Sunday, August 26, 2018

Dear **President Trump and the US Congress,**

I sincerely hope that you will be able to review this letter and that you can start in motion significant health and safety reforms of the DOE's Office of Petroleum Reserve (OPR) and the Strategic Petroleum Reserve (SPR). My grave concerns are that that the SPR has held the title of the most dangerous program in the DOE (besides the BPA) due to their excessive level of deaths and serious accidents for such a small worker population. Additionally, their activities are scheduled to be ramped up with the addition of a large operational budget and an increased scope of work. Historically, those two conditions (higher budget and increased scope), combined with a horrendous safety culture combine to create a very high potential for additional worker deaths and serious injuries if not improved.

There have recently been several official Accident Investigation Boards (AIBs) assembled to investigate two deaths and a very serious accident at the SPR. Part of my activities at the OPR was to investigate these AIBs to determine their affect, if any. I was to investigate if the Corrective Actions Plans (CAPs) based upon each AIB were carried out. What I found was that a vast majority of the specific Corrective Actions listed in the CAPs didn't even remotely address the AIB's recommendations and a majority of those action plans weren't implemented. It was no surprise that many of the AIB recommendations strongly recommended upper management reform. All of my evaluations, experiences and activities with the DOE's OPR and SPR strongly indicate a dysfunctional safety culture and safety culture comes from the management down.

Please turn the tide in a more positive direction. I am confident, based upon my personal, hands-on, site experiences and experiences at the upper management level that with nudges in the right places the safety culture can become a flagship example of your exemplar capabilities as the President and successful businessman. I believe that you can Make America Great Again.

On May 11, 2015, a series of events occurred that led me to the extreme measure of filing a whistleblowers report based on mismanagement and health and safety concerns. This event led me to provide my evaluation of the incident prior to being absent from my office for several weeks. I provided by boss, [redacted] with a document titled BMT-4 Floating Pan Failure 5/21/2015, Summary. This document provided a summary of the reasons that an AIB should be recommended. The strongest reason was the Process Safety Management clause of the DOE's Order 225.1A Appendix A-1, Section 2.c.(4) For facilities in which 29 C.F.R. Part 1910.119, *Process Safety Management of Highly Hazardous Chemicals.* Process Safety Management (PSM) is an essential and critical element of our activities at the SPR. Failure of any link of the PSM chain can lead to catastrophic consequences. The DOE and the SPR were lucky that the floating pan failure didn't result in a catastrophe. I can understand the OPR and SPR's reluctance and resistance to have another AIB called. They are suffering from AIB fatigue. It seems to be more the management's efforts to avoid documenting significant incidents than it is to prevent them through effective management of health and safety.

Actually, this event began the final summation of almost three (3) years of cumulative health and safety reviews by experienced and highly capable health and safety subject matter experts

(SMEs). **As an aside, my employment was terminated by the DOE for reporting on this event. I was wrongly terminated and reluctantly reached a settlement with the DOE regarding that termination.** This whistleblower complaint includes those series of events and others. I have provided a vast trove of paper and electronic documents as evidence of a majority of my allegations. It is discouraging that they seemed to have been either ignored, misunderstood or improperly compiled by the DOE's Office of the Inspector General as I don't see their application or references within this report. I had offered my continual assistance to the Office of Special Council and the DOE's Office of the Inspector Generals on multiple occasions without response. I had shifted my career to remain in the area to provide as much support as needed but to little avail. I also found that none of the multitude of documents were referred to in their report. Instead, it seemed more just a summary of the OPR's and SPR's managements opinions.

I was discouraged by their interview with me as it solidly demonstrated their lack of understanding of the Oil and Gas industry and especially the SPR. The summary of their interview with me was completely mixed up and disorganized to the point that I could barely discern that they were talking to me or what the subject or goal was for the interview. Unfortunately, I heard from many workers interviewed by the DOE's IG that the questions seemed not thought out, fully organized or significantly relevant to the topics of whistleblower case. I had heard from other DOE H&S professionals that the DOE's AIG office has had very little past success with any of their investigations of the SPR.

A Quick Summary

Beginning in May of 2013, I was contracted to join a team of health and safety SMEs designated to work, one at each SPR storage sites. As the principle Certified Industrial Hygienist (CIH) among the others (all Certified Safety Professionals (CSPs)) I became the informal team leader. When I asked to review the Statement of Work, I was told to do what we think we should do. With that directive, I decided that our H&S team of a CIH and 3 CSPs would start with conducting reviews of site activities compliance with applicable regulations including OSHA. Our initial difficulty was determining what regulations actually applied as management (site contractor and DOE) seemed to be ignorant as to what standards and requirements they were to comply regarding health and safety. Our SPR H&S team conducted multiple reviews, investigations, research and provided multiple reports defining what standards, requirements and regulations applied.

I proposed to the DOE that our SPR H&S review team start by:

1. investigating identified regulatory/standards/requirements compliance during their site activities. (1st 6 months)
2. Review contractors' procedures, training, and program element compliance including Respiratory Protection Program, Confined Space Program, Radiation Safety Program, etc., (2nd 6 months) and

3. Review overall programs such as compliance with DOE's Integrated Safety Management, Process Safety Requirements, Accident Investigation Program, Contractual Health and Safety Program, Accident Reporting and Recording, etc.

These investigations and observations resulted in the following:

1. Over 200 violations of OSHA regulations and Health and Safety procedures (within the 1st 6 months)
2. Nine formal reports indicating significant weaknesses in SPR health and safety activities and health and safety compliance by program (i.e. radiation, noise, Industrial Hygiene program, ISM) (2nd 6 months)
3. Multiple formal reports on weaknesses in implementation of ISM, monetary awards for low accident records, accident investigations, accident reporting, role of OSHA's Voluntary Protection Program (VPP) in exacerbating the poor safety culture, and others.

All of these reports and findings were designed to identify significant and serious health and safety problems and provided recommendations to improve. However, during the entire 18 months, very few if any improvements were seriously implemented. Additionally, it was noted that the DOE Project Manager directed the contractor to do nothing in response to the over 200 OSHA violations and the significant H&S deficiencies identified in the program/plan reviews.

At the end of our 18-month contract, our team met to discuss the issues. It was unanimous that we believed that besides general lack of an effective safety culture within the contractor's management, that the DOE management seemed to be significantly responsible for the very weak overall safety culture.

After this contract ended, I applied for a GS-14 Safety and Occupational Health Managers position with the DOE's Office of Petroleum Reserve (OPR). This is the Program management office overseeing the Project Management Office of the DOEs Strategic Petroleum Reserve (SPR). My first inclination was that the OPR wanted an experienced H&S SME with SPR experience to assist with improving the H&S Culture of the SPR. Shortly after being hired by the OPR, I discovered that the OPR was required to hire a full time CIH/CSP based upon requirements dictated in an Accident Investigation of one of the multiple SPR deaths or Serious Injuries. I soon discovered that I was being directed to conduct a report of the SPR's compliance with the accident investigation's reports and that anything, but an acceptable result would not be well received. My supervisors wanted the Accident Investigations closed at all costs. It seemed that the OPR and SPR were experiencing Accident Investigation Fatigue.

It should be noted at this time that the SPR had experienced more deaths and serious accidents than any other division of the DOE with the exception of the BPA. Furthermore, that high number is exacerbated by a relatively low number of workers to average into. On the average, there are about 175 – 200 workers at the SPR with a large number of those working at headquarters and not in the field. So, two (2) deaths and a very serious accident over a few

years is a significantly deplorable statistic and can be taken as a strong sign of a very serious management issue. The presence of which is strongly denied and concealed through multiple levels of harassment and reprisals of which were observed and identified by the H&S team of which I had informally lead. We were told on multiple occasions that we were not to review the DOE but to limit our reviews to the contractors. I was led to believe that working at the level of GS-14, Safety and Occupational Health Manager at the OPR was an opportunity to assist for real change and improvement within the safety culture at the SPR.

At this point in my response, I will provide a limited, somewhat choppy evaluation of this report. I am a lone professional without support, reporting these health and safety issues and the managerial malfeasance. I don't have the continuous resources, manpower or time of the DOE. I have to develop my response after work hours, on weekends and holidays. Being a whistleblower, while a very worthy cause, isn't strongly supported or encouraged in general. In fact, it has caused irrefutable damage to my career and made my life much harder. I have been a career health and safety professional for over 35 years and have seen blatant and serious disregard to workers health and safety on too many occasions. In fact, it seems to be the norm to disregard or work around workers health and safety in the many industries of which I have experienced. I can tell you stories that would be hard to hear and cringeworthy regarding workers and the public's exposures and near misses for catastrophes. I have reached a point in my career and life where I needed to make a stand, to try to make a positive difference.

I have been told that I can't have any more time to finish my response. In leu of just giving up, I will submit this incomplete letter as my response. I hope that it finds a sympathetic ear.

Response to the OIG report regarding Allegations #1 thru #5.

1. **The OPR did not properly review and/or apply the DOE Order 225.1A Appendix A-1 prior to providing the Assistant Secretary with their recommendations. Instead, it was shrugged off with a short sentence stating that PSM didn't apply.**
2. Supporting documentation didn't seem to have been reviewed by the IG's office which showed:
    a. Clarification letter from the OSHA verifying that PSM does apply to ALL activities at the SPR.
    b. Memo from Hoot Gibson to SPR management stating that PSM applied at the SPR
    c. Evidence that PSM wasn't followed by the SPR regarding:
        i. Having up-to-date written procedures,
        ii. Properly following written procedures
        iii. Properly evaluating accidents and incidents, etc.

3. I provided extensive documentation and offered my assistance reviewing and interpreting them. I received no response to my offer or calls to assist.
4. After having had the worst death and severe accident rate within the DOE for many years, the OPR and SPR have AIB fatigue. This means that they are tired of having to respond to Accident Investigation Boards and deplore the publicity. Any thought of being required to do another due to another very serious incident was strongly contested by OPR management.
5. Proper reporting of incidents is a cornerstone of a strong health and safety culture. Accident and incident reporting avoidance and ignorance is the cornerstone of a failing safety culture.

Not **properly** interpreting and/or applying DOE O 225.1A regarding PSM triggers for AIB (DOE O 225.1A Appendix A-1, Section 2.c.(4) For facilities in which 29 C.F.R. Part 1910.119, *Process Safety Management of Highly Hazardous Chemicals,* is applicable*,* an incident that resulted in, or could reasonably have resulted in, a catastrophic release of a highly hazardous chemical in the workplace. The report/e-mail to the Assistant Secretary stated that DOE O 225.1A Appendix A-1, Section 2.c.(4) was not applicable to this incident. That statement was, in fact untrue. (Refer to Appendix A – Program Recommendation Regarding Convening AIB for BMT-4 Incident).

There are multiple documents designating OSHA jurisdiction for the SPR sites. In addition, there is documentation and evidence that Process Safety Management (PSM) (DOE O 225.1A Appendix A-1, Section 2.c.(4)) applies to the SPR and to the Crude Oil Storage Tanks (Part of the entire system per PSM and OSHA clarification). Besides the documented determination by OSHA that PSM applies to all SPR systems and activities, the crude oil storage tanks do not qualify for atmospheric storage tank exemption. According to OSHA, since the BM Crude Oil Storage Tanks have mixers and/or agitators within the tank, PSM applies without reserve. (Refer to Appendix B - OSHA PSM clarification).

The principle aspect of PSM not followed were proper use of and conformance to procedures. Proper written procedures were not followed. (Refer to Appendix C - BM OPS Manual BMT 2 3 4 for filling tanks). OP manual provides a **WARNING** that states that fill rate must be $\leq$ 3000 barrels per hour (bph) up to 6 feet (i.e. fill to bottom of IFR). Section 4.1 of the BM OPS manual for BMT 2, 3, and 4 states:

4.1 Empty Tank Filling Procedure.

WARNING

For low oil levels do not exceed a flow rate of 3000 bph. At oil levels below 6-feet, a space between the oil and floating roof exists. Within this space, explosive vapors can collect creating a dangerous situation. Flow rates above 3,000 bph flowing into this open space can produce high static electricity charges. Refer to Appendix A for the low crude oil level of each tank.

Sunday, August 26, 2018

All reports indicate that the space below the IFR was not prefilled (i.e. empty) as described by the BM DOE Engineer [redacted] to the OPR HQ Engineer [redacted]. There is no indication of prefilling what-so-ever and documents exist proving this fact. The contrary can be found in the buy/delivery report and the measured quantity in the tank post filling. Documents show an empty BMT-4 tank being filled at over 16,000 barrels/hour to match the amount of crude oil purchased by the SPR.

A lack of the application of Process Safety Management is principle cause of this incident and can be associated with other accidents and incidents at the SPR. Whether or not this particular tank will be replaced in the future shouldn't be the excuse to not comply with OSHA's PSM regulations and requirements. How do we know the SPR will create/have and or use the proper procedures in the future?

Sunday, August 26, 2018

Response to the OIG report regarding Allegations #15 and #16

My allegations involved nepotism within the SPR covered some issues with potential nepotism at the Project Managers Office in New Orleans. I stated that [redacted] is the Associate Project Manager and is the number two individual. His recent wife [redacted] was hired after [redacted] separated from his wife and was hired as the head of contracting department. Additionally, [redacted] was hired into the same contracting division. Her husband, [redacted] is another Associate Project Manager for the DOE. There are multiple other examples and instances in the SPR of nepotism that can be cause for concern or questioning. A quick review of Appendix D - US CODE Section 3110 states:

A public official may not appoint, employ, promote, advance, or advocate for appointment, employment, promotion, or advancement, in or to a civilian position in the agency in which he is serving or over which he exercises jurisdiction or control any individual who is a relative of the public official. An individual may not be appointed, employed, promoted, or advanced in or to a civilian position in an agency if such appointment, employment, promotion, or advancement has been advocated by a public official, serving in or exercising jurisdiction or control over the agency, who is a relative of the individual.

There seems to be many instances showing violation of this US Code.

These relationships seem important especially regarding some questionable contracting and contracting payouts by the Project Management Office (PMO). This includes a very long running contract to provide pipe maintenance at the SPR. L.S. Womak Inc. has had the repairs and maintenance contract since the beginning of the SPR over 20 years ago. There seems to be a very cozy relationship between PMO and Womak that deserves a much closer review. This seems to have developed a very costly relationship including free reign of the SPR (i.e. after hours work w/o DOE supervision) minimal, if any cost reviews for most projects that come up for Womak. An example are the emergency repairs or “quick” jobs.

In addition to the above, it seems that [redacted] had a very friendly relationship with [redacted], the recent Director of the SPR contractor, Fluor. This, as a minimum can imply a questionable relationship with the contractor before the award of the contract. [redacted] had known [redacted] since 2009 as evidenced in his Facebook friends party photos from that era before the latest contract award.