

# Why does HSEES want to talk with you?

To keep you out of the We will cover:

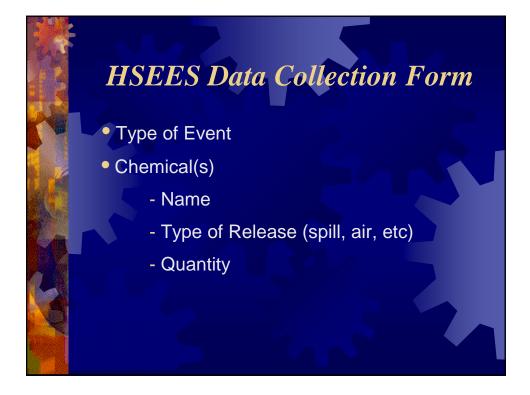
- Who and what is HSEES?
- What do we investigate?
- Where and when do these events occur?
- Who gets injured?
- Why are people getting injured?
- What can be done about it?

HSEES is designed specifically to capture the public health impact of releases like decontamination, evacuation, injury or death



# **HSEES** Objectives

- Describe the distribution and characteristics of emergency events
- Describe the injuries and fatalities resulting from the events
- Identify the risk factors associated with the injuries and fatalities
- Identify strategies aimed at reducing future injuries and fatalities



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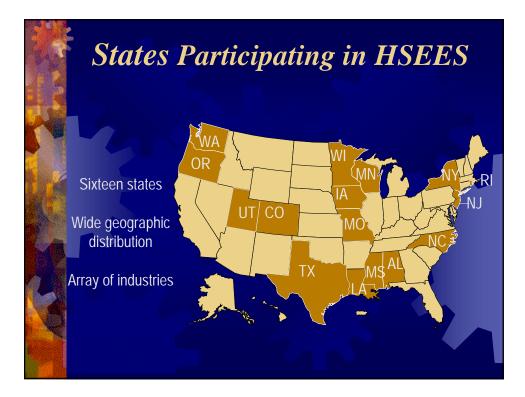
# HSEES Data Collection Form (continued)

- Other Information
- Area
- Response Plan
- Time

- Causal Factors

- Evacuations

- Affected Population
- Environmental Sampling

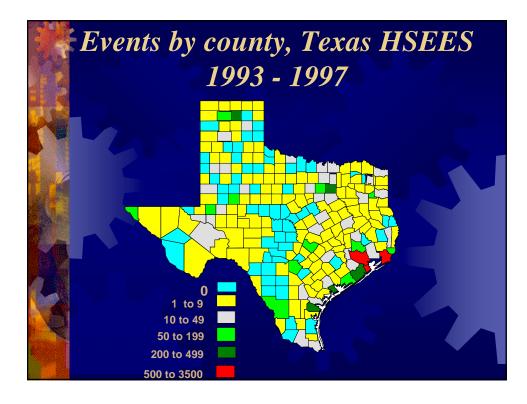


# **Texas HSEES Case Definition**

Sudden uncontrolled or illegal releases or threatened releases of at least one hazardous substance.

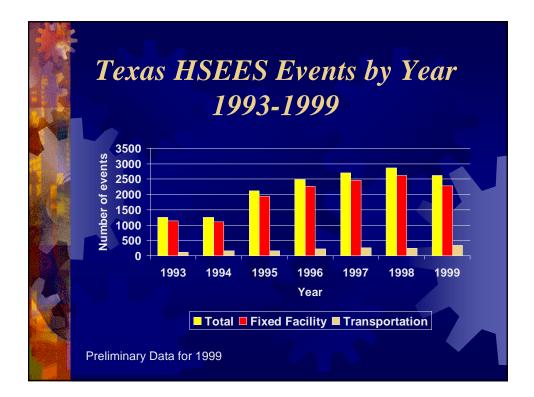
The released material must be greater than 1 gallon or 10 pounds or exceed the CERCLA reportable quantity (RQ).

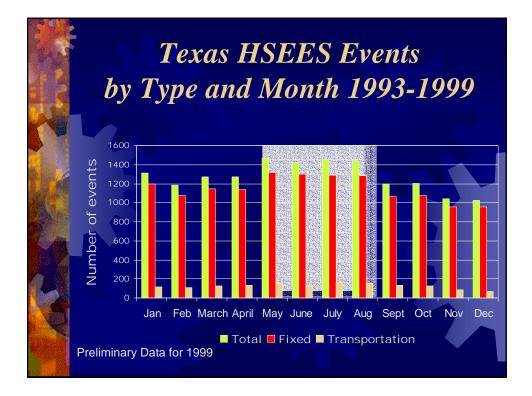
Events involving only petroleum are excluded.

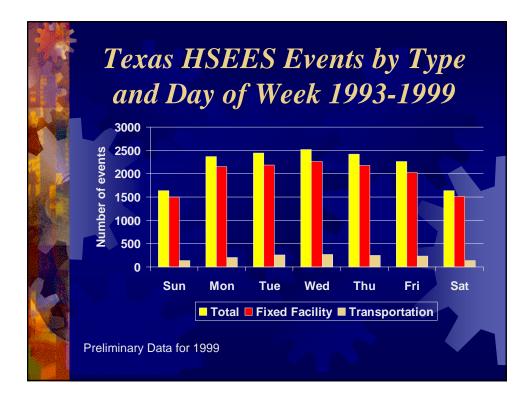


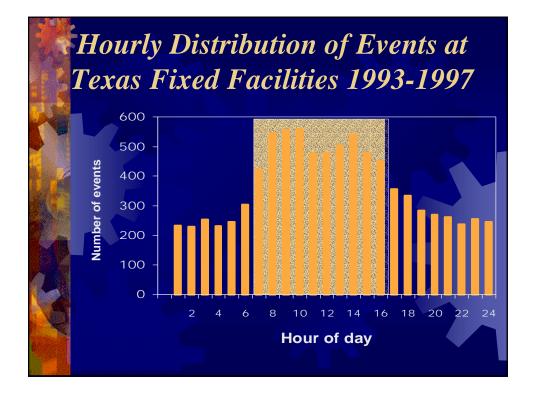
# Texas HSEES, Events by County

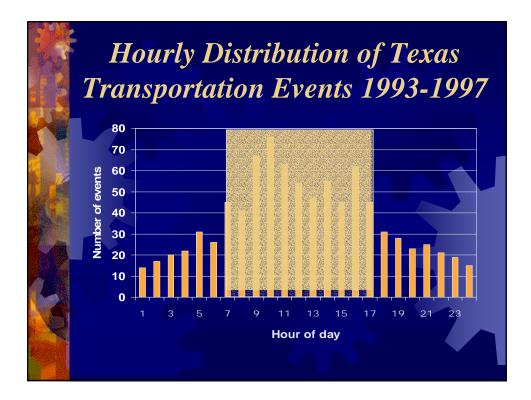
- The counties along the Gulf coast are highly industrialized and account for the largest number of events.
- Harris and surrounding counties accounted for over 60% of the events from 1993 through 1997.













### Lessons Learned

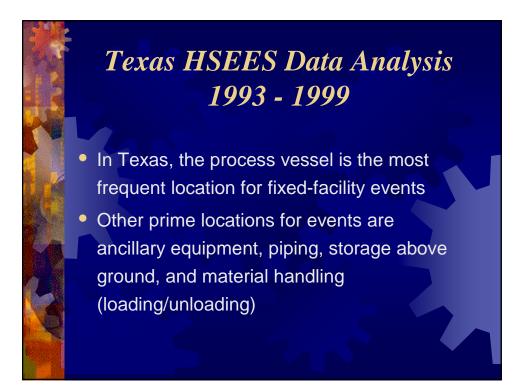
Anticipate cycles with chemical releases Work practices

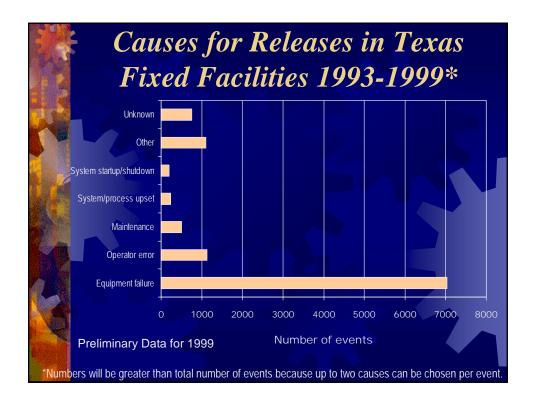
- Better cross training for summer coverage
- Increased staffing or process monitoring
- More frequent maintenance cycles

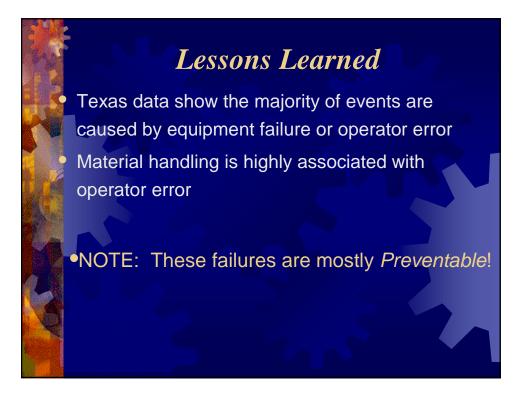
### Improve Process Design

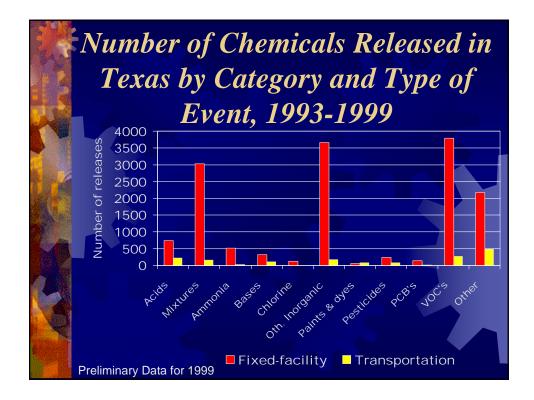
- Back up power generation
- Redundant systems

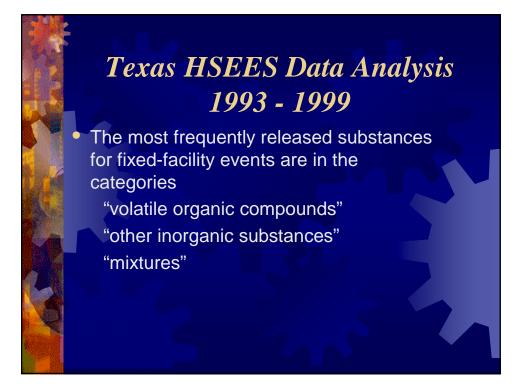


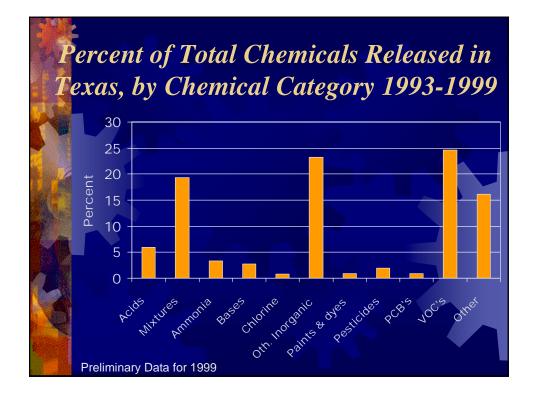


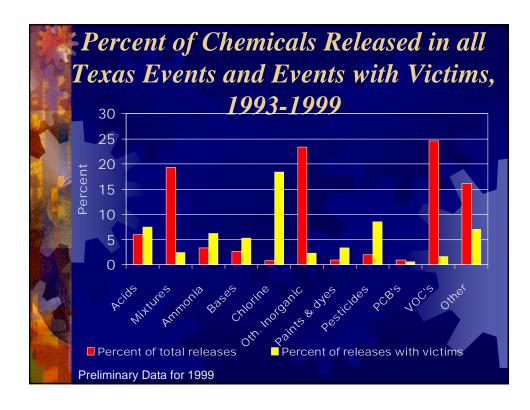


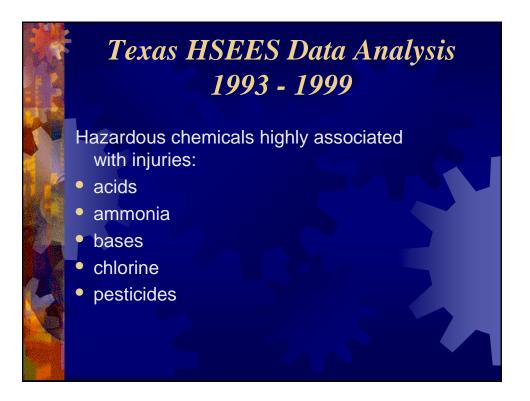






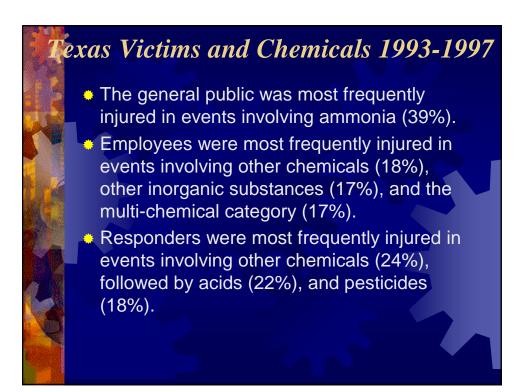


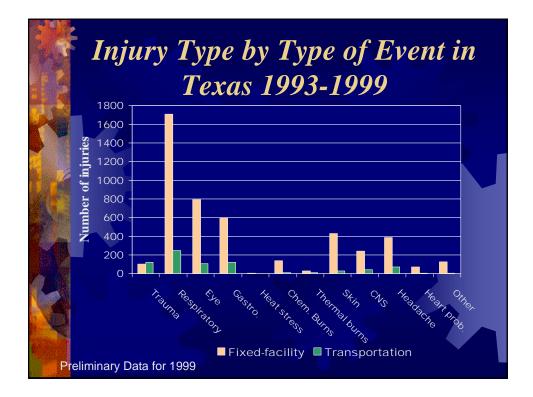












# Texas HSEES Data Analysis 1993 - 1999

- The majority of victims were treated at a hospital and released
  - There were no responder fatalities
- There were 51 deaths, 78% were employees and22% were members of the general public
- 92% of the transportation-related deaths and 65%
  of the fixed-facility deaths were due to trauma



# Water Treatment Plant, 1993

Operator error caused 3,000 gallons of sodium hydroxide to be dumped into the public water supply.

- Injured 251 people
- Injuries included:
  - chemical burns
  - skin irritation
  - GI difficulty
- Underlying causes:
- Poor system design
- Poor supervision and training

# Water Treatment Plant, 1993 Lessons Learned

Lessons Learned?

- Implement standard operating procedures or checklist for processes and better training.

- Improve process control engineering

- Place automated sensor system linked to release cut off valve

# **Chemical Plant**, 1994

During start-up, relief valve activated and released 3,000 lbs of ammonia in 8 min.

- Injured offsite: 580 general public
- Injured onsite: 2 employees and 1 unidentified victim
- Injuries included respiratory and eye irritation, and GI difficulty

### Underlying causes:

 Improper startup caused overpressure in ammonia system triggering pressure relief valve

# Chemical Plant, 1997

- Relief valve on process vessel released almost 200 lbs diketene and was drawn into the building by the fresh air intakes for air conditioning system.
- "Shelter in Place" was ordered and 3 people evacuated for 1 hour
- Injured onsite: 58 employees
- Injuries included respiratory, eye, and skin irritation.

### Underlying causes:

- Systems design problem
- Poor emergency response plan

# Chemical Plants Lessons Learned

### -Lessons Learned?

- Company installed pressure alarm on the vaporizer.

 Develop a step by step standard operating procedure/better training

- Improved and redundant engineering systems at critical points of control (ex: pressure sensors linked to flow cut-off valves, redundant recycling or containment capture controls).

- Be sure of workplace and community contingency plans

# PVC Resin Mfg., 1998

Processing tank containing ethylene dichloride exploded and caused a fire releasing a mixture of 38,654 lbs of carbon monoxide/ethylene dichloride/acid gases.

- Evacuated 1,640 people, including 700 elementary school children for 5 hours.
- Injured 20 employees, 30 general public

Mostly trauma injuries reported from flying debris <u>Underlying causes</u>:

Poor control of processes



# Chemical Plants Lessons Learned

### Lessons Learned?

- Fire control measures should have been anticipated

- Know the hazards of process reactants and degradation products

- Improved polyurethane foam curing techniques

- Implement structural or engineering systems to segregate curing polyurethane foam from stored foam

# Summary Lessons Learned

### <u>Anticipate</u>

- Identify processes likely to create on/off-site consequences (eg. ammonia, chlorine, acids)
- Prepare and exercise emergency response plans with plant and local emergency authorities

### <u>Recognize</u>

 Operator error, equipment failure, and material handling situations are frequently associated with release incidents, AND are often PREVENTABLE.

# Summary Lessons Learned

### <u>Evaluate</u>

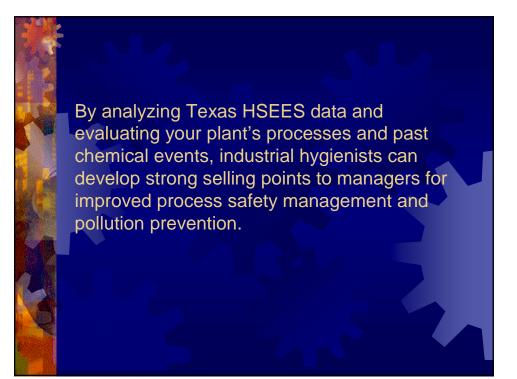
- Form Process Safety Control teams that include operators, maintenance, and process engineers.
- Review processes with high risk or frequency of upsets and past release incidents.

### <u>Control</u>

Use the research and expertise of the Process Safety Control teams to develop and implement integrated control systems using engineering and pollution prevention controls, good workplace practices, and drilled contingency plans.







# For more information, contact:

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