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HAZARDOUS MATERIALS PROGRAMS

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September 17, 2012

Ms. Mary Kay Nye Process Safety Supervisor Shell Oil Products U.S. Martinez Refinery 3485 Pacheco Blvd. P.O. Box 711 Martinez, CA 94553

Dear Ms. Nye:

Subject: Comments on 30-Day Incident Report and RCA – Hydrocracker Compressor Lube Oil Fire (IR#12-08-13-01)

Contra Costa Hazardous Materials Programs (CCHMP) received the 30-day incident report for the Hydrocracker compressor lube oil fire on September 13, 2012. This incident was classified as a Level 2 incident in the County's Community Warning System requiring a Root Cause Analysis (RCA) type of investigation. After reviewing the 30-day report and RCA, CCHMP has the following comments.

- 1. Page 3 of the report identifies that the root cause was, "the operator left the oil reservoir while it was filling, which led to overfilling the oil reservoir and restricting of the oil return line." Root causes should be linked to management system failures instead of action or inaction at the worker level. The report does indicate systems that failed (e.g., management system or procedures that prevent leaving an open valve unattended). As described in Section C.2.1 of our Safety Program Guidance Document, root causes can only be found at the worker level under the following conditions:
  - Management systems were in place and functioning, and provided management with feedback on system implementation and performance.
  - Management took appropriate actions based on the feedback.
  - Management, including supervision, could not reasonably have been expected to take additional actions based on their responsibilities and authorities.
- 2. The discussion on the use of defeating mechanisms for spring actuated valves or similar systems should be further explored. There was no recommendation to evaluate whether this valve system is necessary or whether alternative systems are available. CCHMP finds it curious that after 12 years into complying with the County's Industrial Safety Ordinance that human factors issues remain in existing process areas. In addition, most likely there are similar deadman valve arrangements in the refinery although there was no mention of looking at those for either the prevalence of them being defeated; whether alternative systems are available; or whether they should be ergonomically evaluated as well.



CCHMP expects that responses to the above comment will be submitted by October 1, 2012. Please contact me at 925-335-3237 if you have any questions.

Sincerely,

Original signed by

Michael Dossey Accidental Release Prevention Engineer