police and public works officials out to duty. He requests that if there is another incident that Bayer provide the necessary information to Metro so that the proper responders can do their jobs.

Chief Lilly, Dunbar Fire Department – There was a lack of communication with the plant. Chief Lilly stated he is now aware that the City could send a representative to the County EOC during the emergency. He would like to work out ways to have better communication with the EOC.

Mike Rutherford, Sheriff of Kanawha County – Heard the explosion at his house in St. Albans and immediately went to the Bayer Plant. He requested that the roads by blocked off around the plant and that some roads be shut down. When he arrived at the plant, they were bringing the burn patient out of the gate. There was a haze and smell at the gate. He requested that the command post back off from the gate to Shawnee Park. He spoke with a person inside the plant via cell phone and obtained information that the explosion occurred in the Larvin Unit and that a dangerous Chemical was involved. He had Oakley at the EOC. KC-1 was dispatched. The biggest frustration was that Bayer would not give out any information. He had no complaints with Metro's response.

Lt. Savilla, Nitro Police Department – Extremely please with Metro and their ability to get out the information they had. Biggest concern was lack of information from Bayer. Difficult to get road blocks set up that would keep public and officer's safe due to the lack of communication from Bayer. EOC did as well as they could with the information they were receiving. State Police and Putnam County Sheriff's Department assisted with road blocks.

Ernie Hedrick, Chief of Nitro Fire Department – Were not requested to respond to plant by EOC or Chief 24. Response requested by State Fire Marshal as part of RRT. Had 6 responders with air monitoring devices. Plume was over Nitro. Need to find ways to get information out to the responders.

Andre Higginbotham, Chief of Institute Volunteer Fire Department – Chief 24 – At home when explosion occurred. Put VFD on standby. Set up staging area at entrance and could see fire. Established that no dangerous chemicals were compromised. "I was not in charge of the incident. I was in charge of the resources." Spoke with Chief Johnson at the EOC. Established nothing major was compromised, and there was not threat to the community.

Chief Joe Crawford – There was a secondary explosion that was heard by his officer's. Could see a release from the plant. Was never notified that there were no dangerous chemicals.

Chief Higginbotham – Was at the plant and there was no odor and the air monitoring was clear.

Mike Dorsey, DEP – Would have liked to have had information as to what was being released and what the public was being exposed to. The plant could have notified that certain chemicals were potentially involved and that air monitors showed all clear. Bayer did not brief DEP until 1:15 a.m. There were 3 command centers located at Shawnee, inside the plant and at the main gate of the plant.

Steve Parson, St. Albans Fire Chief – Metro did a good job. No excuse for Bayer not giving out information. Should have at least notified as to the location of the explosion inside the plant. Chief Parson's notified all other emergency responders and worked with other areas. Could not make a decision about a shelter-in-place without information from Bayer. Didn't call Shelter-in-place because Chief 24 said there was no need to do so. In the future, he will issue a shelter-in-place in his town within 10 minutes if he does not have information. When the shelter-in-place was released by the EOC, no one called St. Albans to first determine if the plant was clear. Would like better communication with the EOC before lifting the shelter-in-place.

Dale Petry – explained that the plant notified him that they wanted the shelter-in-place lifted and the roads opened.

Keith Vititoe, Sheriff's Department – Got to the scene and tried to get as close to the problem as possible. Was denied access to the Plant EOC by plant officials until Dale Petry contacted the plant. He, David Armstrong, Deputy Emergency Manager and Sterling Lewis, Fire Marshal were shuffled into a separate room and were not given information. There was a major lack of communication. He kept in contact with the local incident commander and David Armstrong kept in contact with County EOC. Work on sharing information with all command sites. There were air monitors in the plant.

John Smoot, KCEAA – Transporting patients affected by chemical exposure – the paramedics need to know what is involved for decontamination purposes. At one time they were told that there was possible 4 chemicals involved; 1-End Product and 3-used for production. Different products affect different systems. Need to know what the chemical is to properly treat the patient.

Rod Johnson, KCEAA – IC for EMS – Metro did an excellent job. Original call – Explosion but could not confirm where. Sent one unit initially and the others were in staging and standby. Patient that was transported did not get deconed on scene, he was deconed at the hospital. Command was located at Shawnee Park. Timeframe of delay for being told the name of chemical made it difficult to treat. Major problem was the delay in shelter-in-place.

Chuck Runyon, DOT – Metro good job. He was at the Shawnee Command Post. There were cars on the interstate that needed to be re-routed. Had 9 portable message boards dispatched. 30 minutes into situation all traffic was rerouted. Cars were off the interstate relatively fast. Lack of information from Bayer was the biggest problem. Unified command system.

Carolyn Charnock, Director of Metro 911 – Telecommunicators did a great job. Information that we had was sent out to the responders. 2800 calls within 4 hours, which were 6 calls per second. All staff was called out. Increase capacity on calls.

CW Sigman, CAMC Hospital – Too many command posts. Hospitals need to know who and what is being transported.

Chief Crawford – Request that Charnock find out if there were any missed calls.

Sheriff Rutherford – Moved to Shawnee Park because he did not want to put his people in harms way.

CW Sigman – You did what you could with the information that you had

Sheriff Rutherford – Lack of information from Bayer resulted in moving responders elsewhere. The right information must be given out.

Chief 24 – Higgonbotham – Traffic stopped at the gate of the plant. Outside agencies flooded the gate.

Mayor Wolfe – Thanked the Bayer official for attending. Stated that the response needs to be more unified.

Jim Woods, Fire Chief for City of South Charleston – Incident that impacts the City or could impact the City, there needs to be SOP's for the EOC to notify the cities. Commend news media for getting out information to the public. Need some kind of procedure for notifying the cities.

Alan Resnick, National Weather Service – Model running regarding wind direction. Someone form the NWS can be called out and available within 5 minutes. There is a person who is trained to work onsite. Bayer's information can be loaded into the wind information.

Sterling Lewis, State Fire Marshal – Was at the command post at Shawnee. Metro opened roads before it was discussed with the command post.

Chief Crawford – Never was notified that the shelter-in-place had been lifted. Should have notified all agencies.

Lt. Savilla – There needs to be unified command and decisions made at the command post.

Jimmy Gianato, State Emergency Manager – Inaccurate and lack of information from Bayer was the biggest problem. The state makes sure that the local's have the resources they need to respond. The Governor is going to introduce legislation to have industry reporting requirement of 15 minutes.

Tom Dover, Bayer Representative – Fully support and depend on Metro for response. Will work on ways to improve the information flow. Bayer's priorities are to protect employees and public; protect the environment; and protect assets in that order. Stated that he thought that their Incident Commander communicated to metro that there was a standby to be issued and that they may need outside resources and that there was no need for a shelter-in-place. Commended Chief 24.

Jessie Johnson, Citizen – In the area of the explosion on 8/28. Management of issue was extraordinary. The media coverage was good. Higginbotham was described as IC outside of fence – "Is he an employee of the Bayer Plant?" It is an impropriety to have him as an employee and Incident Commander. It is

unacceptable for Bayer to not share information. Internal fire department of the plant is not on the same frequency that is accessible to outside responders and is not recorded.

Bob Aaron, Reporter – Was there a PIO at the Command Post? Would have been better to say we have no information than to not say anything at all.

Delegate Bonnie Brown – Could not get through to the EOC number that was on the TV

Anita Ray, Kanawha Charleston Health Department – Citizens are now calling concerning their gardens and contamination. Would like to have information as to how to respond.

Gretchen Stone, State Journal – Will there be an after action report?

KPEPC – Will review plan and do a GAP Analysis on October 2nd.

Earl Whittington, Chief of Dunbar Police – Who is the responsible part for getting the information out?

Higginbotham – stated that he communicated with Chief Johnson every 15 minutes

KPEPC plan has several methods for notifying the public. The IC is to appoint a PIO to communicate with the media

What channels does the EAS go out on?

Aaron Jones, Resident – Is Bayer going to step up to the plate and change their notification and communications?

Bayer – Work with emergency responders to do better communications. Guard station is always manned 100% of the time and that is why Guard makes calls. Will work with Metro for better communications.

Chief Hedrick – Information to the EOC came from on scene responders instead of Bayer officials.

Asked to Bayer – Are you open to having your radio traffic open to Metro? Bayer responded – We can talk about that.

KPEPC Radios are already onsite. Dale work with Bayer for radio frequency.

Higginbotham – Established contact with inside perimeter commander

PJ Johnson, County Fire Coordinator – Called Chief 24 and reached him 30-40 minutes after incident. Only advised to not to do a shelter-in-place. Did not get information from Chief 24 regarding the chemicals or tanks.

KANAWHA COUNTY COMMISSION

OFFICE OF EMERGENCY MANAGEMENT

Dale A. Petry
Director

200 PEYTON WAY
CHARLESTON, WV 25309

Office: (304) 746-8759

AFTER ACTION REPORT

Explosion and Fire Incident
Bayer CropScience/Institute Site

28 AUGUST 2008

Executive Summary

During the nighttime hours of August 28, 2008, Metro 911 of Kanawha County (Metro) began to receive radio and telephone reports of an explosion in the area of Jefferson, Kanawha County. Subsequent investigation revealed a large presence of fire coming from the Bayer CropScience Insitutute Site (Bayer). Upon notification, I immediately ordered activation of the Kanawha County Emergency Operations Center. Institute Volunteer Fire Department was dispatched to the main gate. Law enforcement self-dispatched to the area. Upon arrival, the fire department ordered two other departments to standby status and requested the county mobile command post.

This incident presented unique response issues because no call was received from the Bayer plant to report either an explosion or fire. Metro personnel who called the plant to get information were sandbagged for hours. Therefore, emergency management staff didn't have the proper information to implement public warning measures. First responders did not know what measures, if any, needed to be undertaken to protect themselves and traffic nearby. Metro received over 2,700 calls on 911 lines in the three hours following the explosion. A reverse-911 message to inform the public was hampered by the congested telephone network.

The event also presented some unworkable command and contol issues. Though the responding fire department commander declared himself as "Command" to Metro, he was sequestered in the guard shack at the main gate. The actual incident commander was part of the plant's internal emergency response team and had no contact with Metro or the EOC. This scenario resulted in confusion surrounding the location of the incident command post and the role of the person who called himself "command".

All of these facts—and more—we're brought to the table during an After Action Review held in September 2008.

Scenario

During routine maintenance in the Larvin® pesticide unit, a chemical reaction created a large explosion and fire within the unit. One worker was apparently killed instantly and another was transported to the burn unit in Pittsburgh where he died some three weeks later. The explosion was significant to be noticed as far away as downtown Charleston and instantly attracted widespread public attention.

Details from Metro's computer dispatch report are enclosed as Attachment 'A'. The first notification to Metro was from a deputy sheriff who radioed in. Almost simultaneously, the first 911 calls were received with non-specific information as to the location of the incident. Attachment 'A' will show that the first 911 call from the Bayer plant was a request for an ambulance for a burn patient.

Lessons Learned

An after action review included members of emergency management, Metro 911, fire, ems, law enforcement, Bayer CropScience, the media, members of the public and the LEPC was held_____. Some recommendations from this meeting along with the LEPC's PIE committee recommendations have resulted in modifications and additions to the Kanawha Emergency Management Plan that are currently in draft form. Those changes are included herein as Attachment 'B' and Attachment 'C'.

Chief among the findings was the need for further Plan-based training focusing on command and control protocol and unified command. Of course, funding remains an obstacle to significant and meaningful training. Further recommendations include:

- a protocol for area command and control
- guidelines that direct the Director of Emergency Management to issue a shelter-in-place when an potential Haz-Mat emergency exists but has not been reported to 911.
- Increased detail for Incident Command and Unified Command guidelines
- Stricter guidelines for fixed industrial facilities involving emergency notification and providing situational awareness to local government and public safety personnel.

Respectfully submitted,

Dale Petry

Mr. STUPAK. Mr. Crawford, your testimony, please, sir.

TESTIMONY OF JOSEPH CRAWFORD

Chief CRAWFORD. Thank you, Mr. Chairman. First of all I would like to thank you very much and brag on your staff. I thought my dealings with them was probably the best I've experienced in my life, in my career in law enforcement. Hats off to your staff, they did an excellent job.

First I want to take this opportunity to thank you, Mr. Chairman, and distinguished members of this committee for allowing me to speak today. My motivation is to provide this committee with the perspective of a responder responsible for the safety of our community, as well as the safety of my officers.

It is my hope and intention that this hearing today will help you understand what happened on the night of August 28th, 2008. I want to give members of the committee the most accurate information, from a responder's perspective, that will help this committee draft legislation and implement changes to make the necessary changes to ensure that the citizens of Kanawha County and the first responders' safety are not compromised. I believe this can be done—this can be accomplished by all of us working together.

The city of St. Albans is southwest and within line of sight of Bayer CropScience Plant. The city of St. Albans is near the western border of Kanawha County. Kanawha River separates the plant and the town. The population of the city of St. Albans is approximately 11- to 12,000 people. U.S. Route 60 is the main highway through town and has a high volume of traffic.

I had three officers on scene, of an unrelated call on the east end of the city, when they heard and observed the fire and explosion. My supervisor radioed to METRO911 Kanawha County Dispatch Center and advised them of the explosion at 10:33 p.m. The officers had direct line of sight to the plant, being almost directly across the river from the explosion.

I was at my residence. It was approximately 2 miles direct line of sight from the plant. The percussion shook my house and rattled pictures on the walls. I contacted my on-duty shift commander by phone and he confirmed that he and two other officers witnessed the explosion and fire at the plant.

Within minutes, I was receiving phone calls from local news media. I and Chief Steve Parsons, the St. Albans Fire Department Chief, responded to the east end of the city and met with my shift commander within 10 minutes of the explosion. It was obvious that there was a large fire in the direction of the plant. We started assessing the situation and wind conditions. We noticed a large plume moving west towards the city of St. Albans and Nitro City, just across from us. Chief Parsons and I were in constant contact with METRO911, trying to learn the gravity of the situation, but were informed that METRO911 was unable to get any information from the plant. Chief Parsons and I had a discussion about ordering a shelter-in-place for the St. Albans-based, and based on our assessment and direction of the plume.

We were waiting on more up-to-date information from the incident commander, which came an hour later. The incident commander advised he did not think a shelter-in-place should be or-

dered for the surrounding areas from his position. Hindsight, if the same situation happened again, we would have ordered a shelter-in-place immediately.

I was also in contact with my colleagues from other law enforcement agencies, because no one knew the substance that was being released from the plant. Area law enforcement officials were making decisions to close highways in the area of the plant to protect the public. I ordered to call all our off-duty officers to assist.

A traffic diversion plan from our emergency response plan was used. Chief Parsons and I activated our Forward Operation Center there in the city at approximately 11:15 p.m., which is about 45 minutes after the initial call.

We still weren't able to obtain information from the Bayer CropScience Plant as to the chemicals that were involved. Forty-five minutes into the event we still did not have any information from the plant. However, we received information that the incident commander on scene was advising that a shelter-in-place order was not needed. The only information about what was involved came from outside sources, that it may be the Larvin Unit. At this time, there were low-lying, hazy clouds over the city.

At 11:18 p.m. we heard a secondary explosion. At 11:21 we received unofficial information that an explosion had occurred in the Larvin and Pesticide Unit. I had a growing concern about our officers being out in that environment and directing traffic for an extended period of time. My colleagues also had the same concern for their officers as well.

At 11:42 p.m., Kanawha County Emergency Management Director Dale Petry issued a shelter-in-place due to lack of information coming from the plant. It is common knowledge that MIC is stored and used at the plant on a daily basis. It is very frustrating not having any information about what was being released and trying to make decisions to protect our officers and citizens.

I was advised at 11:20 p.m. representatives from the County were staged at the main gate of the plant waiting to gain access. I also was advised later that representatives from the Kanawha County Sheriff's Department, County OES, and West Virginia Fire Marshals Office had made numerous attempts to gain access to the BayerCrop Plant. This was being done to help coordinate efforts outside the plant.

Finally, after 30 to 40 minutes, BayerCrop allowed those representatives inside the plant and escorted them to the EOC. They were placed and sequestered, in a separate room connected to the plant EOC, but still had problems getting information to relay back to the County EOC. At 035 hours, 12:35 a.m., Chief 24, the incident commander, radioed METRO911 advising that he still does not know what chemicals are involved.

At approximately 1:15 a.m., there were discussions about evacuation. We were advised that the fire was still burning and it could be out of control, it could not be contained. At 2:09 a.m., we were advised that the shelter-in-place had been lifted, the roadways were reopened. At 2:30 a.m., the St. Albans Police and Fire Department units were released and the Forward Operations Center was closed.

In closing, Mr. Chairman, I would like to make a comment to some key problems we faced that night and steps taken to correct them.

First, the most important issue was the lack of communication and cooperation from the Bayer CropScience plant. The record will reflect on numerous occasions that the security guard at the gate was directed not to give out any information to the 911 center. Then once inside the plant, the officials were not given much information so that they could be relayed back to the county EOC. State legislation has been passed to address the notification process, where a chemical facility must notify the 911 center within 15 minutes.

Bayer has purchased radios to be placed with the security supervisor in their emergency vehicles and operations center. Bayer will have the capability to use the county OES channel and communicate information directly to the 911 center.

The second issue is there was a breakdown in communication between the incident commander and the county EOC. Information was relayed to the incident commander about the impact that the plume had on the surrounding areas, such as St. Albans, Nitro, Institute and Jefferson, and it was ignored. This was an issue about sheltering in place for us.

The incident commander was not able to see the impact outside of the plant. As a city official responsible for the safety and welfare of our citizens and my responding officers, it made it very difficult to make operational decisions. Records will support that the incident commander, Chief 24, was made aware of the conditions in the surrounding areas. This issue will be resolved in the future by ordering a shelter in place if we have not received information from the Bayer CropScience plant within 15 minutes.

The third issue discussed in the critique and after-action reviews were conversations about placing monitors outside of the plant and surrounding areas. Bayer has monitors along the fence line property on the river side of the plant. The discussions also included the capability of the monitors being able to send information back to the county EOC, mobile commander center, and other locations. This would allow command personnel to make better operational decisions to the units out in the field. Bayer officials indicated that would be a good idea, and indicated that Bayer may be able to assist with some funding for that project.

And the last issue is the security of the plant. From a law enforcement perspective, I believe that Bayer needs to make their facility more secure. The reason for this concern is that Bayer could be a potential target for terrorism. When you have an event such as this, the first thing that crossed my mind: Is this an accident or an attack? Due to the nature of the hazards stored and manufactured at the site, one cannot overlook that as a possibility.

Just my observations from outside of the plant, there are no barricades at the main entrance of the plant. What would prevent a vehicle from running the gate at the guard shack? Another concern is access from the river to the plant. There is a fence, but bolt cutters or a saw could give access, and it would go virtually undetected.

Thank you, Mr. Chairman.

Mr. STUPAK. Thank you, Mr. Crawford.
[The prepared statement of Chief Crawford follows:]

Joe Crawford
Chief of Police

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TESTIMONY OF:	Chief Joseph Crawford St. Albans Police Department
DATE:	Tuesday April 21, 2009 12:00pm
BEFORE:	The Committee on Energy and Commerce Subcommittee on Oversight and Investigations
REGARDING:	The investigation of the fire and explosion at the Bayer Crop Science Plant in Institute WV on August 28, 2008.

1. First I want to take this opportunity to thank you Mr. Chairman and the distinguished members of this committee for allowing me to speak here today. My motivation is to provide this Committee with the perspective of a responder, responsible for the safety of the citizens of our community as well as the safety of my officers. It is my hope and intention that this hearing today will help you understand what happened on the night of August 28, 2008. I want to give the members of this committee the most accurate information from a responder's perspective that will help this committee draft legislation and implement changes that need to be made. It is my sincere hope that the Chemical Industry will also make the necessary changes; to ensure that the citizens of Kanawha County and the first responder's safety are not compromised. I believe that this can be accomplished by all of us working together.

2. The City of St. Albans, West Virginia is southwest – and within sight – of the Bayer CropScience Institute Plant. The City of St. Albans is near the western border of Kanawha County. The Kanawha River separates the Plant and the town.

The population of the City of St. Albans is approximately 11,000 to 12,000 people. US Rt. 60 is the main highway thru town and has a high volume of traffic.

3. I had three officers on the scene of an unrelated call in the east end of the city when they heard and observed the fire and explosion. My supervisor radioed to METRO 911, Kanawha County's consolidated dispatch center, and advised them of the explosion at 10:33pm. The officers had direct line of sight to the Plant, being almost directly across the river from the explosion. I was at my residence, which is approximately two miles direct line of sight to the plant. The percussion shook my house and rattled pictures from the wall. I contacted my on-duty shift commander by phone and he confirmed that he and two other officers had witnessed the explosion and fire. Within minutes I was receiving phone calls from the local news media.

4. I and Chief Steve Parsons from St. Albans Fire Department responded to the east end of the City and met with my shift commander within ten minutes of the explosion. It was obvious that there was a large fire in the direction of the plant. We started assessing the situation and the wind conditions. We noticed a large plume moving west towards the Cities of St. Albans & Nitro, a city just across the river from us. Chief Parsons and I were in constant contact with METRO 911 trying to learn the gravity of the situation but were informed that Metro 911 was unable to get any information from the plant. Chief Parsons and I had discussions about ordering a shelter-in-place for St. Albans based on our assessment of the direction of the plume. We were waiting on more up-to-date information from the incident commander, which came an hour later. The incident commander advised that he did not think that a shelter-in-place should be ordered for the surrounding areas from his position. Hind-site if the same situation happened again, we would have sheltered in place immediately.

5. I also was in contact with my colleagues from the other law enforcement agencies. Because no one knew what substance was being released from the plant, area law enforcement officials were making decisions to close highways in the area of the plant to protect the public. I ordered the callout of off-duty St. Albans officers to assist. The traffic diversion plan from the Emergency Response Plan was used. Chief Parsons and I activated our Forward Operations Center at City Hall at approximately 11:15pm. We still were unable to obtain information from the Bayer CropScience Plant as to what chemicals were involved. Forty Five minutes into this event and we still did not have any information from the plant. However, we received information that the Incident Commander on the scene was advising that a shelter-in-place order was not needed. The only information about what was involved came from outside sources that it may be the Larvin Unit. At this time there were low lying hazy clouds over the city.

6. At 11:18pm we heard a secondary explosion. At 11:21pm we received unofficial information that an explosion had occurred in the Larvin pesticide unit. I had a growing concern about our officers being out in that environment directing traffic for an extended period of time. My colleagues also had the same concern for their officers. At 11:42pm, Kanawha County Emergency Management Director Dale Petry issued a shelter-in-place order due to the lack of information coming from the plant. It is common knowledge that MIC is stored and used at that plant on a daily basis. It was very frustrating not having any information about what was being released and trying to make decisions to protect our officers and citizens.

7. I was advised that at 11:20pm, representatives from the County staged at the main gate of the plant waiting to gain access to. I was advised later that representatives from Kanawha County Sheriff's Office, County OES, and the WV State Fire Marshall's Office had made numerous attempts to gain access to the Bayer Crop Plants EOC but were denied. This was being done to help coordinate efforts outside of the plant. Finally after 30 to 40 minutes Bayer Crop allowed those representatives inside the plant and escorted to the EOC. They were placed and

sequestered in a separate room connected to the plant EOC but still had problems getting information to relay back to the County EOC. At 00:35hrs Chief 24 (Incident Commander) radioed METRO 911 advising that he still does not know what chemicals are involved.

8. At approximately 01:15am there were discussions about evacuation. We were advised that the fire was still burning and that it could not be contained.

9. At 02:09am we were advised that the Shelter-in-place had been lifted and the roadways were reopened. At 02:30am the St. Albans Police & Fire Department units were released and the Forward Operations Center was closed.

In closing I would like to comment on some of the KEY problems that we faced that night, and some steps that have been taken to correct them:

- The most important issue was the lack of cooperation and communication from Bayer Crop Science. The record will reflect on numerous occasions that the security guard at the gate was directed not to give out any information to the 911 Center. Then once inside the plant, the officials were not given much information so that it could be relayed back to the County EOC. State legislation has been passed to address the notification process, where a chemical facility must notify the 911 Center of an event within fifteen minutes. Bayer has purchased radio's to be placed with the security supervisor, in their emergency vehicles and operations center. Bayer will have the capability to use the County OES channel and communicate information directly to the 911 center.
- The second issue is that there was a breakdown in communication between the incident commander and the County EOC. Information was relayed to the incident commander about the impact that the plume had on the surrounding areas such as St. Albans, Nitro, Institute, and Jefferson and it was ignored. This was an issue about sheltering-in-place. The

incident commander was not able to see the impact outside of the plant. As a City official and responsible for the safety and welfare of the citizens and my responding officers, it made it very difficult to make operational decisions. Records will support that the incident commander (Chief 24) was made aware of the conditions in the surrounding areas. This issue will be resolved in the future by ordering a shelter-in-place if we have not received information from the plant within 15 minutes.

- The third issue discussed in the Critique and the after action reviews, were conversations about placing monitors outside of the plant in the surrounding areas. Bayer has monitors along their fence line property on the river side of the plant. The discussion also included the capability of the monitors being able to send the information back to the County EOC, Mobile Command Center and other locations. This would allow Command personnel to make better operational decisions to the units out in the field. Bayer officials indicated that would be a good idea and indicated that Bayer may be able to assist with some funding for that project.
- And the last issue is the security of the plant. From a law enforcement perspective, I believe that Bayer needs to make their facility more secure. The reason for this concern is that Bayer could be a potential target for terrorism. When you have an event such as this, the first thing that crosses your mind, is this an accident or an attack? Due to the nature of the hazards stored and manufactured at that site, one **cannot** overlook that as a possibility. Just my observations from outside of the plant, there are no barricades at the main entrance of the plant. What would prevent a vehicle from running the gate at the guard shack? Another concern is the access from the river to the plant. There is a fence, but bolt cutters or a saw could give access to the plant property and go un-noticed.

Respectfully submitted,

Chief Joseph Crawford

Mr. STUPAK. Ms. Nixon, your opening statement, please.

TESTIMONY OF PAMELA NIXON

Ms. NIXON. Thank you, Mr. Chairman.

I am Pam Nixon. I am the environmental advocate with the West Virginia Department of Environmental Protection. My role with the community is to be their ombudsman. I am not a lawyer, and I do not work in that capacity.

On the night of August 28, 2008, while visiting friends in the east end of Charleston, over 10 miles away from the Institute facility, around 10:30 we felt and heard a loud rumble. A statement was made, "At least it didn't break the windows."

When I arrived home around 11 p.m., it was being reported there had been a major explosion and fire at the Institute plant; but there was no additional information on actions for the public to take for their safety. It had been 30 minutes. No shelter in place had been called.

I had lived in West Dunbar, less than 1 mile from the plant, between the years of 1979 and 1990. The Institute area includes three small communities and a university; the communities of Institute, Pinewood Park and West Dunbar, and there is the campus of West Virginia State University, an Historically Black University with an enrollment of 5,000 students. Bayer CropScience is located to the west end of Institute near the university, and sits on the north bank of the Kanawha River. Directly across on the south side of the river is the unincorporated town of Jefferson, and to the west of Jefferson are the towns of St. Albans and Nitro.

Due to their close proximity to the plant, all of the communities are no strangers to chemical emergencies. Depending on the velocity and direction of the wind, it would take less than 15 minutes for a plume from the plant to blow across them. Longtime residents know to stay off the phone and listen to the news for safety instructions during chemical emergencies.

But as the minutes began to tick away, my phone began to ring. Before this, I was a grass-roots activist in the Institute area. I could hear the anxiety in their voices, and also the frustration and anger that this was happening again. Some of the callers said they were going to Charleston to stay at a hotel until it was safe to return. Others just wanted additional information since there was no valid information about public safety being reported on the news.

I knew what they were feeling. It is like a wave that engulfs you when you hear an explosion, when you feel your home shake, when you see the smoke and the glow of the fire go up into the sky, not knowing what will happen next and fearing for the safety of your family. When you live that close to a chemical plant, you learn that every minute counts.

As I said earlier, the plant sits along the river floor. There are two roadways also that follow the valley floor, MacCorkle Avenue, which is Route 60, on the south side, and Route 25 on the north side of the river. Also on the north side of the river and on the hill above the plant is I–64, a major interstate highway. In the Kanawha Valley, due to the terrain, you have to plan your path of egress in case of an emergency, whether it is from a chemical emergency or an accident blocking your way.

For decades, the people of Institute were asking valid health and safety questions, even before the 1984 Bhopal tragedy. The very same questions that were asked back then were questions asked by different individuals during the public forums that were held after last year's fire and explosion. Those questions were: Is it safe for our families to live here? What were the chemicals involved in the plume? What are the potential health risks? When will the plant stop producing and storing dangerous chemicals in our neighborhoods? And is it safe to eat the vegetables from our gardens? This is West Virginia, and people have gardens in their backyards.

Back in 1984, there were no community right-to-know laws. The community and the faculty members from the university, at that time it was a college, organized to form the group People Concerned About MIC. With everybody working together, the group was empowered. They hosted meetings for company officials to explain chemical releases when they occurred. They participated in the national discussions to develop the community right-to-know laws. They worked with universities, medical doctors, and Ph.D.s to conduct health surveys, and they worked with technical advisers on toxic use reduction to present to the plant in 1984 a design for the company to use to reduce the risk to the community.

After the right-to-know laws, they utilized this information for crucial information on the chemicals.

Information was finally getting out, but over the past few years, community members have murmured that they were beginning to lose ground in the quality of information that they were receiving when there was an incident. They had been proactive.

When chemical releases occur, residents say information is not in a timely manner. At times it takes weeks, even months, before the company will list the chemical names and provide the health risks to the community. In the past 2 years, there were two notable chemical releases, one on December 28 of 2007, and the other last year on August 28, 2008. During both events, even the emergency responders complained that they were not given enough information from Bayer CropScience to make informed decisions.

After the December 2007 incident, Bayer CropScience vowed at that time to provide emergency services with detailed information during a release. It wasn't until 2 months later, on February 27, 2008, that Bayer officials described the December incident to the Sub-area Community Improvement Council. They were told the chemical was thiodicarb, also known as Larvin, a hazardous material used in insecticides.

After much criticism about the August 28 incident, Bayer apologized and again vowed to provide detailed information on releases. However, on October 26, 2008, the news media informed Kanawha emergency services personnel of an MIC event that had occurred at Bayer around the end of September of 2008. This became such an issue that West Virginia's Governor proposed legislation, which was passed during this year's 2009 legislative session. This law now requires businesses to report industrial incidents to 911 emergency assistance centers within 15 minutes or be fined up to $100,000.

So as you can see, it is no wonder that residents of western Kanawha County, particularly Institute residents, have lost con-

fidence in Bayer CropScience providing early notification on chemical releases that happen at their plant.

Thank you for allowing me to present this information. I am available for questions.

Mr. STUPAK. Thank you for your testimony.

[The prepared statement of Ms. Nixon follows:]

Pamela Nixon
West Virginia Department of Environmental Protection
Environmental Advocate

Congressional Testimony
April 21, 2009

I'd like to thank Chairman Waxman, Subcommittee Chairman Stupak and the committee members for inviting me to testify today on the impact the Institute Bayer CropScience August 28, 2008, fire and explosion has had on the surrounding communities.

I am Pamela Nixon, the Environmental Advocate with the West Virginia Department of Environmental Protection. I've been employed by the WV DEP since November 1998, and serve as the liaison between the Department and the public. In essence I work closely with individuals and communities regarding environmental concerns.

I am not a West Virginia environmental regulator, enforcement officer, or a public relations officer for the department. My role at the WV DEP is to be the ombudsman for community members.

On the night of August 28, 2008, I was visiting friends in the east-end of Charleston, over 10 miles away, when around 10:30 PM we felt and heard a loud rumble. Not knowing the cause, the statement was made, "At least it didn't break the windows." When I arrived home around 11:00 PM it was being reported that there had been a major explosion and fire at the Institute plant, but there was no additional information on actions the public should take for their safety. It had been thirty minutes, why was there no shelter in place called?

You see, I had lived in West Dunbar, less than one mile from the plant, between the years 1979 to 1990. The Institute area includes three small communities – Institute, Pinewood Park and West Dunbar; and it includes the campus of West Virginia State University, a historically Black university with an enrollment of 5,000 students.

Bayer CropScience is located on the west end of Institute, on the north bank of the Kanawha River. Directly across, on the south side the river is the unincorporated town of Jefferson, and to the west of Jefferson is the town of St. Albans. Due to their close proximity to the plant, those communities are not strangers to chemical emergencies. Depending on the velocity of the wind, it would take less than 15 minutes for a plume from the plant to blow across them.

Long-time residents know to stay off the phones and listen to the news for safety instructions during a chemical emergency, but as minutes began to tick by, my phone began to ring. (You see, before I worked with the WV DEP I was a grass-roots clean-air and community safety activist.) I could hear the anxiety in their voices, and also the frustration and anger *that this was happening again*. Some of the callers said they were

going to Charleston to stay at a hotel until it was safe to return. Others called to see if I had additional information, there was no valid safety information being reported.

I knew what they were feeling. It is like a wave that engulfs you when you hear an explosion, feel your home shake, see the smoke and the glow of the fire in the sky, not knowing what will happen next and fearing for the safety of your family. I know what they felt. When you live that close to a chemical plant you learn that every minute counts.

As I stated described earlier, plant sits along the river valley floor, two roadways also follow the valley floor – MacCorkle Avenue on the south side, and Route 25 on the north side of the river. Along the side of the hill is I- 64, and interstate highway. In the Kanawha Valley, West Virginia, due to the terrain you have to plan your path of egress whether it is a chemical emergency or a car accident blocking your way.

For decades people in the Institute area were asking valid health and safety questions. even before the 1984 Bhopal tragedy. The very same questions that were asked in the 80's and 90's, were asked by different individuals during the public forums held after last year's fire and explosion.

Back in 1984, when we saw on TV thousands dead of people in the streets of India, we were appalled and saddened. Then when we heard it was the result of a run-away-chemical reaction at a US run chemical plant, and that the same chemical process was being run near our homes, there was an extreme urgency to have our questions answered.

- Is it safe for our families to live here?
- What were the chemicals involved the plume?
- What are the potential health risks?
- When will the plant stop producing and storing dangerous chemicals in our neighborhoods?
- Is it safe to eat the vegetables in our gardens?

Back in 1984, there weren't any community right-to-know laws. With no forum from which to speak, in 1985 community members and faculty members from the university (but at that time it was a college) organized to form the group People Concerned About MIC. With everyone working together, the group was empowered to:

- Host meetings for company officials to explain why there was a chemical release
- To participate in national discussions to develop community-right-know laws
- Partner with universities, medical doctors and PhDs to develop and conduct a health survey
- Utilize right-to-know laws to access crucial information on Chemicals that impact the communities
- Join the Kanawha Putnam Emergency Planning Committee and participate in the risk management plan roll-outs that were used to enhance the emergency plans
- Participate in the Sub-area Community Improvement Council, sponsored by Bayer Crop-Science and other companies in the Institute chemical complex

Information was finally getting to the community. Some members began to feel they were having meaningful input in the talks with the companies. But over the past few years community members have murmured that they were beginning to loose ground in their ability to get information. When chemical releases occur residents say information is not in a timely manner. At times it takes weeks even months before the company will list the chemical names and provide the health risks.

In the past two years there have been two notable chemical releases in the Institute area that traveled outside the fence-line. One occurred on December 28, 2007, the other was August 28, 2008. During both events emergency responders complained that they were not given enough information from Bayer CropScience to make informed decisions about actions to take to protect the public.

After the December 2007 incident Bayer CropScience vowed to provide emergency services with detailed information during a release. On February 27, 2008, Bayer officials described the December 2007 incident to the Sub-area Community Improvement Council. They were told the chemical was thiodicarb, also known as Larvin, a hazardous material used in insecticides.

After the much criticism about August 2008 incident, Bayer apologized and again vowed to provide detailed information of releases. However, on October 26, 2008, the news media informed Kanawha emergency services personnel of a MIC event that had occurred at Bayer CropScience around the end of September 2008.

This became such an issue that West Virginia's governor proposed an industrial incident legislation which passed into law during this year's 2009 Legislative session. This law now requires businesses to report industrial incidents to 911 emergency centers within 15 minutes or be fined up to $100,000.

So it is no wonder that folks in the Kanawha Valley, particularly Institute residents have lost confidence in Bayer CropScience providing early notification on chemical releases that happen at their plant.

Mr. STUPAK. Mr. Bresland, your preliminary report, if I may summarize quickly, you indicated that where they are using this new vessel, this residue treater, that there is inadequate training on the computer system, there was a heater undersized, and is that where they bypassed the system? So they sort of bypassed the safety system on the heater, and that day we had a temperature rise, and they were getting different readings off the gauges, and that is when they sent the two employees down to check the gauges?

Mr. BRESLAND. Correct.

Mr. STUPAK. And that is when the vessel blew up, if you will?

Mr. BRESLAND. That is correct.

Mr. STUPAK. And at the time the vessel blew up, the video cameras were not working in that area, nor were the air monitors?

Mr. BRESLAND. That is correct.

Mr. STUPAK. In your preliminary report, is it fair to say that methomyl is the release that had come from this explosion?

Mr. BRESLAND. Methomyl was the cause of the explosion. What happened was a concentrated solution of methomyl was fed into the residue treater. Normally it is diluted in the residue treating with a solvent; but in this case it wasn't diluted with a solvent, and eventually it started to overheat, and it became an uncontrollable reaction, and the vessel exploded.

What exactly happened after that we are not sure yet. We are still doing some work on that, because when the vessel explodes, the methomyl has already reacted, and then there was a major fire as well. That is a continuing part of our investigation, to find out just exactly what the outcome was.

But if you look at a material safety data sheet for methomyl, it lists a series of chemicals that can be formed when it decomposes.

Mr. STUPAK. So methomyl was released because the pipes exploded?

Mr. BRESLAND. Yes.

Mr. STUPAK. Any other chemical? We talked about MIC. Any other chemicals that may have been released that night?

Mr. BRESLAND. Well, the chemicals that would have been released would have been the decomposition products from the decomposition of methomyl. I can give you a list of those chemicals.

Mr. STUPAK. In your preliminary report, you have the exposure symptoms from methomyl, correct?

Mr. BRESLAND. That is correct.

Mr. STUPAK. You have on here nervous system disruption, blurred vision, pinpoint pupils, tremors, muscles twitching, nausea, abdominal pain, respiratory arrest, coma, death, liver damage, anemia; is that correct?

Mr. BRESLAND. That is correct.

Mr. STUPAK. So in this fire, some of this methomyl would be burned in the fire, and some would be washed away when fighting the fire into the river, and some might be carried off into the air, correct?

Mr. BRESLAND. That is the issue that we need to address, just how much was carried off into the air because there was a major fire after the explosion.

Mr. STUPAK. And we have no idea of knowing how much?

Mr. BRESLAND. Not at the present time, no.

Mr. STUPAK. There is the methomyl residue. You can see the pipes where it would be released because of the broken pipe and equipment.

Those goggles that I showed in my opening statement, do you have any idea what the chemicals are that are on the goggle?

Mr. BRESLAND. That is the first time I have seen that photograph, so I am not able to answer that question.

Mr. STUPAK. Let me ask, first responders, Chief Crawford, there seems to be a major disconnect between the story you tell about Bayer's failure to provide information to emergency responders and the story that Bayer tells. They say that they shared everything.

You lead the police department of St. Albans, the city directly across the river from the plant. Your officers saw the massive fireball from the explosion and notified Metro 911. As you began coordinating the emergency response for your community, a large, possibly toxic, cloud started drifting towards you, your officers and your citizens. I would like to show you the transcript of the radio calls between St. Albans Fire Department and Metro 911. It is right there in that document book. You can find it in tab number 2, if you want to follow along.

"ST. ALBANS FIRE: We have a cloud of some type that is dark. It is moving toward Nitro. Can you please try to get some information so you can tell us what it is?

"METRO: Copy. Cloud is moving toward Nitro. I will try and figure out something. The command on seat hadn't said anything about the cloud, but we are still trying to get some information on it.

"ST. ALBANS FIRE: You can see the cloud with the fire right above it for 3 to 4 miles.

"METRO: Still trying to figure out something out on it.

"ST. ALBANS FIRE: If we don't hear something within 5 to 6 minutes, we are going to do a shelter in place in the St. Albans area."

Chief Crawford, did you ever receive any information from Bayer about what this cloud was?

Chief CRAWFORD. No.

Mr. STUPAK. So Metro 911 was forced to go ahead and issue an order to shelter in place without knowledge of what was in that cloud?

Chief CRAWFORD. That is correct. We did not receive any information.

Mr. STUPAK. Did you ever receive any information what they believe was the composition of that cloud?

Chief CRAWFORD. No.

Mr. STUPAK. A week after the explosion, Bayer officials issued a statement that said, "We shared all information available with Metro 911 as that information became available." Do you believe that to be an accurate statement?

Chief CRAWFORD. What is a timely fashion? Some believe an hour and a half. An hour is entirely too long.

Mr. STUPAK. Commissioner Carper, you wrote a letter on September 4 to Bayer. It is tab 6 in that book Mr. Crawford has. You said, "Metro repeatedly asked for information and was refused. In fact, no notification from Bayer, including the mention of the

Larvin Unit, until the all clear the next morning. This is a complete abdication of Bayer's responsibility." Is that correct?

Mr. CARPER. That is correct.

Mr. STUPAK. In your testimony today that you provided in advance, Bayer's president and CEO said the company sent an official to Metro 911 center to provide that information, and let me show you what the Bayer president says. Again, it is in the book there.

"We were initially surprised when we received criticism from our Metro 911 counterparts and others in our community regarding our communications relating to the incident. CropScience sent a representative from the Institute facility to Metro 911 site who was in direct communication with our EOC."

Commissioner Carper, did the official Bayer sent to Metro center provide you with all of the information you needed?

Mr. CARPER. No, sir, because he didn't know anything. With all due respect to the response from Bayer, the record reflects that the only reason they sent a representative was because I insisted on it due to their previous failure to give us information. I believe it was in December of the previous year. I believe December 28. That's why they were there.

I believe it was Mr. Curry, and I had a number of conversations with Mr. Curry, a nice person, but he didn't know anything. Just like their security guard Steve at the gate, he didn't know anything. As your Ranking Member says, alert the public about what?

Now, the record is clear, we have them on tape. We don't have to guess what they told us and what they didn't tell us. They didn't tell us anything.

Mr. STUPAK. As commissioner, have you learned what chemicals your community may have been exposed to that night?

Mr. CARPER. No, sir. I have learned more here today. I had to come to Washington, DC, to find this out.

Mr. STUPAK. Mr. Dorsey, let me turn to you. You were at the Bayer site that night; is that correct?

Mr. DORSEY. Correct.

Mr. STUPAK. It is a PowerPoint presentation Bayer officials created 3 days after the incident. You can find it at tab number 5, page 11. The title of the slide is "Positive Points." The first item on the list reads as follows: "Emergency response went very well. No significant complaints from the community and neighbors."

But in your testimony, you said you weren't allowed into the plant until after 3 a.m., and you said you were only allowed in after a confrontation at the front gate, and even then you weren't allowed to go to the scene of the explosion until nearly 5 a.m. in the morning.

Mr. Dorsey, do you agree with Bayer's claim that the emergency response went very well, and there were no significant complaints from the communities or neighbors?

Mr. DORSEY. Absolutely not. You have heard the testimony and have it written before you.

In my personal circumstance, I was at the front gate with the State emergency response director, Jimmy Gianato, and we were attempting to get into the facility. I was talking to my boss, the secretary of the Department of Environmental Protection, and he was speaking with the Governor. The questions were: Exactly how

bad is it? Exactly what was released? All of the questions you have heard.

I went to the front gate and said, look, I need to get in here. And the fellow at the front gate said, I will let you talk to somebody on the phone. I said, I am not leaving until I get into this plant. Mr. Gianato came immediately after that and said, if we don't get in here, there are going to be some State troopers who will show up, and they will start arresting people. So at that point we were allowed into the plant, and as the other people were earlier, we were ushered into a side room away from the main communication center, and Mr. Crosby came in and Mr. Way, and eventually we made our way to the incident site.

Mr. STUPAK. So it was only after threat of arrest that you actually got in?

Mr. DORSEY. Yes, sir.

Mr. STUPAK. Let me ask you this: In the testimony of Bayer's president and CEO, he states that the only real problem with the emergency response that night was you didn't receive immediate reassurances that you were safe. Do you agree that you needed reassurance that night, or did you need actual information about what was going on?

Mr. DORSEY. We needed real information. As someone stated earlier, the plant's fire department did a good job. That was a major incident, and they did well in there. But it is a dangerous plant. There are miles of piping, and there are thousands of tanks. We needed to know what was happening. The Governor himself was on the way. The 28th was the night of the Democratic National Convention. He flew in. At about 5:00 he got there himself. So that was the level of concern that was there that night on the State level, and we weren't getting what we needed.

Mr. STUPAK. Thank you.

Mr. Walden, questions, please.

Mr. WALDEN. Thank you, Mr. Chairman.

Mr. Crawford, I want to get at the issue of who was controlling the flow of the information inside the plant to outside of the plant, and I believe you said the security guard who you talked to or others talked to said, this is all I can say. I can only tell you there is an emergency. That is all I am allowed to say, language such as that.

Who was controlling what the security guard was allowed to say; do we know?

Chief CRAWFORD. I don't know, sir.

Mr. WALDEN. Mr. Carper.

Mr. CARPER. I know now because I have talked to them. They have changed their procedures. They didn't have an on-site manager present. Remember, now, to some extent, to put this in perspective, they have had one heck of a bad explosion. They have had at least one death, and it turns out two deaths, and they are trying to sort through that and assess it. But frankly, Mr. Walden, had I known then what I know right now, I would have ordered an evacuation. I would not have let those people stay in that footprint if I had known a 100-pound piece of shrapnel was flying through the air, and I specifically asked about the MIC tank.

Mr. WALDEN. What were you told?

Mr. CARPER. Listen, we get more information on a car wreck than we got that night. This was the most unreported. We were led to believe everything was OK. Obviously if we had known that, I think any first responder, a trooper, anybody knowing what that plant has, knowing the damage to that vessel, would have ordered—at least prepared an evacuation at the very least. We didn't do that.

Mr. WALDEN. So who was telling all of these people to keep quiet, in effect, and just say, we have an emergency and we are dealing with our emergency?

Mr. CARPER. As I understand it, they had basically two command structures in the plant. You would have to ask them. That is their responsibility. And remember, it is a fixed-asset industrial plant, so we generally rely upon them to tell us what they have and what we are supposed to do. It is not like a train accident or a commercial incident.

Mr. WALDEN. I guess that is what I am getting to. I assume that they have an emergency plan, and I assume they have protocols, and I assume you have worked those out together so when there is an incident, boom, this is what we do. It sounds like there was one in 2007. It sounds like they pledged that any communication problems then had been fixed. And now you get to the big one or near big one, and there isn't the communication that is essential in a situation like this.

Mr. CARPER. I can explain what we did right and what we did wrong. I can explain what we have changed. But, frankly, I think they will have to explain their lack of giving us information.

If their position is they gave our 911 center adequate information to make an intelligent decision, I disagree with that.

Mr. WALDEN. There is breakdown, clearly.

Mr. Bresland, I have been working through your West Virginia accent, and I have been trying to figure out what part of West Virginia that originates from.

I appreciate the work you are doing to try and bring about safer plant operations. I want to touch on a couple of things. First of all, I believe you said there were three safety interlocks that were disabled?

Mr. BRESLAND. That is correct.

Mr. WALDEN. What were those?

Mr. BRESLAND. Those were safety interlocks that controlled the flow of the methomyl solution into the residue treater, and they had been bypassed to allow the temperature to get up to what they considered to be the appropriate temperature for the decomposition of the methomyl to take place under normal circumstances.

However, in this particular case they were pumping very concentrated methomyl into the reactor. Again, the safety interlocks were bypassed, and you filled the tank with a concentrated solution, which resulted in the explosion.

Mr. WALDEN. How long had these interlocks been disabled?

Mr. BRESLAND. It is my understanding that on a routine basis when they were starting up the residue treater, the interlocks would be bypassed until they got the temperature up.

Mr. WALDEN. Is that a standard operating procedure then?

Mr. BRESLAND. No. Safety interlocks are there for a reason.

Mr. WALDEN. I always believed that when I was dealing with transmitter repair.

Mr. BRESLAND. There is no logical reason to bypass the safety interlock. You are putting the facility in danger when you do that.

Mr. WALDEN. Let me ask you this question, because there is a lot of concern among us and, I assume, most people observing this. If you have these projectiles flying around, and you have the MIC tank nearby, and there is this safety screen of some sort that was there, did it take a hit? Did any of those projectiles hit that safety screen?

Mr. BRESLAND. There was a photograph shown early on of the safety screen, and it did show some indentation.

Mr. WALDEN. I didn't know if that was the design or if that was something that happened during the explosion. Do you know the answer to that?

Mr. BRESLAND. What my lead investigator says, that was caused by a sagging of the material.

Mr. WALDEN. Because of heat?

Mr. BRESLAND. Probably just because of its age. It had been there for some time.

Mr. WALDEN. Do you know in your evaluation of that safety screen, would it have withstood the force of those projectiles had it taken a direct hit?

Mr. BRESLAND. Well, we are going to look at a couple of issues. Number one, what were the design criteria for that safety screen? Was it designed to take, or did somebody make an assumption that there could have been a series of explosions and it could be hit by projectiles? What strength was it built to?

Mr. WALDEN. But we don't have an answer to that?

Mr. BRESLAND. We don't. That is part of our continuing investigation.

Mr. WALDEN. I represent a district that has one of the chemical facilities from the Cold War era, and we are in the process of destroying the mustard gas and the nerve agents, and I know there is an array of air sensors all around that facility. Do you believe in your investigation that there are adequate air sensors either at the plant or outside the plant or around the perimeter or further out, wherever a plume might go?

Mr. BRESLAND. Well, with a chemical like methyl isocyanate, I think it is very important that you have air sensors that would specifically measure the concentration of methyl isocyanate and allow both the facility and the emergency responders and the community to know.

Mr. WALDEN. And are there adequate sensors today, from your perspective?

Mr. BRESLAND. I will have to wait and hear what the Bayer people have said about what they have done since the investigation.

We were not able to get any information on the adequacy of the sensors.

Mr. WALDEN. Why?

Mr. BRESLAND. My understanding is that they were not working at the time.

Mr. WALDEN. The air sensors were not working?

Mr. BRESLAND. That is my understanding.

Mr. WALDEN. One final question. Mr. Crawford, in terms of the shelter-in-place system and how that works, is there an audible alarm that goes off in the communities that they need to shelter in place? This was obviously very late at night.

Chief CRAWFORD. According to our plan, you have a ring-down system.

Mr. WALDEN. Ring down, meaning it calls people in their homes?

Chief CRAWFORD. Yes.

Mr. WALDEN. Did that come off correctly?

Chief CRAWFORD. No.

Mr. CARPER. It was a miserable failure.

Mr. WALDEN. Why?

Mr. CARPER. Well, the vendor that sold it to us hadn't scrubbed the system. We did too large of an area. We tried to do it in one time. It just couldn't handle it. We have since changed the vendor.

Mr. WALDEN. Have you run a test of the system since you changed the vendor?

Mr. CARPER. Yes.

Mr. WALDEN. Does it work now?

Mr. CARPER. It is better. It is still not perfect. It is just part of the tools in the toolbox. We have EBS, the media, ring down, outdoor warning sirens. We have got a good system, but you have to know. To hit the button, you have got to be told.

Mr. WALDEN. I understand. I would encourage you to do the test. We ran into the same problems when they were ramping up the same sort of alert systems out in my district for the decommissioning of the chemical plant. They had false alarms that put the signs up on the freeway to flee. It was a little problematic.

Mr. CARPER. We now have what is called a handshake system on our system. Thanks to Congress and Homeland Security money, we actually know when a siren goes off. We do routine tests of all of these things.

But again, we have cable interrupt; but you have to have the television set on.

Mr. WALDEN. That is why the ring down and the audible alarm systems are critical in the middle of the night.

Mr. CARPER. And somewhat limited, but very effective in the Institute area.

Chief CRAWFORD. And under the cable intercept, that was one of the things that was identified in the after-action review and critique.

Mr. WALDEN. Cable intercept, as in the emergency alert system?

Chief CRAWFORD. With the cable company.

Mr. WALDEN. And did the emergency alert system work, both radio, TV and cable?

Chief CRAWFORD. There was a glitch in that, I believe.

Mr. WALDEN. How so? What was the breakdown there?

Mr. CARPER. Well, we have different cable companies. We have some problem with that. We have our EBS, our emergency broadcast, now working pretty well. But remember, they are just part of the way to warn people.

Mr. WALDEN. I understand.

Mr. CARPER. We want them all to work. They should work every time.

Mr. WALDEN. Thank you. My time has expired.

Mr. STUPAK. Ms. Sutton for questions, please.

Ms. SUTTON. Thank you very much, Mr. Chairman, and thank you for your very informative testimony.

On the next panel, we will hear from Bayer CropScience president and CEO William Buckner, but I want to share with you a portion of his prepared testimony and get your reactions to it.

After the August 2008 explosion, the Chemical Safety Board received thousands of pages of documents from Bayer about its plant's operations. In February, more than 4 months after the accident, Bayer informed CSB that many of these documents contain sensitive security information, or SSI, as we have heard here today. And under law, SSI cannot be disclosed to the public.

So let's look at why Bayer took this position, according to the testimony of Mr. Buckner. He admits that his company initially hoped to use SSI to avoid responding to the Chemical Safety Board's request for information about the plant's large stockpile of MIC. When that failed, Bayer tried to invoke SSI to block discussion of the MIC with the general public.

So, Mr. Bresland, in your experience at the CSB, has any other company ever tried to withhold documents from the Board under the guise of homeland security?

Mr. BRESLAND. We have been in operation since around 2001, 2002, and we have completed approximately 55 major investigations. This is the first time that we have been exposed to this issue where someone came in and said, all of the documents that we have submitted to you, you're eligible to receive them and look at them, but you can't tell anybody else about them.

For example, when we look at the list of some of the documents that they told us we couldn't tell, an incident, near miss on environmental release reports, these are basically public documents. Operator training records, I just could not understand how these would be considered security related. To me—and I worked in the chemical industry for 35 years. I ran chemical plants, and I know how they work. I know the difference between security and process safety, and the documents that they were asking to be considered as SSI were not security documents, they were process safety documents, the sort of documents that we on a routine basis get from all of the companies that we investigate. And we routinely get them cooperatively from the companies. Then we use those documents in our reports.

We are having a public meeting in West Virginia on Thursday evening, and we have a PowerPoint presentation that will give a lot of information about what happened at this accident, much more than we have time to present today. There will be no SSI in that. We worked with the Coast Guard, and they took out one item from our PowerPoint presentation. Everything else is what we would normally present.

However, if we have to go and look at 2,000 documents, or in the case of our BP Texas City accident where we got 6 million documents, if we have to look through 20 percent, a million documents, we might as well pack up and go home because there is no way we can do these investigations under these circumstances.

Ms. SUTTON. Mr. Bresland, thank you.

Mr. Buckner in his testimony says, "We frankly admit" that one of his company's goals was to "avoid making the controversial chemical MIC part of the public debate during the incident."

He further acknowledged that there were, of course, some business reasons that also motivated our desire for confidentiality. These included a desire to limit negative publicity generally about the company or the Institute facility to avoid public pressure to reduce the volume of MIC that is produced and stored at Institute by changing to alternative technologies, or even calls by some in our community to eliminate MIC production entirely.

So, Mr. Dorsey, I would shift to you. We have examined the statute and regulations at issue here, and nowhere can we locate a provision allowing a company to conceal information in order to limit negative publicity. That is not a proper basis to label something as SSI, is it?

Mr. DORSEY. Not in my opinion, no. As I touched on briefly in my testimony, there are a number of laws, Federal and State, that require the submission of information on processes, waste streams, et cetera, which could at least potentially be covered under these types of claims. And I think that is not what was intended by the coverage under that type of statute.

Ms. SUTTON. And yet Mr. Buckner acknowledges that public discussions and CSB recommendations about alternative technologies and inventory amounts would be a sensitive matter for the company. And he concludes, "We concede that our pursuit of SSI coverage was motivated in part by a desire to prevent the public debate from occurring in the first place."

If I can shift very quickly, and I know I am running out of time, Ms. Nixon, I know you have been involved with the safety of chemical plants in West Virginia for two decades; is that correct?

Ms. NIXON. Yes, it is.

Ms. SUTTON. Have you ever heard anything like this, the president of Bayer basically admitting in his testimony that his company was abusing this process in order to prevent the public debate about MIC? What do you think about that?

Ms. NIXON. I have never heard anything like that. I do know that 1 month after the incident occurred last year, the community group People Concerned About MIC held a forum in Institute. At that time the company refused to attend their meeting. They waited another month to hold a meeting of their own. Even with that, we still haven't been given the information as to what was in the plume or the health risks that the community may have been exposed to.

Ms. SUTTON. Do you have an opinion about what should happen to a company for doing this?

Ms. NIXON. Many in the community, I can tell you, would like for the company to stop producing the chemical. Some would like the company to close.

I would like the company to be a safe company, to eliminate the production of MIC so close to a university and to communities that are surrounding it. As I said, it takes less than 15 minutes for a plume to engulf the communities of Institute, and across the river to Jefferson and St. Albans.

Ms. SUTTON. Thank you.

Mr. STUPAK. Thank you, Ms. Sutton.

Mr. Burgess, questions.

Mr. BURGESS. Thank you, Mr. Chairman.

Just continuing on that thought, Mr. Carper, you may not be the correct person to ask this, but historically how has this evolved that there is such close proximity with neighborhoods and institutions of higher learning?

Mr. CARPER. Kanawha County and Charleston, West Virginia, at one time was the chemical center of the world. We had over 50,000 to 70,000 chemical jobs from one end of the county to the other. West Virginia is blessed with natural resources. We have got good water. Union Carbide started there, and chemical plants flourished. West Virginia State University at one time was an Historically Black College. It was built there. We didn't think about things in those days. People just kind of got along, and they melded into each other.

Mr. BURGESS. Now, the storage of the methyl isocyanate, is that recent?

Mr. CARPER. No. They have produced that, and you would have to ask them since when, but that has been a multiple-decade activity at that plant. I think it is the only one now existing in the U.S.

Mr. BURGESS. Part of this goes back to what Mr. Walden was asking. Presumably recognizing today that we have got, in juxtaposition to an institution of higher learning and neighborhoods, a chemical that has been shown to be very, very toxic if it is released all of a sudden, what sort of plans—do you and the chemical plant work on disaster drills? Do you have an ongoing dialogue?

Mr. CARPER. They might get an F for this response, but I will give them an A-plus for that. They are very good about that. They are working with us. We have worked quite well with the first responders as far as emergency planning and preparedness. They will tell you, I suspect, that they are in the process of doing a drill in the next couple of months. They are very cooperative on that. That is not a problem.

Mr. BURGESS. Just one last question. This is just for background information, and I don't mean to imply anything by it. How many jobs are at this plant? What is the economic impact to the community?

Mr. CARPER. It is significant. I think in the Larvin Unit, it is 140 or some. It is better for that to come from them.

Listen, these are West Virginia workers. They are good, safe workers with a long history in Kanawha County and West Virginia of producing necessary chemicals safely.

Mr. BURGESS. I appreciate that point. Certainly in our Texas City area where we have a long history of refining, it is a similar environment.

Now, Mr. Bresland, you said you could provide us with a list of the products of decomposition from the fire of the methomyl that was released, and you will do that?

Mr. BRESLAND. Yes, sir. I don't know if we gave you the most up-to-date PowerPoint presentation, but in our presentation on Thursday night, we do list those chemicals. It is in the PowerPoint presentation that I have here.

Mr. BURGESS. That is part of our record? I don't know that I have that. It is not urgent that I have it right now, but I would like to see what the compounds are that we are talking about.

Mr. BRALEY [presiding]. It is slide 37.

Mr. BURGESS. What is next from your perspective? You have a hearing or meeting Thursday night?

Mr. BRESLAND. We have a meeting on Thursday night that is being held at West Virginia State University, and there will be a presentation by our investigators to the community. And we have invited the whole community to attend the meeting, and there will also be a panel discussion when we have some of the emergency responders, some of the people who are here.

Mr. BURGESS. So your intended audience is the community?

Mr. BRESLAND. Yes. The purpose of the meeting is twofold. One is to tell the community here is what we have discovered so far; and also hear from the community what are their concerns or issues with this incident and/or our investigation.

Mr. BURGESS. Looking at this list, I can almost imagine what their concerns would be. These are the by-products of burning methomyl that I am looking at on page 37? Methomyl thermal decomposition, hydrogen cyanide, methyl isocyanate?

Mr. BRESLAND. Yes, I have them here.

Mr. BURGESS. Again, I can imagine what their concerns are going to be.

At this point I don't know that we have established whether the sensitive security information argument is correct or not, but are there going to be issues surrounding sensitive security information that are going to be discussed at your meeting?

Mr. BRESLAND. At our meeting we plan to tell the public here is what happened in the incident. We don't plan on getting into too much of a discussion of SSI, because at least in terms of our PowerPoint presentation, we have reached agreement with the Coast Guard on what is SSI.

Mr. BURGESS. So you have?

Mr. BRESLAND. We sent it to them, and they said there is one issue that we would not like you to disclose, and that was the time of day at which the methyl isocyanate was transferred within the facility.

Mr. BURGESS. OK. Just in general, with having dealt with this problem and the issues about sensitive security information, I'm assuming it has hindered your work so far. Is that an accurate assumption on my part? Do you see it as continuing to hinder your ability to do this investigation going forward?

Mr. BRESLAND. Don't take this the wrong way. It is a less than accurate assumption. It has just about killed us. We have spent a lot of our time dealing in a very cooperative manner with the Coast Guard; but internally within our agency, and we only have 37 people, we are a small agency, the team that has been doing the investigation has been tied up with this. The same team is investigating a major explosion at a sugar refinery in Georgia that killed a number of people. That investigation has basically been put on hold until we resolve this issue. It has really taken up a lot of our time.

I keep getting calls from the news media about this and doing interviews. I don't want to underestimate this at all. It has taken up a lot of our time.

Mr. BURGESS. Going forward is this something that is going to quickly be resolved after today?

Mr. BRESLAND. My fervent hope is after today we will move ahead. What I worry about is when we publish our final report, which is typically 100 to 150 pages long, and it is a technical report with lots of information, we will send that to the Coast Guard, and they will review it also. We will be going back and forth with this issue when we do our final report. I do worry about that.

Mr. BURGESS. As part of your investigation, do you involve yourself at all as to whether or not there is adequate security surrounding the plant? If there is sensitive security information that it is better not get out into the public domain, is there robust enough security around the plant to protect it from the type of damage that we might want to prevent someone from knowing about?

Mr. BRESLAND. As someone who worked in the chemical industry for many years, we are obviously concerned about security, but we don't get involved in evaluating the security at the facility. We don't feel that we are qualified to do that. We leave that to the experts, either Homeland Security or the Coast Guard in this case.

Mr. BURGESS. Thank you.

Mr. BRALEY. The Chair recognizes himself for 5 minutes.

One of the reasons why this is such an important conversation is because it is easy to understand why the citizens of Kanawha County are angry and frustrated. The Washington Post reported on Sunday: "West Virginia chemical plant shut down, fined $2 million over emissions. State and Federal authorities announced Monday that Dupont and Lucite International have agreed to pay $2 million to settle air pollution violations at a West Virginia plant. The violations stem from sulfur dioxide releases from a sulfuric acid unit owned by Lucite, but operated by Dupont at its plant in Kanawha County." This announcement said Lucite voluntarily agreed to close the unit by next April.

Mr. Carper, this gets back to the point you were raising earlier, Ms. Nixon, and that is this takes away jobs. And I assume that this county in West Virginia has a high unemployment rate, like many other counties in this country, and when you are not a responsible corporate citizen, and these plants get shut down, it affects people's livelihoods. That is why I want to follow up on your earlier conversation, Ms. Nixon, about frustration and anger that this was happening again. I want to talk about the history of prior accidents.

The committee's investigation has determined that the August 28 accident was not an isolated incident. The Institute plant has a long history of chemical accidents and failures to provide timely and actionable information to the public and first responders, both during the explosion and after.

On December 28, 2007, just 8 months before, a chemical reaction caused a release at the Larvin Unit. Bayer's own internal documents characterize the event as a "decomposition incident." In plain English, dangerous chemicals escaped.

On August 13, 2001, shortly before Bayer took over, 10 workers received medical treatment from a chloroform leak at the Aventis portion of the Institute plant. In all, there have been as many as 11 chemical accidents at the plant dating back to 1985.

Ms. Nixon, since you have lived through a number of these chemical incidents, have you ever been personally harmed by a chemical incident at the plant?

Ms. NIXON. Yes. On August 11, 1985, there was a release of aldicarb oxime and methylene chloride. There were 135 of us that ended up in emergency rooms. When I say "of us," I was one of them. We ended up in emergency rooms.

Mr. BRALEY. What does this pattern of incidents that I just recited tell us about how confident we should be about Bayer's commitment to being able to prevent another major chemical event at this plant?

Ms. NIXON. There seems to be some sort of inherent process defect in the way that the process goes on, that it continually occurs in this facility, at least in the insecticide part of the plant.

Mr. BRALEY. One of the things that concerns the committee is that the investigation has shown that there is not just a pattern of chemical accidents, there is also a pattern of accidents in which the community has demanded information from the company that was not forthcoming. For example, in a letter from Bayer to the EPA after the December 2007 incident, and this is at tab 27, the company admitted the following: Bayer CropScience is aware that area officials were frustrated with their inability to answer all questions that were being asked. We agree that Institute and Metro 911 can and should communicate more efficiently and quickly. Bayer acknowledged that they could do better, but the August episode has shown they have not lived up to their own promise.

Ms. Nixon, you concluded your testimony by saying that the Institute residents have lost confidence in Bayer CropScience. What role has Bayer's continuing failure to provide adequate information to the community played in that loss of confidence?

Ms. NIXON. As I said, the company is in such close proximity to the community, that whenever there is a release, it is only minutes before it gets into the community. The lack of communication has caused a lot of concern among the community residents on what they have been exposed to from the chemicals that were released.

Mr. BRALEY. Mr. Carper, you used a phrase that is very common to a lot of us, and that is the question of good faith. One of your colleagues, Mr. Dale Petri, who is the director of the Office of Emergency Services for the Kanawha County Commission, told members of the committee staff that it is a matter of building trust every time the plant has changed hands. So I ask you: How is Bayer going to regain your trust and the trust of your emergency personnel who selflessly serve in your community?

Mr. CARPER. Mr. Braley, I don't know if I can give you a clear answer on that. I know they are trying. I have met with Mr. Crosby, the plant manager, a number of times. They will tell you they are making changes. They are bringing in a full-time safety person. They are going to do a drill. They are going to do outreach to the community.

But, you know, I think part of their biggest problem now is this SSI thing. They are giving that acronym a bad name. If I was the Social Security Administration, I would make them quit using it. It really sends the wrong message. The fact that they are the very first company to ever do this; the fact that Congress, who wrote the law, says it doesn't apply, maybe they ought to find something to do with their time and invest in rebuilding community trust.

They have to have a transparent process. The community has to believe that they actually know the risk. That takes a long time. Mr. Petri is here with me. He has 25-plus years in the fire service. He is our emergency manager. He nailed that correctly. The plant has changed a lot, but they have to rebuild trust. That is not going to be an easy thing to do.

Mr. BRALEY. Mr. Crawford, have you ever heard the phrase "action speaks louder than words"?

Chief CRAWFORD. Yes, I have.

Mr. BRALEY. You have seen a lot of policies down on paper, I assume?

Chief CRAWFORD. That is correct.

Mr. BRALEY. It is one thing to have those policies on paper, and it is another to act like you believe in them; would you agree with that?

Chief CRAWFORD. Yes, I do.

Mr. BRALEY. Is that the type of commitment you are looking for from Bayer is a demonstrated proof that they really have an action to commit to carrying these policies forward to protect the citizens of your community?

Chief CRAWFORD. Yes, and we want to do what is right. From a first responder's point of view of making a decision, to a plant manager making those decisions, we need to do what is right and be responsible.

I mean, we are all held responsible. That is the bottom line.

Mr. BRALEY. Thank you.

The Chair now recognizes the gentlewoman from the Virgin Islands for 5 minutes.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Before I ask my question, there is an extensive body of evidence that toxic plants are more likely to be located near minority communities, so I asked for the demographics of Kanawha County and was told 91 percent white, 8 percent black, 1 percent other. But I see if you look at the closer-in picture, and we have heard from Mr. Carper, that it is largely a minority community.

I consider students at a university to be a particularly vulnerable population. Ms. Nixon, do you know if there was any specific information given? We know that the general community and the public safety officials didn't get much, but was there any kind of communication specifically to West Virginia State?

Ms. NIXON. As you will note, the incident occurred August 28, 2008. This was the beginning of the year for the students at West Virginia State University. They had gone through orientation. They had heard this information. They had heard about shelter in place and chemical plant being there, along with all of the other information that they received as new students on campus. This was on

a hot evening in August. The students were outdoors, and that is when the explosion occurred, and they are close to the plant.

Mrs. CHRISTENSEN. I see that.

Ms. NIXON. They did receive information during orientation, but it takes drills and things before it is learned.

Mrs. CHRISTENSEN. But no specific information that evening?

Ms. NIXON. I believe some of the dormitory captains did advise their residents to go inside and shelter in place. But some students were outdoors.

Mrs. CHRISTENSEN. That was on their own?

Ms. NIXON. On their own, yes.

Mrs. CHRISTENSEN. Although we don't know specifically what chemicals might have been in the air, have you seen any public health activity in the area surveying individuals? We have heard some of the kinds of symptomatology from some of the possible chemicals. Has there been any public health surveying of the population?

Ms. NIXON. I do know that the Kanawha County Poison Control Center was very frustrated with the lack of information that they had received also. That was brought out at one of the critique meetings that was held in the Kanawha Valley.

The question that people had about their gardens and whether they should eat from their gardens, there was no direct information coming from the plant. When the plant manager was asked that, all he said was, you usually wash your garden plants before you eat them. And there had been reports about residue being on the plants after the incident.

Mrs. CHRISTENSEN. We have heard, and you have mentioned the bill that was passed this year, and it requires that businesses report industrial incidents. The incident was reported; there was just no specific information on which to make a determination to inform and protect the public. From what you know of the bill, do you think it goes far enough? It requires notification? I have not seen the bill. Does it satisfy you? You said that you can't rely on the company. Does this bill reassure you in talking to the public? Is the public feeling more protected?

Ms. NIXON. I haven't had a chance to review the whole bill because it was just passed this spring, and it is April, and I am here, and so I haven't had a chance to review the full content of the bill.

Mrs. CHRISTENSEN. Mr. Bresland, Bayer is the only company in the United States that makes and stores large amounts of MIC, as we understand it, and I would like to show a photograph of the section of the Bayer plant where the explosion occurred. It should come up on the screen, CSB 22. I think that Mr. Walden's line of questioning and your responses have already determined that the residue tank could have gone just as easily in the other direction into the MIC tank. If that 2-ton residue tank had blasted into the MIC tank, it is possible that MIC could have been released into the surrounding communities, correct?

Mr. BRESLAND. That is correct. In this photograph, the accident takes place in the middle right of the photograph, and the MIC tank is the tank that is marked on the left-hand side.

Mrs. CHRISTENSEN. This wasn't the first explosion in this facility, as we have heard. We regret the loss of life, and we extend our

sympathies to the families as well, but in 1993 there was another explosion.

My question is why in the world is Bayer putting the community at risk by storing large amounts of this deadly chemical in a tank that is vulnerable to these kinds of accidents? MIC doesn't need to be stored in that way. There are safer alternatives that exist. We had a near miss in August. We might not be as lucky next time. As part of the report, will CSB make a recommendation as to whether Bayer should adopt alternative technologies that do not require storage of large amounts of MIC?

Mr. BRESLAND. After the Bhopal incident in 1984, there were at least two major manufacturers of MIC. One was Dupont, and one at that time was Union Carbide. Dupont, within a very short period of time, switched their process to a type of process that ultimately gives the same product, which is a similar product to the one that is being made at Institute, but they switched the process to one in which MIC was formed, but immediately used, so there wasn't any—and that operation or facility is still there. So they are manufacturing MIC, but there is only a very minute amount that is—that is stored.

Mrs. CHRISTENSEN. So are you going to make a recommendation in your report?

Mr. BRESLAND. We're certainly going to make a recommendation that Bayer explain to us what would the issue be that would prevent you from doing this.

Obviously, there is a technical capability. I don't know if that capability belongs to Dupont. I don't know if that's available to other manufacturers and then there would be an economic evaluation that they would have to do as well. But certainly keeping in mind the community interest in this, I'm sure that Bayer will be actively moving in this direction to look at this and come up with an evaluation, and that would certainly be a recommendation that we would make.

Mrs. CHRISTENSEN. Thank you.

My time is up, and I have to go to the floor, but I will try to return.

Mr. STUPAK [presiding]. Thank you.

Let me follow up with that, if I may.

Are you familiar with a report reducing the storage of methyl isocyanate at the Institute in West Virginia? It is a 1994 report, November 12, 1994, by—community groups put it together. Are you familiar with that report at all?

Mr. BRESLAND. I know the report has been written. I haven't read it.

Mr. STUPAK. Again, this report is 15 years ago and is after Bhopal. In the report it says, the plant may be a disaster waiting to happen. They talk about a 1993 incident in which there were numerous points of neglect by the company management, including a company-wide yield enhancement program that accelerated production outputs at the plant without ensuring adequate safety reviews.

Looks like we have the same thing here. We have a new residue treater being there. We have it jerry-rigged, a bypass system put on it. So the safety valves—the interlocking safety valves—you don't have any monitors, air monitors, no video cameras. It seems

like we have the same thing. Because it says here that a worst-case MIC release at the plant could cause deaths for a 9-mile radius and injuries for up to 28 miles from the plant.

I went on and read this report; and it said the plant here at Institute, Virginia, stores 3 times more than actually was released in Bhopal.

And as to your point, it went on to say that Dupont, through a no-storage continuous feed system, whatever they need that day they produce it, they use it. So you're not storing this MIC chemical. And the Israeli firm had found different ways of making the same product with different materials, avoiding the use of MIC entirely.

Again, this is 15 years ago. I'm sure science has progressed in 15 years. What is the purpose of using MIC then? If that might be one of your recommendations, why would you need to use this dangerous chemical stored in such large volumes?

Mr. BRESLAND. The issue I think is more the amount stored at the facility. Is there a way to make it and use it immediately?

I used to run a large chemical plant in Philadelphia. We had a major explosion. As a result of that, we did away with the chemical that caused that explosion. I was a little skeptical about it when it happened, but that plan has been running very successfully ever since it was rebuilt without the storage of this dangerous material.

Mr. STUPAK. You could use a day's supply——

Mr. BRESLAND. We didn't store any at all. We zapped it on through. It went from one process unit to another.

Mr. STUPAK. Let me just ask one question, and if Mr. Walden has any follow up we'll go to the next panel.

This blast blanket—appears to be some controversy whether or not it has gone as we said in our opening statement, but we just received an e-mail saying that part of it's still at the plant. After an accident like this occurs, you are in charge, right?

Mr. BRESLAND. Yes.

Mr. STUPAK. The Chemical Safety Board? So if they were to move the blast curtain or blanket, they would have to ask you to remove it.

Mr. BRESLAND. That would be my assumption, that they would ask us, if you were moving a particular piece of equipment that is involved or at least peripherally involved in the incident.

Mr. STUPAK. So if part of it is still in the plant, you would be interested in your investigation of seeing this blast mat or blast blanket around the MIC?

Mr. BRESLAND. Oh, sure, absolutely. We would be.

Mr. STUPAK. You haven't seen it since then? Since this investigation commenced?

Mr. BRESLAND. Let me ask our—we have had an opportunity to take a look at it since——

Mr. STUPAK. I have no other questions. Mr. Walden.

Mr. WALDEN. I yield to the last panel.

Mr. STUPAK. Ms. Sutton and Mr. Burgess. I'm afraid to ask Mr. Burgess, because I know——

Mr. BURGESS. Yes, Mr. Bresland, I just have one last question on the heater, I guess, that you described in the bypassing of the safe-

ty mechanism. Do you have an idea as to how long that heater had been defective?

Mr. BRESLAND. Well, it wasn't that the heater was defective. It was during the start-up operation to get the temperature—to allow the temperature to rise to the appropriate temperature for the reaction to take place inside the tank. They had to bypass the 3 safety controls that were there—that were there with the purpose of preventing inappropriate reaction.

Mr. BURGESS. Well, that, to me, though, suggests that the heater was inadequate to do the job that it was intended to do——

Mr. BRESLAND. That's correct.

Mr. BURGESS [continuing]. And so we had to rely on the heat of the chemical reaction to get us up to the ignition or the start-up temperature or whatever would be appropriate there.

Mr. BRESLAND. Yes.

Mr. BURGESS. How long had that—it just seems like—if you look for a root cause, we have an inadequate heater where we're having to bypass and use a chemical reaction to make things work. It just defies logic on something as critical as that that you would have a nonfunctioning apparatus there. Buy a bigger heater, for Christ sakes.

Mr. BRESLAND. I think Mr. Carper brought up an interesting point here. This facility was Union Carbide, and in our presentation later this week we'll show the number of different owners that the facility has had. Every time you change corporate ownership, you probably bring in new management, new cultures, new safety cultures and ways of operating things. And this can be confusing for, well, for the employees, it can be confusing for the community.

While one set of management might have an approach that we are really going to work closely with the community, another set of management might say, well, we don't really need to deal with them too much. That's in issue that may not be exactly involved in this instance. But when I see a facility in which ownership is changing, it—it raises some questions in my mind that—that that could be an issue.

Mr. BURGESS. So in a brief answer to the question, the inadequate heating element likely predated the ownership of——

Mr. BRESLAND. Of Bayer?

Mr. BURGESS. Of Bayer.

Mr. BRESLAND. It probably was back there when this particular facility was built, when this particular operation was built.

Mr. BURGESS. OK.

Mr. BRESLAND. So it may have been there for years and years.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. STUPAK. Thank you. And let me thank this panel for your testimony today and your interest, and we will continue to work with you and hopefully get some legislative changes made. Thank you very much for your testimony.

Mr. Bresland, you will stay with us for the second panel I take it?

Mr. BRESLAND. Yes.

Mr. STUPAK. So I won't reintroduce you again as the Chairman of the U.S. Chemical Safety and Hazard Investigation Board, but you can stay.

Mr. BRESLAND. Do you want me to do my presentation again as well?

Mr. STUPAK. Only if you wish.

Mr. BRESLAND. No, that's OK.

Mr. STUPAK. We will call up our second panel of witnesses: Rear Admiral James Watson, who is the Director of Prevention Policy for Marine Safety, Security and Stewardship of the U.S. Coast Guard; Mr. William Buckner, who is the President and CEO of Bayer CropScience, LP; Mr. Nick Crosby, who is Vice President, Institute Site Operations for Bayer CropScience; and Mr. John Bresland, of course, is going to stay with us.

It is the policy of this subcommittee to take all testimony under oath. Please be advised that you have the right under the rules of the House to be advised by counsel during your testimony. Do any of you wish to be represented by counsel during your testimony?

Mr. BUCKNER. My counsel is present.

Mr. STUPAK. Mr. Buckner, you have counsel? Would you, just for the record, want to identify them? You would have to answer questions, but any time during questioning if you want to stop and consult with your counsel you are allowed to.

Mr. BARNETT. Bob Barnett principally with Williams & Connolly.

Mr. STUPAK. OK, Mr. Barnett, very good.

Please rise, raise your right hand and take the oath.

Mr. Bresland, you don't have to. You are still under oath from the last one.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect the witnesses have replied in the affirmative. They are now under oath.

STATEMENTS OF REAR ADMIRAL JAMES WATSON, DIRECTOR OF PREVENTION POLICY FOR MARINE SAFETY, SECURITY AND STEWARDSHIP, U.S. COAST GUARD; WILLIAM BUCKNER, PRESIDENT AND CEO, BAYER CROPSCIENCE LP; NICK CROSBY, VICE PRESIDENT, INSTITUTE SITE OPERATIONS, BAYER CROPSCIENCE; AND THE HONORABLE JOHN BRESLAND, CHAIRMAN, U.S. CHEMICAL SAFETY AND HAZARD INVESTIGATION BOARD

Mr. STUPAK. We will begin with a 5-minute opening statement. Admiral would you like to go first? If you want to pull that, press that button, get that green light on, we'll be ready to go.

STATEMENT OF REAR ADMIRAL JAMES WATSON

Admiral WATSON. Yes, sir, thank you very much.

Good afternoon, Mr. Chairman and distinguished members of the committee. Thank you for the opportunity to provide this testimony on the Coast Guard's role and response related to the incident at the Bayer CropScience facility in Institute, West Virginia. I'm Rear Admiral James Watson, Director of Prevention Policy.

At the outset, I would like to express my sincere condolences to the families, friends, and community of the 2 plant workers who lost their lives as a result of the explosion and fire. I would also

like to underscore the Coast Guard's commitment to cooperate with those responsible for investigating this accident in order to assist partner agencies to help ensure these tragedies are prevented in the future.

As a maritime first responder, I know the importance of having accurate information about hazardous chemicals that might be present at waterside facilities and fully support accurate disclosure of this information as required by law, including the disclosure to appropriate emergency preparedness officials under the Emergency Planning and Community Right to Know Act, EPCRA.

As we also understand the importance of ensuring that safety investigators have access to critical information, that's why we have ensured the U.S. Chemical Safety and Hazardous Investigation Board, CSB, has access to all the information regarding the Bayer CropScience chemical plant in Institute, West Virginia, including information that claimed to be security sensitive information, or SSI. I firmly believe that SSI requirements and EPCRA requirements can coexist for the benefit of the public in the current regulatory framework.

As mandated by the Marine Transportation Security Act of 2002, MTSA, and in fulfillment of the Coast Guard's regulatory responsibilities under the Port and Waterways Safety Act of 1972, the United States Coast Guard conducts annual safety and security inspections on over 3,200 regulated waterfront facilities. As the agency with primary responsibility for coordinating maritime security on America's waterways, we also know that public disclosure of certain security related information can make facilities such as chemical plants more vulnerable to terrorists or nefarious acts or general security breaches. That's why some information is designated SSI.

The relationship between the Coast Guard and the CSB in this instance is actually an excellent example of two agencies working together to achieve the appropriate balance between public disclosure of safety details and protection of SSI. It successfully demonstrates that a balance of safety and security can exist without compromising the mission of either agency.

Mr. Chairman and distinguished members of the committee, the August, 2008, incident at Bayer CropScience is an unfortunate and tragic event that highlights the importance of ensuring that all agencies responsible for oversight and post-accident investigation of chemical facilities work together in partnership with industry to prevent future accidents and be prepared to respond to incidents that may occur. We will continue to carry out our regulatory responsibilities as we support the Chemical Safety and Hazard Investigation Board's investigation of the incident at process.

Thank for the opportunity to provide this testimony on the Coast Guard's role and response. I'm happy to answer questions.

Mr. STUPAK. Thank you, Admiral.

[The prepared statement of Admiral Watson follows:]

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DEPARTMENT OF HOMELAND SECURITY

U. S. COAST GUARD

STATEMENT OF

REAR ADMIRAL JAMES WATSON
DIRECTOR OF PREVENTION POLICY

ON THE

EXPLOSION AND FIRE AT BAYER CROPSCIENCE (BCS) FACILITY IN INSTITUTE, WEST VIRGINIA, ON AUGUST 28TH, 2008.

BEFORE THE

COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION

U. S. HOUSE OF REPRESENTATIVES

APRIL 21, 2009

Good afternoon Mr. Chairman and distinguished Members of the Committee, and thank you for the opportunity to provide this testimony on the Coast Guard's role and response related to the explosion and fire at the Bayer CropScience facility in Institute, West Virginia. I am Rear Admiral James Watson, Director of Prevention Policy.

At the outset, I would like to express my sincere condolences to the families, friends, and community of the two plant workers who lost their lives as a result of the explosion and fire. The Coast Guard understands safety as we conduct thousands of maritime safety and casualty investigations each year. As a first responder for maritime environmental emergencies, the Coast Guard understands and appreciates the complexities and hazards faced by first responders at waterfront facilities that handle chemicals and other hazardous materials. We share your concern that Sensitive Security Information (SSI) designations should never be abused to obstruct a safety investigation or to circumvent information disclosure required by the Emergency Planning and Community Right-to-Know Act (EPCRA). We also firmly believe that SSI requirements and EPCRA requirements can coexist for the benefit of the public in the current regulatory framework. I would also like to underscore the Coast Guard's commitment to cooperation with those responsible for investigating this accident in order to prevent such tragedies in the future.

Background and Coast Guard Jurisdiction

As mandated by the Maritime Transportation Security Act of 2002 (MTSA) and in fulfillment of the Coast Guard's regulatory responsibilities under the Port and Waterways Safety Act of 1972 (PWSA), the United States Coast Guard conducts annual safety and security inspections on over 3,200 regulated waterfront facilities. At many of these facilities, oil and chemicals are transferred in bulk as well as in packaged form. Under PWSA and other environmental and safety statutes, the Coast Guard regulates the safety of only a limited area of these facilities, specifically that area designated as the marine transfer area which extends from the vessel/facility interface up to the first valve within the facility's secondary containment. Other federal agencies such as the Environmental Protection Agency (EPA), the Occupational Safety and Health Administration (OSHA), as well as State and local government agencies regulate safety beyond the marine transfer area.

The Coast Guard regulates the security of the MTSA-portion of the facility which extends beyond the traditional marine transportation-related portion of the facility and includes areas that are contiguous, adjacent and under common owner or operators extending to the furthest security perimeter. Coast Guard facility inspectors conduct required annual security inspections, as well as random security spot checks, which provide additional opportunities to identify safety and security concerns. Under the MTSA, the Coast Guard is required to issue regulations that require maritime facility and vessel operators to develop security plans detailing the types of security measures to be implemented under varying threat conditions. Industry groups were allowed to use an Alternative Security Program (ASP) whereby a participating facility creates its individualized security plan under the framework of a broader security plan that addresses security based on common operations within a specific maritime sector. For example, Bayer CropScience uses the American Chemistry Council's (ACC) Alternative Security Program. These plans are reviewed and approved by the Coast Guard.

In order to meet statutory deadlines for implementation of these facility security plans, the Coast Guard issued a series of final rules on October 22, 2003, requiring facility and vessel operators to submit security plans to the Coast Guard for approval. In order to protect the security of regulated facilities and vessels required to possess a facility security plan under the requirements of MTSA, it was necessary to ensure that such plans and their related facility specific security information were subject to limitations on the disclosure of the information. Therefore, the Transportation Security Administration (TSA) issued an interim final rule expanding the scope of its Sensitive Security Information (SSI) regulation so that it covered security plans and other information about security measures required by the Coast Guard's MTSA regulations.

Bayer Crop Science

Bayer CropScience is a waterfront facility regulated by the Coast Guard under 33 CFR 105 – covering Maritime Security Facilities; 33 CFR 154 – covering Facilities Transferring Oil or Hazardous Materials in Bulk; and 33 CFR 156 – covering Oil and Hazardous Material Transfer Operations. Bayer CropScience uses the ACC Alternative Security Program (ASP). This ASP was initially approved on December 22, 2003, and reviewed and approved again on October 11, 2007 due to updates incorporating Transportation Worker Identification Card requirements. As approved by the Coast Guard, the ASP requires that a site specific facility security plan be submitted to the cognizant Captain of the Port (COTP). The Coast Guard reviewed Bayer CropScience's site specific plan in conjunction with a successful MTSA facility inspection conducted on September 27, 2005. On August 14, 2008 the Coast Guard reviewed and approved appropriate plan amendments related to the forthcoming implementation of Transportation Worker Identification Credential (TWIC) requirements.

Although the incident occurred within the MTSA-regulated portion of the facility there is no indication the explosion and subsequent fire at the Bayer CropScience facility was caused by or related to a security breach or had any security nexus. At the time of the incident the Coast Guard worked closely with the Kanawha County Emergency Operations Center to monitor the events. The Coast Guard also established a safety zone on the Kanawha River. The site of explosion was beyond the marine transfer area of the facility, therefore responsibility for further investigation into safety or pollution issues fell within the jurisdiction of other Federal, State and local agencies. The Coast Guard will assist these agencies, if requested, to address areas within our jurisdiction or expertise.

Cooperation with the Chemical Safety and Hazards Evaluation Board (CSB)

The Chemical Safety and Hazards Evaluation Board (CSB) is conducting an investigation of this incident. The Coast Guard met with the Chemical Safety Board and Hazards Evaluation staff on February 26, 2009, at CSB's headquarters in Washington, DC. Both agencies agreed to work together to protect sensitive security information while preserving CSB's ability to conduct an independent safety investigation. CSB stated their desire to hold a public meeting, initially scheduled for March 19th, to discuss preliminary findings of the investigation. Since then, CSB rescheduled their public meeting for April 23rd. During the February 26th meeting, CSB indicated a desire for, and the Coast Guard indicated a willingness to, review any presentation for the public meeting scheduled for April 23rd.

In a subsequent phone conference with CSB staff on March 5, 2009, it was mutually agreed that the Coast Guard would review a draft presentation to identify and make CSB aware of any SSI concerns. The Coast Guard and CSB would then work together to appropriately address issues identified by verifying the status of the information and then take one of the following actions: protect SSI from disclosure, specifically authorize disclosure, or determine that the material had lost its designation as SSI and did not require further protective measures. CSB forwarded their draft presentation for Coast Guard review on March 18, 2009. CSB addressed limited SSI concerns raised by the Coast Guard; concerns that would not compromise the integrity of the safety investigation and the proposed public presentation.

The Coast Guard does not have any concerns with CSB having access to all SSI material, as CSB members are "covered persons with a need to know" under the SSI regulations found in 49 CFR Part 1520. If after consulting with CSB we determined that, for the sake of safety, SSI information must be disclosed, the Coast Guard would then authorize disclosure. The Coast Guard intends to continue working cooperatively with CSB during its investigation in an effort to help resolve any SSI issues which may arise. We anticipate being asked by CSB to review their final accident report to identify potential SSI concerns and then address them in the same manner as we did with the material to be presented at the forthcoming public meeting.

Mr. Chairman and distinguished Members of the Committee, the August 2008 incident at Bayer CropScience is an unfortunate and tragic event that highlights the importance of ensuring that all agencies responsible for oversight and post-accident investigation of chemical facilities work together in partnership with industry to prevent future accidents and be prepared to respond to incidents that may occur. We will continue to carry out our regulatory responsibilities as we support the Chemical Safety and Hazards Investigation Board's investigation of the incident at Bayer CropScience. Thank you for the opportunity to provide this testimony on the Coast Guard's role and response. I am happy to answer any questions you may have.

Mr. STUPAK. Mr. Buckner, your opening statement, please, sir. Pull that light forward and turn on the green light there.

STATEMENT OF WILLIAM BUCKNER

Mr. BUCKNER. Thank you very much, Mr. Chairman; and good afternoon to everybody. My name is Bill Buckner, and I am the President and CEO of Bayer CropScience LP. With me today is Mr. Nick Crosby, who is the site manager at our Institute site.

On August 28th, 2008, we had a tragic accident at the Institute that claimed the lives of 2 of our colleagues at our facility. We are all saddened by this loss. We also regret that the community did not promptly receive assurance that it was not in danger.

Over the last 7 months, we have been working with several agencies to examine this incident to learn from it and to improve our performance both to prevent another such accident and to improve our emergency communications.

Our initial communications with Metro 911, while well intentioned, inadvertently created confusion and concern. Under our emergency response plan, further information about the explosion should have been provided to Metro 911 in a timely manner.

Throughout the incident, our emergency responders did an excellent job under very difficult circumstances. Within a few minutes, the Institute's community fire chief was at our facility and in direct contact with our incident commander's team and Metro 911. Our emergency operation center opened several additional lines of communication to Metro 911. When our incident commander determined that the circumstances warranted a shelter in place for the 2 nearby communities, we immediately communicated that recommendation to Metro 911.

Again, however, we recognize that the initial communications contributed to confusion. That was never our intention, and we will do better. We have established new procedures, we have established dedicated radio and telephone lines to Metro 911, we have hired a new emergency services leader and provided new real-time chemical monitoring technology to Metro 911.

We have received questions about whether the chemical, MIC, was released into the community during the incident. Let me assure you we monitor for this, and there was no indication that MIC was released the night of August 28th. Our control room operators continually monitor the MIC day storage tank in the affected unit. Our incident commander monitored the tank and noted that it was not compromised nor in danger of being compromised. Our emergency operations center and incident commander employed air monitoring technology and detected no potentially harmful chemical emissions that might threaten the community. Most important, the multiple layers of protection in place to protect the MIC day tank storage functioned as intended and it worked.

There had been reports about the CSB's investigation to the effect that our company used the law protecting sensitive security information, or SSI, to restrict the scope of the investigation. This was the first time that CropScience had ever considered the issue of SSI in the context of a Federal or State investigation. It is our understanding that it was also the first time that the CSB and the Coast Guard had confronted these issues in this context. As our ex-

perience demonstrates, there is need for further education and guidance regarding the interplay between the SSI regulations and CSB investigations.

As explained in my written statement, we had various reasons for wanting to limit public discussion of these issues. For about 1 week in January, 2009, there were some in our company who thought that the Maritime Transportation Security Act could be used to withhold certain information to the CSB regarding aspects of our MIC operations that were not involved in the accident. One week later after getting further advice we understood the company could not deny the CSB access to this information, only that the law might prevent the CSB from disclosing certain of this information publicly.

The company sought guidance from U.S. Coast Guard officials to determine whether our understanding of the law was correct. We were told it was.

CropScience did not withhold information from CSB on the grounds that it was SSI. SSI information was provided to the CSB. We complied with the law, and we cooperated with the CSB and the Coast Guard.

In closing, we welcome the opportunity to participate in this hearing. We are proud of our company, our employees, and our community.

Mr. Chairman, we stand ready to answer your questions. Thank you.

Mr. STUPAK. Thank you.

[The prepared statement of Mr. Buckner follows:]

STATEMENT OF WILLIAM B. BUCKNER,
PRESIDENT AND CHIEF EXECUTIVE OFFICER OF BAYER CROPSCIENCE, LP

INTRODUCTION

My name is Bill Buckner, and I am the President and Chief Executive Officer of Bayer CropScience, LP ("CropScience"). With me today is Nick Crosby, who is the Vice President for Institute Site Operations and the top company official at our manufacturing facility in Institute, West Virginia. CropScience is one of the world's leading innovative crop science companies in the areas of crop protection, non-agricultural pest control, seeds and plant biotechnology. As an innovative and research-based company, we are committed to delivering an outstanding range of products and extensive service backup for modern, sustainable agriculture and for non-agricultural applications.

On August 28, 2008, we had a tragic accident at our Institute facility that claimed the lives of two colleagues at our site. This tragedy continues to remind us that the safety of our employees, neighbors, and community is and must remain our highest priority.

Over the past seven months, we have been working with several agencies to examine this incident, to learn from it, and to improve our performance. We also have been conducting our own investigation into both the causes of the incident and our response. We have received feedback from many in our community about our public communications relating to the incident. We feel strongly that our emergency responders did a tremendous job under difficult circumstances in responding to the incident and followed the communications protocols set forth in our region's emergency response plan.

After the fact, however, we realized that our communications in the initial minutes after the incident, while well-intentioned, inadvertently created confusion and concern. Many members of our community, who understandably became concerned upon hearing a loud

explosion and seeing a large fire either directly or on television, did not receive immediate reassurance that they were not in danger.

In addition to taking steps to prevent such an incident from happening again, since the incident we have taken several specific actions to improve our emergency communications. For example, we have implemented new procedures for communicating with our region's emergency response center, Metro 911, installed dedicated methods of communication with Metro 911, hired a new emergency services leader to work with Metro 911 and other first responders in the region, and provided new real-time chemical monitoring technology to Metro 911.

I. CROPSCIENCE HAS BUILT UPON OUR EMERGENCY RESPONSE TO THE AUGUST 28th INCIDENT.

At approximately 10:30 p.m. on August 28, 2008, a residue treatment tank in an insecticide production unit at the Institute facility ruptured due to over-pressurization, causing an explosion and fire that led to the deaths of two of our employees. Our Institute facility maintains a emergency brigade on-site that has been specifically trained and equipped to respond to chemical fires. Our brigade immediately responded and did a tremendous job in bringing the fire under control. The on-scene incident commander determined that the fire should be allowed to continue to burn in a controlled manner in order to consume the chemicals involved in the incident. During the incident, ongoing monitoring showed no potentially harmful chemicals being released off-site. Local fire companies also responded and provided assistance.

Our public communications for emergencies at the Institute facility are intended to follow the Kanawha Putnam Emergency Planning Committee's emergency management plan ("KPEPC plan"). The KPEPC plan was the result of extensive coordination among many interested parties, including the various first responders in the Kanawha Valley, facilities like Institute, and the community's emergency response center, Metro 911. In the aftermath of the incident, we

believed that our initial emergency communications followed the protocols in the KPEPC plan. For example, within roughly 45 minutes of the explosion, we had established communication between our Emergency Operations Center ("EOC") and Metro 911 to ensure the timely and accurate flow of information between the Institute facility and the community. In addition to communicating with Metro 911 by phone, CropScience sent a representative from the Institute facility to Metro 911's site who was in direct communication with our EOC. Metro 911 also sent two of their representatives to Institute's EOC and was directly receiving information from the Fire Chief of the Institute community's Fire Department, who was in direct contact with our Incident Commander's team.

For these reasons, we were initially surprised when we later received criticism from our Metro 911 counterparts and others in our community regarding our communications relating to the incident. These criticisms chiefly centered around the communications in the first few minutes after the explosion—specifically, our initial reliance on landline communications that became overloaded with calls and impeded our ability to reach Metro 911, and statements to Metro 911 by the security guard at the Main Gate of our facility that he could not tell them the location of the explosion within the facility. To be clear, at no time was our security guard instructed to withhold any information from Metro 911. In fact, the guard reached Metro 911 within four minutes of the explosion and provided information to Metro 911 that was consistent with the protocols specified in the KPEPC plan for incidents at an industrial facility. In addition, shortly after these initial communications difficulties, we had activated our EOC and opened several additional direct methods of communication between our EOC and Metro 911, so that the guard was no longer the primary means of transmitting information to Metro 911. There was criticism for not reporting the location of the explosion during the initial calls to Metro 911, but

the Fire Chief of the Institute Fire Department has reported that Metro 911 was aware of the location of the explosion and reported it to him at the time that his Fire Department was dispatched to our facility, just minutes after the explosion occurred. Nevertheless, we recognize the fact that the initial statements from the security guard at our Main Gate, while well-intentioned, contributed to an atmosphere of confusion that our emergency response plan is intended to prevent. Many members of our community, upon hearing a loud explosion and seeing a large fire on television or across the Kanawha River, did not receive immediate reassurance that they were not in danger.

There also was some criticism relating to a perceived delay in our recommendation of a Shelter-in-Place ("SIP") for certain of our neighboring communities.[1] There was no delay in ordering the SIP. Upon evaluating the situation immediately after the explosion, our incident commander determined that a SIP was not warranted in the circumstances. Approximately 45 minutes later, however, the incident commander observed that the fire was heating up nearby storage bins and, as a precautionary measure, recommended a SIP for two neighboring communities. Our EOC reported the incident commander's SIP recommendation to Metro 911 within two minutes. After the incident, however, some members of our community assumed incorrectly that there had been a 45-minute delay in recommending a SIP. This is not the case: our recommendation that Metro 911 order a SIP was because of developments that occurred 45 minutes after the explosion, not because of the explosion itself.[2] Again, however, we recognize that the communications problems at our Main Gate may have contributed to this misimpression.

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[1] The Institute facility can recommend a SIP to Metro 911, but the facility cannot order one.

[2] We also received some criticism relating to road closures that certain law enforcement officials ordered immediately after the explosion. We had no role in those decisions.

The effects of the August 28th incident go well beyond simply understanding and preventing the causes of the explosion, for us, our neighbors and the local community. That is why, in addition to taking actions to improve operational safety at our site, we have taken many significant actions to improve emergency communications with our community. For example:

- We have established new procedures for communicating with Metro 911;
- We have established multiple dedicated methods of communication with Metro 911, including a hotline from Institute's dedicated EOC facility to the Community's EOC as well as communication links by radio to avoid overloaded phone lines;
- We have hired an Emergency Services Leader to enhance our coordination and emergency communications with Metro 911 and the community; and
- We are equipping Metro 911 with the "SAFER" system, which is the same real-time, computer-based system for monitoring and modeling chemical dispersions that we use in our EOC.
- We also have intensified our long-time practice of dialogue and outreach to our neighbors, nearby organizations, civic officials and other stakeholders. This has included continued discussions with our neighbors at the monthly meetings of our Community Improvement Council.
- In addition, we will be attending the public meeting held by the Chemical Safety and Hazard Investigation Board ("CSB" or "Board") on April 23, 2009, where there will be a discussion of the incident and our emergency communications. We have cooperated, and will continue to cooperate, with

the Chemical Safety Board and this Subcommittee in connection with the events of August 28, 2008.

- We will support the "15 minute rule" proposed by our Governor, Joe Manchin, to require timely notification of future incidents of this nature.
- We also support the recent proposal by Metro 911 to order a Shelter-In-Place as a precautionary measure if Metro 911 does not have sufficient information to evaluate the risks to the community within 10 minutes after a similar incident.

Obviously, improving our incident response starts with preventing incidents in the first place. For that reason, in addition to our communications-related improvements, CropScience has taken a number of steps to prevent another incident like the one that happened on August 28th. CropScience conducted an extensive internal investigation that identified multiple factors leading to this incident. Based on the findings, we have implemented a number of measures—including safety improvements, additional operational procedures and safeguards, and an extensive training and compliance regime—to ensure that this kind of incident cannot occur again.

II. SENSITIVE SECURITY INFORMATION.

There have been several reports about the Chemical Safety Board's investigation to the effect that CropScience used the law protecting sensitive security information ("SSI") to restrict the scope of the CSB's investigation.

CropScience acknowledges that in January 2009, there were some in company management who initially thought that the Maritime Transportation Security Act of 2002, 46 U.S.C. Chapter 701 ("the Act"), could be used to refuse to provide information to the CSB

about issues regarding Methyl isocyanate ("MIC") beyond those related to the MIC day storage tank in the unit involved in the incident. We admit that.

Here is the background. On January 15, 2009, during the course of interviews of Institute employees, CSB investigators asked questions not only regarding the MIC "day storage tank" and its related transfer piping in the unit of the Institute facility where the August 28, 2008 explosion occurred, but also about several other matters relating to MIC, including the company's inventory amounts and protective measures, and alternate technologies for MIC. At that time, the company pointed out to CSB investigators that MIC is the primary and integral building block of virtually all of the company's insecticide units at Institute, and that public discussions and CSB recommendations about alternate technologies and inventory amounts would be a sensitive matter for the company. The company nevertheless offered to make a presentation to the CSB about MIC production and discussed the need for confidentiality because of Homeland Security issues.

This exchange prompted a review of the Act, and resulted in the initial views by some at CropScience that the Act could be used to withhold certain information regarding MIC. This was the first time that CropScience had ever considered the issue of sensitive security information in the context of a federal or state investigation, and it is our understanding that it was also the first time that the CSB and the Coast Guard had confronted these complex issues in this context as well. The company proceeded to contact U.S. Coast Guard officials to inquire whether the requested additional information regarding MIC was in fact SSI, which might discourage the CSB from even seeking this information and limit the CSB's inquiry to the Methomyl unit where the explosion occurred.

Approximately one week later, however, after further review of the Act and its related regulations, the company determined that it could not deny the CSB access to information about MIC, but that the law could be used to prevent the CSB from discussing SSI information publicly. The company learned that it was up to the Coast Guard to determine what could be publicly disclosed. The company continued to have discussions with Coast Guard officials regarding whether the company's understanding of what constituted SSI was correct, and whether such information could be blocked from public disclosure.

There were several reasons why the company sought confidentiality and SSI protection, including legitimate security concerns, the proper scope of the CSB's investigation, and, we frankly admit, the desire to avoid making the controversial chemical MIC part of the public debate regarding the incident. There were, of course, some business reasons that also motivated our desire for confidentiality. These included a desire to limit negative publicity generally about the company or the Institute facility, to avoid public pressure to reduce the volume of MIC that is produced and stored at Institute by changing to alternative technologies, or even calls by some in our community to eliminate MIC production entirely. In any such debate, we believed that because of security concerns, we would have been prevented from a full public defense of our safety and security measures and the multiple layers of protection we employ for our MIC processes. However, we concede that our pursuit of SSI coverage was motivated, in part, by a desire to prevent that public debate from occurring in the first place.

To be clear, however, CropScience did not withhold any information from CSB by claiming that it was sensitive security information. Sensitive security information regarding MIC has been provided to the CSB. We understand that CropScience was obligated to notify the CSB that some of the information that it had already disclosed to the CSB included sensitive

security information that the Act requires be kept confidential. But ultimately, it is up to the Coast Guard and the Transportation Security Administration—not CropScience—to determine whether certain information is or is not SSI, and whether SSI can or cannot be disclosed to persons other than covered persons. We have come under criticism for over-designating materials previously produced to the CSB as SSI, and we fully acknowledge the need for further guidance on what materials should and should not be marked as SSI.

Contrary to some reports, CropScience did *not* ask the CSB to cancel a public hearing—a fact that has since been confirmed publicly by a Board official: "Bayer never requested that the CSB cancel the hearing." Dan Horowitz, CSB Director of Congressional and Public Relations, BNA Occupational Safety and Health Daily, Mar. 19, 2009. To the contrary, we understand that Coast Guard officials have reviewed CSB's proposed presentation for the upcoming public meeting on April 23rd, and that the two agencies have resolved any issues relating to SSI in the presentation.

As our experience demonstrates, there is a need for further education and guidance regarding the interplay between the SSI regulations and CSB investigations. We do believe that whatever tension may exist between CSB's desire to inform the public and the Coast Guard's mandate to protect homeland security, these two important federal interests can be reconciled. We look forward to the ongoing dialogue between these two agencies and their efforts to balance these important federal interests.

III. CROPSCIENCE EMPLOYS MULTIPLE LAYERS OF PROTECTION FOR ITS METHYL ISOCYANATE OPERATIONS.

Finally, there have been questions raised about whether the chemical Methyl isocyanate ("MIC") was involved in the August 28, 2008 incident. MIC is a chemical that is used to produce various products that protect food crops. We are not aware of any evidence that MIC

was released during the incident. To the contrary, during the incident, the operators in the affected unit's control room continually monitored the temperature and pressure in the MIC day storage tank that supplies the unit to confirm the incident commander's first-hand observations that the tank was not compromised or in danger of becoming compromised. Our EOC and incident commander also continually monitored the air around the facility and detected no potentially harmful chemical emissions that might threaten the community. Ultimately, these and other important safety measures in place to protect the MIC day storage tank and its related piping functioned as intended.

Some have asked why CropScience continues to use MIC, or why CropScience does not use another type of technology that might manufacture MIC on an as-needed basis at Institute instead of having to store it. MIC is a critical and necessary building block in the manufacture of important insecticides that help protect crops both in the United States and around the world. The Institute facility has manufactured MIC for decades, since well before CropScience acquired the facility in June 2002, and the facility has an impressive safety record relating to MIC. Our MIC safety performance starts with our experienced operators, many of whom have worked at Institute for years, if not a decade or more, and who have received extensive operational and safety training regarding MIC. Most important, however, CropScience, continuing the work previously done at the Institute site, has invested significant time, thought, effort, and financial support into ensuring that we employ robust and safe production strategies for our various production units that use MIC. We have examined alternative technologies for MIC and determined that our process is as safe as those other technologies. Our MIC processes at the Institute facility employ multiple layers of protection that, working together, protect our employees, our neighbors, and our community from a harmful release of MIC. Those layers of

protection worked as intended during the August 28th incident to protect the MIC day storage tank located in the same unit where the explosion occurred. While it is our understanding that the Maritime Transportation Security Act may prevent us from describing many of these layers of protection publicly in detail, we have disclosed them to the Coast Guard, the CSB, the Subcommittee's Staff, and other government officials, and we would welcome the opportunity to discuss them further with the Subcommittee in executive session. Above all, the safety of our employees, neighbors and the community remains our highest priority.

CONCLUSION

In closing, we welcome the opportunity to participate in this hearing. We are proud of our company, our employees, and our community. We stand ready to answer your questions.

Mr. STUPAK. Mr. Crosby your opening statement.

Mr. CROSBY. I have no opening statement. I will stay with the statement of Mr. Buckner.

Mr. STUPAK. OK. Thank you.

We will go right to questions.

Mr. Buckner, Exhibit 26 there in the book right there—that's our document there. In there is some of the documents that Bayer was going to make under SSI, and 2 of them sort of caught my eye because I'm trying to figure out something here, the responsibility you had to let people know what chemical may have possibly been in that toxic cloud.

So on page 13—it is BCD 10 004. It's right on the top there. It is a copy of the BCS incident report for the exposure involving the MIC equipment for the accident that occurred late September, 2008, including this response associated with procedures or protocols for working involving process equipment, process line equipment, opening particular equipment.

Is there anything in there in your policies that tell you that you have to tell the emergency response people what kind of fire they may be fighting?

On the next page, if you will—that's page 13. On page 14, the only document in there indicates any MIC equipment installed on or near the Larvin Unit information shall include but not be limited to maximum inventories, emergency dump tanks, deluge systems, spill containment refrigeration system, back-up power, area detection alarms, include a copy of the most PHA and all the emergency procedures. So do you have any procedures at all in the company that you are supposed to communicate with emergency personnel if a fire or something occurs?

Mr. BUCKNER. Yes, sir, we do have these procedures; and I would like to refer this question, if I could, please, to Mr. Crosby, who has got the background on this.

Mr. STUPAK. Sure. Were these procedures in place on August 28th, 2008?

Mr. CROSBY. We have a number of procedures that we use for communicating with our outside responders.

Mr. STUPAK. So why didn't you tell the emergency response or Metro 911 what was in that cloud or what you suspected to be in the cloud that night?

Mr. CROSBY. We have a very experienced and 24/7 incident commander on our site. That commander is on site 24 hours a day, 7 days a week, 365 days a year.

Mr. STUPAK. With all of that experience he would be able to make a decision and be able to tell you what might possibly be in that cloud, could he not?

Mr. CROSBY. He did.

Mr. STUPAK. Why didn't you tell the communities and emergency responders?

Mr. CROSBY. He was highly trained. He went to the scene——

Mr. STUPAK. Right. But my question is, why didn't you tell him? I'm sure he's highly trained, and I'm sure he's an expert and had an idea what was in the cloud, the 3 to 4 miles that was drifting over Nitro and the rest of the area. And with the university right

up to your fence line, why wouldn't you let people know what they were facing?

Mr. CROSBY. He made the decision based upon his observation of the incident that there were no toxic chemicals being released from——

Mr. STUPAK. How did he make that determination with his expertise and his knowledge? Because your monitors weren't working.

Mr. CROSBY. We have—we have fence line monitors which were working.

Mr. STUPAK. But on the west side you had no monitors. They were not working.

Mr. CROSBY. The incident commander summed up, he used his experience, as any firefighter would in that particular situation, sir, and he drew the conclusion—we believe the conclusion was right, that there were no——

Mr. STUPAK. Let us assume for a moment that he was right. Then why wouldn't you tell—if it wasn't a problem, why wouldn't you tell the emergency firefighters what it was?

Mr. CROSBY. Our objective is to communicate to the firefighters and our emergency response center. There were 2 parts to——

Mr. STUPAK. Right. You are supposed to communicate with them. Aren't you supposed to communicate on what the chemicals are?

Mr. CROSBY. Yes, we are.

Mr. STUPAK. Why didn't you do it that night?

Mr. CROSBY. Basically, the security guard who was accountable for relaying that message, he became overwhelmed by the incident, and he failed to relate information correctly to 911 in a timely manner.

Mr. STUPAK. So you're saying you told the security guy and he failed to do it?

Mr. CROSBY. No, I—I'm the site leader and accountable for what goes on in the Institute site.

Mr. STUPAK. So why didn't you tell them what chemicals might possibly be in the cloud?

Mr. CROSBY. Because we didn't believe there were chemicals in that cloud.

Mr. STUPAK. Why did you issue then in your plant shelter in place for all your employees? So if it is not dangerous to the outside community, why was it dangerous to your employees where you would put a shelter in place right after the thing exploded?

Mr. CROSBY. The initial assessment of the incident indicated that there were no toxic chemicals being released.

Mr. STUPAK. Then why do a shelter in place?

Mr. CROSBY. That was validated by one of the volunteer fire department chiefs who arrived at the fence line on their side.

Mr. STUPAK. No danger, then why do a shelter in place for your employees? It seems to be a contradiction.

Mr. CROSBY. As the incident progressed, what happened, sir, was our incident commander became concerned because he felt nearby storage bins were potentially being compromised by the fire. They were starting to heat up. And so he ordered a precautionary shelter in place for part of the area.

Mr. STUPAK. Why didn't you tell the community that then?

Mr. CROSBY. Excuse me?

Mr. STUPAK. Why didn't you tell the community that?

Mr. CROSBY. We passed the information through to Metro 911. We make the recommendations in place, and then Metro 911 informed the community.

Mr. STUPAK. But, with all due respect, if you read the Metro 911, they constantly say, this was all I'm allowed to tell you. Basically, I know, but I can't tell you.

That was—Mr. Reck was it? Or who is the gentleman——

Mr. CROSBY. This was the security guard who initially on the gate who made the calls to Metro 911.

Mr. STUPAK. Right, every time Metro 911 asked or called, it was like, I can't tell you; this is all I can tell you; I'm not allowed. They wouldn't even tell them if the Larvin Unit was damaged or if the chemicals were coming from there. All he was told is this is all I can tell. You we have an emergency.

Mr. BUCKNER. If I could, please.

Mr. STUPAK. Sure.

Mr. BUCKNER. We acknowledged fully that we had a breakdown in these communications. It is my responsibility to make sure that these don't happen again. I think we have the process in place again to ensure that it doesn't happen again.

Mr. STUPAK. Sure. But you even said, Mr. Buckner, in your opening statement that the lack of communication was inadvertent and there was confusion.

Here is what your Bayer CropScience—Steve, at the main gate, who was communicating from Mr. Crosby. Mr. Crosby is dealing with Steve, and Steve would say, well, I can't give out any information. Like I say, we'll contact you with—with the proper information.

Now this was at 22:39 hours.

22:42 hours, 3 minutes later, well, I can't give out any information until I get my information.

Here he is at 23:15: What it is, we have an emergency at Bayer CropScience plant; and the only information I can give you is that you will need—you might want to alert the community—my supervisor informed me to tell you, alert the community there is an emergency in the plant right now.

Here it goes on at 23:34: My instructions are to tell you to keep the community alerted, and we're responding to the emergency.

Even at 5:55 in the morning, the only thing they told 911 was we have an emergency. God, we all knew that. It blew up. We heard it. We saw the fire. We knew it was an emergency. Why didn't you tell them something more?

Mr. BUCKNER. It is my understanding, Chairman Stupak, that communications had been established through the emergency onsite control center with the Metro 911.

Mr. STUPAK. You are talking, but you're not saying anything to the community that needs to know. How about these kids right there, right on your fence line? Don't they have a right to know?

Mr. BUCKNER. Sure, and I have acknowledged the fact that we had a breakdown in these communications; and now we have policies in place to correct this situation.

Mr. STUPAK. Have you ever told the community yet what chemicals you believe went up in smoke that night in that cloud? Do we know?

Mr. CROSBY. As far as our analysis is concerned, the chemicals that were released were consumed in the fire. We are not aware of any toxic chemicals that left the site that evening.

Mr. STUPAK. How do you reconcile that with the Chemical Safety Board which basically says, well, if it is methomyl, some of it was burned, some of it was washed away in the fire, some of it evaporated up in the air. That's their preliminary investigation. You are familiar with that, are you not?

Mr. CROSBY. I'm not familiar with the absolute details, but we will be attending the hearing with the CSB on Thursday, and I expect to get more information.

Mr. STUPAK. Let me help you.

Methomyl solution sprayed from residue theater. Broken pipes and equipment. Some burned in fire. Some remain on ground and nearby equipment. Some might have been carried in the air.

And the physical reaction to the exposure: Again, nervous system disruption, blurred vision, pinpoint pupils, tremors, muscle twitching, nausea, abdominal pain, respiratory arrest, coma, death, liver damage, anemia. I think we had 6 firefighters had respiratory problems and nausea, which sounds like there was exposure.

Mr. CROSBY. Our analysis shows that there wasn't. When methomyl——

Mr. STUPAK. How do you account for the 6 officers, firefighters being sickened?

Mr. CROSBY. We are aware of 2 firefighters who visited a medical center that evening. They were both suffering from heat exhaustion, and they were treated and released.

Mr. STUPAK. You say all your air monitors didn't show anything, but you admit that some of your air monitors were not working.

Mr. CROSBY. Our fence line air monitors were working that evening.

Mr. STUPAK. They were not working, right?

Mr. CROSBY. Our fence line air monitors were working that evening.

Mr. STUPAK. But not the air MIC monitors, were they?

Mr. CROSBY. I'm not aware of that fact.

Mr. STUPAK. Wait a minute. You're the incident command officer. You are telling me under oath you have no idea that part of your——

Mr. CROSBY. I was not the incident site leader.

Mr. STUPAK. OK. Now, under oath, you're telling me you didn't know that part of your monitors, air monitors by the MIC unit, was not——

Mr. CROSBY. At that time, no, I didn't, sir.

Mr. STUPAK. OK. But, today, under oath, you know that part of them were not working, right?

Mr. CROSBY. Yes, I'm aware now.

Mr. STUPAK. You're aware your cameras weren't working, right?

Mr. CROSBY. I was aware there was a video camera that wasn't working that evening, yes.

Mr. STUPAK. OK. And you're aware you bypassed the interlock safety valves on this retreat vessel, right?

Mr. CROSBY. I'm aware of the full findings of the internal investigation.

Mr. STUPAK. And you are aware that the computer training wasn't adequate.

Mr. CROSBY. We respectfully disagree with that comment.

Mr. STUPAK. OK. So you learned all this stuff today. That night, you didn't know that the monitors weren't working and the videos weren't working and had jerry-rigged this thing?

Mr. CROSBY. As I said at the time of the incident, I was not aware the MIC monitors were not working. I was certainly aware that the monitors were working around the site, and we certainly completed our full investigation, and we understand now fully——

Mr. STUPAK. Well, when you and your expert decided there was no problem in the air, you must have looked at the monitors. When you looked at the air monitors, you must have realized some of them weren't working. So when you made that decision that night you didn't have all the information necessary to fully inform the public, did you? Because part of your monitors—you had to realize that night because you had to look at the screens, right?

Mr. CROSBY. We used the full expertise that we got on that night, sir, that was available to us. I believe that those guys made a proper assessment of the situation. I believe that they drew the right conclusions. I believe that we made the right decisions.

Mr. STUPAK. Mr. Walden for questions, please.

Mr. WALDEN. Thank you, Mr. Chairman.

Mr. Crosby, were you actually at the plant that night when this first happened?

Mr. CROSBY. At the point at which the incident occurred I was actually about 3 hours away. I was attending a West Virginia business summit meeting.

Mr. WALDEN. So you weren't on site at the time of the event. At what point did you take command—or is that the right term?

Mr. CROSBY. I arrived on site approximately about 2:30 on the Thursday morning.

Mr. WALDEN. So 2:30 on Thurs—on the morning. This is overnight, right? So you are like 3 hours after the explosion.

Mr. CROSBY. Three or 4 hours after the event, yes, sir.

Mr. WALDEN. So were you in charge of the incident as you made your way there? If not, who was?

Mr. CROSBY. What happens is that, in the event of an incident, we call our emergency operations center.

Mr. WALDEN. All right.

Mr. CROSBY. And the key role in that operation center was—actually, that seat was occupied by the production leader, who was in charge and accountable for that methomyl unit.

Mr. WALDEN. Who is the production leader? Who was the person in charge since you weren't?

Mr. CROSBY. That production leader came in and took charge of the incident.

Mr. WALDEN. Right. Who is that?

Mr. CROSBY. His name is Rick Clay; and I believe he has been interviewed by your staff, sir.

Mr. WALDEN. And so he would have been the one overseeing all these decisions at that time, because you weren't on site.

Mr. CROSBY. I wasn't on site, but he has a team of people who form around him. Typically, when we have—if we have an incident like this, we form a team of—an emergency response coordination team. There were 15 to 20 people or more in that room that night all advising him.

Mr. WALDEN. I would hope you could appreciate our frustration in terms of the breakdown in communication.

Mr. CROSBY. Absolutely.

Mr. WALDEN. You've alluded to that, Mr. Buckner. I got to tell you, when I hear you use words like "well intentioned but inadvertently caused confusion," I really think that's lawyer speak and really misses the point. Because if—as you heard, I've been in the broadcast business, and it may have been well intentioned, but it sure doesn't read that way in the transcript. It really reads more like either lack of knowledge or stonewalling, one of the two. And my interpretation is more stonewalling when you have the fellow at the gate saying, I'm not allowed to tell you any more, and we have an emergency.

And I concur with the Chair. I mean, everybody knew that.

Mr. Buckner, have you taken an opportunity to meet with community leaders and first responders leaders to make sure everybody is on the same page going forward?

Mr. BUCKNER. No, sir, I haven't.

Mr. WALDEN. Is that something you would be willing to do?

Mr. BUCKNER. Absolutely.

Mr. WALDEN. Because as I watched you testify and watched their reactions I still think you have a communication problem here. I'm not—that's for you all to figure out, but I just sense that there is a lot of mistrust right now, and I think if you were in their shoes you might feel that way.

Mr. CROSBY. Could I just say a huge part of my own personal efforts now is maintaining or establishing and maintaining that outreach with our—what I would call our local stakeholders. I maintain personal communications with Commissioner Carper, with the folks of Metro 911, with our Congresswoman Capito. I work with the governor. I work with the community councils. It is my accountability, primary accountability to do that; and I am throwing myself 100 percent into that.

Mr. WALDEN. I think that's an important move, no doubt about it.

I'm troubled, too, by the information Mr. Bresland seeks, has, wants. You've heard his testimony. Correct me if I am wrong, Mr. Bresland, but I sense from your testimony that you feel there is still an issue here about getting all the information you want or that you felt that there was a withholding of information that otherwise did not pose a security risk to share, correct? Am I summarizing that correctly?

Mr. BRESLAND. We are still concerned about the issue of sensitive security information, and we still have 2,000 documents that have been stamped SSI by Bayer. So we're——

Mr. WALDEN. Mr. Buckner, are you familiar with 2,000 documents stamped as SSI by Bayer?

Mr. BUCKNER. I was familiar with them, yes.

Mr. WALDEN. And do you still believe they should be stamped SSI?

Mr. BUCKNER. We sent this information out to outside legal counsel for their review. We didn't believe we are qualified enough to interpret exactly what constitutes SSI in this situation. So we sent all these documents. And it was my understanding that 12 percent of the documents that we sent over to the outside legal counsel actually were classified as SSI by these individuals.

Mr. WALDEN. Twelve percent.

Mr. BUCKNER. Twelve percent, that's correct. Or 90 percent—roughly 88 percent of them actually were not SSI.

Mr. WALDEN. So of those 88 percent that your outside counsel say are not SSI are you freeing those up for CSB to have access to?

Mr. BUCKNER. Absolutely.

Mr. WALDEN. Has that happened?

Mr. BRESLAND. The problem is not allowing CSB to have access, but the problem is our use of the documents. We are an agency that prides ourselves on being very public. We have public meetings. We have press conferences. We prepare videos. Our issue is what do we do with these documents that we want to use in our outreach—maybe not the exact document but certainly information in the document. What do we do with that in the future? I'm thoroughly confused by this.

Mr. WALDEN. Let's take that 88 percent of those documents that they say they don't believe have SSI problems. Is there something else that poses a problem to you for your use of those documents?

Mr. BRESLAND. No, no.

Mr. WALDEN. So everybody is OK on that question. So it is the remaining 12 percent that's at issue here. Am I tracking this correctly?

Mr. BUCKNER. If I could, sir, we don't have issue with the 12 percent. They have been classified as SSI.

Mr. WALDEN. Who classified them as SSI? Your outside counsel?

Mr. BUCKNER. Outside counsel.

Mr. WALDEN. And did the Coast Guard make that call, whether they are SSI or not?

Mr. BUCKNER. It is my understanding that's correct.

Mr. WALDEN. Have you reviewed these 2,000 documents, Admiral?

Admiral WATSON. No, sir. The Coast Guard has not reviewed any of those documents.

Mr. WALDEN. Have you sought to review them and not gotten them? Or how does the process work?

Admiral WATSON. We review documents that are submitted to the Coast Guard. And SSI is a classification that can be applied by any covered person, which is a person who by the law and regulation is authorized to handle SSI information and sometimes create SSI information, as in the case of Bayer. The system is up to them——

Mr. WALDEN. It's up to them to decide whether it's classified or not, is that what you're saying?

Admiral WATSON. I'm sorry?

Mr. WALDEN. It is up to Bayer to decide what is SSI?

Admiral WATSON. Yes, sir. There is 16 categories that require labeling a document as SSI. These are categories which would cause the information to be transportation security sensitive.

Mr. WALDEN. And does anybody external of a company review that decision making? And, if so, who is that?

Admiral WATSON. Well——

Mr. WALDEN. Couldn't somebody just say, I don't want all this stuff released, so I think we will call it SSI and I get to decide, right?

Mr. BRESLAND. Well, here is a perfect example. This is a list of all of the—generally, a list of all of the documents that have been supplied to us; and every page on this list is marked SSI.

Mr. WALDEN. Every page?

Mr. BRESLAND. Every page.

Mr. WALDEN. If you go to tab 23 and maybe 26 as well, Admiral, in e-mail traffic a Bayer CropScience outside lawyer is instructing OSHA about its obligations to protect sensitive information, and then he instructs OSHA how to do this. Review of SSI is the language of the citations should be liberal and OSHA should strike any reference to any piece of equipment, piping or document involving these two chemicals, chlorine and MIC. Tab 23.

Admiral WATSON. Tab 23.

Mr. WALDEN. Third page in, on tab 23.

Admiral WATSON. What paragraph, sir?

Mr. WALDEN. Second paragraph—third paragraph, I'm sorry.

So I guess from your outside counsel, is that right, Mr. Buckner?

Mr. BUCKNER. I haven't seen the document.

Admiral WATSON. That's the first I have seen that document.

Mr. STUPAK. Eric Kahn.

Mr. BUCKNER. Yes, he is with our outside counsel.

Mr. WALDEN. And so you haven't seen this document?

Mr. BUCKNER. No, sir, I have not.

Mr. STUPAK. It's dated February 23rd. The third paragraph: Accordingly, your review for SSI and the language of the citation should be liberal; and OSHA should strike references to any piece of equipment, piping or document involving those two chemicals. You should be particularly cautious about PHA and PNID references to those chemicals or their interconnectivity on the parts to the unit.

Does this make sense, the company dictating what and how to label SSI to a Federal agency, Admiral?

Admiral WATSON. Sir, I'm looking at it against the different categories upon which you label something SSI; and it really doesn't fall into any of those categories, in my opinion.

Mr. WALDEN. Do the instructions even make sense? I mean, where is the transportation security nexus concerning a piece of equipment or document? Is that what you're saying, that there is no nexus from your quick evaluation?

Admiral WATSON. My quick evaluation, there is no nexus.

Mr. WALDEN. So I think this is the public policy question. Whether it is Bayer or somebody else, if you can have your attorney you didn't know had done this tell an agency what to do and what not to do—and here, Admiral, you're the one saying, I don't even see

where this fits the 16 criteria. And poor Mr. Bresland over here is being shut down in his ability to use these data points.

Mr. BRESLAND. Earlier in the testimony or earlier in your statement you mentioned Mr. Buckner's written testimony in which I understood that he said the reason that they applied the SSI categorization was to slow us down in our investigation and avoid—hopefully avoid us having a public meeting. Am I correct in saying that?

Mr. WALDEN. I don't believe that was——

Mr. STUPAK. Business concern, negative response. It was more—not necessarily slow you down. And avoid discussion——

Mr. WALDEN. I believe it is in the submitted testimony but not what he read this morning.

Mr. BRESLAND. Correct.

Mr. WALDEN. Which is different.

Mr. BRESLAND. I just don't understand.

Mr. WALDEN. Well, there is a motive issue here that strikes some of us as disconcerting, to say the least.

Mr. BRESLAND. Yes.

Mr. WALDEN. Am I correctly capturing that your submitted testimony is different from what you read today?

Do we have the submitted here with the language? Where is it? Can we get that?

Page 80 of your submitted—where you say, there were several reasons why the company sought confidentiality and SSI protection, including legitimate security concerns, the proper scope of CSB's investigation and, we frankly admit, the desire to avoid making the controversial chemical MIC part of the public debate regarding the incident.

Now, I wouldn't think in any of those 16 criteria that avoiding public debate is on that list.

Mr. BUCKNER. No, sir, it's not.

Mr. WALDEN. So do you appreciate what Mr. Bresland is getting at here?

Mr. BUCKNER. I appreciate the dilemma that we have in understanding SSI in its context.

As I stated in this particular statement that you reference, Congressman, we have two issues that we are dealing with. One is the obligation for us to acknowledge that we can't supply confidential information that may in fact be contrary to Homeland Security—the Homeland Security Act. The other is this information that I was made aware of of an internal discussion we had relative to our efforts to keep this from becoming a public issue. That's outside—in my way of thinking, that's outside the scope of the SSI issue.

Mr. WALDEN. Right. And I think ours, too, which is using SSI to avoid some other discussion by taking a liberal approach in how things get labeled.

Mr. BUCKNER. Again, sir, we supplied that information to our outside counsel. We let them determine what that is. There was a period of time, if I could, please, of a span of 1 week, roughly—I mentioned this earlier—to where this internal discussion took place. Once we received the information from our outside counsel, we readily supplied all this information that the CSB had requested.

Mr. WALDEN. So this memo we have from February 23rd of this year, was that within that 1-week period?

Mr. BUCKNER. No, sir, the 1 week took place previous to that. It was from January 15th up through the latter part of January itself.

Mr. WALDEN. So how do you explain this memo then from Eric Kahn that is somewhere toward the end of February that appears to say use SSI liberally to OSHA?

Mr. BUCKNER. I can't explain that.

Mr. WALDEN. Is Mr. Kahn one of your counsel?

Mr. BUCKNER. Yes, he is.

Mr. WALDEN. That reviews all of these things?

Mr. BUCKNER. That's correct.

Mr. WALDEN. So I guess in your testimony you said there were some in company management who initially thought that the Maritime Transportation Security Act of 2002 could be used to provide information to CSB.

Mr. BUCKNER. This was in that period of time in January, yes.

Mr. WALDEN. Would you characterize Mr. Kahn's memo as still of that opinion, that SSI can be used?

Mr. BUCKNER. I would have to take a moment to review the memo and discuss it with counsel. I can't make—this is the first time I have seen this document, and I can't make a judgment on that. I'm sorry.

Mr. WALDEN. I know my time has expired.

I would encourage you to take a look at this. I didn't realize that it would surprise you today to not know of that memo.

Mr. STUPAK. Let me try to clear it up, if I may.

Isn't it true there is a January 13th, 2009, document—the Bayer personnel responsible for examining whether or not to seek confidentiality for the MIC documents identified only 1 specific reason do so and that was a concern that information contained in them would be used by CSB to recommend reduction or elimination of MIC storage at the plant by using inherently safer technologies.

Mr. BUCKNER. That's true. I have seen that document.

Mr. STUPAK. So there is no evidence prior to January 13th of '09 that the company was discussing national security concerns over the release of documents?

Mr. BUCKNER. Well, again, I would say, in the context of the requested information from the CSB, we felt like it was going beyond the scope of the accident itself and moving off into a direction of looking at all the other information surrounding MIC; and this individual made a speculation and a PowerPoint presentation.

Mr. STUPAK. Right, it was a PowerPoint presentation, and there was no real concern prior to that time about national security.

Mr. BUCKNER. Not before that time, because we didn't really understand it.

Mr. STUPAK. Mr. Burgess for questions?

Mr. BURGESS. I don't know that I have much more to add. But just for my own clarification, the night of the incident there would have been no reason for the plant operator who made the 9/11 call to have assumed that there was sensitive security information that he must be careful of what he disclosed or didn't disclose to the responders; is that correct?

Mr. BUCKNER. That's correct.

Mr. BURGESS. So I guess we are better left to assume that the disconnects there are more because of a crisis and people have made mistakes in the process of doing their job?

Mr. BUCKNER. That's correct.

Mr. BURGESS. You are going to fix that because the plant is important to the community. We have heard that testimony in the previous panel; and, obviously, we are putting people at risk in the plant, people who come in to help when you have a problem and the people next door at the college. So we're going to reassure the community at large that that is happening and an ongoing part of your internal safety protocol.

Mr. BUCKNER. You are absolutely correct.

Mr. BURGESS. That that really has nothing to do with national security.

Mr. BUCKNER. No, sir.

Mr. CROSBY. If I could add to that, we have already changed our procedures and protocols; and we are in a position now where we're going to carry out a drill, an emergency drill to really test those again to make sure we have done the right things.

Mr. BURGESS. I'm just like Mr. Walden. I would suspect that there is some significant bridge building that needs to occur between the community and first responders, because that was a serious, serious——

Mr. CROSBY. A lot——

Mr. BURGESS. A lot of people at risk. And I think they justifiably feel they weren't getting accurate, timely information that they needed to do their jobs and do it safely.

And, Admiral Watson, if I could ask you—let's just assume that there was significant sensitive security information; and had Bayer CropScience not followed the protocol, what penalty would they be facing today? What if they had released sensitive security information, opened the books? Mr. Bresland comes in and says, let me see what you've got. They open the books. Sensitive security information is sitting right out there on page 1, and they disclose it. What happens?

Admiral WATSON. That would have been perfectly fine, sir.

Mr. BURGESS. No whistles, no bells, no lights?

Admiral WATSON. No, the CSB, like this committee, is a covered person. So if you have a need to know, you're authorized by law to have access to SSI.

Mr. BURGESS. OK. Well, let's take it even one step further. What if it was the Daily Herald that came in and they opened the books up and there is SSI on the front page and it gets printed in the newspaper?

Admiral WATSON. Then Bayer has an obligation to keep that information secure.

Mr. BURGESS. What's the worst-case scenario for them?

Admiral WATSON. Well, the worst case would be a civil penalty.

Mr. BURGESS. I——

Mr. BRESLAND. Can I make 1 point?

Mr. BURGESS. Yes, please.

Mr. BRESLAND. The issue for the Chemical Safety Board was not the receipt of the information. We were allowed to receive it. Our

issue was could we have a public meeting and explain what happened on that night of August 28th without disclosing what was alleged to be sensitive security information. Had we done that and had that been shown to be sensitive security information, I could have lost my job. There could have been penalties against me. Our investigators could have lost their jobs. That is the penalty that's laid down in the regulations. That's why we were concerned about this.

Mr. BURGESS. Sure, I understand that. That would have been the case whether or not Bayer CropScience said it was sensitive security information or not, would it not? Had you disclosed information that put national security at risk—does Bayer's interpretation of the information at this point, does that then—is that what's guiding you on releasing the information or not releasing the information?

Mr. BRESLAND. It appears that Bayer is the decisionmaker on what is SSI. They say it is SSI——

Mr. BURGESS. Admiral, is that the intent of this, protection for national security?

Admiral WATSON. Yes.

Mr. BURGESS. That Bayer would make that determination?

Admiral WATSON. Bayer is supposed to know their duties and responsibilities under the regulation for SSI, which is pretty clear. There are 16 categories. They evaluate each piece of information against those categories of SSI. They label it SSI. And then it is perfectly normal for the CSB to assume if it is marked SSI that it is SSI.

There is a process by which they can sort of appeal that classification, and that's the case where it would go to the Coast Guard or Transportation Security Administration.

Mr. BURGESS. All right. Is there any penalty for Bayer inappropriately labeling something SSI when it is not? Since they're the arbiter, it is determinate as to whether or not—it is their obligation to——

Admiral WATSON. There is definitely a penalty for not labeling something SSI that should be SSI. I don't know the answer to your question about mislabeling.

Mr. BURGESS. Well, I'm just wondering if there is a scenario where Bayer might be prone to over interpret to stay out of trouble, stay out of congressional committees and writs and subpoenas and the sort of things that we do.

I'm just asking the question because I honestly don't know. It seems there is some definitional difficulties that we have that are leading to certainly making Mr. Bresland's life miserable on what he can and can't do and created a congressional committee to work well into the afternoon on this. But that is just purely conjecture on my part. It seems like this is something that could be tightened up considerably, but I'll leave that up to the Coast Guard.

Mr. BRESLAND. We are an independent agency, and we have the authority to go out and investigate chemical accidents. As much we love the Coast Guard, we don't to be going to them every time we write a report and say please check this for SSI. Especially if the information is what I'd consider to be frivolous when it comes to a definition of SSI.

We have no interest in guards, guns, fences. There are experts at DHS and the Coast Guard who deal with that issue. We have absolutely nothing to do with that, and we have no interest in ever dealing with that.

Mr. BURGESS. I guess that's what I'm having difficulty in understanding, is how we came to such an impasse on this. Was it the inappropriate labeling of documents that say SSI by Bayer? Was Bayer doing that in an abundance of caution because they did not want to invoke civil penalties? I guess that's where I'm having the disconnect.

Mr. BRESLAND. Well, I think Mr. Walden made an interesting point in asking what was the motive here. I can't read people's minds. I don't know what their motive was.

Mr. BURGESS. You have obviously said it to counsel and you got solicited advice that you paid for and you took them for their word when they said you better not disclose this; is that correct?

Mr. BUCKNER. That's correct.

Mr. BURGESS. I yield back the balance of my time.

Mr. STUPAK. Thank you, Mr. Burgess.

There is no civil penalty if you produce too much information. There is only a civil penalty under the Maritime Act if you don't take sensitive information and label it.

So you can bury a company with SSI information. For instance, 2,000 documents they declared are SSI here that we feel have no national security inference. So that's 2,000 documents. How many pages in each document? You're probably talking thousands and thousands of pages the Coast Guard would have to go through to make a determination if there is national security interest. Maybe there should be a penalty for companies that use the Maritime Act to overwhelm us with paperwork that has nothing to do with national security.

Mr. BURGESS. Well, exactly the point. I think perhaps—I don't know whether it is our jurisdiction, but perhaps there could be some clarity for the company and all concerned. Because it doesn't sound like there was an abundance of clarity in that situation.

But, again, I yield back.

Mr. STUPAK. Well, if we had a literal approach as opposed to a liberal approach as we saw in the memo maybe we wouldn't have been on that issue so long.

Let me ask you, Mr. Crosby, the committee staff has heard from several people, including Bayer employees, that the startup and shutdown is the most dangerous part of any chemical process; is that correct?

Mr. CROSBY. Yes, it is.

Mr. STUPAK. And I understand that this explosion occurred as we were restarting the methomyl unit, right?

Mr. CROSBY. We had been in the process of restarting that unit over a number of days, yes.

Mr. STUPAK. Well, if it is a particularly dangerous time, then isn't that precisely when you'd want to make sure your MIC air monitors were working and the video cameras were recording?

Mr. CROSBY. As I explained to you, at the time I wasn't aware that the MIC monitors were not working at the time of the inci-

dent. I subsequently found that out. Those monitors are there to——

Mr. STUPAK. Some Bayer employee must know that, right? If it is the most dangerous part and you are restarting this unit and your safety devices, the air monitors and video cameras, if the process is not working, someone had to decide to restart the thing even though the safety——

Mr. CROSBY. We also have a lot of—a number of operators actually working that area as well. We have eyes and ears and levels of instrumentation——

Mr. STUPAK. Sounds like your eyes and ears weren't on that day.

Mr. CROSBY. Our eyes and ears—we have highly trained chemical operators who were starting that process. They were supported by a number of technical folks that were there. We have round-the-clock technical cover, and they were working on the restart process.

Mr. STUPAK. Unfortunately, the real eyes and ears went to check, because the monitors were indicating an increased temperature, and those folks were killed, right?

Mr. BUCKNER. We did an internal investigation, a very thorough one; and out of that we identified several multiple factors that contributed to the accident itself. We've gone back and we dedicated the site, further trained the individuals to look at our standard operating procedures to ensure that this accident never happens again.

Mr. STUPAK. Well——

Mr. BUCKNER. Including everything that you just acknowledged.

Mr. STUPAK. You have had it since 2002. So you have had it about 7 years. And we have got about 3 or 4 incidents—in fact, the one in September of—8 months before this one, September of '07. And we seem to have repeat complaints about lack of communication and things like this. And you bypassed the internal safety systems on this heater unit to get it to work.

Mr. BUCKNER. I wasn't aware of that, and I can assure you that it will not happen again.

Mr. STUPAK. If we're really concerned safety then—and I know you didn't want MIC to be part of the public debate. That's why you had the SSI invoked, to try to stop that public debate. But in light of what we have learned today of the recent accident of last August will you, on behalf of Bayer CropScience, commit today to implementing a safer technology that eliminates the MIC stockpiles at your plant?

Mr. BUCKNER. I won't commit to eliminating, endorsing or bringing in inherent safer technologies. I think what we have to do is we have to continue to assess new technologies as they become available.

Mr. STUPAK. Why wouldn't you eliminate it in light of the accident and near worst-case scenario we almost had? Is it a monetary thing, the cost of reduplication? I mean, the Dupont plant did it; and as I read from the earlier report from '94, the Israelis used different chemicals to get the same results from their pesticides. Why are we the only company left that still has the storage and this MIC unit? Why don't you just produce what you need that day and that's all for that day? Why don't you do that?

Mr. BUCKNER. I'll let Mr. Crosby answer that question.

Mr. CROSBY. We believe the process that we use to produce and store MIC at Institute is the safest process available for the products that we make.

We have 4 different manufacturing plants. Some of those operate continuously, and some operate on a patch-wise process. If we were to introduce inherently safer technology, then we would essentially have to implement 4 independent small units, each operating in conjunction with each of those manufacturing plants.

Mr. STUPAK. That would be today's use.

Mr. CROSBY. Yes.

Mr. STUPAK. Wouldn't that be safer than what you are doing now?

Mr. CROSBY. We don't believe so, the reason being those 4 plants would go through multiple startups and shutdowns and that itself imposes an inherent risk. We prefer and believe the safest way of making MIC and using that in our production is to make it a 1 point of use, is to store a quantity of a maximum of 2 to 3 days of inventory. That's all that we store—processes.

Mr. STUPAK. You or Mr. Buckner can answer, if you don't want to stop storing it like I think you should, then how about this? Will Bayer agree then to have a third party come in and conduct an independent analysis of your safety use of MIC? Will you commit to have someone else look at it other than just you?

Mr. BUCKNER. I would have to take that back and have a discussion with our plant operators to ensure, one, what we have done in the past was thorough enough and, two, really challenge the fact whether there are inherent safer technologies out there before I commit 100 percent.

Mr. STUPAK. Mr. Bresland, if they won't stop storing it and they won't have a third party look at it, I hope one of your recommendations is that Bayer should eliminate the storage of large quantities of MIC at this plant. And if they have to do 4 different systems, let them do 4 different systems. I hope that is one of your recommendations. I know that Mrs. Christensen and some of the others brought that up, and I would suggest that.

Mr. BUCKNER. Chairman Stupak, we look forward to the opportunity to work with the CSB to understand what ideas that they might have for us as well as part of the process.

Mr. STUPAK. That's good. But I hope, since you are reluctant even to have a third-party independent review your safety procedures on how you are handling this MIC, especially when you put a bypass system in, the monitors aren't working, the air quality and the cameras—it seems like all of the things that should have been in place, you bypassed them or turned them off during the most dangerous time, which is loading and unloading and starting up the process.

Maybe we shouldn't use it. Why should we just allow one company in this country to stockpile this much? I guess I find that ironic. We dodged a bullet here today. The next one we might not.

Even the notification for the emergency response people, having been there and having done that myself—we alluded to traffic accidents. Even traffic accidents, when you have an 18-wheeler roll over, right on the truck it says what it is so we know when the firefighters approach it. Or a train. But in your case we never got

past the front door, so we did not know what it was. The people on the first panel said they didn't know what was coming out—methomyl or whatever it was.

We look forward to your investigation and your report on Thursday and look forward to continuing to work with you and get this matter resolved.

I have no further questions.

Mrs. Capito, I thank you again for staying with us all today.

Mr. BURGESS. Mr. Chairman, we have two questions from counsel that are so involved and intricate that I am going to submit them in writing because I don't understand them.

Mr. STUPAK. Thank you.

That concludes our questioning. I want to thank all of the witnesses for coming today and for your testimony.

The committee rules provide that members may have 5 days to submit additional questions for the record.

That concludes our hearing. The meeting of the subcommittee is adjourned.

[Whereupon, at 3:05 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

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MEMORANDUM

April 21, 2009

To: Members of the Committee on Energy and Commerce, Subcommittee on Oversight and Investigations

Fr: Majority Staff, Committee on Energy and Commerce

Re: Supplemental Information Regarding the 2008 Bayer Chemical Plant Explosion

On Tuesday, April 21, 2009, at 12 noon in room 2322 of the Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled, "Secrecy in the Response to the Fatal Bayer Chemical Plant Explosion." This memo provides supplemental information to assist members in preparing for the hearing.

I. EXECUTIVE SUMMARY

On August 28, 2008, an over-pressurized waste tank containing Methomyl exploded at a Bayer CropScience facility in Institute, West Virginia, sending a fireball hundreds of feet into the air. One Bayer employee was killed instantly, and another suffered third-degree burns and died over one month later. Eight other individuals, including six emergency responders and two contract employees, reported symptoms of chemical exposure as a result of the explosion.

The Committee initiated its investigation because the explosion came dangerously close to compromising another nearby tank filled with several tons of methyl isocyanate (MIC), an extremely toxic chemical that killed approximately 4,000 people after a leak in Bhopal, India, in 1984. Twenty-five years later, Bayer's facility in West Virginia is the only site in the United States that continues to produce and store large amounts of MIC.

The explosion at Bayer's plant was particularly ominous and unnerving because a "residue treater" weighing several thousand pounds rocketed 50 feet through the plant, twisting steel beams, severing pipes, and destroying virtually everything in its path. Had this projectile struck the MIC tank, the consequences could have eclipsed the 1984 disaster in India.

As part of its investigation, the Committee reviewed more than 200,000 pages of documents, as well as audio and video recordings, obtained from Bayer, the Coast Guard, the Environmental Protection Agency, and the Chemical Safety and Hazard Investigation Board (CSB), the independent federal agency charged with investigating chemical accidents. Committee staff also inspected Bayer's plant in West Virginia and interviewed more than 20 Bayer employees, first responders, elected officials, and concerned residents.

Evidence obtained by the Committee demonstrates that Bayer engaged in a campaign of secrecy by withholding critical information from local, county, and state emergency responders; by restricting the use of information provided to federal investigators; by undermining news outlets and citizen groups concerned about the dangers posed by Bayer's activities; and by providing inaccurate and misleading information to the public.

On the night of the explosion, Bayer failed to provide emergency responders with critical information about the scope of the explosion, the potential chemical hazards involved, or the actions needed to safeguard the surrounding community.

The Committee obtained transcripts of radio communications among fire, police, and emergency medical personnel that show extreme frustration with the lack of information from Bayer. First responders repeatedly complained that "we can't get through to the Plant," "we still don't have contact with the Plant," "they're not giving us anything," and "we have no contact with anybody from the plant."

When the company refused to provide information on whether the explosion involved MIC or other toxic chemicals inside the plant's Larvin unit, emergency officials contacted Bayer employees directly. One emergency responder stated: "I got a report from the Sheriff that got a report from the engineer at the Plant and this is in the Larvin Unit, and he said it's a serious situation." Another stated: "I spoke to a mechanic that works in the Plant and another gentleman that works in the Plant, and they are both saying it's poisonous."

As fire department officials from the town of St. Albans reported a potentially toxic "cloud of some type" moving westward toward them, emergency responders ordered a "shelter in place" for community residents. Officials at all levels condemned Bayer's actions:

- Joe Crawford, the police chief of St. Albans, said there was "absolutely no excuse" for Bayer's actions and called them "ludicrous."

- Kent Carper, the President of the Kanawha County Commission and a member of the Governing Board of the Metro 911 call center, called this a "complete abdication of Bayer's responsibility to your neighbors and our first responders."

- Mike Dorsey, the Chief of Homeland Security and Emergency Response for the West Virginia Department of Environmental Protection, stated: "It would have been very difficult for them to have handled this any worse."

In testimony for today's hearing, CSB Chairman John Bresland expresses concern that Bayer officials told first responders 15 minutes after the explosion that "no dangerous chemicals had been released." According to Chairman Bresland, "That statement is clearly incorrect, since Methomyl is toxic, and its uncontrolled decomposition may release highly toxic byproducts."

Serious questions have also been raised about Bayer's handling of key evidence related to the explosion. During the Committee's investigation, Bayer officials revealed that:

- Critical video footage of the explosion is missing because an unidentified contractor disabled the recording function from surveillance cameras inside the Larvin unit;
- Air monitors designed to detect MIC inside the Larvin unit were "out of service for maintenance repair" at the time of the explosion; and
- A protective "blast mat" around the MIC tank was removed and destroyed after the explosion, foreclosing further analysis of damage caused by shrapnel and debris.

In the months following the explosion, Bayer launched a media and legal strategy to stem public disclosures about its actions. For example, the Committee obtained an internal "community relations strategy" document in which Bayer's public relations firm recommended undermining local community groups and news outlets. It stated: "Our goal with People Concerned About MIC should be to marginalize them. Take a similar approach to *The Charleston Gazette*."

Bayer also attempted to conceal information about the explosion from the public by invoking, and in some cases misusing, a statute governing maritime transportation security to label unprecedented amounts of material as "sensitive security information" (SSI). CSB officials called this effort "overbroad" and "palpably ridiculous," and they warned that it could impair efforts to enhance chemical safety in the future.

In testimony for today's hearing, Bayer President and CEO William Buckner states that company officials initially thought they could "refuse to provide information to the CSB." They later began labeling documents as SSI in order to "discourage the CSB from even seeking this information."

Mr. Buckner concedes that "business reasons" motivated Bayer officials, including "a desire to limit negative publicity" and "avoid public pressure to reduce the volume of MIC that is produced and stored at Institute by changing to alternative technologies."

Bayer contends that its current process "appears to be as safe as the other alternative methods to produce MIC." Bayer's actions stand in stark contrast to other chemical companies that have already switched to safer technologies. In 1985, for example, directly after the MIC catastrophe in India, another chemical company, DuPont, altered its processes to eliminate the storage of large volumes of MIC.

II. FAILURE TO PROVIDE INFORMATION TO EMERGENCY RESPONDERS

Evidence obtained by the Committee indicates that following the explosion at the Bayer chemical plant in West Virginia at approximately 10:30 p.m. on August 28, 2008, the company failed to provide emergency first responders with critical information about the scope of the explosion, the potential dangers involved, or the actions recommended for the surrounding community. The evidence also demonstrates that Bayer delayed or refused entry to officials from local, county, and state governmental agencies seeking to access the facility to investigate the explosion.

The Committee obtained transcripts from an emergency radio channel shared by multiple fire departments and emergency responders in Kanawha County. These transcripts show that first responders tried repeatedly to obtain information from Bayer with no success:

> 10:40 p.m.: "at this time we can't get through to the Plant."
>
> 10:41 p.m.: "We need to find out what we got before we roll in there. ... Be advised we still don't have contact with the Plant."
>
> 10:44 p.m.: "they're not giving us anything. To be honest with you, I don't even know if anybody's even called in from there. ... there is heavy smoke and a whole lot of flames. ... I'm here across from the Plant and we've got a western wind. It's blowing down toward the western end."
>
> 10:46 p.m.: "I've tried calling Bayer and nobody answers the phone. They called us, and I talked to the call taker, and they're not releasing any information."
>
> 10:51 p.m.: "confirmed explosion and have a working fire, no further information at this time."
>
> 11:16 p.m.: "we have no contact with anybody from the plant."[1]

The evidence also indicates that for hours following the explosion, Bayer refused to provide first responders with information to address key safety questions, including (1) whether the explosion occurred in the Larvin unit of the plant, which contains a significant amount of toxic chemicals; (2) whether a large smoke cloud traveling westward after the explosion contained toxic chemicals; (3) whether emergency paramedics should be decontaminated after treating victims; and (4) whether to order a "shelter in place" for surrounding communities.

The radio transcripts show first responders discussing these issues in the aftermath of the explosion:

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[1] Metro 911 of Kanawha County, *Verbatim Radio Transcripts from Metro – Fire Departments* (Aug. 28, 2008).

10:52 p.m.: "it's for sure over in the general area of the Larvin Unit. I spoke to a mechanic that works in the Plant and another gentleman that works in the Plant, and they are both saying it's poisonous."

11:03 p.m.: "God, I know you're busy but at some point could you inquire whether or not we need to decon ourselves. … Yeah, I'm not getting clear information, but if I was you, I would, up there at the hospital."

11:03 p.m.: "I got a report from the Sheriff that got a report from the engineer at the Plant and this is in the Larvin Unit, and he said it's a serious situation."

11:06 p.m.: "no EMS units in the western part of the County … just to stay kind of up wind until we can find out for sure what's going on."

11:20 p.m.: "All we know right now is the only thing we've been told is a shelter in place in the west, that's all, because nobody else has told us anything."

11:20 p.m.: "Have we confirmed the product? … Well, we know it was in the Larvin Unit, and there's a mixture as of right now. John, we're really not confirmed exactly what it is. … So, the clouds you have reported is a product cloud? … As far as I know, yes. Instead of taking any chances, that's what we're going to go with. … Like I said, John, we're not getting this information. We're trying to get it from the Plant. We haven't gotten anything yet."

11:21 p.m.: "I think I have confirmed that here at the gate, but I don't know, they couldn't tell me what was in the Larvin Unit."

11:42 p.m.: "All stations and units on authority of Kanawha County Office of Emergency Services issuing a shelter in place for all areas west of the City of Charleston, repeating a shelter in place for all areas west of Charleston, includes the cities of South Charleston, Dunbar, Nitro, St. Albans."[2]

A transcript obtained by the Committee of a 10:57 p.m. telephone exchange between the Kanawha County Metro 911 call center and officials from the fire department in St. Albans, West Virginia, also reflects discussion of a potentially toxic cloud moving over the community:

St. Albans Fire: [W]e have a cloud of some type that is dark, its moving more towards Nitro can you please try to get some information so you can tell us what it is?

Metro: Copy cloud is moving towards Nitro. I will try and figure out something. The command on scene hadn't said anything about the cloud but we are still trying to get some information on it.

St. Albans Fire: You can see the cloud with the fire right above it for 3 or 4 miles.

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[2] *Id.*

Metro: [S]till trying to figure something out on it.

St. Albans Fire: If we don't hear something within 5 or 6 minutes we are going to do a shelter in place in the St. Albans area.[3]

In the hours following the explosion, Bayer provided first responders with little information beyond confirming there was an emergency at the plant. The Committee obtained audio and written transcripts of eleven telephone exchanges from 10:39 p.m. to 5:50 a.m. on the night of the explosion between Bayer officials and the Metro 911 call center. At 11:15 p.m., the Metro 911 call center had the following exchange with the guard at the main gate of the Bayer facility:

Bayer CropScience: What it is we, we have an emergency at uh Bayer Crop Science plant, and the only information I can give you is that will need and uh, you might want to uh alert the community, I've, uh, my supervisor informed me to tell you to uh alert the community that there is an emergency uh in the plant right now … so that's that's what it amounts to, just alert the community that there's emergency in the uh Bayer Crop Science plant, and we will uh, keep you informed.

Metro: Ok, just real quick, uh we had reports that was in the Larvin unit, are you able to confirm or deny that?

Bayer CropScience: No that's all. I'm I'm only allowed to tell you that we have an emergency in the plant.

Metro: Ok and who was it that told you to tell us that? I'm sorry.

Bayer CropScience: The uh, my uh the shift leader.[4]

In addition, during the Committee's investigation, officials from local, county, and state governmental agencies expressed concern that Bayer hindered or prevented them from entering its facility to investigate the explosion on the night of the incident. These officials included:

- Michael Dorsey, Chief, Homeland Security and Emergency Response, West Virginia Department of Environmental Protection;
- Sterling Lewis, West Virginia State Fire Marshal;
- Keith Vititoe, Sergeant, Kanawha County Sheriff's Department;

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[3] Metro 911 of Kanawha County, *Bayer Explosion – Nitro Fire Transcript* (Aug. 28, 2008).

[4] Metro 911 of Kanawha County, *Calls from Bayer Crop Science to Metro 911 and 911 to Bayer Crop Science Incident* (Aug. 28, 2008).

- Jimmy Gianato, Director, West Virginia Division of Homeland Security and Emergency Management; and

- David Armstrong, Deputy Director, Kanawha County Office of Emergency Services.

Kent Carper, the President of the Kanawha County Commission and President of the Governing Board of the Metro 911 call center, oversees first responders throughout the community. On September 4, 2008, he wrote a letter to Bayer objecting to the company's refusal to provide critical information to emergency responders. He wrote:

> Metro 911 repeatedly asked for information and was refused. The Emergency Plan, as well as government reporting requirements, call for your company to provide information to the community in a timely manner during such emergencies. This did not happen. In fact, no notification from Bayer included mention of the "Larvin Unit" until the all-clear the next morning. This was a complete abdication of Bayer's responsibility to your neighbors and our first responders, who were sent uninformed to an explosion because no one was "allowed" to inform us. [5]

On April 3, 2009, Committee staff interviewed Joe Crawford, the police chief of St. Albans, West Virginia. He explained the reasons he was concerned about the failure of Bayer officials to provide any information about a potentially toxic cloud heading westward toward his town. He stated: "Prevalent winds always blow stuff into our town. ... Over an hour and still we had not had a confirmation of if there had been a release or what type of chemical had been released." He said there was "absolutely no excuse" for this and called it "ludicrous."[6]

On April 4, 2009, Committee staff interviewed Mike Dorsey, the Chief of Homeland Security and Emergency Response for the West Virginia Department of Environmental Protection. When asked whether Bayer's response to the explosion was adequate, he responded: "It would have been very difficult for them to have handled this any worse." He added: "This was appalling. People were downright angry. ... We have a responsibility to the citizenry and we were denied the ability to do our jobs."[7]

Hazo Carter, the president of West Virginia State University, which is adjacent to the Bayer facility and had 500 people on campus at the time of the explosion, wrote to Bayer the day after the explosion. He stated:

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[5] Letter from W. Kent Carper, President, Kanawha County Commission, to Nick Crosby, Plant Manager, Bayer CropScience (Sept. 4, 2008).

[6] House Committee on Energy and Commerce, Interview of Joe Crawford (Apr. 3, 2009).

[7] House Committee on Energy and Commerce, Interview of H. Michael Dorsey (Apr. 4, 2009).

> The decisions we make regarding the safety of our students are influenced by the information that is provided. Following the August 28th incident, I do not believe that enough accurate information was given in a timely manner.[8]

In written testimony for today's hearing, John Bresland, the Chairman of the Chemical Safety and Hazard Investigation Board (CSB), concludes that there were "serious deficiencies in internal communications, and emergency response planning on the part of Bayer." He states:

> I am very troubled by our observations of the inadequacy of Bayer's emergency response and emergency communications. For example, the county's 9-1-1 call center was told, fifteen minutes into the response, that no dangerous chemicals had been released. ...
>
> That statement is clearly incorrect, since Methomyl is toxic, and its uncontrolled decomposition may release highly toxic byproducts. ...
>
> Of particular concern is that apart from the two fatally injured workers, eight other people reported symptoms of chemical exposure following the accident. These include six outside volunteer firefighters and two rail contractors, who were on-site the night of the accident.[9]

In public, Bayer initially denied that there were any problems with the company's response to the explosion. On August 31, 2008, Bayer officials developed a PowerPoint presentation about the incident. A slide entitled "Positive Points" stated: "Emergency Response went very well – no significant complaints from the community and neighbours."[10] A week later, on September 5, 2008, Bayer officials issued a statement to the media in response to a story in the *Charleston Gazette.* It asserted: "We shared all available information with Metro 911 as that information became available."[11]

When faced with criticism, Bayer has sought to undermine its critics in community groups and the press. The Committee has obtained an internal "community relations strategy"

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[8] Letter from Hazo W. Carter, Jr., President, West Virginia State University, to Nick Crosby, Plant Manager, Bayer CropScience (Aug. 29, 2008). *See also* Letter from Hazo W. Carter, Jr., President, West Virginia State University, to Nick Crosby, Plant Manager, Bayer CropScience (Jan. 9, 2008) (raising similar concerns about Bayer's "lack of timely, direct notification to the University and this community" after another chemical incident at the plant in December 2007).

[9] Testimony of John Bresland, Chairman, Chemical Safety and Hazard Investigation Board, before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on Secrecy in the Response to the Fatal Bayer Chemical Plant Explosion,* 111th Cong. (Apr. 21, 2009).

[10] Bayer CropScience, *Methomyl Incident at BCS Institute, WV on 2008-08-28* (Aug. 31, 2008).

[11] Bayer CropScience, *Response to Metro 911 Allegations as Reported in the Charleston Gazette* (Sept. 5, 2008).

document dated December 29, 2008, in which Bayer's public relations firm outlined this approach. The document stated:

> Our goal with People Concerned About MIC should be to marginalize them.
>
> Take a similar approach to *The Charleston Gazette*. For as many years as it has been in print, *The Gazette* has chosen to be anti-business and champion environmental activists' causes. Marginalize its effectiveness.[12]

III. VULNERABILITIES OF BAYER'S INVENTORY OF MIC

Documents obtained by the Committee raise serious questions about the vulnerabilities of Bayer's inventory of methyl isocyanate (MIC) during the 2008 explosion and about MIC monitoring systems that were out of service at the time of the explosion. The documents also raise questions about whether Bayer has adequately considered the feasibility of reducing its MIC stockpile or switching to inherently safer technologies.

A. Near Miss of MIC Storage Tank

Bayer uses MIC in the production of several different pesticide products. The facility manufactures MIC on-site and stores it in large volumes underground. It also maintains a 37,000 pound above-ground "day tank" of MIC. This day tank is covered by a metal blast mat designed to absorb the impact of debris, shrapnel, and other projectiles.[13]

Documents obtained by the Committee raise two key questions about Bayer's MIC day tank: (1) how close was it to being compromised during the 2008 explosion; and (2) would it have been compromised as a result of a direct impact from the "residue treater" that propelled through the facility?

MIC is an extremely dangerous toxic substance. On December 3, 1984, approximately 50,000 to 90,000 pounds of MIC gas leaked from a Union Carbide chemical plant in Bhopal,

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[12] E-mail from Ann S. Green, Ann Green Communications, to Nick Crosby, Plant Manager, Bayer CropScience (Feb. 19, 2009) (attaching community relations strategy). *See also* E-mail from Tom Dover, Manager, Tenant Services and Public Affairs, Bayer CropScience, to Greg Coffey, Bayer CropScience (Jan. 30, 2009) (attaching a list of "upcoming events/opportunities for reputation enhancement & public interaction and other key dates").

[13] Testimony of John Bresland, Chairman, Chemical Safety and Hazard Investigation Board, before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on Secrecy in the Response to the Fatal Bayer Chemical Plant Explosion,* 111th Cong. (Apr. 21, 2009).

India. Although estimates vary, approximately 4,000 people died and several thousand other individuals experienced permanent or partial disabilities.[14]

On the night of August 28, 2008, a vessel in the Methomyl/Larvin unit known as a residue treater experienced a runaway chemical reaction that caused the vessel to rupture. The MIC day tank is located 80 feet to the southwest of the explosion.[15] In written testimony for today's hearing, CSB Chairman John Bresland describes the damage caused when this vessel became a dangerous projectile:

> The entire vessel was violently propelled in a northeasterly direction into the production unit – demolishing process equipment, twisting steel beams, and breaking pipes and conduits. The vessel finally came to rest about 50 feet away, grossly deformed and flattened. In its wake, it left a continuous swath of destruction. ... As far as we can determine, the direction of the residue treater was a matter of random chance. The violent rupture of the vessel might have propelled it horizontally in any direction.[16]

Photos obtained by the Committee show that shrapnel and other debris from the explosion struck the blast mat surrounding the MIC day tank. The photos also show that the blast mat was warped and unbolted in places. Other photos appear to show large smoke and burn marks on the MIC blast mat.[17] The Bayer staff in the Emergency Operations Center noted in the log of the evening's events that the fire was affecting the nearby MIC day tank. At 12:37 a.m., the log notes: "MIC tank warming some. Pumps shut down. Monitoring pressure of MIC tank."[18]

On April 14, 2009, Committee staff conducted a transcribed interview with Michael Wey, the head of the Health, Safety, and Environment Expertise Center at Bayer. During his interview, Mr. Wey conceded that "there was one piece of shrapnel that was captured in the blast curtain." He asserted that there was "no evidence that the ballistic curtain was damaged," although he acknowledged that the company "did not do any formal evaluation of the blast curtain for damage."[19]

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[14] *Bhopal's Tragedy Revisited; 10 Years After the Gas, No End to Tears*, New York Times (Dec. 11, 1994); *Trying to Limit Disclosure on Explosion*, New York Times (Mar. 28, 2009).

[15] Testimony of John Bresland, Chairman, Chemical Safety and Hazard Investigation Board, before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on Secrecy in the Response to the Fatal Bayer Chemical Plant Explosion,* 111th Cong. (Apr. 21, 2009).

[16] *Id.*

[17] Chemical Safety and Hazard Investigation Board, *Photos of Bayer CropScience Facility after August 28, 2008 Explosion* (Photo Nos. 6, 16, and 21) (Aug. to Oct. 2008).

[18] Bayer CropScience, *EOC Notes 8-28-08, Methomyl Unit Incident* (Aug. 28, 2008).

[19] House Committee on Energy and Commerce, Interview of John Michael Wey (Apr. 14, 2009).

After the explosion, Bayer contracted with Baker Engineering and Risk Consultants to conduct a perforation analysis of the blast mat to ascertain whether it could withstand shrapnel weighing less than 100 pounds.[20] This analysis did not evaluate whether the MIC tank could have withstood a direct impact from the residue treater projectile, which weighed more than 2 1/2 tons.

Soon after the explosion, the company removed the blast mat, destroyed it, and replaced it with a new blast mat with different design specifications. When asked about these actions during his interview with Committee staff, Mr. Wey responded:

> The primary reason why the curtain was replaced is we wanted to expedite the reconstruction and the restart of the MIC tank so that we could restore operations to our FMC production unit.[21]

Mr. Wey did not explain why the blast mat had to be replaced in order to restart the MIC tank. When asked during his interview if Bayer consulted with CSB before destroying the blast mat, he responded that the company did and that CSB did not instruct Bayer to retain it.[22] According to CSB Chairman John Bresland, however, CSB has no written record of any discussion with Bayer regarding the decision to remove or replace the blast mat.[23] Mr. Bresland states in his written testimony for today's hearing:

> We are still awaiting from Bayer any written documentation to indicate the design basis of the blast blanket, the standards to which it was constructed, and the scenarios it may be deigned to withstand. Without this information, it is difficult to draw any conclusion about how much danger the tank might have been exposed to on August 28.[24]

Bayer officials have also informed the Committee that key video footage of the explosion is missing. On April 2, 2009, Committee staff inspected the Bayer facility in West Virginia and received a tour and briefing from Michael Wey. When Mr. Wey explained that Bayer's Emergency Operations Center received video feeds from surveillance cameras inside the Methomyl/Larvin unit where the explosion occurred, Committee staff asked whether Bayer had

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[20] Letter from Raymond H. Bennett and Douglas B. Olson, Baker Engineering and Risk Consultants, to Michael Wey, Head, Health, Safety, and Environment Expertise Center, Bayer CropScience (Dec. 22, 2008) (withheld from release as potential Sensitive Security Information).

[21] House Committee on Energy and Commerce, Interview of John Michael Wey (Apr. 14, 2009).

[22] *Id.*

[23] E-mail from John Bresland, Chairman, Chemical Safety and Hazard Investigation Board, to Staff, House Committee on Energy and Commerce (Apr. 17, 2009).

[24] Testimony of John Bresland, Chairman, Chemical Safety and Hazard Investigation Board, before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on Secrecy in the Response to the Fatal Bayer Chemical Plant Explosion,* 111th Cong. (Apr. 21, 2009).

the video recording from the camera closest to the explosion. Mr. Wey responded that a construction contractor had disabled the recording function prior to the explosion and that the footage did not exist.[25]

Although Bayer's attorneys have confirmed this basic version of events with Committee staff, they have not identified the contractor who disconnected the recorder, produced any documents relating to the person responsible for this action, provided the reason it was undertaken, or determined the length of the gap in record.[26] CSB is also apparently investigating this issue. On December 18, 2008, CSB requested "[v]ideo camera footage recorded on the Methomyl/Larvin unit camera that was disabled before the incident on August 28, 2008."[27]

B. Adequacy of Bayer's Air Monitoring

In his transcribed interview with Committee staff on April 14, 2009, Bayer official Michael Wey conceded that MIC air monitors inside the facility were not functioning the night of the explosion. He stated:

> We have come to understand that the MIC analyzer array, for want of a better term, the series of analyzers to monitor MIC in the Larvin unit, that device that measures that concentration, was out of service for maintenance repair.[28]

Mr. Wey could not explain why the MIC detectors inside the Methomyl/Larvin unit were out of service on the night of the explosion. He also failed to explain why Bayer officials have not informed the public of this fact. For example, at a public meeting on October 8, 2008, Nick Crosby, the site leader at the Bayer plant, reassured the crowd that the facility's air monitors detected no harmful chemical releases the night of the explosion. He stated:

> We have automatic instrumentation on the edges of our site, on the fringes of our site where we're able to detect if harmful chemicals are actually leaving our site. And that night we detected no harmful chemicals were leaving our site.[29]

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[25] Briefing by Michael Wey, Head, Health, Safety and Environment Expertise Center, Bayer CropScience, for Staff, House Committee on Energy and Commerce (Apr. 2, 2009).

[26] Telephone conversation between Majority Staff, House Committee on Energy and Commerce, and Chris Manning, Williams & Connolly LLP (Apr. 20, 2009).

[27] E-mail from John B. Vorderbrueggen, Supervisory Investigator, Chemical Safety and Hazard Investigation Board, to Michael Wey, Head, Health, Safety and Environment Expertise Center, Bayer CropScience (Dec. 18, 2008).

[28] House Committee on Energy and Commerce, Interview of John Michael Wey (Apr. 14, 2009).

[29] Bayer CropScience, *Remarks of Nick Crosby, Site Leader, Bayer CropScience Institute, before the Community Improvement Council* (Oct. 8, 2008). *See also* Bayer CropScience, *Methomyl Incident at BCS Institute, WV on 2008-08-28: Update 2008-08-31* (Aug. 31, 2008) (stating that "MIC was not directly involved in the explosion and no levels of MIC were detected on or off the Site").

On February 18, 2009, Christopher Warner, the general counsel for CSB, sent an e-mail to Bayer's counsel asking him why "air monitoring data for MIC was 'not available.'"[30] In a response two days later, Bayer's attorneys stated:

> BCS does have monitoring equipment in the Methomyl Unit (a central analyzer and 15 pickup points throughout the Unit) that is calibrated to detect MIC. The MIC monitoring results are not recorded, but the detection of MIC in the Unit does result in an alarm in the control room. Based on all of the information available to BCS at this time, there were no MIC detection alarms during or after the incident on August 28, 2008.[31]

This response also failed to disclose that the MIC detectors in the Methomyl/Larvin unit of the plant were out of service on the night of the explosion.

In addition, Bayer has no air monitors on the western side of the plant. On the night of the explosion, the winds were blowing toward the west.[32] As a result, at 11:42 p.m., Metro 911 ordered a "shelter in place" for all areas west of the City of Charleston, including St. Albans, Dunbar, Nitro, and South Charleston.[33] In his interview with Committee staff, Mr. Wey conceded that, although Bayer has chemical detectors on three sides of the plant, "There are none directly west on the western edge of the property."[34]

The Committee also obtained the log from Bayer's internal Emergency Operations Center from the night of the explosion. Several entries in the log suggest concern with a potential chemical release and exposure. For example, two entries relate to toxic chemicals in the air near the Methomyl/Larvin unit. They state:

> 12:13 a.m. West of Larvin under toxic vapor cloud – SIP [shelter in place] in west end of plant requested
>
> 12:15 a.m. Announced all person west of Larvin Unit to shelter in place.[35]

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[30] E-mail from Christopher Warner, General Counsel, Chemical Safety and Hazard Investigation Board, to Robert C. Gombar, McDermott Will & Emery LLP (Feb. 18, 2009).

[31] Letter from Robert C. Gombar, McDermott Will & Emery LLP, to Christopher W. Warner, General Counsel, Chemical Safety and Hazard Investigation Board (Feb. 20, 2009).

[32] National Weather Service, Charleston, *WV Climate Summary* (Aug. 28, 2008).

[33] Metro 911 of Kanawha County, *Verbatim Radio Transcripts from Metro – Fire Departments* (Aug. 28, 2008).

[34] House Committee on Energy and Commerce, Interview of John Michael Wey (Apr. 14, 2009).

[35] Bayer CropScience, *EOC Notes 8-28-08, Methomyl Unit Incident* (Aug. 28, 2008).

Two other entries suggest that employees and others near the explosion may have been exposed to toxic chemicals. These include Bayer employee Bill Oxley who later died of his injuries. They state:

> 12:55 a.m. EE [Employee] sent to hosp was not decon HCN, Sulfide, Hexane, MIBK, Methomyl Residue (Majority)
>
> 12:56 a.m. Oxley was not decontaminated prior — Methomyl, MIBK, Hexane, DMS, CAN, Methomyl residues majority.[36]

C. Evaluating Inherently Safer Processes

Twenty-five years after the disaster in Bhopal, India, Bayer's facility in West Virginia is the only site in the United States that produces and stores large amounts of MIC. Documents obtained by the Committee raise questions about whether Bayer has adequately considered reducing its MIC stockpile or switching to safer technologies that do not require the storage of such large amounts of MIC.

On September 16, 2008, Manuel Gomez, the Director of Recommendations at CSB, wrote an e-mail to John Vorderbrueggen, CSB's lead investigator on the Bayer investigation, copying CSB Chairman John Bresland. In his e-mail, Mr. Gomez recommended a "strong focus on whether Bayer made any effort or investigation about how to manufacture MIC in an inherently safer manner, or to use it in a way that involves much smaller inventories."[37]

On March 13, 2009, Mr. Gomez sent an e-mail to Mr. Bresland, explaining:

> The primary issue from the standpoint of our mission, and from the expectations of the public, media, and political leaders, is that the explosion could have potentially caused a large release of MIC, and we (CSB) do not know what the company(ies) have done about this risk, before or after the incident.[38]

In 1985, after the MIC accident in Bhopal, India, another chemical company, DuPont, altered its process for using MIC in pesticide production in order to eliminate the storage of large volumes of MIC at its facility in La Porte, Texas. At this facility, DuPont had stored 250,000 pounds of MIC. Within months of the Bhopal tragedy, DuPont implemented a continuous point-

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[36] *Id.*

[37] E-mail from Manuel R. Gomez, Director of Recommendations, Chemical Safety and Hazard Investigation Board, to John Vorderbrueggen, Supervisory Investigator, Chemical Safety and Hazard Investigation Board (Sept. 16, 2008).

[38] E-mail from Manuel R. Gomez, Director of Recommendations, Chemical Safety and Hazard Investigation Board, to John Bresland, Chairman, Chemical Safety and Hazard Investigation Board (Mar. 13, 2009).

of-use process that produces MIC and consumes it immediately, eliminating the need to transport and store the chemical.[39]

According to documents obtained by the Committee, after Bayer purchased the facility in West Virginia in 2002, it formed a team to "review the overall safety and handling for Methyl IsoCyanate."[40] As part of this review, Bayer evaluated existing literature relating to alternative methods of producing MIC. On May 13, 2003, Michael Wey wrote a memorandum to Dietmar Westphal, a senior vice president for Bayer CropScience, summarizing the team's conclusions. He stated:

> Based on the literature available at this time, the current process appears to be as safe as the other alternative methods to produce MIC at Institute.[41]

This 2003 memorandum did not explain which alternative methods Bayer considered or whether the "close-coupled" process implemented by DuPont was among them. The memo also did not discuss the extent to which the company analyzed the costs and benefits of changing its storage or inventory procedures. Instead, the memo recommended that Bayer consider adding measures to mitigate the potential damage from an MIC release.[42]

The Committee also obtained from Bayer a PowerPoint presentation dated August 12, 2003, that describes various scenarios for reducing the MIC inventory at the facility. One slide suggests an effort to "evaluate eliminating" the MIC day tank, but it does not provide any details on whether the company followed through.[43] The presentation also used models to evaluate the technical feasibility and financial impact of limiting the site's maximum MIC capacity. The company concluded only that "forcing MIC inventory levels down appears feasible, but costly."[44]

IV. CONCEALING INFORMATION FROM THE PUBLIC

Documents obtained by the Committee indicate that Bayer CropScience is now attempting to conceal information about the explosion by invoking, and in some cases misusing, a statute governing maritime transportation security to designate unprecedented amounts of material as "sensitive security information" (SSI).

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[39] *Process Eliminates Transportation and Storage of Toxic Gas,* United Press International (June 6, 1985).

[40] Memorandum from Michael Wey, Head, Health, Safety, and Environment Expertise Center, Bayer CropScience, to Dietmar Westphal, Senior Vice President, Bayer CropScience (May 13, 2003).

[41] *Id.*

[42] *Id.*

[43] Bayer CropScience, *MIC Inventory Model Preliminary Runs' Results* (Aug. 12, 2003).

[44] *Id.*

After the explosion in 2008, Bayer produced thousands of pages of documents in response to requests from federal investigators at CSB. In 2009, however, Bayer began to retroactively label these documents as SSI. Bayer now argues that the company's facility in West Virginia is governed by the Maritime Transportation Security Act of 2002 and subsequent regulations. In a letter to CSB's lead investigator on March 27, 2009, Michael Wey explained why Bayer began designating documents as SSI. He wrote:

> BCS [Bayer CropScience] has an obligation under MTSA and the regulations promulgated under MTSA to protect SSI. ... [T]he Plant contains and uses three critical chemical assets: Chlorine, Methyl Isocyanate ("MIC"), and Methyl Mercaptan. ... [T]he potential vulnerabilities associated with these three critical chemical assets and the protective measures in place to protect against those vulnerabilities ... are, by law, designated as SSI.[45]

Although the statute was passed in 2002, Bayer made its legal argument for the first time in 2009, immediately following questions by federal investigators at CSB about the vulnerability of the company's MIC stockpile and about alternative storage and inventory options. During a briefing with Committee staff on March 11, 2009, CSB Chairman John Bresland stated that CSB had conducted many investigations of facilities on navigable waterways that may be subject to the Maritime Transportation Security Act. Bayer's assertion was the first time any facility had argued that information provided to CSB must be withheld from the public as SSI.[46]

CSB officials have expressed concern that Bayer's assertion of SSI could have the perverse effect of impairing safety improvements for the surrounding community. On February 26, 2009, Sandy Gilmour, a public affairs official at CSB, sent an e-mail to Daniel Horowitz, CSB's Director of Congressional, Public, and Board Affairs, regarding Bayer's new SSI assertions. He wrote:

> Making this all a secret now would be palpably ridiculous. ... [T]he CSB is the agency to properly and independently determine what caused the accident and whether the MIC tank was in harm's way and should be moved. Such a determination could actually increase the security of the plant in the near term if such a recommendation were adopted.[47]

According to written testimony submitted for today's hearing, Bayer CropScience President and CEO William Buckner admits that his company was attempting to block public

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[45] Letter from Michael Wey, Head, Health, Safety, and Environment Expertise Center, Bayer CropScience, to John Vorderbrueggen, Supervisory Investigator, Chemical Safety and Hazard Investigation Board (Mar. 27, 2009).

[46] Briefing by John Bresland, Chairman, Chemical Safety and Hazard Investigation Board, to Staff, House Committee on Energy and Commerce (Mar. 11, 2009).

[47] E-mail from Sandy Gilmour, Public Affairs Support Contractor, Chemical Safety and Hazard Investigation Board, to Daniel Horowitz, Director of Congressional, Public, and Board Affairs, Chemical Safety and Hazard Investigation Board (Feb. 26, 2009).

discussion of safety improvements to its MIC stockpile, which would be costly to implement. Mr. Buckner's testimony states that "we frankly admit" that one of the company's goals in withholding information from the public was "the desire to avoid making the controversial chemical MIC part of the public debate regarding the incident."[48]

Mr. Buckner's testimony also states that "business reasons" motivated Bayer's actions, including "a desire to limit negative publicity" and "to avoid public pressure to reduce the volume of MIC that is produced and stored at Institute by changing to alternative technologies." He also states that "public discussions and CSB recommendations about alternate technologies and inventory amounts would be a sensitive matter for the company." He concludes: "we concede that our pursuit of SSI coverage was motivated, in part, by a desire to prevent that public debate from occurring in the first place."[49]

According to Mr. Buckner's testimony, Bayer initially believed it could withhold information about its MIC stockpile from federal investigators at CSB. His testimony states:

> [T]here were some in company management who initially thought that the Maritime Transportation Security Act ... could be used to refuse to provide information to the CSB about issues regarding Methyl isocyanate ("MIC") beyond those related to the MIC day storage tank in the unit involved in the incident. We admit that.[50]

When Bayer realized that it could not withhold information from CSB, Bayer approached the Coast Guard, the agency that oversees the Maritime Transportation Security Act, about using the SSI designation to deter CSB from inquiring about MIC. According to Mr. Buckner's testimony:

> The company then proceeded to contact U.S. Coast Guard officials to inquire whether the requested additional information regarding MIC was in fact SSI, which might discourage the CSB from even seeking this information.[51]

Documents obtained by the Committee show that Bayer was not merely seeking the Coast Guard's neutral advice on whether information could be disclosed, but instead was actively pushing the Coast Guard for sweeping new SSI determinations to blunt the CSB investigation and any negative public disclosures that might flow from it.

On January 24, 2009, Michael Wey wrote an e-mail to the Coast Guard commander at the Marine Safety Unit Huntington in West Virginia explaining that "the issue of sharing the

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[48] Testimony of William Buckner, President and CEO, Bayer CropScience LP, before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on Secrecy in the Response to the Fatal Bayer Chemical Plant Explosion,* 111th Cong. (Apr. 21, 2009).

[49] *Id.*

[50] *Id.*

[51] *Id.*

requested information with the Chemical Safety and Hazard Board is of great concern for us."[52] He added: "We would like to pursue this matter further with headquarters to have a positive determination that this information is security sensitive information."[53]

After the local commander offered to contact officials at Coast Guard headquarters, Mr. Wey responded on January 29, 2009: "We would like to have the opportunity to discuss this further with your headquarters so that we can better communicate to the CSB and possibly discourage them from even seeking this information."[54]

On March 13, 2009, Commander Shannon Gilreath of the Coast Guard sent an e-mail to David Kantor, the Deputy Chief, Office of International and Maritime Law at the Coast Guard, summarizing Bayer's efforts to have the Coast Guard identify broad new categories of information as SSI. He stated: "We discovered internally that Bayer's counsel had spoken with MSU Huntington and CG-5441 about material it considered SSI and their intended course of action although that may have been slightly misrepresented by Bayer."[55]

CSB officials have expressed concern that, even if some information could be considered SSI, Bayer is applying the label far more broadly than allowed under the statute and regulations. On February 17, 2009, the deputy general counsel at CSB, Ray Porfiri, sent an e-mail to the general counsel at CSB, Christopher Warner, evaluating the SSI claims put forth by Bayer's attorney, Robert Gombar. Mr. Porfiri wrote:

> [I]t seems that Gombar's explanation of what would constitute SSI is much more expansive than the regulations. ... For example, Gombar stated that facility photographs, piping diagrams, and even publicly available information could not be disclosed by the CSB or even referred to by the CSB at a public meeting. Gombar's assertions appear overbroad, at best.[56]

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[52] E-mail from Michael Wey, Head, Health, Safety, and Environment Expertise Center, Bayer CropScience, to Commander Kevin C. Kiefer, Commanding Officer, Marine Safety Unit Huntington, U.S. Coast Guard (Jan. 24, 2009).

[53] *Id.*

[54] E-mail from Michael Wey, Head, Health, Safety, and Environment Expertise Center, Bayer CropScience, to Commander Kevin C. Kiefer, Commanding Officer, Marine Safety Unit Huntington, U.S. Coast Guard (Jan. 29, 2009).

[55] E-mail from Commander Shannon Gilreath, Chief, Prevention Law Group, U.S. Coast Guard, to David Kantor, Deputy Chief, Office of International and Maritime Law, U.S. Coast Guard (Mar. 13, 2009).

[56] E-mail from Ray Porfiri, Deputy General Counsel, Chemical Safety and Hazard Investigation Board, to Christopher Warner, General Counsel, and Christopher Kirkpatrick, Attorney-Advisor, Chemical Safety and Hazard Investigation Board (Feb. 17, 2009).

Bayer's overbroad approach to SSI is confirmed by instructions its counsel sent to the Occupational Safety and Health Administration that review for SSI "should be liberal" and "should strike any references to any piece of equipment, piping or document involving" MIC.[57]

On February 27, 2009, CSB's general counsel sent an e-mail to Commander Gilreath at the Coast Guard stating CSB's official position. He wrote:

> Based on our research and our discussions with DHS ... we believe the documents provided to us by Bayer CropScience are not SSI.[58]

To date, the Coast Guard has agreed in part with CSB's concerns and overruled some of Bayer's SSI labeling. On March 27, 2009, for example, Bayer official Michael Wey sent a letter to CSB asserting that "documents and other forms of information created by the CSB," including "photographs" of the Bayer facility, the MIC tank, and its protective blast mat, "almost certainly" contain SSI.[59]

On April 16, 2009, the Committee sent a letter notifying the Coast Guard that it intended to disclose these CSB photographs and a video taken by CSB investigators at today's hearing.[60] On April 17, 2009, the Coast Guard informed the Committee that "[t]he photos are not SSI, so the CG has no objection to them being shown at the hearing."[61]

Nevertheless, questions remain about whether Bayer is abusing the SSI process to conceal information about the extent to which the MIC stockpile may have been in danger during the explosion in August 2008. For example, Bayer officials have asserted that the metal blast

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[57] E-mail from Eric Conn, McDermott Will & Emery LLP, to Donald Neely, Department of Labor (Feb. 23, 2009).

[58] E-mail from Christopher Warner, General Counsel, Chemical Safety and Hazard Investigations Board, to Commander Shannon Gilreath, Chief, Prevention Law Group, U.S. Coast Guard (Feb. 27, 2009).

[59] Letter from Michael Wey, Head, Health, Safety, and Environment Expertise Center, Bayer CropScience, to John Vorderbrueggen, Supervisory Investigator, Chemical Safety and Hazard Investigation Board (Mar. 27, 2009).

[60] Letter from Rep. Henry A. Waxman, Chairman, House Committee on Energy and Commerce, and Rep. Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, to Admiral Thad W. Allen, Commandant, U.S. Coast Guard (Apr. 16, 2009). *See also* Chemical Safety and Hazard Investigation Board, Photos of Bayer CropScience Facility after 2008 Explosion (Photo Nos. 1-22 and Video No.1) (Aug.-Oct. 2008).

[61] E-mail from Office of Congressional and Governmental Affairs, U.S. Coast Guard, to Staff, House Committee on Energy and Commerce (Apr. 17, 2009) (10:36 a.m.). *See also* E-mail from Office of Congressional and Governmental Affairs, U.S. Coast Guard, to Staff, House Committee on Energy and Commerce (Apr. 17, 2009) (12:15 a.m.) (notifying Committee that video taken by CSB investigators inside the Bayer facility "contains no SSI info.").

mat covering the MIC tank worked as intended and was not compromised by the explosion.[62] Although Bayer officials have conceded that shrapnel struck the blast mat, they have asserted that any information describing the facility's safeguards and procedures used to mitigate or prevent an MIC release, including the blast mat, constitutes SSI.[63]

As discussed earlier, after the explosion, Bayer removed the damaged blast mat, which was originally installed in 1982, and replaced it with a new blast mat with different specifications.[64] Bayer has not explained why the specifications of the blast mat that was destroyed and is no longer in use should be concealed from the public.

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[62] House Committee on Energy and Commerce, Interview of John Michael Wey (Apr. 14, 2009) (stating that the company has "no evidence that the ballistic curtain was damaged").

[63] Letter from Michael Wey, Head, Health, Safety, and Environment Expertise Center, Bayer CropScience, to John Vorderbrueggen, Supervisory Investigator, Chemical Safety and Hazard Investigation Board (Mar. 27, 2009) (attaching "Sensitive Security Information Log").

[64] Testimony of John Bresland, Chairman, Chemical Safety and Hazard Investigation Board, before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on Secrecy in the Response to the Fatal Bayer Chemical Plant Explosion,* 111th Cong. (Apr. 21, 2009).

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

JOE BARTON, TEXAS
RANKING MEMBER

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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Minority (202) 225–3641

MEMORANDUM

April 17, 2009

To: Subcommittee on Oversight and Investigations Members and Staff

Fr: Committee on Energy and Commerce Staff

Re: Hearing on "Secrecy in the Response to Bayer's Fatal Chemical Plant Explosion"

On Tuesday, April 21, 2009, at 12:00 noon in room 2322 of the Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing to examine the August 28, 2008, explosion at the Bayer CropScience facility in Institute, West Virginia. The Committee will consider the initial emergency response to the accident, subsequent efforts by Bayer to withhold information from the public as "Sensitive Security Information," and the question of whether Bayer uses the safest chemical processes at its plant in West Virginia.

I. COMMUNICATIONS WITH FIRST RESPONDERS

At 10:25 p.m. on August 28, 2008, a tank containing waste materials in a pesticide production unit exploded at a chemical plant in Institute, West Virginia, owned by Bayer CropScience. The blast sent a fireball more than 100 feet into the sky and was felt ten miles away in the capital city of Charleston.[1] The explosion instantly killed one Bayer employee. Another employee suffered third-degree burns and died 40 days later.[2]

Bayer's West Virginia facility produces pesticide products from a variety of chemicals, including methyl isocyanate (MIC), a highly toxic substance that has been stored at the facility for decades.

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[1] *Institute Plant's Safety History is Rocky: Inquiry into Deadly Bayer Explosion Could Take Weeks,* Charleston Gazette (Aug. 30, 2008).

[2] *Second Bayer Employee Dies from August Explosion,* Charleston Gazette (Oct. 12, 2008).

In the immediate aftermath of the August 28, 2008, explosion, state and local emergency responders attempted to ascertain the exact location of the explosion, which chemicals had been released, and the risks posed by a release of MIC or other chemicals to the surrounding community. According to emergency responders, Bayer did not provide information needed to make critical decisions about how to protect the safety of the surrounding community.[3] Dale Petry, the director of the Office of Emergency Services for Kanawha County, stated, "We didn't know what to do. We couldn't get anything out of them. We want to protect the community, and we need more information to do that."[4]

Emergency officials relied on local media outlets for information. According to one local police chief, the emergency response was "mass chaos."[5] Eyewitnesses observed a plume rising from the plant but could not determine what chemicals, if any, were released.[6] As a result, emergency responders instructed local residents to "shelter-in-place," to remain indoors to avoid chemical contamination.[7]

II. WITHHOLDING INFORMATION FROM THE PUBLIC

On August 29, 2008, the day after the explosion, the U.S. Chemical Safety and Hazard Investigation Board (CSB) initiated an investigation into the cause of the explosion. Established by the Clean Air Act Amendments of 1990, the CSB investigates chemical accidents and provides recommendations on steps to prevent similar incidents in the future. Modeled after the National Transportation Safety Board, the CSB was granted statutory independence from all other agencies and is charged with making its findings and recommendations public.

Pursuant to its investigation, the CSB requested and received Bayer documents relating to the plant and the explosion. The CSB scheduled a public hearing on March 19, 2009, to brief Kanawha County residents about its preliminary findings. Prior to the public meeting, however, Bayer asserted that much of the information it provided to the CSB must be withheld from the public as "Sensitive Security Information" (SSI).

Specifically, Bayer claimed for the first time that the SSI designation was appropriate under the Maritime Transportation Security Act of 2002 (MTSA), the post-September 11, 2001, statute that charges the U.S. Coast Guard with protecting all U.S. ports and waterways, because the Bayer facility sits on the Kanawa River, a navigable waterway. Pursuant to regulations, information is considered SSI if it is gathered in the context of security activities and its public

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[3] *Bayer Delays Triggered Response 'Chaos': Communication Gaps, Problems Followed Blast,* Charleston Gazette (Sept. 18, 2008).

[4] *Bayer Withheld Details of Fatal Blast in Calls,* Charleston Gazette (Sept. 5, 2008).

[5] *Id.*

[6] *Bayer Blast a Stark Reminder of Chemical Dangers in Kanawha Valley,* Charleston Gazette (August 30, 2008).

[7] *Bayer Delays Triggered Response 'Chaos': Communication Gaps, Problems Followed Blast,* Charleston Gazette (Sept.18, 2008).

release would "[b]e detrimental to the security of transportation."[8] SSI may be shared only with "covered parties" such as the CSB, but may not be disclosed to the public.[9]

As a result of Bayer's objections, the CSB announced on February 25, 2009, that it had postponed its public meeting.[10] After working with the Coast Guard to finalize a presentation that did not present SSI concerns, the CSB rescheduled the public meeting for April 23, 2009.[11] The CSB Chairman, John Bresland, remains concerned with this new precedent, however, and has stated that he does not "like the idea that if we went to a meeting in West Virginia and someone asked a question, we'd have to say, 'Sorry, we can't talk about it.'"[12]

III. THE SAFETY OF BAYER'S CHEMICAL PROCESSES

One of the primary concerns of local residents and emergency responders on August 28, 2008, was what might have happened if the explosion had caused the release of MIC. MIC caused the deaths of more than 2,000 people when it leaked at a Union Carbide plant in Bhopal, India, in 1984. The Bayer plant in Institute is considered a sister plant of the facility in India, both having been built and operated by Union Carbide at the time of Bhopal accident.[13]

Since the catastrophe at Bhopal, other companies have acknowledged the dangers of storing MIC in their chemical facilities and have modified their practices accordingly. DuPont, which uses MIC in its facility in Manchester, Texas, developed a new technology in 1985 to create a closed-loop process for producing MIC on demand, thereby eliminating the need for its storage and transportation.[14]

IV. WITNESSES

The following witnesses have been invited to testify:

The Honorable John D. Rockefeller, IV
United States Senator, West Virginia

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[8] 49 C.F.R. §1520.5 .

[9] *Id.*

[10] *Board Cancels Hearing under Bayer Pressure*, Charleston Gazette (Feb. 25, 2009).

[11] U.S. Chemical Safety and Hazard Investigation Board, *History, Press Release: CSB to Hold Public Meeting in Institute, West Virginia on April 23; Investigators will Present Preliminary Findings and Board Will Hear Public Comments on the Fatal Explosion at Bayer CropScience* (Apr. 14, 2009) (online at www.csb.gov/index.cfm?folder=news_ releases&page=news&NEWS_ID=442).

[12] *Trying to Limit Disclosure on Explosion*, New York Times (Mar. 29, 2009).

[13] *Carbide Raises Specter of Sabotage*, Washington Post (Mar. 20, 1985).

[14] *Pesticide Makers Being to Adapt in Bhopal's Wake,* Chemical Week (Jan. 23, 1985).

Mr. Joseph Crawford
Chief of Police
City of St. Albans, West Virginia

Mr. Michael Dorsey
Chief of Homeland Security and Emergency Response
West Virginia Department of Environmental Protection

Mr. Kent Carper
President
Kanawha County Commission
Kanawha County, West Virginia

Ms. Pamela Nixon
Environmental Advocate
West Virginia Department of Environmental Protection

The Honorable John Bresland
Chairman
U.S. Chemical Safety and Hazard Investigation Board

Rear Admiral James Watson
Director of Prevention Policy for Marine Safety, Security and Stewardship
U.S. Coast Guard Insert Coast Guard witness

Mr. William Buckner
President and CEO
Bayer CropScience LP

Mr. Nick Crosby
Vice President, Institute Site Operations
Bayer CropScience

Staff Contacts: David Leviss and Alison Cassady at (202) 226-2424.

Statement of
Representative John D. Dingell
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
Hearing on "Secrecy in the Response to Bayer's Fatal Chemical Plant Explosion"

April 21, 2009

Thank you, Mr. Chairman, for holding this hearing. The August 28, 2008, explosion at Bayer CropScience's chemical facility in Institute, West Virginia, provides another striking example of how supposed threats to the nation's so-called "homeland security" can be invoked to justify preventing the release of crucial information to the public. To be sure, the federal government has the obligation to protect the American people from all threats, domestic and foreign, but it would seem in this case that the rather excessive concern with secrecy reflected in the policies of and laws enacted by the previous Administration has thwarted attempts to respond to and investigate what could very well have been the United States' own Bhopal disaster.

As Chairman of the Committee on Energy and Commerce in 1990, I was an author of the Clean Air Act, which established the U.S. Chemical Safety and Hazard Investigation Board (CSB). CSB's statutory mandate is to prevent threats to public health and safety by fully examining chemical-related incidents and making public recommendations for preventing them in the future. As we have learned, Bayer invoked the Maritime Transportation Security Act (MTSA) of 2002 to have information concerning the chemical methyl isocyanate (MIC) classified as "sensitive security information" (SSI), thereby retaining the right to withhold that information and stymie CSB's investigation of the explosion at the company's facility in West Virginia. In so doing, Bayer was able to derail CSB's important work and delay potential improvements in chemical safety that would undoubtedly better protect the public.

I am not satisfied that the manner in which information is classified as SSI under MTSA is beneficial to the public. Moreover, I suspect that Bayer's application to have information about MIC at its West Virginia facility designated as SSI was motivated not by an abiding concern for the public health, but instead was a stonewalling tactic meant to deter an investigation of the company's potentially negligent safety practices. One could very reasonably conclude that corporations seeking to escape public scrutiny can exploit MTSA and thus subvert the law's intent of mitigating threats to public safety. In this light, I invite the Subcommittee to consider the effects of MTSA on safety investigations by other federal entities, such as the National Highway Traffic Safety Administration (NHTSA) and the Occupational Safety and Health Administration (OSHA).

I hope that the Subcommittee's investigation of this matter will yield legislation balancing the need to protect national security with the government's sworn duty to

safeguard public health and safety. I stand ready to assist you in this endeavor, Mr. Chairman, and yield back the balance of my time.

STATEMENT OF
CONGRESSMAN MICHAEL C. BURGESS, M.D.

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON ENERGY AND COMMERCE

April 21, 2009 HEARING
"Secrecy in the Response to Bayer's Fatal Chemical Plant Explosion"

The issue before the Committee today seems a jurisdictional battle, a turf war if you will, where on the one hand you have a company that has been entrusted with making an inherently dangerous chemical like methyl isocyanate (MIC) in a residential community, while on the other hand you have a community who is entitled to know when – and all the details of – an accident's occurrence as soon as possible. Whenever a tragic accident occurs, we search the facts to discover how we can improve and in this regard I applaud all involved for the advancements which have been made.

For instance, this committee held a hearing just two years ago on the tragic explosion which occurred at BP Texas City in 2005. We heard the facts and we made recommendations for improvement. We also will recall the 1984 explosion in Bhopal, India where a Union Carbide plant making MIC killed thousands of people. Though the accident occurred overseas, ***WHETHER*** the accident occurs in Texas or India – or in this case West Virginia –, people must have the ability to protect themselves from harm and we, as Congress, must focus on the appropriate remedies when our citizens are unable to do so.

But the questions we must answer today are not so starkly black-and-white. In order to find the answers in this accident, and move forward to prevent such accidents from occurring again, we now debate for the first time a chemical company's citation to anti-

terrorism laws to protect the releasing information. Here Bayer CropScience stated that the storage of MIC is governed by the "sensitive security information" (SSI) provisions of the Maritime Transportation Security Act of 2002 and thus they do not have to release all the information regarding this tragic accident to the Chemical Safety Board.

I have always been a strong advocate for our national security. But our foremost concern should always be the safety and protection of our citizens. The people in West Virginia must be assured their lives are not compromised through the business of Bayer CropScience.

So it is with acute interest I participate in today's hearing so we can answer the questions of how we ensure the safety of our citizens in our communities while at the same time protecting the safety of all of our citizens in our national defense.

If it is the Coast Guard's recommendation that Bayer CropScience's invocation of SSI is accurate, then we should do nothing to compromise our national security. However, we should keep in mind that we, Congress, gave the Chemical Safety Board the investigatory power to investigate major chemical accidents at fixed facilities – and this power invokes authority not through fines or regulations but merely through the revelation of findings and recommendations – so we can make sure our citizens are safe as we store and transport chemicals.

Thank you.

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

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House of Representatives

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MARSHA BLACKBURN, TENNESSEE
PHIL GINGREY, GEORGIA
STEVE SCALISE, LOUISIANA

May 11, 2009

Mr. John Bresland
Chairman and Chief Executive Officer
U.S. Chemical Safety and Hazard Investigation Board
2 175 K Street N. W., Suite 400
Washington, DC 20037

Dear Mr. Bresland:

Thank you for appearing before the Subcommittee on Oversight and Investigations on April 21, 2009, at the hearing entitled "Secrecy in the Response to Bayer's Fatal Chemical Plant Explosion".

Pursuant to the Committee's Rules, attached are written questions for the record directed to you from certain Members of the Committee. In preparing your answers, please address your response to the Member who submitted the questions and include the text of the question with your response, using separate pages for responses to each Member.

Please provide your responses by May 25, 2009, to Earley Green, Chief Clerk, in Room 2125 of the Rayburn House Office Building and via e-mail to Earley.Green@mail.house.gov. Please contact Earley Green or Jennifer Berenholz at (202) 225-2927 if you have any questions.

Sincerely,

Henry A. Waxman
Chairman

Attachment

The Honorable Joe Barton

1. I understand that the National Transportation Safety Board (NTSB) is the Federal agency on which CSB is modeled. Further, I understand the NTSB has been dealing with Sensitive Security Information (SSI) for many years through the Aviation Transportation Security Act and has not had a problem with SSI. Do you believe you need to be different from NTSB in this regard when your mission and authorities are supposed to be the same? If so, when, in what circumstances, and why?

2. You mentioned that you are concerned about how Sensitive Security Information rules will affect your investigations. Do you think that SSI prevents you or any other Federal agency from obtaining SSI from a company?

3. I noticed that as part of your FOIA regulations, 40 CFR Part 1601.2 states that "if another law sets specific procedures for disclosure, the CSB will process a request in accordance with the procedures that apply to those specific documents. That being the case, don't you think it appropriate to have CSB establish and memorandum of agreement with either the Coast Guard, the Transportation Security Administration, or the Department of Homeland Security for future instances of determining what items are of a truly sensitive security nature and should not be released to the general public? Why or why not?

4. Does CSB release information that is otherwise protected by FOIA during its public presentations or reports on investigations it has conducted? If so, please detail those instances.

5. After September 11, 2001, several reading rooms and websites with sensitive information about critical infrastructure were either shutdown or severely restricted. 40 CFR Part 1601.1 states that "Except as authorized by this part or as otherwise necessary in performing official duties, no employee shall in any manner disclose or permit disclosure of any document or information in the possession of the CSB that is confidential or otherwise of a nonpublic nature, including that regarding the CSB". Do you read this regulation as a justification for CSB to release sensitive information? Does CSB believe it has an obligation to protect truly sensitive security information from public disclosure? Does CSB respect the actions of other agencies that are obligated under other security protection laws and executive orders? Does CSB support placing any information it wants in its official reports, even if that means that homeland security is compromised?

6. SSI regulation establishes certain requirements for the handling and dissemination of SSI, including restrictions on disclosure and civil penalties for violations of those restrictions. Do you believe SSI currently applies to CSB employees? Do you believe that Federal workers should not be punished for deliberately revealing sensitive security information as the law currently allows?

7. In your response to Representative Sutton, you argued that "if we have to go and look at 2,000 documents, or in the case of our BP Texas City accident where we got 6 million documents, if we have to look through 20 percent, a million documents, we might as well pack it up and go home because there is no way we can do these investigations under these circumstances." For clarification purposes, are you suggesting CSB should not be burdened with protecting legitimate SSI in large investigations if would inconvenience CSB too much? If so, what law would allow you to overcome information protections for national security reasons based upon convenience?

8. Under questioning, you mentioned that Bayer failed to use safety processes already that were already part of their machinery? Would a new law forcing Bayer to use inherently safer technologies correct certain human factors or deliberate, improper use of safety devices that are already part of the manufacturing process?

Responses to Congressman Joe Barton:

Question #1.

I understand that the National Transportation Safety Board (NTSB) is the Federal agency on which CSB is modeled. Further, I understand the NTSB has been dealing with sensitive security information (SSI) for many years through the Aviation Transportation Security Act and has not had a problem with SSI. Do you believe you need to be different from the NTSB in this regard when your mission and authorities are supposed to be the same? If so, when, in what circumstances, and why?

> **Answer:** The Chemical Safety Board was modeled after the legislative authority of the National Transportation Safety Board. Investigations of the two agencies have many similarities. Both agencies are authorized by Congress to investigate accidents, to report to the public their findings, and to make recommendations for improved safety to workers and the public. In addition, both agencies conduct their investigations with public transparency as to significant factual findings and other safety issues that may arise. To carry out this mission both agencies need to maintain their independence, their ability to access information and to discuss this information in a public forum to bring about needed safety changes.
>
> In this light both agencies may face similar potential issues in dealing with SSI information. The CSB, however, due to the nature of its inquiries into accidents at chemical and petrochemical facilities, which are likely covered either by CFATS or MTSA, may face more frequent security issues than may arise during a NTSB transportation-related accident investigation. The CSB is prepared to deal with security issues that are genuine e.g. guard force schedules at a facility, use of security cameras, types of fencing around the facility. However in our Bayer CropScience investigation of the Institute, West Virginia explosion the company designated much of their process safety related information as SSI. We found this designation to be unnecessary and it certainly delayed our investigation.

Question #2.

You mentioned that you are concerned about how Sensitive Security Information will affect your investigations. Do you think that SSI prevents you or any other Federal agency from obtaining SSI from a company?

> **Answer.** I do not believe that a company's designation of information as SSI pursuant to federal law would prevent the CSB from obtaining such information from a company. I cannot answer for other federal agencies. Each agency's specific statutory authority would govern whether the agency would have access to SSI, but it is likely that other agencies with a legitimate interest in such information and appropriate statutory authority would be able to obtain SSI marked information.
>
> The CSB's central concern is not about access to SSI information from companies but about the ability of the CSB to use information that companies have marked as SSI (properly or improperly) in reporting to the public on accidents. Our reporting to the public takes place in community meetings, in written reports and in video representation of the accidents. The current regulations under CFATS and MTSA can be improved so that critical security information is protected without impairing the ability of the CSB to undertake chemical facility or oil refinery process accident investigations.

Question #3.

I noticed that as part of your FOIA regulations, 40 CFR Part 1601.2 states that "if another law sets specific procedures for disclosure, the CSB will process a request in accordance with the procedures that apply to those specific documents. That being the case, don't you think it appropriate to have CSB establish an Memorandum of Agreement with either the Coast Guard, Transportation Security Administration, or the department of Homeland Security for future instances of determining what items are of a truly sensitive security nature and should not be released to the general public? Why or why not?

> **Answer**: The CSB has held preliminary discussions with TSA regarding a possible Memorandum of Understanding (MOU) to help provide efficiency and procedures for dealing with SSI matters that may arise during CSB investigations. The process, however, is more complex and is not necessarily resolved merely by having a MOU. Bayer CropScience, for example, testified to the committee that it had marked a large number of documents as SSI (years after MTSA was enacted) in part to thwart public debate about the safety of methyl isocyanate use at its site in Institute, West Virginia. This should be viewed as contrary to the intent of MTSA; however, under MTSA there is not a clear or efficient process for removing these unnecessary SSI markings.
>
> Accordingly my hope is that we can address both the procedures for dealing with SSI matters that may arise during CSB investigations and clarify the parameters of SSI so that vital process safety information continues to be available for use in safety investigations, which is the key to saving lives throughout industry from process-related accidents.

Question #4.

Does CSB release information that is otherwise protected by FOIA during its public presentations or reports on investigations it has conducted? If so, please detail those instances.

Answer. The CSB does not release information that is exempt from disclosure under the FOIA, and otherwise protected by statute, during its public presentations or reports on investigations. For example, other than SSI, the information of greatest concern to the CSB is trade secrets and confidential business information (CBI), which are protected by FOIA Exemption 4. According to judicial decisions interpreting the FOIA, information within the scope of Exemption 4 is also covered by the disclosure prohibitions of the Trade Secrets Act, 18 U.S.C. § 1905, so agencies are not able to make discretionary releases of such information. Thus, the CSB conducts a pre-disclosure review process for public presentations and reports on investigations. During that process, the company or companies involved have the opportunity to review a proposed draft of the presentation/report and identify any information believed to be trade secret/CBI. Identified information that the CSB confirms meets the legal definition of trade secret or CBI is not released in the final presentation or report.

Moreover, there is generally no need to include in CSB public presentations and reports the kind of information that would be protected by other FOIA exemptions, such as information covered by a legal privilege (Exemption 5) or personally identifiable private information (Exemption 6).

Question #5:

After September 11, 2001, several reading rooms and websites with sensitive information about critical infrastructure were either shutdown or severely restricted. 40 CFR Part 1601.1 states that "Except as authorized by this part or as otherwise necessary in performing official duties, no employees shall in any manner disclose or permit disclosure of any document or information in the possession of the CSB that is confidential or otherwise of a nonpublic nature, including that regarding the CSB." Do you read this regulation as a justification for the CSB to release sensitive information? Does the CSB believe it has an obligation to protect truly sensitive information? Does the CSB respect the actions of other agencies that are obligated under other security protection laws and executive orders? Does the CSB support placing any information it wants in its official reports, even if that means that homeland security is compromised?

Question: Do you read this regulation as a justification for the CSB to release sensitive information?

Answer: Absolutely not – the CSB is very aware of its responsibility to protect sensitive information.

Question: Does the CSB believe it has an obligation to protect truly sensitive information?

Answer: Yes, the CSB is aware of its responsibilities to protect truly sensitive information and it complies with all applicable regulations.

Question: Does the CSB respect the actions of other agencies that are obligated under other security protection laws and executive orders?

Answer: Yes.

Question: Does the CSB support placing any information it wants in its official reports, even if that means that homeland security is compromised?

Answer: Of course it does not; such an issue has never arisen in our ten-year history, during which time we have completed more than 50 reports and studies. We believe our investigations benefit public safety and lead to more robust safety at chemical plants and oil refineries, making them less susceptible to accidental releases or other events that might threaten the public.

The CSB is directed by Congress to investigate major chemical accidents, to report to the public its findings and to make recommendations for improved safety to workers and the public. Transparency is essential for identifying, correcting, and preventing these types of incidents and improving the handling and processing of these chemicals in the future. The CSB intends to carry out this

statutory mission while protecting truly sensitive information the disclosure of which would be detrimental to homeland security.

Question #6:

SSI regulation establishes certain requirements for the handling and dissemination of SSI, including restrictions on disclosure and civil penalties for violations of those restrictions. Do you believe that SSI currently applies to CSB employees? Do you believe that Federal workers should not be punished for deliberately revealing sensitive security information as the law currently allows.

Question: Do you believe that SSI currently applies to CSB employees?

Answer: I believe that SSI regulations apply to CSB employees.

Question: Do you believe that Federal workers should not be punished for deliberately revealing sensitive security information as the law currently allows?

Answer: Federal workers should be held accountable for deliberately revealing genuine sensitive security information, a situation that we understand has almost never occurred.

However, given the various interpretations of what may or may not qualify as SSI material, I believe that, resulting from this penalty provision, there could be a chilling effect on what the Board may be willing to say in public during future chemical facility and oil refinery accident investigations.

The CSB also has a statutory responsibility to report publicly on the facts and circumstances surrounding chemical accidents, which may occur at MTSA- or CFATS-regulated facilities. As I noted in my testimony to the committee on April 21, I believe that requirements under both MTSA and CFATS should be clarified to ensure that federal safety compliance documents and other routine business records are not within the definition of protected security information (unless a very cogent security argument can be presented). Without this clarification, companies may simply include every document they can within their vulnerability assessments in an effort to shield such information against possible future investigations or litigation.

Second, the disparate information security requirements under MTSA and CFATS should be harmonized. I believe that industry as well as the CSB and other safety agencies will benefit from a single, coherent set of rules that provides clear guidance to companies and preserves the public's right-to-know about chemical hazards. We hope to work with Congress on this issue as they proceed to renew chemical plant security legislation this year.

Third, given the likelihood that there will be some specific issues where it is uncertain whether matters are covered by SSI, in discharging its official, statutory responsibility to report on accidents, the CSB should not be subject to potential penalties and sanctions from homeland security agencies unless there is clear

evidence that the CSB or its employees intentionally disclosed protected information or had acted in clear disregard of the need to protect security information.

Question #7:

In your response to Representative Sutton, you argued that "if we have to go and look at 2,000 documents, or in the case of our BP Texas City accident where we got 6 million documents, if we have to look through 20 percent, a million documents, we might as well pack it up and go home because there is no way we can do these investigations under these circumstances." For clarification purposes, are you suggesting CSB should not be burdened with protecting legitimate SSI in large investigations if it would inconvenience CSB too much?. If so, what law would allow you to overcome information protections for national security reasons based upon convenience?

> **Question:** Are you suggesting CSB should not be burdened with protecting legitimate SSI in large investigations if it would inconvenience CSB too much?
>
> **Answer:** No. Legitimate sensitive material should be protected. The challenge is to prevent companies exploiting the lack of clarity in the regulations and purposefully designating large volumes of material as SSI in an effort to impede public safety investigations (as Bayer CropScience has admitting doing). My point is that if BP had adopted a similar approach to Bayer CropScience, and sought a massive designation of material as SSI it would place a huge and unnecessary administrative burden on both us and the Coast Guard. The regulations should be clarified so that CSB investigations can proceed as expeditiously as possible while still respecting, of course, any legitimate homeland security information.
>
> Once a company has designated facility information as SSI it is very difficult and time consuming to relax that restriction even when it is clear that the information is not SSI and that it would be beneficial to make it publically available as part of a CSB investigation report.
>
> **Question:** If so, what law would allow you to overcome information protections for national security reasons based upon convenience?
>
> **Answer:** We are not aware of such a law and we are not suggesting that there should be one.

Question #8:

Under questioning, you mentioned that Bayer failed to use safety processes already that were already (*sic*) part of their machinery. Would a new law forcing Bayer to use inherently safer technologies correct certain human factors or deliberate, improper use of safety devices that already part of the manufacturing process?

Answer: No.

A decision by a facility to use inherently safer technologies requires a complex analysis of the technological alternatives, the economics of the alternative processes and the likelihood of being able to operate the process successfully.

Approaches to inherently safer technology fall into these categories:

- Minimize – significantly reduce the quantity of hazardous material or energy in the system, or eliminate the hazard entirely if possible
- Substitute – replace a hazardous material with a less hazardous substance, or a hazardous chemistry with a less hazardous chemistry
- Moderate – reduce the hazards of a process by handling materials in a less hazardous form, or under less hazardous conditions, for example at lower temperatures and pressures

The CSB has been asked by the House Committee on Energy and Commerce to "*Conduct an investigation to determine options for Bayer to reduce or eliminate the use or storage of methyl isocyanate (MIC) at its West Virginia facility by switching to alternative chemicals or processes and the estimated cost of these alternatives*" This study would include the use of MIC in the methomyl unit where the accident occurred. It has been reported that the DuPont Company operates a methomyl process which requires very small inventories of MIC. As part of our response to the Committee, the CSB will be reviewing the DuPont process to determine if it is technologically feasible for use in Institute, recognizing of course that DuPont may have business and competitive reasons for not wishing to disclose their process technology.

However, to answer the second part of your question, regardless of which process is used in a chemical plant i.e. whether or not the process uses inherently safer technology, the facility still has the obligation to operate its processes in a safe manner. In a chemical plant this would include complying with some or all of the elements of OSHA's Process Safety Management program or EPA's Risk Management Program regulations, e.g.:

- Process safety information
- Process hazard analysis
- Operating procedures
- Training

- Mechanical integrity
- Incident investigation
- Management of change