



## Chemical Safety and Hazard Investigation Board

OFFICE OF GENERAL COUNSEL

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### Memorandum

To: Board Members

From: Richard C. Loeb *RC*

Cc: Leadership Team  
Mark Kaszniak  
Christina Morgan

Subject: Board Action Report – Notation Item 2013-17

Date: February 26, 2013

On February 14, 2013, the Board approved Notation Item 2013-17, thereby designating Recommendation 2003-13-I-LA-R7, to the Honeywell Baton Rouge Facility (from the Honeywell Chemical Incidents investigation), with the status of Closed – Acceptable Action.

### Voting Summary – Notation Item 2013-17

**Disposition: APPROVED**

**Disposition date: February 14, 2013**

	Approve	Disapprove	Calendar	Not Participating	Date
R. Moure-Eraso	X				2/05/2013
M. Griffon	X				2/20/2013
B. Rosenberg	X				2/14/2013



## U. S. Chemical Safety and Hazard Investigation Board RECOMMENDATIONS STATUS CHANGE SUMMARY

<b>Report:</b>	<b>Honeywell Chemical Incidents</b>
<b>Recommendation Number:</b>	<b>2003-13-I-LA-R7</b>
<b>Date Issued:</b>	<b>August 8, 2005</b>
<b>Recipient:</b>	<b>Honeywell International, Inc. Baton Rouge Facility</b>
<b>New Status:</b>	<b>Closed- Acceptable Action</b>
<b>Date of Status Change:</b>	<b>February 14, 2013</b>

### Recommendation Text:

*Conduct training to emphasize that MOC evaluations must consider whether emergency shutdown procedures need to be changed when there are changes in material inventory.*

### Board Status Change Decision:

#### A. Rationale for Recommendation

The recommendation was issued pursuant to the CSB's investigation of the July 20, 2003 chlorine release incident at the Honeywell Baton Rouge facility which injured seven workers and resulted in a shelter-in-place advisory for nearby residents. At the time of the accident, the process unit used chlorine supplied by a railcar holding 90 tons of chlorine. When the unit was originally built, however, chlorine was supplied by one-ton cylinders. When the facility switched to a railcar system, which resulted in a ninety-fold increase in the quantity of chlorine available to the process, the facility conducted a Management of Change (MOC) analysis. The MOC analysis did not, however, recommend additional safeguards to mitigate the impacts of potential chlorine releases, such as integrated procedures and equipment for isolating the railcar and shutting down the process unit.

#### B. Response to the Recommendation

Honeywell reported to the CSB that its updated Management of Change procedure makes clear that a change in material inventory would necessitate an MOC analysis. They also report that their MOC checklist requires a process hazard analysis (PHA) following changes in material inventory, which would include a review of emergency shutdown procedures. Honeywell also provided copies of training materials and evidence that all Baton Rouge employees received training.

#### C. Board Analysis and Decision

Because Honeywell reports actions consistent with the intent of the CSB's recommendation, the Board voted to change the status of this recommendation to "Closed- Acceptable Action."