1. Use of ambiguous, overbroad, or undefined terms or phrases and wording changes greatly changes/confuses intent and modifies regulation from prevention of catastrophic events to address virtually everything. WSPA looks forward to working with L&I to clarify language.

- Ambiguous language and/or lack of clarity results in difficulty for regulator and employer to consistently understand, comply with and enforce the regulations. Examples include: process equipment definition ("not limited to" used with list of equipment) and utilities; and safe work practices provisions. What process data does L&I have to show that expanding the scope of the PSM standard will actually improve safety and reduce the frequency or severity of releases?

From 10/24 discussion: An example discussed was from Emergency Response Section: “any other emergency...” Is this consistent with LNI Emergency Response WAC? Is this duplicative of Personal Safety WACs?

From 10/24 Discussion: L&I will discuss documentation needed to demonstrate PSI is “accurate, verified & complete”

From 10/24 Discussion: What is the definition of “root cause analysis”?

From 10/24 Discussion: Going from a defined list to an unlimited unknown list of process equipment. Not sure how to manage and distracts from the focus of prevention of process safety incidents. What problem is being solved by adding “not limited to” and “appurtenances” to definition? Is L&I aware of incidents that have occurred involving this broader set of process equipment?

- Can L&I explain the thought process behind adjective choices? For example, “effective” was kept in many places, where as “highly” and “major” were two adjectives that were removed almost entirely (for example, highly hazardous and major incident) and “written” was added in several places. What objective criteria would L&I suggest for determining whether something is effective?

- What is the intent of removing the phrase “hazardous chemical” from the clause regarding interconnected equipment in the definition of “process”? The new phrasing suggests that it applies to the release of anything including fresh water, compressed air, nitrogen, etc. L&I stated intent was not to include utilities that don’t impact the process or have the potential to cause a process safety incident, however language includes all utilities.

- Within the operating procedures section, what is non-routine work? How does this differ or why isn’t this already covered by temporary procedures, safe work practices required by the operating procedures provision that address such issues as opening process equipment/piping, lockout/tagout, confined space entry, etc., or management of change?

- The definition of “affected employees” is changed considerably from the 1st discussion draft and indicates anyone who controls, manages, or performs job tasks in or near a process”. What is the intent in making this change in definition? How near is near? How far through the organization is this intended to span? Can the regulation be clearer on this?

  - Employee representatives are included in affected employee definition when they may be from a local or international union or another refinery process area or from outside of the refinery and not working in or around the process. Some of the collaboration provision requirements may not make sense for employee representatives if they are from outside the refinery.
Updated 10/30/2018 – with sections highlighted that were not discussed 10/24

Key: Yellow Highlight – topics to be discussed 11/13; Red Text – 10/24 Discussion Notes

- Employee representative “authority and qualifications” are based on definition of qualified. Does that appropriately capture the intent?
- The definition of “affected employee” includes contract employees; contractors are not employees within the normal context of the term. Are contractors affected employees that should be included in all parts of the regulation impacting affected employees? What about operations, maintenance, and contractor representatives who by L&I’s definition do not need to be employees or even located on or near a covered process. Can L&I explain the basis for including them in the list of affected employees? Are contractors affected employees that should be included in all parts of the regulation impacting affected employees? It seems contractors are now being treated as employees rather than contractors if these individuals would need to be trained in operating procedures. Some of the collaboration provision requirements may not make sense for contractors.

2. Process Safety Incident Definition

- What was the intent of removing "major incident", which has an established definition, and replacing with "process safety incident"? Process Safety Incident definition broadens scope of required investigations, SPAs that need to be conducted and DMRs requiring review; it also makes PHA incident review scope unclear. By treating all incidents the same, focus is shifted from prevention of high consequence incidents when implementing and applying PSM practices. What is objective of the rule – to prevent catastrophic events or all events? The original purpose of the process safety rule was to prevent catastrophic events.

From 10/24 Discussion: Would L&I consider a 5 gallon diesel spill at ambient temperature a process safety incident?

3. Employee Collaboration Replaces Employee Participation

- How will the Employee Collaboration provision work in Washington? Why will this work in Washington when it has been demonstrated to be problematic in California? What are the deficiencies of Employee Participation in the current Washington rule? Is this the best way to address those deficiencies? The 2nd discussion draft continues to use collaboration and invites interpretation by the regulator especially since: 1) a definition for “collaboration” has been removed from the 2nd discussion draft; and 2) “collaboration” is almost always modified by “effective” (which is a subjective judgment); 3) significant departure from federal regulations and suggest expanded authority/autonomy for employees; 4) Does “collaboration” imply a shared responsibility and liability for process safety and regulatory compliance? If the employer retains all the liability for process safety, then shouldn’t final decisions reside with the employer?

4. Changing definitions from norms (something that is usual, typical or standard) that industry and regulators understand: isolate, RAGAGEP, hot work, preventative maintenance and qualified.

- The definition of RAGAGEP is outside of federal and WA RMP norms and completely eliminates employer internal practices from consideration. That is inconsistent with federal OSHA and a recent Occupational Safety and Health Review Commission decision. What is the rationale for this? Why is L&I not adopting the Federal memorandum on RAGAGEP?

- WSPA understands that L&I may include CCPS on the list of organizations that develop RAGAGEP. RAGAGEP does not include published CCPS practices/recommendations as CCPS
does not create consensus-based industry standards. What other organizations is L&I considering adding that produce RAGAGEP beyond what is in the draft rule?

- The **proposed definition of qualified** is subjective and different from the typical industry definition when applied to “qualified operator”. What is the reasoning behind this change? Also, in the training section, the employer is required to define “the requirements that an employee must meet in order to be designated as qualified”. This is confusing since the definition section has a definition of qualified and the training section gives the employer the right to determine qualified. What is the source of L&I’s definition of “qualified” as it is far more expansive than the dictionary definition of qualified? With respect to many of these terms, the only key question is whether the relevant employees can do their jobs correctly and not whether experience is necessary for them to be able to manage or solve problems. For example, why would an employee who is participating in an MOC need experience in solving problems?

From 10/24 discussion: What is L&I intent for including “collaboration” as part of the qualification definition?

- What is intended with modifications to the definition of isolate? Isolation is typically used to describe isolation of energy. Is there overlap with how isolation and LOTO are used? The definition of “isolate” includes a specific list of isolation techniques. Is this list exhaustive, or is it a list of examples as indicated by the words “such as”? If exhaustive, on what basis does L&I exclude other means of isolation for worker protection?

From 10/24 discussion: Is prevention of working in a rich atmosphere covered in safe work practices WACs and not needed here?

- The term “isolate” or “isolating” is only used in conjunction with the response to leaks. The isolation techniques contained within the definition of “isolate” are likely to be inappropriate during the emergency response phase of addressing a leak. Can L&I explain their intent?

From 10/24 discussion: Is the Hierarchy of Hazard Control analysis need to be conducted as a stand-alone study without the flexibility of conducting it as part of a PHA?

5. **The use of prescriptive requirements that reduces flexibility, may not work for all situations and may distract resources from more important work.** Originally the federal PSM rule was intended to be a performance-based standard. The preamble from the 1992 final federal regulation stated that prescriptive requirements may freeze technology. Examples of prescriptive requirements include: HCA stand-alone studies, additional requirements for PSCAs, SPA requirements for potential process safety incidents and the requirement triggered by discovering an equipment deficiency to evaluate similar equipment.

- HCAs are, in effect, a design review of all of the equipment in a process and an assessment of all procedures, which ask whether inherently safer technology can be utilized in existing process to reduce risk. For existing facilities, this will be extremely time-consuming with little to no benefit. What data does L&I have to show that this type of extensive design review for an existing process improves process safety? Why does the Hierarchy of Hazard Control analysis need to be conducted as a stand-alone study without the flexibility of conducting it as part of a PHA?

- The revised provision for Process Safety Culture Assessment (PSCA) has identified several new elements to be considered during the assessment. If the processes are being audited every three years, what is the need to do a second audit of some of the same topics every five years? Did L&I rely on any particular guidance or existing documents for determining the elements that need to be considered in a PSCA? If so, what were those guidance documents? What evidence is available to show that PSCAs can improve process safety performance?
WSPA Topic List for L&I PSM Stakeholder Meetings

Updated 10/30/2018 – with sections highlighted that were not discussed 10/24

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- In Mechanical Integrity, section (4) Equipment Deficiencies, subsection (a) the following was added: "If a temporary repair fails, the employer did not take necessary means to ensure safe operation." What is the intent of adding this? Can the employer rebut the presumption that the temporary repair failed or that the condition is not safe even if there was a failure of the temporary repair? If so, can language be added to that effect? Paragraph (f) indicates that if an equipment deficiency is found, all other equipment in the refinery in similar service must be inspected for the same issue. Oftentimes, the existence of a mechanical deficiency on one item of equipment has no bearing on the condition of a similar item even if the service is similar. What is L&I's justification for this change?

- The MOOC provision includes a 15% trigger. How would L&I suggest that this be quantified? How will an employer know that they are complying?

6. Major change definition and impacts on other elements. The definition for major change is misleading and unlimited because most changes would be considered major under the definition and the elimination of "highly" from "highly hazardous" further expands the scope. What is the intent with the definition of major change?

The designation of major change also requires other elements that are prescriptive in nature and are not compatible with a performance-based standard and may not be appropriate given the change. This does not distinguish between higher risk and lower risk activities.

7. The scope of the rule is substantially different than the current rule: Justification for focusing just on petroleum refineries and broadening the scope of the rule with respect to processes in facilities that are covered. (It only applies to petroleum refineries; it applies to hazardous chemicals not highly hazardous chemicals so apparently includes more substances; there are no limits to the applicability of this rule within the refinery boundaries to processes that have 10,000 pounds or more of flammable liquids; the usual exemptions for fuel used for on-site consumption and atmospheric storage tanks have been eliminated).

All other L&I health and safety regulations identify the employer as the responsible entity for compliance. However, this draft requires that the refinery manager be identified as responsible for overall compliance and for individual elements: MOOC certifications and signatory for PSCA reports, corrective action plans and interim assessments. WSPA understands L&I does not intend to cite individuals and therefore does not understand why L&I would specify a specific responsible person as this imposes organization structure, which is solely the purview of the employer. Why has L&I chosen this approach instead of treating this regulation the same as other L&I regulation?

8. Process for working with L&I to revise language in sections of rule where there needs to be additional provisions for compliance (such as timing)? Examples include implementation timing for new studies or programs such as 90 days for developing a Stop Work Authority procedure; timing for incident investigation report completion which may not be completed in 4 months for a complex/major incident (the 2nd draft removed the allowance to gain additional time if needed); MI deficiency repair completion at the first outage if materials are not available or if planning timeframe impacts ability to complete work safely; and corrective action due dates.

Examples: Incident investigation report due dates, human factors program and process safety culture actions.

9. The definition and application of the term “outage”: Intent of the definition of outage including a reduction in pressure and temperatures? It may not be possible to complete repairs on the “first outage” by the definition in the 2nd draft if a piece of equipment is still in service with reduced temperature or pressure. For example, if a heat exchanger bank is taken off line for cleaning
and the temperature in an associated vessel decreases, the vessel may still be in service and not available for a repair. Given that “first outage” triggers specific repair requirements, the regulation should distinguish between planned and unplanned outages and tie the repair requirements to planned outages.

10. **The human factors analysis must be based upon RAGAGEP. What does L&I consider to be RAGAGEP for this human factors analysis?** What existing guidance can employers use to develop their human factors analysis program. **What does it mean to include “process safety” and “health and safety” to the list of human factors?**