Department of Energy

Washington, DC 20585

May 25, 2011

MEMORANDUM FOR GLENN S. PODONSKY
CHIEF HEALTH, SAFETY AND SECURITY OFFICER
OFFICE OF HEALTH, SAFETY AND SECURITY

FROM: WILLIAM H. ROEGE
DEPUTY DIRECTOR
OFFICE OF ENVIRONMENTAL PROTECTION, SUSTAINABLITY SUPPORT AND CORPORATE SAFETY ANALYSIS

SUBJECT: Request Approval to Amend the Independent Review Board Report of the July 8, 2010 Fatality at the Strategic Petroleum Reserve – Bryan Mound Site and Close the Investigation.

BACKGROUND: In consultation with the Assistant Secretary for Fossil Energy (FE), the Chief Health, Safety and Security Officer appointed an Independent Review Board (IRB) on July 20, 2010, under the provisions of the Department of Energy (DOE) Order 225.1A, *Accident Investigations,* that represented a modified Type A accident investigation. The Office of Health, Safety and Security (HSS) IRB was tasked to analyze the information collected by the (1) Occupational Safety and Health Administration (OSHA) investigation, and (2) Strategic Petroleum Reserve (SPR) Project Management Office (PMO) comprehensive safety review. The final HSS IRB report was issued on September 27, 2010.

The final HSS IRB report identified several safety system deficiencies and advised FE and SPR of the need for timely management attention and corrective actions. In addition, it was noted that the cause of death had not yet been determined by the local coroner and the OSHA investigation had not been closed. HSS recommended that further review of any corrective actions may be warranted when this information became available.

Subsequently, the following relevant actions occurred:

On November 3, 2010, OSHA closed their investigation and issued *Citation and Notification of Penalty* to one SPR subcontractor for $8,400 and on November 7, 2010, issued a *Citation and Notification of Penalty* to a different SPR subcontractor in the amount of $14,800.

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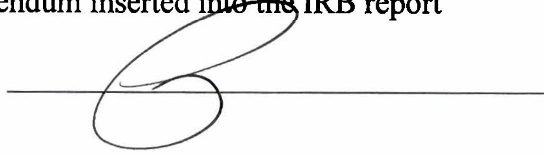
On November 17, 2010, SPR submitted to FE an integrated and consolidated corrective action plan. FE-1 directed the FE program office to review the SPR corrective actions, and that HSS be requested to provide feedback on those planned actions.
On January 4, 2011, the Galveston County Medical Examiner's Office provided HSS with their report and identified the cause of death as asphyxiation due to lack of oxygen. Upon review of the physical and laboratory evidence in the report, the Department's Chief Medical Officer concurred with the findings and conclusions of the Medical Examiner.
On March 14, 2011, the Office Director for Corporate Safety Programs provided feedback to SPR on the corrective action plan. Comments were provided on how the plan might be improved to address HSS IRB identified Opportunities for Improvement. Overall, if implemented effectively, the corrective actions should help prevent recurrence of a similar accident.

SENSITIVITIES: There was initial local news media attention in Texas when the fatality was first reported in July, 2010, but none since. No Freedom of Information Act request relative to the HSS accident investigation has been received. SPR has indicated that several months ago a public notice appeared in the local newspaper near the accident site that a wrongful death suit was being brought against the tank cleaning subcontractor. HSS has received no formal indication of pending legal actions related to this accident.

RECOMMENDATION: Recently completed activities are deemed sufficient basis for the Chief Health, Safety and Security Officer to close this investigation.

Please (1) approve the closeout for the Independent Review Report with your signature below; and (2) signify by your signature on the attached your authorization to have the addendum inserted ~~into the~~ IRB report

APPROVE: 

DISAPPROVE: ______________________

DATE: 5/20/11

REPORT ADDENDUM

March, 2011

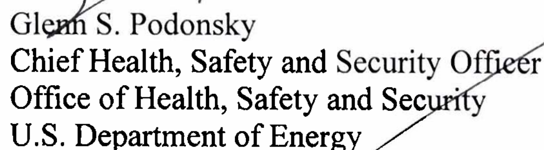
The Office of Health, Safety and Security (HSS) established an Independent Review Board (IRB) of the July 8, 2010 fatality at the Strategic Petroleum Reserve (SPR) Bryan Mound Site which generated this report. As stated in the report, final determinations could not be made until the Galveston County Medical Examiner's Office ascertained the cause of death.

On January 4, 2011 the Galveston County Medical Examiner's Office provided HSS the final report. Upon consideration of the physical and laboratory evidence, it was the conclusion of the Medical Examiner that the fatality was an accident. The cause of death reported by the Medical Examiner was asphyxiation due to lack of oxygen. The Department's Chief Medical Officer has reviewed and concurred with the findings and conclusions of the Medical Examiner.

HSS reviewed the results of the accident investigation with Occupational Safety and Health Administration (OSHA) and determined the facts gathered by OSHA where consistent with the facts gathered by the HSS investigation. In January 2011, OSHA issued citations and notification of penalties associated with this accident.

On March 14, 2011, HSS provided the SPR comments to their integrated corrective action plan to address the Opportunities for Improvements contained in the HSS IRB report. HSS emphasized the needed for addressing the extent of condition of oversight management system weaknesses across SPR; the need for professional industrial hygiene expertise within the oversight process; and the need to establish a formal process to validate the effectiveness of corrective actions.

In consideration of these actions and my responsibilities as the IRB Appointing Official under DOE Order 225.1A, *Accident Investigations* (the prevailing policy at the time I appointed this IRB), I have determined that this accident investigation to be closed and the IRB report be amended by insertion of this addendum.



Glenn S. Podonsky
Chief Health, Safety and Security Officer
Office of Health, Safety and Security
U.S. Department of Energy