

## COMMENTS ON PROPOSED ACCIDENTAL RELEASE REPORTING RULE

CSB-2019-0004, RIN 3301-AA00

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These comments are submitted by Congressman Ted W. Lieu (CA-33), and the following local, state and national organizations and coalitions in response to the Request for Comments by the Chemical Safety and Hazard Investigation Board (“CSB” or “Board”) on the “Accidental Release Reporting – Notice of Proposed Rulemaking:” Air Alliance Houston, Alaska Community Action on Toxics, California Safe Schools, Center for Progressive Reform, Citizens’ Environmental Coalition, Clean Power Lake County, Clean Water Action, Coalition for Clean Air, Coming Clean, Communities for a Better Environment, Faith in Place Action Fund, Ohio Valley Environmental Coalition, Natural Resources Defense Council, Public Employees for Environmental Responsibility, Texas Environmental Justice Advocacy Services, Torrance Refinery Action Alliance, and United Support and Memorial for Workplace Fatalities.<sup>1</sup>

### Introduction

The requirement to promulgate an accidental release reporting regulation is one of the three primary duties assigned to the CSB in its 1990 enabling legislation: the CSB “shall establish by regulation requirements binding on persons for reporting accidental releases into the ambient air subject to the Board’s investigatory jurisdiction.” 42 U.S.C. § 7412(r)(6)(C)(iii). Yet, the Board failed to issue such a regulation for more than two decades of its existence, and issued the current proposal to comply with a court order in a case brought by some of these commenters. *Air Alliance Houston v. CSB*, 365 F. Supp. 3d 118 (D.D.C. 2019). However, the proposal creates only the appearance of compliance, as it limits and strips down the reporting

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<sup>1</sup> A list of the signatories with a short description of the organizations’ purposes follows these comments.

requirement to the point of rendering it almost completely useless. Congress would not have required the reporting regulation as one of CSB's three primary duties, and the District Court would not have ordered its issuance, if they had not intended a robust rule that would support the CSB's statutory duties and serve the cause of chemical safety.

While the Board protested to the court that a reporting regulation would be highly burdensome to implement, the reporting proposed is limited to filling out a form, estimated to take 15 minutes, with only the most basic information available within four hours of an accidental release. There is no requirement to ever correct or supplement that initial report with additional information as it becomes available. Even the extremely limited information required would not be made available to the public except through a Freedom of Information Act (FOIA) request, and would not be part of a searchable database of information on chemical incidents that would be useful to the Board and others in identifying damages and other impacts, trends, patterns, vulnerabilities, and opportunities for improvements in chemical safety. It would be used solely to inform the Board's decisions about deployment to investigate a chemical accident.

The proposal does not support CSB's statutory functions, or even the purposes for such a rule recognized by the Board itself in the past. It should be substantially revised to require full reporting over time as information becomes available; to provide for prompt placement of all reporting information in a publicly available, searchable database; and to include other requirements as detailed below.

1. **The Purpose and Functions of the Proposed Rule are Too Narrow**

The fundamental fault with the proposed rule, and the source of most of its deficiencies, is that its purpose and functions are far too narrow. The proposal is limited to a bare-bones notification of accidental releases on a form taking 15 minutes to complete, intended solely to

facilitate decisions on whether the CSB should deploy an investigation team. *See* 84 Fed. Reg. 67899, 67904 (Dec. 12, 2019) (stating the information required is limited to “provision of information useful to CSB in assessing its jurisdiction and making deployment decisions”); *see also id.* at 67908. Even this limited information will not be made routinely and effectively available to the public, but must be requested under FOIA, and is not slated to be made part of a searchable public database.

This falls far short of how a reporting rule could and should serve the statutory purposes and functions of the CSB, and stands in stark contrast to the purposes for a reporting rule articulated by the CSB itself in its earlier Advance Notice of Proposed Rulemaking (ANPR). 74 Fed. Reg. 30259 (June 25, 2009). There, the CSB stated that the rule “could help the agency develop better information on chemical incidents occurring in the United States, and help both the agency *and other organizations* to identify issues and trends.” *Id.* at 30260 (emphasis added). CSB specifically noted that the purpose of the rule was not limited – as it is now -- to “mere notification,” but instead extended to “surveillance goals and more accurate incident data.” *Id.*; *see also, id.* at 30261: “The CSB foresees that a reporting rule will further its current efforts to improve data collection and would permit more accurate surveillance of chemical incidents.” As the Government Accountability Office stated in a review of CSB performance, a reporting regulation would increase the CSB’s ability to “target its resources, identify trends and patterns in chemical accidents, and prevent similar accidents.” GAO–08–864R, at 7. Such information and data could also help the “other organizations” referenced by CSB in the ANPR - - such as community groups, state and local regulatory agencies, industry, academia, labor, emergency responders, and health professionals -- to identify weaknesses in chemical safety

systems and particular risks to industries, workers and communities; and to focus their resources to prevent, mitigate and respond to future incidents.

By drastically limiting the mandatory reporting requirement, the CSB proposal abandons the ANPR's goal to "collect more complete and in-depth information on incidents than is generally available in the minutes and hours immediately after an incident," to address "the data quality problems of accuracy and completeness of information on incidents in the CSB's database" and to "gather detailed information on the consequences, as well as the processes and chemicals involved, beyond what is contained in media or NRC [National Response Center] reports." 74 Fed. Reg. 30262. These goals cannot possibly be met by the preliminary and rudimentary reporting that is proposed. *See* 84 Fed. Reg. 67908 (requiring only "minimal contact information and a basic description of the accidental release" .... "if known" within four hours of the release).

Despite previously setting forth these goals, the CSB now claims that its current narrow focus is required by its authorizing statute, or needed to avoid conflict with other statutory programs. However, these were not found to be barriers to the broader focus in the 2009 Notice, and in fact the CSB's authorizing statute necessitates the broader focus. The authorizing statute nowhere states that the purpose of the reporting rule requirement is limited to informing CSB investigative deployment decisions, which is only one subset of the duties assigned to CSB in the statute. CSB's duties also include recommending measures and regulatory actions to "reduce the likelihood and consequences of accidental releases" and to "make chemical production, processing, handling and storage as safe and free from risk of injury as is possible." 42 U.S.C. 7412(r)(6)(C)(ii). Limiting the reporting regulation to informing CSB investigation deployment decisions is particularly concerning because CSB only investigates a small fraction of the

chemical incidents each year, but its duties, particularly in the areas of prevention and improving chemical safety, are much broader. For example, CSB would be far better positioned to advocate for a particular regulatory improvement if it had conclusive data that the particular safety issue was the cause of many accidents in the past, whether or not they had been subject to CSB investigations.

CSB is also tasked with conducting research and studies with respect to the potential for accidental releases where there is evidence of a potential hazard, 42 U.S.C. 7412(r)(6)(F), and producing annual reports which include “information on accidental releases which have been investigated by *or reported to the Board* during the previous year,” as well as recommendations for legislative or administrative action, priorities for study and investigation, progress in the development of risk-reduction technologies and the response to and implementation of significant research findings on chemical safety in the public and private sector.” 42 U.S.C. § 7412(r)(6)(S) (emphasis added).

All of these functions would be better served by a much more robust reporting rule that requires detailed information about chemical releases, their damages, impacts and potential causes, both immediately following the release and at later points when more information has been gathered. The proposal completely ignores CSB’s basic duties related to the *prevention* of chemical accidents and their resulting harms.

In addition, the proposed rule does not even serve to fully support the Board’s investigatory duties to determine “facts, conditions, and circumstances and the cause or probable cause[s]” of accidental releases. 42 U.S.C. § 7412(r)(C)(i). This function would be far better served by requiring reporting of more in-depth information that could inform a determination of facts and causation. Compiled data on previous incidents., whether or not subject to a CSB

investigation, would also benefit CSB in its future deployment decisions because it would provide information as to where the greatest risks were.

In sum, the purpose of the reporting rule should not be limited to informing isolated CSB investigation deployment decisions, but should include the earlier-identified purposes of creating a valuable and publicly available searchable database of accident information that could be used by CSB and other parties to identify issues, trends, vulnerabilities, and potential regulatory recommendations and measures to prevent future chemical incidents and resulting damages and injuries.

## 2. **Lack of Accuracy and Utility of the Required Reporting Information**

The proposed reporting system, because of its sole intent to inform CSB deployment decisions and its effort to put as little burden as possible on regulated industries, is structured in a manner that will result in particularly unreliable and unhelpful information. Some reports go to the NRC, where they will get mixed with the whole mass of other NRC reports submitted under other statutes and having no relevance to chemical safety issues within the CSB's jurisdiction. There is no apparent way to identify reports submitted to NRC that are within the Board's jurisdiction. On the other hand, some reports will go directly to the CSB. Locating relevant reports, through a FOIA request or otherwise, will be difficult if not impossible.

In addition, the reports do not use standard identifiers for facilities – such as latitude and longitude, Dun & Bradstreet (DUNS) number, parent company name, North American Industry Classification System (NAICS) code(s), Federal Employer Identification Number (FEIN), and EPA Risk Management Program Facility ID (if applicable) – to assist identification and so the reports can be related to other databases.

Crucially, the cursory initial reports are not subject to any data quality or accuracy requirements, and corrections of inaccurate information are entirely voluntary. In short, there is no control at all on the quality of information. CSB at the least should require that the person submitting the report attest to its accuracy and commit to revising any inaccuracies and providing additional information discovered later. It is doubtful whether these reports could meet the Board's own data quality guidelines, intended "to ensure and maximize the quality, objectivity, utility, and integrity of information" it disseminates.

<https://www.csb.gov/assets/1/6/finaldataqualityguidelines1.pdf> at 1. The guidelines apply to information other parties provide to the CSB that it disseminates. *Id.*

Equally important, there is no centralized location for these reports at all, even if they become public after FOIA requests. Thus, there is no way to use the data – assuming it were reliable -- to analyze trends, issues, vulnerabilities, and so on.

Because there is no requirement for follow-up after reports of what is known in the first four hours, most useful and accurate data about the release and its causes will never be reported. Without mandatory follow-up reporting, the rule is useless for generating an accurate accident database. This is particularly important with regard to accidents that the CSB does *not* investigate, and therefore about which CSB does not obtain additional information, which is all but a few accidents each year. The reporting rule could and should provide an important source of information on those incidents that are not subject to a formal CSB investigation. This function, of course, is entirely ignored in the context of a rule directed solely at informing deployment decisions.

3. **Reporting Limited to What Is Known in the First Four Hours Will Provide Little Information Useful to Understand the Incident, or to Determine Root Causes or Even Whether the Incident Is Reportable**

Experience shows, as would be expected, that little useful information is known about chemical accidents after four hours. In many cases, a major chemical accident is not a discrete, instantaneous event but unfolds over hours or even days, as the nature of the event becomes more apparent. For example, the CSB's report on the July 2009 fire at the CITGO refinery hydrofluoric acid (HF) alkylation unit in Corpus Christi, TX, notes that the initial hydrocarbon fire continued to burn for "several days," accompanied by an ongoing release of HF into the ambient air. One critical event – the exhaustion of the fresh water supply needed to partially suppress the HF release – occurred more than 11 hours after the fire began, according to CSB's own report.

In another notable example, according to the CSB's own investigation report on the peroxide fires at the Arkema chemical plant in Crosby, TX – one of the specific incidents that prompted the lawsuit about the CSB's lack of a reporting regulation – the incident unfolded over a number of days, including a large evacuation on August 29, 2017; a peroxide fire on August 31, 2017, with accompanying exposure of 21 emergency responders; and several subsequent peroxide fires extending until September 3, 2017.

In the case of the CSB's largest investigation ever – of the April 20, 2010, Deepwater Horizon rig explosion in the Gulf of Mexico – there was no definitive information on the fate of rig workers the day after the blowout (see for example <https://www.csmonitor.com/USA/2010/0421/Gulf-towns-pray-for-news-from-Deepwater-Horizon-oil-rig-explosion>). It was only on April 23, 2010 – three days after the blowout – that the Coast Guard suspended its search for 11 missing workers, who were then presumed killed.



(See Presidential Oil Spill Commission final report, <https://www.govinfo.gov/content/pkg/GPO-OILCOMMISSION/pdf/GPO-OILCOMMISSION.pdf>). An accident report filed four hours after the blowout – and compliant with the CSB’s proposed rule – could have omitted all the fatalities and had an inaccurate estimate of property damage.

While initial reporting certainly serves an important function of alerting the CSB, and ideally the public, to the incident, it must be followed up with updated reporting as more information becomes known. As described below, other more effective regulatory schemes require immediate reports and then follow-up reports at, for example, 72 hours, 30 days, and beyond until investigations are complete. Initial reports after four hours also cannot be expected to contribute to understanding root causes. As noted above, for incidents that the Board does not investigate (representing the overwhelming majority of serious incidents), information from the reporting rule may be the only opportunity to do so.

Not only will useful information about the incident be lacking, but even information that would determine whether the incident is reportable – i.e. meeting thresholds for injuries or property damage – is often lacking at four hours. As described above with regard to the Deepwater Horizon accident, in the first few hours after an incident, people may be missing or unaccounted for, and thus even fatalities and serious injuries are unknown. Medical diagnoses are unlikely to be made in the first four hours. Property damage often takes days or weeks to assess, as the American Chemistry Council commented with respect to the ANPR. Assessing the extent and monetary value of property damage has a number of time-consuming steps, including making an accident site safe for entry, arranging for examinations by engineers and insurance assessors (who must often travel in for the purpose), and obtaining estimated replacement costs for large, complex (often custom-made) equipment from suppliers.

Because follow-up reports are voluntary, if there is not information meeting the reporting threshold at four hours, it is not at all clear that a company would ever be required to report, even if deaths, serious injuries or major property damage later come to light.

4. **The Board Should Adopt Staged Reporting Similar to Other Regulatory Schemes**

The one-time reporting at four hours after an accident is clearly insufficient and should be replaced with multi-stage reporting of progressively more in-depth and detailed information, as is required in other regulatory schemes. This would dispense with CSB’s false dichotomy of either requiring “prompt reporting of basic information” or “additional detailed information.” 84 Fed. Reg. 67908. There is no reason that the rule cannot require both. For example, the Pipeline and Hazardous Materials Safety Administration (PHMSA) requires reporting of pipeline spills by telephone within one hour, an update within 48 hours, and a written report within 30 days. The agency notes that it uses the information to “mitigate risk, analyze gaps, and enhance safety.”<sup>2</sup> The 30-day accident report must be supplemented within 30 days of receipt of changes in the information reported or additions to the original report. 49 CFR 195.54. The 30-day report requires detailed information about the substances released, injuries and fatalities, whether the pipeline was shut down as a result of the incident, evacuations, equipment involved in the incident, environmental consequences, results of investigations conducted, apparent causes, damages, and much more.<sup>3</sup>

As another example, the Contra Costa County, California Health Services “Hazardous Materials Incident Notification Policy” requires immediate notification of any release with the

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<sup>2</sup> <https://www.phmsa.dot.gov/incident-reporting>

<sup>3</sup> <https://www.phmsa.dot.gov/sites/phmsa.dot.gov/files/docs/subdoc/3211/currenthlaccidentformphmsa-f-7000-110-2014-and-beyond.pdf>

potential for an adverse health effect from exposure to the chemicals released, and follow-up reporting at 72 hours and a final written report at 30 days, or if a final report has not been completed at that time, an interim report with monthly status reports every 30 days until the incident investigation is complete and a final report issued.<sup>4</sup>

5. **The Board Should Require Submission of Reports Required to be Prepared for Other Agencies, But Not Currently Collected**

Facilities regulated under the OSHA Process Safety Management standard (29 C.F.R. 1910.119) or EPA Risk Management Program (40 C.F.R. 68), are already required to conduct detailed causal investigations of actual or potential accidental releases. Some state and local agencies also require submission of investigatory reports. However, the CSB's draft rule fails to require facilities to submit this information that they have already generated and could provide at essentially no cost. Such reports contain a wealth of detailed information on accident risks and causes – already prepared at significant expense to industry – but currently not collected together by any federal agency.

6. **Near-Miss Situations are Improperly Excluded**

The CSB now claims it lacks statutory authority to require reports that do not cause death, serious injury or substantial property damage, because they are supposedly not within the CSB's investigatory jurisdiction. However, this claim contradicts both the statutory language and the Board's own statements in the ANPR and even in the proposed rule itself. The statute states:

*In no event shall the Board forego an investigation where an accidental release causes a fatality or serious injury among the general public, or had the potential to cause substantial property damage or a number of deaths or injuries among the general public.*

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<sup>4</sup> [https://cchealth.org/hazmat/pdf/incident\\_notification\\_policy.pdf](https://cchealth.org/hazmat/pdf/incident_notification_policy.pdf)

42 U.S.C. § 7412(r)(6)(E) (emphasis added). Thus, at least where there is a threat to the general public, the Board *must* investigate near-miss situations. The Board admits this in the proposed rule, stating such investigations are not only within its investigatory jurisdiction, but *mandatory* under the statute. 84 Fed. Reg. 67905. Likewise in the ANPR, the Board stated that the reporting rule should include reports of “substantial near miss situations.” 74 Fed. Reg. 30261.

Thus, for example, the reporting rule should cover situations where there are evacuations because of the potential for harm, even if no injuries or property damage materialize. A large-scale release of toxic HF into a community – the example cited in the proposed rule (84 Fed. Reg. 67907) – is exactly the kind of incident that should be reported to the Board whether or not any actual injuries or deaths happened to occur. Facility operators should be required to report any near-miss large-scale release of toxic HF, such as that which occurred at the Exxon-Mobil refinery in Torrance, California, on February 18, 2015, when a 40-ton piece of debris landed within five feet of a modified hydrofluoric acid settler tank after an explosion.<sup>5</sup> The legislative history of the Clean Air Act Amendments, and the development of the Board’s accident-prevention requirements in the aftermath of the 1984 Bhopal gas tragedy, indicate that Congress was particularly concerned about such incidents in establishing the Board and delineating its duties.

The reporting or investigation of near-miss incidents can result in identifying steps to be taken to prevent more serious incidents from occurring. They can also aid in identifying trends, developments and situations that would be predictive of future serious incidents, and can identify incipient problems for further research.

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<sup>5</sup> Source: South Coast Air Quality Management District, Refinery Committee Presentation, April 28, 2018, slide 13 (available upon request).

7. **The Property Damage Threshold is Too High**

The one-million-dollar threshold for property damage in the proposed rule is far too high and is not supported by any authority or data. Even the American Chemistry Council (ACC), in comments on the ANPR, suggested a \$50,000 threshold for reporting, consistent with the Department of Transportation regulatory limit. For CSB to use a threshold 20 times higher than what ACC suggested has no rational basis and can only indicate an effort to minimize reporting.

In addition, apart from the utility of reporting for incidents that the Board does not investigate, a brief review of the Board's own past investigations indicates that the CSB has from time to time deployed investigators to accidents or near-misses that caused less than \$1 million in property damage (and had no other reportable consequences such as deaths or serious injuries). (See for example [https://www.csb.gov/assets/1/17/statement\\_-\\_final\\_to\\_post\\_3\\_16\\_2012\\_-\\_2.pdf?14356](https://www.csb.gov/assets/1/17/statement_-_final_to_post_3_16_2012_-_2.pdf?14356))

The proposed rule justifies this limit by citation to the legislative history which states that \$100 in damage would not be substantial. 84 Fed. Reg. at 67906. This certainly cannot justify a threshold of \$1 million.

The damage threshold should be set at no higher than \$50,000, with the understanding that it includes *potential* damage if it might affect the general public.

8. **Limiting Informing the Public to FOIA Requests Fails to Provide Timely, Useful Information to Workers, Unions, Affected Communities, and other Interested Parties**

Making reporting information available to the public only through FOIA requests severely undermines the utility of the rule to inform workers, unions, affected communities and other interested parties of the existence and nature of accidental releases in a timely fashion. Interested parties might not even be aware of an accidental release to know to request the information, a problem that would be resolved by having all reports under the regulation

immediately posted in a publicly available database. Even if a person or organization did know about the release, they might not have identifying information that would facilitate a successful FOIA request, or they might not know whether the report had gone to the CSB or to the NRC, and they would not get all the information they seek by means of a request to either agency.

Even if the requester had enough information to make a proper FOIA request, the information would not likely be provided in a useful timeframe. By statute, an agency has 20 business days (four weeks) to respond to a FOIA request. 5 U.S.C. § 552(a)(6)(A)(i). This alone prevents access to prompt information about a release for possibly affected parties. However, the experience of these commenters is that the CSB often does not respond to FOIA requests for many months. For example, commenter PEER has two outstanding FOIA requests from February 2019 concerning accidents involving hydrofluoric acid (HF) for which no documents have yet been produced. According to the CSB itself in its 2019 Chief FOIA Officer Report (p. 7), “The percentage of requests that make up the CSB’s backlog out of the total number of requests received in Fiscal Year 2018 is 57%.” The Board also stated that its backlog was “of concern to the agency management.”<sup>6</sup> This sort of delay would make the information of little utility, for example, to an emergency responder seeking to determine what chemicals had been released, or to an individual or her medical practitioner seeking to discover the chemicals to which she had been exposed.

CSB justifies its limitation on making the reports public by claiming that neither 42 U.S.C. § 7412(r)(6)(C)(iii) nor 42 U.S.C. § 7412(r)(6)(Q) authorize the immediate disclosure of accidental release information other than through FOIA. 84 Fed. Reg. 67909. However, 42

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<sup>6</sup> Available at [https://www.csb.gov/assets/1/6/chief\\_foia\\_officer\\_report-questions\\_for\\_fy17\\_50\\_or\\_more\\_requests\\_-\\_from\\_csb\\_to\\_oip\\_may\\_3,\\_2019\\_.pdf](https://www.csb.gov/assets/1/6/chief_foia_officer_report-questions_for_fy17_50_or_more_requests_-_from_csb_to_oip_may_3,_2019_.pdf)

U.S.C. § 7412(r)(6)(Q) *does* explicitly require that all reports to the Board shall be available to, among others, the public, unless it is found by the Board to contain confidential information, and the exception for confidential information specifically excludes release or emissions data.

Subsection Q would be superfluous and basically meaningless if reports to the CSB were to be made available only through FOIA, since FOIA applies to all federal agencies in any event.

Clearly, accidental release reports are not only authorized, but *required* to be made public pursuant to the Board's authorizing statute.

Reports provided under the regulation should be immediately posted on a Board website or portion of its website dedicated to these reports.

#### 9. **The Proposed Regulation Should be Revised**

The proposal should be revised to do the following:

1. The purpose of the regulation should include not only facilitating the Board's investigatory deployment decisions, but also creating a public database of accidental release information that would serve to surveil such incidents nationwide; improve the quality and completeness of the information on accidental releases obtained by the Board; inform research and studies by the Board; enable the Board to better target its resources and to make recommendations for regulatory measures and actions to reduce the risk of chemical accidents and mitigate their consequences; and aid the Board as well as other organizations and the public in identifying trends, patterns, vulnerabilities, and opportunities for improvements in chemical safety in order to prevent, mitigate and respond to future chemical accidents.
2. The regulation should require reporting of all known or available information about accidental chemical releases at the time of each report, including the name of the

facility and including standard identifiers (e.g., parent company, geographic location, industry sector, and other facility and regulatory status identifiers), names and quantities of chemicals released, duration of the release, a description of how the chemicals came to be released, the consequences of the release including health impacts and property damage, both on and off-site, public impacts such as evacuations or orders to take shelter, and all information related to the root cause of the accident, as that later becomes available through company investigations or other means. Reports should be provided within four hours of the incident and follow-up reports correcting and supplementing the original report should be required 72 hours following the incident, 30 days following the incident, and every 30 days thereafter as long as any data continues to be gathered or investigation into the incident continues. Reports should include any reports made or information provided to other government agencies, or otherwise required to be produced under existing regulatory schemes, including those of state and local governments.

3. If an owner or operator concludes at the four-hour point that a chemical release does not meet the requirements for reporting, it must re-evaluate that conclusion at 72 hours and 30 days and file reports if required.
4. All reports and information, including reports initially submitted to the NRC, should be immediately entered into a public, searchable database maintained by CSB.
5. The requirement for reporting an accidental release should extend to any accidental release resulting in a fatality, serious injury or substantial property damage *and* to any release that had the *potential* to cause substantial property damage or a number of deaths or injuries among the general public.



6. The definition of “substantial property damage” should be estimated property damage at or outside the stationary source equal to or greater than \$50,000, and include potential property damage affecting the general public.

## **PROPOSED REGULATION**

(changes from the CSB Proposed Regulation are in italics)

### **PART 1604 — REPORTING OF ACCIDENTAL RELEASES**

Sec. 1604.1 Purpose.

1604.2 Definitions.

1604.3 Reporting an accidental release.

1604.4 Information required in an accidental release report submitted to the CSB.

1604.5 Failure to report an accidental release.

1604.6 Public availability of accidental release records.

Authority: 42 U.S.C. 7412(r)(6)(C)(iii); 42 U.S.C. 7412(r)(6)(N)

#### **§ 1604.1 Purpose**

The enabling legislation of the Chemical Safety and Hazard Investigation Board (CSB) provides that the CSB shall establish requirements binding on persons for reporting accidental releases into the ambient air subject to the Board's investigative jurisdiction. 42 U.S.C. 7412(r)(6)(C)(iii).

This part establishes the rule required by the enabling legislation. The purpose of this part is to require prompt notification of any accidental release within the CSB's investigatory jurisdiction, *as well as follow-up reports as additional information becomes available, to develop better information on chemical incidents for the CSB and the public useful to identify trends, patterns, and causative factors in chemical accidents and prevent similar accidents.*

## § 1604.2 Definitions.

*Accidental release* means an unanticipated emission of a regulated substance or other extremely hazardous substance into the ambient air from a stationary source.

*Ambient air* means any portion of the atmosphere inside or outside a stationary source.

*Extremely hazardous substance* means any substance which may cause death, serious injury, or substantial property damages, including but not limited to, any “regulated substance” at or below any threshold quantity set by the Environmental Protection Agency (EPA) Administrator under 42 U.S.C. 7412(r)(5).

*General public* means any person except for:

- (1) Workers, employees or contractors working for (or on behalf of) the owner or operator of a stationary source from which an accidental release has occurred; and
- (2) Any person acting in the capacity of an emergency responder to an accidental release from a stationary source.

*Owner or operator* means any person or entity who owns, leases, operates, controls, or supervises a stationary source.

*Property damage* means damage to or the destruction of tangible public or private property, including loss of use of that property.

*Regulated substance* means any substance listed pursuant to the authority of 42 U.S.C. 7412(r)(3).

*Serious injury* means any injury if it results in any of the following:

- (1) Death; one or more days away from work; restricted work or transfer to another job; medical treatment beyond first aid; loss of consciousness;

(2) Any injury or illness diagnosed by a physician or other licensed health care professional, even if it does not result in death, days away from work, restricted work or job transfer, medical treatment beyond first aid, or loss of consciousness.

*Stationary source* means any buildings, structures, equipment, installations, or substance-emitting stationary activities which belong to the same industrial group, which are located on one or more contiguous properties, which are under the control of the same person (or persons under common control), and from which an accidental release may occur.

*Substantial property damages* means estimated property damage *or potential property damage affecting the general public* at or outside the stationary source equal to or greater than \$50,000.

### **§ 1604.3 Reporting an accidental release.**

(a) The owner or operator of a stationary source must report in accordance with paragraph (b) or (c) of this section, any accidental release resulting in a fatality, serious injury or substantial property damages *or that had the potential to cause substantial property damage or a number of deaths or injuries among the general public.*

*For purposes of this section, any accidental release shall be considered to have had such potential if it causes any of the following:*

- (1) members of the public to be evacuated or advised to shelter in place,*
- (2) offsite property damage, regardless of monetary value, or*
- (3) the release of any extremely hazardous substance into ambient air at a level that may reasonably be anticipated to exceed the level considered AEGL 2 (10 minutes) as measured, estimated, or modelled at the property fence line.*

*(b) If an accidental release does not appear to meet the criteria of this section at the time the first report would be due four hours after the release, the need to report shall be re-evaluated 72 hours after the release and 30 days after the release. If it is then determined that the criteria in this section are met, reports shall then be filed in accordance with this rule.*

*(c) If the owner or operator has submitted a report to the National Response Center (NRC) pursuant to 40 CFR 302.6, the CSB initial reporting requirement may be satisfied by submitting the NRC identification number to the CSB immediately following submission of the report to the NRC. The CSB will immediately post such reports submitted to the NRC on the public database created by this section. The owner or operator will be subject to the requirements for follow-up reports in subsection (d) below, to be submitted to the CSB.*

*(c) If the owner or operator has not submitted a report to the NRC and notified the CSB under paragraph (b) of this section, the owner/operator must submit a report directly to the CSB within four hours of the accidental release and must include the required information listed in § 1604.4. A report may be made by email to: [report@csb.gov](mailto:report@csb.gov).*

*(d) Follow-up reports with all then-available information listed in § 1604.4 shall be submitted to the CSB by email and posted on the public database created by this section 72 hours after the accidental release and 30 days after the accidental release, and every 30 days thereafter until any investigation of the accidental release is completed. Such reports shall supplement and correct, to the extent necessary, any previous reports submitted under this rule.*

*(e) All notification and investigative reports concerning the accidental release submitted to (or required to be prepared by) any other federal, state, or local agency, and any official internal company investigative reports concerning the accidental release, shall also be submitted to the CSB and posted on the public database created by this rule.*

**§ 1604.4 Information required in an accidental release report submitted to the CSB.**

The reports required under § 1604.3(c) *and* (d) must include the following information regarding an accidental release as applicable *and ascertainable at the time of each report*:

- (a) The name of, and contact information for, the owner/operator;
- (b) The name of, and contact information for, the person making the report;
- (c) The location information and facility identifier, *as available, the facility's latitude and longitude, Dun & Bradstreet (DUNS) number, parent company name, North American Industry Classification System (NAICS) code(s), Federal Employer Identification Number (FEIN), and/or EPA Risk Management Program Facility ID (if applicable)*.
- (d) *The name and contact information for any union representing workers at the facility;*
- (e) The *date and* approximate time of the accidental release;
- (f) A description of the accidental release *including a description of the processes involved, how the chemicals came to be released and all information related to the root cause of the accident.*
- (g) An indication whether one or more of the following has occurred, *either on or off site*:
  - (1) Fire;
  - (2) Explosion;
  - (3) Death;
  - (4) Serious injury; or
  - (5) Property damage;
- (h) *A statement by the owner or operator attesting to the report's accuracy and committing to revising any inaccuracies and submitting additional information that is required by this part and discovered later;*

- (i) The name of the material(s) involved in the accidental release, the Chemical Abstract Service (CAS) number(s), or other appropriate identifiers;
- (j) The amount of the release;
- (k) The number of fatalities;
- (l) The number of serious injuries;
- (m) Estimated property damage at or outside the stationary source;
- (n) Whether the accidental release has resulted in an evacuation order impacting members of the general public and others, and,
  - (1) The number of people evacuated and/or advised to shelter in place;
  - (2) Approximate radius of the evacuation zone; and
  - (3) The type of individuals subject to the evacuation order (i.e., employees, members of the general public, or both).

**§ 1604.5 Failure to report an accidental release.**

- (a) It is unlawful for any person to fail to make reports required under this part, and suspected violations of this part will be forwarded to the Administrator of the EPA for appropriate enforcement action.
- (b) Violation of this part is subject to enforcement pursuant to the authorities of 42 U.S.C. 7413 and 42 U.S.C. 7414, which may include—
  - (1) Administrative penalties;
  - (2) Civil action; or
  - (3) Criminal action.

**§ 164.6 Public availability of accidental release records.**

(a) Accidental release records collected by the CSB under this rule *shall immediately be placed in a publicly-available, searchable database, which shall include all reports to the CSB, the NRC, any other federal, state, or local government entity, and any official internal investigative report by the facility concerning the release. The database shall be available on a CSB website.*

(b) *In addition to placing accidental release records in the public database, the CSB shall notify the representative of any union representing employees of the facility as soon as any initial or follow-up report of an accidental release is received by the CSB.*

*Any such union shall supply the CSB with the contact information for the person to be notified within 30 days of the effective date of this regulation, and shall update such information as needed.*

SIGNATORIES TO COMMENTS ON  
PROPOSED ACCIDENTAL RELEASE REPORTING RULE

**Congressman Ted W. Lieu (CA-33)**

**Air Alliance Houston**

Dr. Bakeyah Nelson, Executive Director

Air Alliance Houston is a non-profit advocacy organization working to reduce the public health impacts of air pollution and advance environmental justice.

Air Alliance Houston was a plaintiff in the case that ordered the CSB to promulgate the chemical incident reporting rule.

**Alaska Community Action on Toxics (ACAT)**

Pamela Miller, Executive Director

ACAT is an environmental health and justice research and advocacy organization. We believe everyone has a right to clean air, clean water, and toxic-free food. Driven by a core belief in environmental justice, ACAT empowers communities to eliminate exposure to toxics through collaborative research, shared science, education, organizing, and advocacy.

**California Safe Schools**

Robina Suwol, Executive Director

California Safe Schools, founded in 1998, is a children's environmental health and environmental justice coalition located in Los Angeles, California.

**Center for Progressive Reform (CPR)**

David Flores, Policy Analyst

Founded in 2002, CPR is a network of university-affiliated Member Scholars with expertise in legal, economic, and scientific fields. CPR Member Scholars and staff prepare studies, reports, articles, and other analyses, and participate in educational forums and conferences to promote informed and effective public policy.

**Citizens' Environmental Coalition**

Barbara Warren, RN, MS, Executive Director

Citizens' Environmental Coalition is a statewide environmental health organization in New York, whose work includes prevention of chemical disasters.

**Clean Power Lake County (CPLC)**

Dulce Ortiz, Co-Chair

CPLC's mission is to organize within frontline environmental justice communities to shift Lake County, Illinois to healthy, renewable energy—and to achieve the self-determination of immigrant, low-income, and working-class families.

**Clean Water Action**

Lynn Thorp, National Campaign Director

Clean Water Action is a national organization was founded in 1972 during the campaign to pass the Clean Water Act in 1972. Its mission is to protect our environment, health, economic well-being and community quality of life. Clean Water Action organizes strong grassroots groups and



coalitions, and campaigns to elect environmental candidates and to solve environmental and community problems.

### **Coalition for Clean Air**

Joseph K. Lyon, PhD, President and CEO

Coalition for Clean Air is a California organization founded in 1971, dedicated to protecting public health, improving air quality, and preventing climate change.

### **Coming Clean**

Steve Taylor, Program Director

Coming Clean is a national environmental health and justice collaborative of 200 organizations working to reform the chemical and fossil fuels industries so they are no longer a source of harm, and to secure systemic changes that allow a safe chemical and clean energy economy to flourish.

### **Communities for a Better Environment (CBE)**

Julia May, Senior Scientist

Founded in 1978, the mission of CBE is to build people's power in California's communities of color and low income communities to achieve environmental health and justice by preventing and reducing pollution and building green, healthy and sustainable communities and environments.

### **Faith in Place Action Fund**

Celeste Flores, Lake County Outreach Director

Faith in Place empowers Illinois people of all faiths to be leaders in caring for the Earth, providing resources to educate, connect, and advocate for healthier communities.

### **Natural Resources Defense Council (NRDC)**

David Petit, Senior Attorney

NRDC works to safeguard the earth—its people, its plants and animals, and the natural systems on which all life depends. NRDC combines the power of more than three million members and online activists with the expertise of some 700 scientists, lawyers, and policy advocates across the globe to ensure the rights of all people to the air, the water, and the wild.

### **Ohio Valley Environmental Coalition (OVEC)**

Vivian Stockman, Executive Director

OVEC is a nonprofit organization based in Huntington, West Virginia. Our mission is to organize and maintain a diverse grassroots organization dedicated to the improvement and preservation of the environment and communities through education, grassroots organizing and coalition building, leadership development, strategic litigation and media outreach.

### **Public Employees for Environmental Responsibility (PEER)**

Paula Dinerstein, General Counsel

PEER protects public employees who protect our environment. We are a service organization for local, state, federal and tribal law enforcement officers, scientists, land managers, and other professionals dedicated to upholding environmental laws and values. Through PEER, public

servants can choose to work as “anonymous activists” so that public agencies must confront the message, rather than the messenger.

PEER was a plaintiff in the case that ordered the CSB to promulgate the chemical incident reporting rule.

**Texas Environmental Justice Advocacy Services (t.e.j.a.s.)**

Juan Parras, Director

t.e.j.a.s. is dedicated to providing community members with the tools necessary to create sustainable, environmentally healthy communities by educating individuals on health concerns and implications arising from environmental pollution, empowering individuals with an understanding of applicable environmental laws and regulations and promoting their enforcement, and offering community building skills and resources for effective community action and greater public participation.

**Torrance Refinery Action Alliance (TRAA)**

Steve Goldsmith

Acting President

TRAA is a grassroots organization of residents and business owners who live or work in neighborhoods surrounding the Torrance and Wilmington, California HF (hydrofluoric acid) refineries. We formed our group after an explosion at the ExxonMobil Torrance Refinery (now PBF Energy’s Torrance Refining Company (ToRC)) on February 18, 2015 rocked Torrance and surrounding cities and covered us in fine dust. TRAA advocates for a ban on HF.

**United Support and Memorial for Workplace Fatalities (USMWF)**

Tammy Miser, Founder and Assistant Director

USMWF offers support, guidance and resources to those affected by preventable deaths or serious injuries.

USMWF was a plaintiff in the case that ordered the CSB to promulgate the chemical incident reporting rule.