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REGION 6 LEPC Update



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This month, we will be discussing the organization and duties of the Chemical Safety Board. Their efforts are important for all LEPCs.

Special thanks to Kristen Hendrix, Texas Tech University student and EPA intern, for her research and assistance in developing this information.

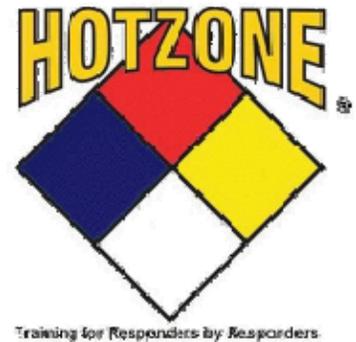
As always, if you received this Update from someone else, and would like to be added to the email list, just email us at the email above.

Steve & Angie

10th Annual HOTZONE Conference

The goal of the HOTZONE conference is to train and equip local, state and federal responders for safe, coordinated and efficient response to releases of hazardous materials which threaten public health and the environment.

People who should attend include local fire, police, emergency management personnel, emergency medical services, health care providers, and state and federal response personnel who participate directly in the incident command system or in its immediate support at the scene of a hazmat response or terrorist event in Federal Region 6.



THIS YEAR, HOTZONE 10 will be held:
October 22-25, 2009 -- Crowne Plaza Hotel - Reliant Park -- Houston, TX

GO TO OUR WEBPAGE FOR MORE CONFERENCE INFORMATION, REGISTRATION, AND SCHOLARSHIP OPPORTUNITIES
www.hotzone.org

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Local Government Reimbursement Success Story!

EPA Headquarters has evaluated an application submitted by the City of Dyer, Arkansas, under the Local Government's Reimbursement (LGR) Program.

Based on the evaluation, the City of Dyer is eligible for an award of \$ 16,143.99 for costs incurred responding to a chemical fire in November, 2008.

For more information concerning the LGR program, please visit the webpage:

<http://www.epa.gov/oem/content/lgr/index.htm>



Chemical Safety and Hazard Investigation Board (CSB)

About the CSB

The CSB is an independent federal agency charged with investigating industrial chemical accidents. The agency's board members are appointed by the president and confirmed by the Senate.

CSB investigations look into all aspects of chemical accidents, including physical causes such as equipment failure as well as inadequacies in regulations, industry standards, and safety management systems.

The Board does not issue citations or fines but does make safety recommendations to plants, industry organizations, labor groups, and regulatory agencies such as OSHA and EPA.

History of the Board

The U.S. Chemical Safety Board is authorized by the Clean Air Act Amendments of 1990 and became operational in January 1998. The Senate legislative history states:

"The principal role of the new chemical safety board is to investigate accidents to determine the conditions and circumstances which led up to the event and to identify the cause or causes so that similar events might be prevented."

Congress gave the CSB a unique statutory mission and provided in law that no other agency or executive branch official may direct the activities of the Board.

Following the successful model of the National Transportation Safety Board and the Department of Transportation, Congress directed that the CSB's investigative function be completely independent of the rulemaking, inspection, and enforcement authorities of EPA and OSHA.

Congress recognized that Board investigations would identify chemical hazards that were not addressed by those agencies.

The legislative history states:

The investigations conducted by agencies with dual responsibilities tend to focus on violations of existing rules as the cause of the accident almost to the exclusion of other contributing factors for which no enforcement or compliance actions can be taken. The purpose of an accident investigation (as authorized here) is to determine the cause or causes of an accident whether or not those causes were in violation of any current and enforceable requirement.



Although the Board was created to function independently, it also collaborates in important ways with EPA, OSHA, and other agencies. The Board has entered into a number of memorandums of understanding (MOUs) that define the terms of collaboration.



For example, in cases where several agencies are conducting investigations of a particular accident, the MOUs outline mechanisms for coordination in the field. The goal of the MOUs is to allow each agency to carry out its statutory mission efficiently and without unnecessary duplication of effort.

Mission of the CSB

The CSB conducts root cause investigations of chemical accidents at fixed industrial facilities. Root causes are usually deficiencies in safety management systems, but can be any factor that would have prevented the accident if that factor had not occurred. Other accident causes often involve equipment failures, human errors, unforeseen chemical reactions or other hazards.

Congress designed the CSB to be non-regulatory and independent of other agencies so that its investigations might, where appropriate, review the effectiveness of regulations and regulatory enforcement.

The CSB investigative staff includes chemical and mechanical engineers, industrial safety experts, and other specialists with experience in the private and public sectors.



Chair of the Board:

John S. Bresland was appointed by President George W. Bush as chairman and chief executive officer of the U.S. Chemical Safety Board in March of 2008.

Mr. Bresland previously served as a CSB board member from August 2002 until August 2007. Before joining the Board he was President of Environmental and Safety Risk Assessment LLC, a chemical process safety consulting company based in Morristown, New Jersey.

In addition he was a Staff Consultant to the Center for Chemical Process Safety of the American Institute of Chemical Engineers, working as a project manager on two committees writing books on dust explosions and the management of reactive chemical hazards.

John has been a good friend to Region 6, speaking at two of our LEPC Conferences in the past, as well as helping us on accident investigations in the past.

"Our investigations of accidents have led to significant safety changes at both the federal and the state level. For example, six years after the West explosion, the U.S. Occupational Safety and Health Administration, OSHA, announced that it is developing a new regulation to prevent combustible dust explosions ... this follows a CSB safety recommendation issued in 2006."

John Bresland

"The CSB's mission is to prevent [sic] accidents from happening, and we do that by thoroughly determining the causes, issuing detailed public reports, and seeking changes to regulations, industry standards, and practices across the country."

John Bresland



CSB Process

After a CSB team reaches a chemical incident site, investigators begin their work by conducting detailed interviews of witnesses such as plant employees, managers, and neighbors.

Chemical samples and equipment obtained from accident sites are sent to independent laboratories for testing. Company safety records, inventories, and operating procedures are examined as investigators seek an understanding of the circumstances of the accident.

Investigators sift through evidence, consult with Board members, and review regulations and industry practices before drafting key findings, root causes and recommendations.

During this process, investigators may confer with plant managers, workers, labor groups, and other government authorities. The investigative process generally takes six to twelve months to complete, and a draft report is then submitted to the Board for consideration.

In addition to investigations of specific accidents, the Board is authorized to conduct investigations of more general chemical accident hazards, whether or not an accident has already occurred.

In 2002, the Board's first hazard investigation on reactive chemicals reviewed more than 150 serious accidents involving uncontrolled chemical reactions in industry.



This investigation led to new recommendations to OSHA and EPA for regulatory changes. A second hazard investigation on combustible dusts is now in progress.

Both accident investigations and hazard investigations lead to new safety recommendations, which are the Board's principal tool for achieving positive change. Recommendations are issued to government agencies, companies, trade associations, labor unions, and other groups.

Implementation of each safety recommendation is tracked and monitored by CSB staff. When recommended actions have been completed satisfactorily, the recommendation may be closed by a Board vote.



While some recommendations may be adopted immediately, others require extensive effort and advocacy to achieve implementation. Board members and staff work to promote safety actions based on CSB recommendations.

In many cases, the lessons from CSB investigations are applicable to many organizations beyond the company investigated.

Many CSB recommendations have been implemented in industry, leading to safer plants, workers, and communities.

The CSB and Emergency Planning / Preparedness

On the evening of April 12, 2004, a chemical reactor overheated at the MFG Chemical manufacturing plant in Dalton, GA, releasing toxic allyl alcohol vapor. The resulting cloud sent 154 people to a local hospital and forced the evacuation of nearby residents. Vegetation and aquatic life near the plant were killed.

The accident occurred during the company's first attempt to make a production-scale batch of triallyl cyanurate (TAC), a chemical used in rubber manufacturing.

CSB Chairman Carolyn Merritt said, "... The 2004 accident in Dalton underscores the vital role of communities in preparing for chemical accidents and minimizing the harm to the public. Effective prevention and effective emergency planning go hand-in-hand."



Inadequate emergency response planning by the City of Dalton and Whitfield County was a contributing cause of the injuries and exposures among the public and responders, the CSB said. None of the responding police officers had the proper training or protective equipment to safely enter the toxic vapor cloud.

The city had no automated emergency notification system or evacuation plan, and police officers were instructed to drive into the chemical cloud to alert neighborhood residents to evacuate. After the toxic vapor forced the unprotected police officers to retreat, firefighters wearing special breathing apparatus were eventually called in to complete the evacuation.

Examples of Current Investigations by the CSB

ConAgra Foods Explosion and Chemical Release

June 9, 2009: 3 workers were fatally injured and dozens others injured when an explosion occurred at the ConAgra Foods facility in Garner, North Carolina.



Silver Eagle Refinery

January 12, 2009: 2 refinery operators and 2 contractors suffered serious burns resulting from a flash fire at the Silver Eagle Refinery in Woods Cross, Utah.

The accident occurred when a large flammable vapor cloud was released from an atmospheric storage tank, known as tank 105, which contained an estimated 440,000 gallons of light naphtha. The vapor cloud found an ignition source and the ensuing flash fire spread up to 230 feet west of the tank farm.



Indspec Chemical Corporation Oleum Release

October 11, 2008: a transfer operation overflowed an oleum process tank, filling a vent system and releasing the oleum into a storage building at Indspec Chemical Corporation in Petrolia, Pennsylvania .

The release of oleum created a cloud of sulfuric acid mist that filled the building and flowed out into the facility and surrounding community. Plant personnel evacuated the facility, while emergency responders evacuated about 2,500 residents from the towns of Petrolia, Bruin, and Fairview.



To view a complete list of current and completed investigations, visit their website at:

www.csb.gov

Frequently Asked Questions:

What are CSB recommendations?

Recommendations are suggestions for actions to specific parties, issued with the intention of future accident prevention. They are based on the lessons derived from each investigation or study, and can be found at the conclusion of each report.

Who are the recipients of CSB recommendations?

Recommendations are issued to government agencies (federal, state, and local), companies, trade associations, labor unions, and other groups.

Do recipients follow CSB recommendations?

Yes. Although CSB recommendations are not mandatory, they provide realistic and effective solutions for protecting environmental and workplace safety and health. Recipients generally understand that complying with CSB recommendations can help prevent similar incidents.



How does the CSB evaluate responses from recommendations recipients?

Each recommendation is monitored by CSB staff from the time it is issued to closing. CSB staff evaluate recipient responses, and the Board votes to assign status designations to recommendations based on staff evaluation. Recommendations are considered "open" while in progress and "closed" when evidence of appropriate action has been provided. The CSB website is continually updated with each recommendation's status.

What do the status designations for each recommendation mean?

The CSB assigns a status to each recommendation after reviewing the recipient's actions or proposed actions. Below is a brief explanation of the categories with abbreviations in parentheses.

- **Open - Awaiting Response or Evaluation/Approval of Response (O - ARE/AR)** - The recipient has not submitted a substantive response, or the evaluation by CSB staff of a response is pending, or the Board has not yet acted on staff recommendation of status.
- **Open - Acceptable Response or Alternate Response (O - ARAR)** - Response from recipient indicates a planned action that would satisfy the objective of the recommendation when implemented.
- **Open - Unacceptable Response (O - UR)** - Recipient responds by expressing disagreement with the need outlined in the recommendation. The Board believes, however, that there is enough supporting evidence to ask the recipient to reconsider.
- **Closed - Acceptable Action (C - AA)** - The recipient has completed action on the recommendation. The action taken meets the objectives envisioned by the Board.
- **Closed - Exceeds Recommended Action (C - ERA)** - Action on the recommendation meets and surpasses the objectives envisioned by the Board.
- **Closed - Unacceptable Action/No Response Received (C - UA/NRR)** - Recipient responds by expressing disagreement with the need outlined in the recommendation and the Board concludes that further correspondence on, or discussion of, the matter would not change the recipient's position.
- **Closed - No Longer Applicable (C - NLA)** - Due to subsequent events, the recommendation action no longer applies (e.g., the facility was destroyed or the company went out of business).
- **Closed - Reconsidered/Superseded (C - R/S)** - Recipient rejects the recommendation and also supports the rejection with a rationale with which the Board concurs. This designation may apply when later facts indicate that the concerns expressed in the recommendation were actually addressed prior to the incident, or when a recommendation is superseded by a new, more appropriate recommendation.

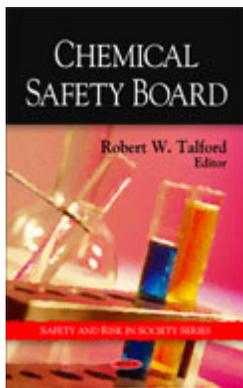


Videos:

The CSB produces safety videos and messages as part of their mission of preventing accidents. Topics include preventing dust explosions, emergency preparedness, workplace accidents, and reactive hazards. These videos can be viewed on their website at: www.csb.gov

Or on YouTube at:

www.youtube.com/profile?user=USCSB
www.youtube.com/user/safetymessages



CSB Releases Safety Video on Need for Chemical Emergency Preparedness, Based on Findings from a Decade of CSB Accident Investigations

Washington, DC, June 10, 2009 - The U.S. Chemical Safety Board (CSB) today released a new safety video showing the need for emergency response agencies, companies, and communities to work closely together to prepare for the kinds of tragic chemical accidents the CSB has investigated over the past decade.

The new video, entitled "Emergency Preparedness: Findings from CSB Accident Investigations," uses computer animations, interviews, and news footage to depict a series of chemical accidents that illustrate the need for effective training, communications, and community planning.

In some incidents, firefighters and police were overcome by toxic chemicals and forced to retreat from neighborhoods; in others, firefighters and workers were tragically killed and others injured.

The video is available online at www.csb.gov and on YouTube. It can be ordered free of charge on a new two-DVD set of all CSB safety videos by filling out the request form in the Video Room of www.csb.gov.



In the video, CSB Chairman John Bresland notes, "Preparations by companies, emergency responders, government authorities, and the public are critical to reducing injuries and saving lives. It's not only important to be prepared, but everyone must communicate, have an up-to-date plan in place and practice that plan regularly. We hope that our findings will help keep communities safe."

In addition to comments by CSB investigators and board members, the video features observations by fire chiefs, a state fire marshal, and an expert on emergency preparedness and local emergency planning.

Danvers, Massachusetts, Fire Chief James P. Tutko, who led the effort to battle a massive fire and explosion at an ink plant in 2006, and oversaw the community evacuation, said he recommends "Emergency Preparedness" as well as other CSB safety videos. "I can recommend CSB safety videos for their content and accuracy. They can be used for all aspects of emergency response training," Chief Tutko said, adding, "Don't wait for an accident in your jurisdiction to learn about the CSB's findings."

The video begins with an animation of a boiling liquid expansion vapor explosion, or BLEVE, in a large propane tank that killed two firefighters and injured seven others in a 1998 accident in Albert City, Iowa.

The firefighters had not received accurate training or guidance on BLEVE hazards and approached within 100 feet of the burning tank when it suddenly blew apart.

"The Herrig Brothers farm explosion animation provides a tragic but important starting point for the video," said Board Member William Wark.

"Every day firefighters face challenges like these and sadly, sometimes lose their lives. We hope the video will make the case that training and communication are critical so that responders can do their jobs without death or injury."

Another propane explosion seen in the video - which destroyed a convenience store and killed two propane service technicians, a volunteer fire captain, and an EMT in Ghent, West Virginia - shows the need for training to rapidly evacuate such danger zones.



West Virginia State Fire Marshal Sterling Lewis states in the video, "We take a vow to protect life and property. Life comes first." Commenting on the video's central theme, Fire Marshal Lewis said, "We must train until it becomes second nature. We must educate ourselves and the public to the point we can help each other."

Apex, North Carolina, Fire Chief Mark Haraway, whose department is depicted in the video as battling a "worst case scenario" due to a lack of information from a hazardous waste facility that caught fire in 2006, said, "I recommend this and other CSB safety videos for the training opportunities they provide."



Other accidents highlighted in "Emergency Preparedness" include an allyl alcohol toxic chemical release in Dalton, Georgia; chlorine releases in Festus, Missouri, and Glendale, Arizona; a reactive chemical explosion in Jacksonville, Florida; and a recent reactive chemical explosion and community evacuation in Institute, West Virginia.

Timothy Gablehouse, a preparedness expert who appears in the video as president of the National Association of SARA Title III Program Officials (NASTTPO) and a member of the Colorado Emergency Planning Commission, said, "The CSB has done us all a great favor by compiling many of their investigation findings into a crisp and clear lessons learned message - a great reminder for us all."

Contact Information:

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Or visit their website at:
www.csb.gov



NIMS Directives and Liability

By BRADLEY M. PINSKY

Fire Engineering, Pennwell Publishing, March 2009

http://www.fireengineering.com/display_article/355911/25/none/none/Deepar/NIMS-Directives-and-Liability



When President Bush signed Homeland Security Directive 5 (HSPD-5), he likely did not envision increasing occasions for fire departments' and first responders' liability.

HSPD-5 directed the secretary of the Department of Homeland Security (DHS) to develop and administer a National Incident Management System (NIMS), which would provide a consistent, nationwide approach for federal, state, local, and tribal governments to work together to prevent, prepare for, respond to, and recover from domestic security incidents.

Most states have implemented NIMS; if a state fails to implement NIMS, the result is a loss of significant federal funding opportunities.



For possibly the first time, a high-level court in New York State held that the failure to follow a mandatory, nondiscretionary NIMS directive served as a basis for liability against a fire department. Although the holding is law only in New York State, many states follow similar legal principles. The holding, therefore, should concern first responders in all states.

In this article, I will discuss the court's holding and its impact on first response agencies. Then I will ask you to consider other policies and procedures that the first response agency may have adopted that also possibly could lead to liability if the document does not include proper wording.

MARCH 7, 2002

On this date, the Manlius (NY) Fire Department in Onondaga County responded to a basement fire in a two-story residence in the Pompey Hill Fire District. An incident command structure was in place. At least one county fire coordinator (CFC) responded to assist in command operations.

In central New York, fire departments are not "countywide" departments but are controlled by various smaller municipalities such as villages, cities, and fire districts. CFCs assist in locating resources.

Members of the first-due Manlius unit were assigned to perform vertical ventilation. Following its completion, they were assigned to fire suppression. Efforts to attack the basement fire had been ineffective, although the on-scene incident commander (IC) might not have fully known it.

Pretrial discovery revealed allegations that the CFC did not report to either the IC or the operations officer after his on-scene arrival. Instead, testimony revealed that the CFC decided to take a "quick look" at the fire. Testimony further alleged that the CFC told the firefighters about to enter the structure, "We're going to have to get a line in here." It is unclear exactly to what that statement referred. There is disputed testimony about whether the CFC was wearing a white (command) or black fire helmet. Thus, the question of whether the CFC assumed a command role outside of the incident's command structure arose. This fact was vital to the court's inquiry.



Immediately thereafter, two firefighters from Manlius Truck 2 entered the house's first-floor mud room, while a third firefighter fed the attack line to them from the garage. As the third firefighter tried entering the mud room, he saw that the first floor had collapsed and his fellow crew members had fallen into the involved basement. One of the fallen firefighters was able to reach up and grasp the third firefighter's hands.



The CFC, the Manlius deputy chief, and the third firefighter made rescue efforts. Unfortunately, the heavy involvement of the basement, first floor, and garage areas forced the rescuers' evacuation and the rescue effort's termination. Two firefighters died.

One of the firefighter's wives sued the CFC and Onondaga County, his employer.

Although the law in many states precludes firefighters' families from suing a fire department or other fire agency for causing their injuries or death, New York State permits such suits under New York State General Municipal Law 205-a.

The fallen firefighter's wife alleged that her husband's death was a direct result of the CFC's command given outside of that incident's command structure and, had that command not been given, her husband would not have entered the building at that time and died minutes later.

In most states, including New York State, juries cannot base liability on a firefighter's on-scene decision.

That rule is based on the principle that the public should not second-guess a first responder's emergency decision or tactic.

New York State's second highest court ruled that the failure to follow NIMS may serve as a basis for liability, as it "mandates a reasonably defined and precedentially developed standard of care, and does not require the fact's trier to 'second-guess [a firefighter's] split-second weighing of choices.' "



This surprising ruling means that first responders and their paid or volunteer agencies may be held liable for failing to adhere to those mandatory NIMS requirements. Although in this case the lawsuit was brought by a firefighter's wife, most states do not prohibit a citizen from suing a fire department.



Whether the suit is brought by a firefighter, a firefighter's family member, or an injured civilian, the concern is the same: Failing to follow portions of NIMS can lead to the loss of a lawsuit.

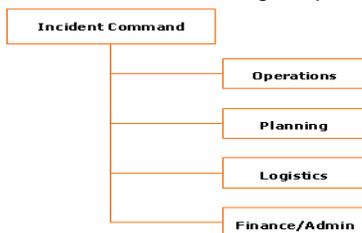
Review of the 130-page NIMS manual (available at: http://www.fema.gov/pdf/emergency/nims/nims_doc_full.pdf)

reveals many directives that impact the fire service and other first responders. Thus, if the failure to follow such mandatory directives results in harm, this could lead to liability.

It is unclear whether the NIMS program drafters intended the word "must" to carry liability for noncompliance, but the New York court viewed the word's use seriously. Following are examples of NIMS directives that presumably require no "split-second weighing of choices":

"Accountability. Effective accountability at all jurisdictional levels and within individual functional areas during incident operations is essential. To that end, the following principles must be adhered to:

- (1) Check-In. All responders, regardless of agency affiliation, must report in to receive an assignment in accordance with the procedures established by the IC.
- (2) Incident Action Plan (IAP). Response operations must be directed and coordinated as outlined in the IAP.
- (3) Unity of Command. Each individual involved in incident operations will be assigned to only one supervisor.
- (4) Span of Control. Supervisors must be able to adequately supervise and control their subordinates, as well as communicate with and manage all resources under their supervision.
- (5) Resource Tracking. Supervisors must record and report resource status changes as they occur."



"Establishment and Transfer of Command. The command function must be clearly established from the beginning of incident operations. The agency with primary jurisdictional authority over the incident designates the individual at the scene responsible for establishing command. When command is transferred, the process must include a briefing that captures all essential information for continuing safe and effective operations." (p. 18)



"Exercises. Incident management organizations and personnel must participate in realistic exercises—including multidisciplinary, multijurisdictional, and multisector interaction—to improve integration and interoperability and optimize resource use during incident operations." (p. 11)

"Incident Management Communications. Preparedness organizations must ensure that effective communications processes and systems exist to support a complete spectrum of incident management activities." (p. 55)

OPERATING PROCEDURES AS A BASIS FOR LIABILITY

NIMS is used as a basis for liability because it was an adopted state standard that required no discretion. If an agency is not careful, operating procedures and policies could also serve as standards against which a judge or jury evaluates negligent or reckless conduct.

The law in many states precludes evaluating a first responder's actions when such actions involve decision making or "judgment calls."

However, some first response agencies have implemented policies under the title Standard Operating Procedures, which give the impression that certain actions are mandatory and not discretionary.

Such documents could be introduced into court against the agency to prove that the first responder failed to follow adopted, nondiscretionary procedures.



Many states prohibit the introduction of policies into evidence in a court proceeding when such policies implement a standard of care higher than the recognized standard of care.

This exclusionary rule's purpose encourages, not discourages, agencies from imposing expectations of the best conduct by creating liability for not meeting that conduct. First response agencies will customarily be liable for not adhering to the standard of care if that standard's breach resulted in injury or death but will not be liable for failing to provide the "best" care.

The question will arise as to what the standard of care may be in any given circumstance. First response agencies increase the risk that their policies are introduced as the "standard of care" by using the term "standard" in the name of the document. Documents such as "Standard of Care" and "Standard Operating Guidelines" create confusion and increase the risk that juries can view these documents as the "standard" against which the first responder must have acted.

Therefore, consider the following actions:

- Name the document Best Practice Guidelines. Most states do not permit the introduction of the "best practice" when such practice is stricter than the recognized "standard of care."
- Insert introductory language in your Best Practice Guidelines, which describes the document's purpose. An example of such language follows:
 - This document represents a series of best practices. The document is intended only for the use of this agency and not for any other agency. The document is not intended to be relied on by any other individual, public or private, or agency. The document may not be used in court or in any other forum against the agency or against any individual, other than use by the agency. The imposition of discipline by the agency against any individual under control of this agency is not proof of the failure to comply with the standard of care, but only with this agency's practices. In many cases, these best practices strive to exceed the standard practice. Adoption of the NFPA [standard], when done, is not a recognition of the standard but an attempt to achieve the best practice. Failure to adopt the NFPA [standard] is not the failure to meet a standard of care but a conscious choice of which practices are the best practice for this agency.
- Eliminate words such as "must" and "shall" from best practices, and use words such as "should." Words that indicate there is no discretion might permit that procedure as a "standard."

- Separate policies from procedures, and keep them in separate manuals or sections of a manual. Determine what items are policies and what are “best practices.” Policies are mandatory in nature. There is no discretion or judgment as to how to follow a procedure. Generally, firefighting issues are all discretionary and should not be policies. Examples of policies include wearing seat belts while in a vehicle, avoiding engaging in sexually harassing conduct, and keeping medical information confidential. Breaches of policies usually involve some sort of discipline. Breaches of procedures usually involve retraining or reviews of decisions.
- Review which policies and procedures are actually being enforced. If a policy is not being enforced, either enforce it or change the policy. For example, many departments require emergency vehicles to stop at red lights when responding to an emergency; if operators are only “slowing down” at lights, the policy is not effective. Change the policy to mandate only that conduct required by state law, or enforce the policy as written.

An unenforced policy is a liability that the agency cannot afford to maintain. Again, policies carry discipline. Is the agency ready to discipline for violations of a policy? Are the officers ready to avoid ignoring such violations?

Fact Sheet: NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS) INTEGRATION CENTER NIMS COMPLIANCE REQUIREMENTS FOR LEPCs

March 1, 2007

www.fema.gov/emergency/nims

NIMS Integration Center 202-646-3850



Since October 1, 2005, all 56 States and Territories were required to meet NIMS implementation requirements to be eligible to receive Federal preparedness assistance in the form of grants, cooperative agreements and direct contracts.

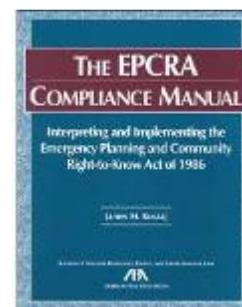
LEPCs participate in the communities within the States by assisting in the preparation of emergency response plans to prepare for and respond to chemical emergencies.

What is a Local Emergency Planning Committee?

LEPCs were established under EPCRA. LEPCs are non-profit community organizations that must include in their membership, at a minimum, local officials including police, fire, civil defense, public health, transportation, and environmental professionals, as well as representatives of facilities subject to the emergency planning requirements, community groups, and the media. LEPCs must assist in the development of emergency response plans, conduct annual reviews at least annually, and provide information about chemicals in the community to citizens.

What are required elements of a community response plan developed by an LEPC?

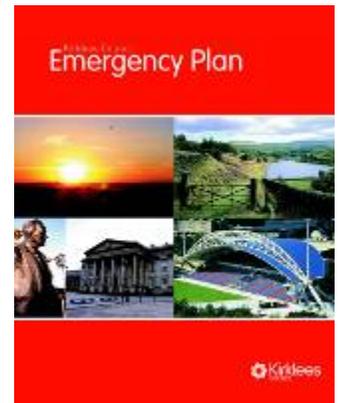
- Identify facilities and transportation routes of extremely hazardous substances;
- Describe emergency response procedures, on and off site;
- Designate a community coordinator and facility coordinator(s) to implement the plan;
- Outline emergency notification procedures;
- Describe how to determine the probable affected area and population by releases;
- Describe local emergency equipment and facilities and the persons responsible for them;
- Outline evacuation plans;
- Provide a training program for emergency responders (including schedules); and,
- Provide methods and schedules for exercising emergency response plans.



What actions must LEPCs take to comply with National Incident Management compliance requirements?

LEPC Emergency Response Plans: The Governor of each State has designated a State Emergency Response Commission (SERC) to implement EPCRA statewide.

The SERCs, in turn, have appointed about 3,500 local emergency planning districts and appointed an LEPC for each district. The SERC supervises and coordinates the activities of the LEPC and reviews the local emergency response plans. LEPC developed emergency response plans are local emergency operations plans.



Incorporation of NIMS into ALL EOPs within the State is a specific requirement for States to be NIMS compliant. Therefore, LEPC emergency response plans must be NIMS compliant.

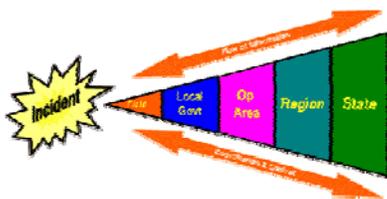
For more information on plan development, LEPCs should reference the NIMS Guide; *Local and Tribal NIMS Integration: Integrating NIMS into Local and Tribal Emergency Operations Plans and Standard Operating Procedures, Version 1.0*. This guide can be downloaded at:

http://www.fema.gov/pdf/emergency/nims/eop-sop_local_online.pdf

What courses must LEPC members complete to comply with NIMS compliance requirements for FY 2007?

Train on NIMS National Standard Curriculum: State and local personnel with a direct role in emergency response or incident management must complete training in ICS 100, ICS 200, IS 700 and IS 800. Many members of the LEPC who have jobs that deal with incident management or response will be required to take these courses.

LEPC members who do not perform specific response or incident management functions are not required to take these courses. However, the NIMS Integration Center encourages ALL LEPC members to familiarize themselves with NIMS.



LEPC's receive grant funds under the DOT's Hazardous Materials Emergency Preparedness Program. Will the LEPC lose those funds if all of the LEPC members have not taken ICS training?

No. DHS does not require LEPC members who do not function as emergency responders or incident managers to take ICS courses in order for the LEPC to receive grant funds. However, some States may impose stricter requirements for local recipients of Federal preparedness grant funds. LEPCs should check with their respective SERCs for guidance.

How can DHS make rules for grant programs that are managed by other federal agencies?

The NIMS Integration Center was established under HSPD-5 - *Management of Disasters*. HSPD-5 established and designated the NIMS Integration Center to lead in Federal coordination of NIMS implementation. HSPD-5 also specifies that all recipients of Federal preparedness awards implement the NIMS.

The NIMS Integration Center has established a Federal Partners Workgroup to ensure NIMS is implemented across federal agencies in a similar manner. One of the program goals is to have federal agencies with emergency preparedness grant programs provide information on NIMS compliance to their grantees.

All federal agencies with emergency preparedness grant programs are members of this workgroup. It is the responsibility of all Federal agencies that administer preparedness grants and awards to monitor NIMS implementation in their respective programs.

Are LEPCs going to be subject to grant monitoring by DHS?

No. LEPC's would never be directly monitored by DHS. DHS monitors the 56 States and Territories implementation of NIMS through the State Homeland Security Grant Program. States monitor local recipients of State Homeland Security Grants within their respective State.

Practical Advice for Local Emergency Planning Committees

NIMS AND ICS COMPLIANCE FOR LEPCs

Issue 07-03

National Association of SARA Title III Program Officials (NASTTPO)

<http://www.nasttpo.com/home/LinkClick.aspx?fileticket=KpcQl0im4Y0%3d&tabid=81&mid=381>

LEPCs are not response agencies. Nonetheless, awareness and training in NIMS and ICS are appropriate. This is true even though it should be expected that various members of the LEPC will hold NIMS and ICS training levels consistent with their duties.

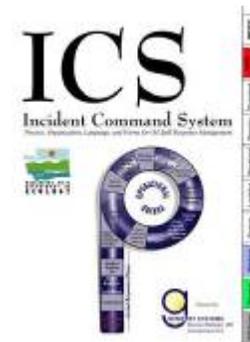
It is NASTTPO's view that all LEPC members should complete the on-line FEMA IS-700: NIMS, An Introduction and the on-line IS-100: Introduction to ICS course.

The benefit of the IS-100 series of courses is that there are some catering to specific community groups.

These course are available at <http://training.fema.gov/IS/NIMS.asp> and are not time-consuming.

NASTTPO has adopted this view for some very pragmatic reasons:

- First, NIMS and ICS are critical to the modern systems of emergency management. If an LEPC is to be relevant to the first responders in their community it is important that they have a background in these systems.
- Second, we agree with the statement of the NIMS Integration Center: "The benefit of NIMS is most evident at the local level, when a community as a whole prepares for and provides an integrated response to an incident." We do not believe this is feasible unless the LEPC embraces NIMS and ICS.
- Third, emergency services will be provided to key community organizations, such as schools, commercial enterprises and regulated facilities using NIMS and ICS. The LEPC needs to be able understand and explain these procedures in order to promote community safety.



A Guide to Developing a Hazardous Materials Training Program

A new publication "What You Should Know: A Guide to Developing a Hazardous Materials Training Program" is now available for download from the PHMSA webpage: <http://www.phmsa.dot.gov/hazmat>.



This guide explains the training requirements in the Hazardous Materials Regulations, identifies those employees who must be trained, and provides a tool to help hazmat employers determine what type of training and training environment may be best for their employees.

The guide was developed under a partnership agreement between the Dangerous Goods Advisory Council and the U.S. Department of Transportation, Pipeline and Hazardous Materials Safety Administration.

Life's Lessons, and 5 to Grow On

Written By Regina Brett, of The Plain Dealer Newspaper, Cleveland, Ohio

"To celebrate growing older, I once wrote the lessons life taught me.. It is the most-requested column I've ever written."

- Life isn't fair, but it's still good.
- When in doubt, just take the next small step.
- Life is too short to waste time hating anyone.
- Your job won't take care of you when you are sick. Your friends and parents will. Stay in touch
- Pay off your credit cards every month.



- You don't have to win every argument. Agree to disagree.
- Cry with someone. It's more healing than crying alone.
- Save for retirement starting with your first paycheck.
- When it comes to chocolate, resistance is futile.
- Make peace with your past so it won't screw up the present.



- It's OK to let your children see you cry.
- Don't compare your life to others. You have no idea what their journey is all about.
- If a relationship has to be a secret, you shouldn't be in it.
- Take a deep breath. It calms the mind.
- Get rid of anything that isn't useful, beautiful or joyful.



- Whatever doesn't kill you really does make you stronger.
- It's never too late to have a happy childhood. But the second one is up to you and no one else.
- When it comes to going after what you love in life, don't take no for an answer.
- Burn the candles, use the nice sheets, wear the fancy clothes. Don't save it for a special occasion. Today is special.
- Over prepare, then go with the flow.



- Be eccentric now. Don't wait for old age to wear purple.
- No one is in charge of your happiness but you.
- Frame every so-called disaster with these words, 'In five years, will this matter?'
- Forgive everyone everything.
- What other people think of you is none of your business.



- Time heals almost everything. Give time time.
- However good or bad a situation is, it will change.
- Don't take yourself so seriously. No one else does.
- Don't audit life. Show up and make the most of it now.
- Growing old beats the alternative -- dying young.



- Your children get only one childhood.
- All that truly matters in the end is that you loved.
- If we all threw our problems in a pile and saw everyone else's, we'd grab ours back.
- Envy is a waste of time. You already have all you need.



- The best is yet to come.
- No matter how you feel, get up, dress up and show up.
- Yield.
- Life isn't tied with a bow, but it's still a gift.



HAS YOUR LEPC:

- Established a permanent address for facilities, the SERC, and EPA to mail required forms and information;
- Notified the SERC of any changes to the LEPC structure, especially a change in the chair or address;
- Provided EPCRA training to local emergency responders, specifically local fire departments who often can provide information to facilities during fire inspections and police departments who respond to haz-mat incidents?
- Established a 24-hour manned emergency phone number (i.e., sheriff's office, 911, fire department) for facilities to make release notifications -- an answering machine is not sufficient;

The articles contained herein are provided for general purposes only.

EPA does not accept responsibility for any errors or omissions or results of any actions based upon this information.

Please consult the applicable regulations when determining compliance.

Mention of trade names, products, or services does not convey, and should not be interpreted as conveying official EPA approval, endorsement, or recommendation.

Region 6 Emergency Notification Numbers

Arkansas Dept. of Emergency Management	800-322-4012
Louisiana State Police	877-925-6595
New Mexico State Police	505-827-9126
Oklahoma Dept. of Environmental Quality	800-522-0206
Texas Environmental Hotline	800-832-8224

National Response Center	800-424-8802
EPA Region 6	866-372-7745
CHEMTREC	800-424-9300