

The Buncefield Incident

11 December 2005

The final report of the
Major Incident Investigation Board

Volume 2



Buncefield Major Incident Investigation Board

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In the early morning of Sunday 11 December 2005, a series of explosions followed by a large fire destroyed large parts of the Buncefield Oil Storage and Transfer Depot and caused widespread damage to homes and businesses surrounding the site.

The then Health and Safety Commission (now Health and Safety Executive) appointed a Major Incident Investigation Board with an independent chair, Lord Newton of Braintree. This was a new departure in major incident investigation which allowed the Board to contact individuals and organisations who were affected or who had expert knowledge and experience, and to keep the public informed of progress with frequent reports.

This is the ninth and final report of the Buncefield Major Incident Investigation Board. It is made to the Boards of the Health and Safety Executive and the Environment Agency that together form the joint Competent Authority responsible for regulating the Buncefield site.

Volume 1 draws attention to some of the ways the Board has set about its business. It explains the significance of the Buncefield Depot and describes briefly how the explosions and fires happened and the damage they caused. It also summarises all the Board's recommendations to regulators, industry and government.

Volume 2 brings together all the Board's previous reports in a single publication for the public record and for future reference: three progress reports; an Initial Report; a report into the explosion mechanism; and reports giving recommendations on design and operation of fuel storage sites, emergency preparedness for, response to and recovery from incidents, and land use planning and the control of societal risk around major hazard sites.

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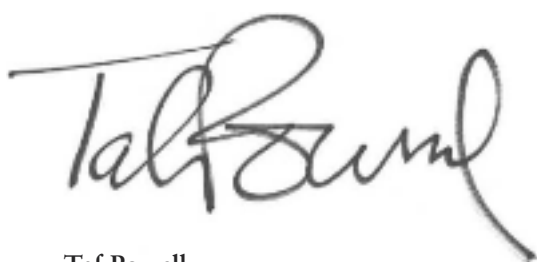
Foreword

This second volume of our final report brings together all of our previous eight reports in their original form. We have not abridged any of the reports because to do so would diminish their usefulness as an accurate record of the Buncefield Board's work over the thirty-four months of its existence. We expect this collection of reports to be useful for anyone with a responsibility for bringing into effect our recommendations or for understanding them, and for those with an interest in how the Board's thinking developed over the period of its tenure.

Each of our reports had a specific purpose. The first three reports were from me to the Board describing progress with the investigation in understanding the incident; the first confirming a vapour cloud explosion had occurred, the second describing the environmental impact, and the third describing what had happened, and how.

Our fourth report was the Board's own 'Initial Report' and discharged our fifth term of reference. It marked the stage at which the Board set out its main areas of concern and turned its full attention to making recommendations for improvements in these areas. Accordingly, the next four reports made recommendations on design and operation of fuel storage depots; on the emergency preparedness, response to and recovery from major incidents; on the mechanism of the Buncefield explosion; and on land use planning and the control of societal risk around major hazard sites. We placed extensive annexes, glossaries and references in all of our reports to enhance the understanding of the reports, to support the recommendations, and to direct the interested reader towards further information. All of these annexes, glossaries and reference sections are included in their original form here in Volume 2.

As well as making our reports available as soon as we could, we tried to be accessible at all times to everyone via an open e-mail system and website. We placed all of our reports, public statements, key correspondence and other relevant information on our website. The website was recorded on CD, a copy of which is included here in Volume 2.

A handwritten signature in black ink, appearing to read 'Taf Powell', with a long, sweeping underline.

Taf Powell
Chief Inspector, Investigation Manager
Buncefield Major Incident Investigation Board

The Buncefield Investigation

Progress report



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Photographs are courtesy of the Chiltern Air Support Unit and Hertfordshire County Council

Foreword

At the first meeting of the Major Incident Investigation Board (MIIB) on 24 January I was asked to prepare, for the second (10 February) meeting, a progress report on the Buncefield Major Incident Investigation by the Health and Safety Executive (HSE) and the Environment Agency (EA). This was to bring together relevant background material and to cover progress with the investigation and such facts as have been established to this point.

The MIIB said that this progress report would not constitute the 'initial report' required by Terms of Reference 6, since some of the main facts have yet to be established. This progress report is a stepping stone towards the initial report.

The report describes the incident and the nature of the site and surrounding communities and the initial responses by EA and HSE. Importantly, the report describes the most likely nature of the explosion and fires that have so far been ascertained from eyewitness statements and CCTV records. The explanation of what the investigation team believes is most likely to have led to the devastation of the area is not yet verified by scientific modelling and other evidence but I have sufficient confidence in the evidence to believe on balance it should be made public.

The report does not describe how what happened occurred. This is because I am not in a position to say anything with sufficient confidence for it to be other than a line of inquiry amongst others. Speculating publicly on causation would be undesirable because I am not in a position to confirm the likelihood of the theory, nor to deal authoritatively with the implications arising out of the theory. It may also lead to nugatory remedial actions by depot operators. I believe verification is required from records of fuel movement and storage to confirm any theory related to loss of containment, not least of all because this may alter the balance between system and mechanical failure, and this knowledge is vital in formulating a competent response to the Buncefield incident.



Taf Powell

Buncefield Investigation Manager and Member of Buncefield Major Incident Investigation Board

Part 1 The Investigation so far

1.1 The incident

1 At around 06.00¹ on Sunday 11 December 2005, a number of explosions occurred at Buncefield Oil Storage Depot, Hemel Hempstead, Hertfordshire. At least one of the initial explosions was of massive proportions and there was a large fire, which engulfed over 20 large fuel storage tanks over a high proportion of the site.² There were 43 people injured in the incident, none seriously. There were no fatalities. Significant damage occurred to both commercial and residential properties in the vicinity and a large area around the site was evacuated on emergency service advice. About 2000 people were evacuated. Sections of the M1 motorway were closed.

Figure 1 This photograph shows the Buncefield site on the first day of the fire. The Northgate building can be seen burning towards the lower left corner of the photograph.

¹ Preliminary analysis of seismic records published by the British Geological Survey indicates that the initial explosion event occurred at 06:01 GMT.

² Figure 5 on page 8 shows the damaged area. For a description of the site see Part 2.1 of this report.



2 The fire burned for several days, destroying most of the site and emitting large clouds of black smoke into the atmosphere, dispersing over southern England and beyond. Large quantities of foam and water were used to control the fire, with risks of contaminating water courses and ground water (see Figure 2).

Emergency response

3 The emergency services (primarily the Fire and Rescue Service and the police) led the initial response to the incident and its immediate aftermath. As a Category 1 responder under the Civil Contingencies Act, EA worked closely with the Fire and Rescue Service, the police, the Health Protection Agency (HPA) and the Strategic Health Authority, including advising on the water pollution aspects of the fire-fighting activities. HSE is a Category 2 responder, so during the early phase of the incident stood ready to provide advice and expertise on request in support of the emergency services and EA.

Figure 2 This photograph shows the fire-fighting operation in progress with the appliance in the avenue between bunds 'A' and 'B'

4 Hertfordshire Police co-ordinated the emergency response and worked closely with other responders including the Hertfordshire Fire and Rescue Service, Hertfordshire County Council, Dacorum Borough Council, EA and HPA. The police



set up an exclusion zone around the site which remained in position for several days. The Hertfordshire Fire and Rescue Service was supported by staff drafted in from many other brigades and used equipment and foam brought in from around the country. Shortly before Christmas the police were able to hand back the security of the site to the depot operators but the fire service retained a presence on site until the New Year as quantities of uncontained fuel remained on site.

5 At the peak of the incident – on Monday lunchtime, 12 December – there were 26 Hertfordshire pumps on site, 20 support vehicles and 180 firefighters. More than 250 000 litres of foam concentrate were used, together with 25 million litres of water and 30 km of high-volume hose.

6 The investigation team wishes to acknowledge the work of the emergency services and especially the invaluable support given to HSE and EA in securing vital evidence in the initial period when the site was dangerous and under the control of the emergency services.

Securing the site

7 Once the Buncefield fire had been extinguished, HSE issued formal notices on the two operators of the part of the depot that had suffered the greatest damage. Prohibition Notices were served on both Hertfordshire Oil Storage Ltd (HOSL)³ and British Pipeline Agency Ltd (BPA) on 16 December 2005 prohibiting operations on site under their control unless appropriate risk assessments had been agreed with HSE. Each of these operators were also served with Notices requiring that the parts of the depot under their control were left undisturbed. The Notices were issued to ensure that key pieces of evidence remained in place for examination by the investigation team and that the clear up operations were carried out in a safe manner. The operators have co-operated with HSE and EA to achieve these goals.

Water pollution

8 EA worked with the Fire and Rescue Service to develop a plan that minimised the potential for firewater run-off. This included recirculating cooling water. The main concern was the containment of liquid on site due to the presence of a drinking water aquifer nearby. Some material did leave the site into Three Cherry Trees Lane. EA believe most of this was contained by the natural contours of the land, which prevented it reaching surface waters. Pollution of the River Ver is low and no impact on its fish and animal life has been seen.

9 From the start of the incident both the Meteorological Office (using a long-range pollution dispersion model) and EA (using a short-range model) worked to model the plume and provided data to HPA on likely plume direction and ground level concentrations. On the advice of HPA a number of schools were closed as a precaution.

10 Air pollution in London and the Home Counties was measured by four regional air quality monitoring networks managed by King's College, London, and comprising over 130 local authority monitoring sites. A number of parameters were measured including particulates. Air samples were sent for particulate analysis and the results are awaited.

³ For more details of the HOSL and BPA sites see Part 2.1 of this report.

Social and economic impact

11 The Buncefield Depot is close to the Maylands Industrial Estate, home to some 630 businesses employing about 16 500 people. All businesses were disrupted by the explosions and fire, some severely. The premises of 20 businesses employing 500 people were destroyed; the premises of 60 businesses employing 3500 people are under repair and not yet usable. Most businesses face difficulties in delivering pre-incident levels of service from dispersed and temporary accommodation. Reduced trading and supply disruptions have affected businesses over a wider area. Impact on employment has been limited so far, but job losses could become significant over the next few months.

Figure 3 The smoke plume rising and spreading above the Buncefield site.





Figure 4 Depot and surroundings prior to incident

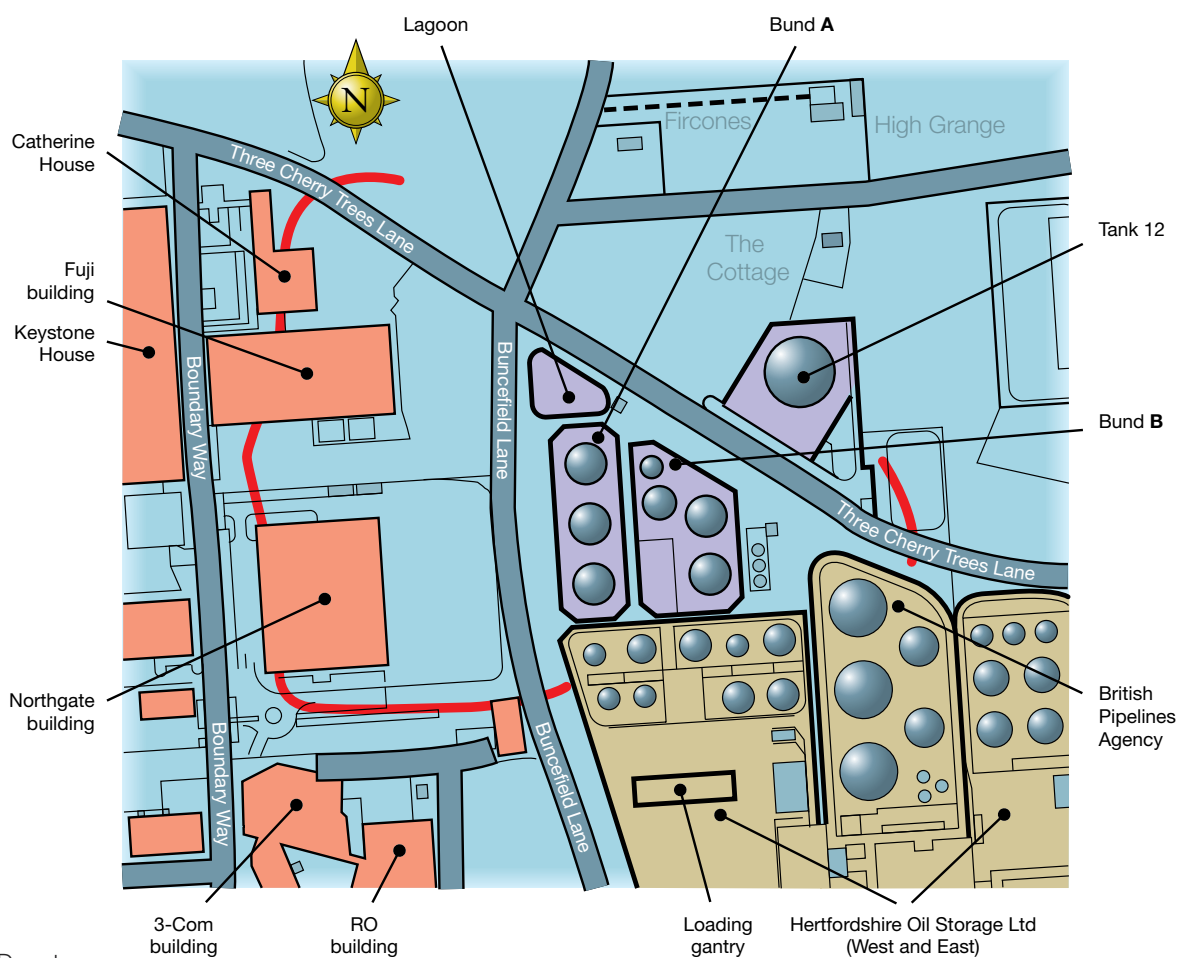


Figure 5 Layout of Depot and surroundings also showing limit of flammable mixture indicated by burned material

12 The incident also damaged nearby housing, mainly in Dacorum district, but also in St Albans district. Some houses closest to the site suffered significant structural damage; several families are living in temporary accommodation while their houses are repaired. At least 300 houses suffered lesser damage.

13 The incident disrupted fuel supply to London and South-East England. Remedial measures by the industry have restored supplies of road transport, commercial and domestic fuels generally back or close to pre-incident levels. However, supplies to Heathrow remain disrupted. This has required fuel rationing by the BAA to allow the airport to function normally, with no flight cancellations. For all supplies the industry is trying to find permanent solutions to replace the current transitional arrangements.

1.2 What is known about the explosions and fire

14 Evidence obtained so far points to the formation of a flammable mixture of petrol, or similar spirit, and air that ignited, leading to the explosions and fire. The flammable mixture appears associated with a visible mist. This evidence includes reports from eyewitnesses, CCTV records and forensic material, as briefly summarised below.

Eyewitness reports

15 On-site at the west side of the tanker loading gantry on HOSL West site:

- Witnesses describe seeing mist at about 05:50 GMT in the vicinity of one of the tanks in bund A⁴ (see Figure 4). They also describe a mist variously between one and three feet in height rolling from bund A towards the tanker loading gantry. Witnesses also report a moving mist near the trees (along Buncefield Lane to the west of the site) about one and a half feet high and wisps of vapour on the ground near the end of the loading bay.
- These witnesses mention a strong smell at this time, variously described as petrol or aviation gasoline.
- None of the witnesses describe the flames reaching them as they moved from the tanker loading gantry towards the site exit. None of them report having suffered burn injuries.

16 Off-site in the vicinity of the Fuji building carpark to the west of the site:

- Witnesses describe a thick fog 'above head height' or 'between 15 and 20 feet high' between 05:50 and 06:00 GMT. This was first seen near the junction where Three Cherry Trees Lane meets Buncefield Lane. The fog continued to spread to the west towards Catherine House.
- These witnesses noticed a strong smell, but were not certain of its nature and in general there is a degree of disagreement among witnesses as to the nature of the smell. These witnesses also describe various responses from their car engines including 'revving uncontrollably', 'running rough' and 'stalling'.
- From the witness statements and lack of burn injuries, the flame does not appear to have travelled as far as Boundary Way.

CCTV records

17 Examination of CCTV images for the HOSL site and for the RO building off-site has provided the following evidence.

⁴ A bund is an enclosure designed to contain fluids should they escape from the tank or vessel inside the bund.

18 HOSL West

- Before the event there was no evidence of mist or fog at ground level showing on any of the camera images. This includes the surface of the fire water lagoon in the north-west corner of the HOSL West site.
- The first unusual indication was at 05:38 GMT, 23 minutes before the explosion. At the north-west corner of bund A, a light mist is seen flowing from inside bund A towards the west. This is at the north-west corner of bund A. The mist is low-lying and about one metre deep. Its appearance is consistent with a mist that is denser than the surrounding air.
- During the next few minutes mist is seen flowing towards Three Cherry Trees Lane via the lagoon and flowing out of bund B at the north-east edge of the site, along the roadway on-site.
- Cameras at the eastern edge of the HOSL site adjacent to the BPA site first show the mist eight minutes after its first appearance crossing the wall of bund A.
- By this time, the cameras along the western edge of the site, along Buncefield Lane, show that the mist has thickened to about two metres deep. It is now so dense that it is not possible to see through it. It appears to flow away from bund A in all directions.
- There is no indication on the cameras that the visible mist has spread as far south as the tanker filling gantry.
- All the cameras stopped recording at the time of the explosion.

19 HOSL East

- There is no evidence of the mist seen on the HOSL West site having reached as far as any of the cameras on the HOSL East site. The cameras show evidence of the fire, but it is not possible to learn anything of significance.

20 RO building

- This building is to the south of the Northgate building, approximately level with the tanker loading gantry on the HOSL West site. There is no evidence of the mist having reached as far as any of the cameras at this building. The images show a flash of light at the time of the explosion, followed by evidence of explosion damage.

Figure 6 HOSL West gates



Initial forensic examination

21 Initial examination of the evidence of damage around the site by the Health and Safety Laboratory (HSL) allows the approximate extent of the flammable mixture to be judged from the effects of the flash fire on vulnerable surfaces:

- Scorched vegetation on a row of trees between the Northgate building and the 3-Com building.
- Scorched leaves underneath these trees.
- Scorched upholstery to unignited cars at this location.

22 In addition the north-east corner of the Northgate building has been on fire. There are burnt cars and trees between the Northgate building and the Fuji building.

23 Cars on Three Cherry Trees Lane near to Catherine House were set on fire and vegetation along the side of Three Cherry Trees Lane was scorched at this location.

24 Evidence of the extent of any flammable mixture over the HOSL site is masked by damage from the resulting tank and bund fires.

Initial conclusions regarding the extent of the flammable mixture.

25 The explosion(s) that caused the extensive damage on and off site, and the early fires, can probably be ascribed to the ignition of a flammable mixture that is thought to have been associated with the visible mist reported by eyewitnesses and visible on CCTV records.

26 Initial indications are that the flammable mixture of fuel and air extended to the west almost as far as Boundary Way in the gaps between the 3-Com, Northgate and Fuji buildings. To the north-west it extended as far as the nearest corner of Catherine House.

27 It may have extended to the north of the HOSL site as far as BPA tank 12. It may have extended across part of the HOSL site, but there is no evidence of it having spread as far south as the tanker filling gantry, although the visible mist had just started to reach this point. Figure 5 shows the most likely extent of the flammable mixture based on the investigation so far.

28 The visible mist seen in the CCTV records and described by witnesses is assumed to arise from the evaporation of the more volatile fractions of an escape of fuel. This evaporating fuel would be cold compared to the surrounding air, which is known from weather records to have had high humidity. The cooling would result in the condensation of water in the air. The visible mist thus indicates the approximate extent of the fuel air mixture.

29 The source of the fuel release is not yet known, although the CCTV records indicate that it was in the vicinity of bund A on the HOSL West site. The most plausible scenarios involve large-scale loss of containment of vessels or pipework within bund A. Resources are being directed to clarify these early indications and to find out what underlying causes there may have been.

Initial findings regarding the explosion

30 It is clear from the witness accounts and the evidence of damage both on and off site that there was a massive explosion early in the developing incident. There appear to have been several explosions, but the exact sequence of events has not yet been established. Initial indications from examination of the explosion damage are that the main explosion event appears to have been located in the area of the car parks between the HOSL West site and the Fuji and Northgate buildings. The heaviest damage can be seen in this area. This does not necessarily mean that the ignition of the flammable mixture occurred here, but that the highest flame speeds were in this location. The mechanism for this is not yet understood. This forms part of the ongoing investigation.

Initial advice to duty holders

31 In response to the incident HSE will advise duty holders what steps to take in the light of what is known so far about the nature of the Buncefield explosion. The advice will be systematically followed up with duty holders by HSE inspectors.

1.3 The continuing Investigation

32 Immediately after the incident HSE and EA set up a joint investigation team under the leadership of HSE. The Investigation team was tasked with finding out what had happened, including the factors leading up to it and the root causes. The full terms of reference are at Annex 3.

33 The team divided the Investigation into a number of strands and assigned specialist staff to take each one forward. The Investigation is led by specialists in inspection and investigation. The main technical strands are in mechanical engineering, process engineering, fire and explosion engineering, control and instrumentation, and environmental impact assessment. Human factors experts will be increasingly involved as more evidence becomes available concerning the operation of the site. The site has been segmented into areas to assist the early Investigation.

34 The team commissioned staff from the HSL to assess the damage caused by the explosion. This assessment has enabled the team to determine the approximate location and extent of the flammable mixture that had formed, and the probable sources of ignition that led to both the fire and the explosion.

35 Work is continuing to find out the exact nature and composition of the flammable mixture and to determine the precise mechanism which led to such a violent explosion. This includes establishing the nature and composition of the fuel from which the mixture was formed. Priority is being given to this work so that HSE's advice to local planning authorities about developments adjacent to Buncefield and other fuel storage sites can be reviewed and, if necessary, amended. Site surveys have been carried out to enable the team to determine the volume and physical and chemical properties of the flammable mixture; this important work is continuing.

36 Inspectors are continuing painstaking work to restore and view CCTV evidence from the site and adjacent premises. There is a large amount of electronic evidence relevant to the operation of the depot and much of this was contained in buildings severely damaged by the blast. As much of this as possible has now been secured and work continues to restore and then examine these highly specialist electronic records to determine the operating conditions before and at the time of the incident.

37 The Investigation team is also examining the detailed technical documentary records relating to plant design and operation. Examination of the damage to plant on site and forensic examination of key parts of tanks and pipework is only just commencing. Following the extensive damage and contamination of bunds with fuel products and run-off fire water, access to many parts of the site has been restricted. Priority has been given to making these areas safe and only recently have inspectors been able to turn their attention to this aspect of the investigation.

38 On environmental issues the team has focused on containment of products and fire-fighting materials on site and releases to the environment. It is working to identify pathways of pollutants into the environment and to quantify the scale of impact to the environment both on and off site with regard to land and water. As the clean-up operation has progressed samples have been taken from lagoons, boreholes and surrounding watercourses and gaining photographic evidence of the developing situation both on and off site. Staff are also obtaining documentary evidence of how containment was designed, constructed and maintained on site, including the provision for containing fire-fighting water.

39 The Investigation team continues to investigate the scale of environmental impact from the liquids released from the site, as well as closely monitoring the clean-up work. Team members are working to identify the root causes of any containment failings as well as identifying where measures on site have prevented greater impact.

Ongoing objectives

40 The Investigation is at a very early stage. The team has yet to start examining previous inspection reports and assessments of safety reports. This will be necessary to identify whether any issues linked to the root causes of this incident had been raised previously with the operators and if so what the operators had done about them. The investigation will also examine the on- and off-site emergency plans.

41 A critically important focus for the site Investigation is to find out why and where there was a release of hydrocarbons. It is therefore vital to continue work on the examination of pipework and storage tanks to ascertain the precise source of the release and the mechanism of formation of the flammable mixture and why preventive control measures were inadequate.

42 The Investigation still needs to establish whether the incident has caused serious danger to the environment, as set out in the definition of a 'major accident' affecting the environment in the Control of Major Accident Hazards Regulations 1999 (COMAH).

43 Work on all strands of the Investigation is continuing. Further work is needed before a clear and definitive picture will emerge, both of how and why there was a release of fuels on 11 December 2005 and of the underlying reasons for it.

44 As part of the Investigation, the team will also examine all this collective evidence against the standards required by the COMAH Regulations and other health, safety and environmental legislation.

Emergency plans

45 The COMAH Regulations require on- and off-site emergency plans for the Depot (see Part 2.2). HSE and EA are examining the adequacy of these plans in conjunction with the operators and the emergency services. The plans will be compared to the operational response and lessons drawn for the future.



Figure 7 The area prior to incident

Developments around the Buncefield Site

46 COMAH sites are subject to a special planning regime which is described in Part 2.2. At Buncefield this resulted in zones being drawn around the site within which HSE was consulted on developments by the local planning authorities. The outer zone (the 'consultation distance') was set at approximately 190 metres from the perimeter of the site. The investigation will examine the history of planning applications within the vicinity of the site and in particular, when the precise nature of the explosion and fire has been determined, will address the question of whether or not advice to local planning authorities at Buncefield and similar sites should be changed.

1.4 Review of HSE/EA roles in regulating activities at Buncefield

47 Point 3 of the Buncefield Investigation terms of reference (Annex 3) requires the Investigation to examine HSE's and EA's role in regulating the activities on this site under the COMAH Regulations, considering relevant policy guidance and intervention activity. HSE and EA together form the Joint Competent Authority for the regulation of major hazard sites (such as Buncefield) under the COMAH Regulations.

48 This review will address both the nature of the compliance with policy and procedures for regulating health, safety and environmental matters, and the efficacy of the policy and procedures.

49 HSE and EA will initially conduct separate reviews, sharing findings and aligning outputs as necessary. The final product will be a single report of the regulation of the Buncefield site together with recommendations arising out of the review.

50 Review teams have been set up in both organisations, site visits undertaken and plans for reviewing documentation and previous regulatory involvement have been drawn up.

51 The review findings on the HSE and EA roles will be subject to full scrutiny by the independent members of the Major Incident Investigation Board (see Part 1.5).

1.5 Major Incident Investigation Board

52 On 12 January 2006 HSC appointed a six-person Board to oversee the formal Investigation. This Board comprises an independent non-executive Chairman, two independent experts, one in fire safety, the other in occupational and environmental medicine, and three senior regulatory operations managers, two from HSE and one from EA.

53 In broad terms the purpose of the Board is to oversee the Investigation and ensure that:

- the Investigation is carried out effectively and the best professional advice is used in establishing causation;
- the confidence of the public is maintained in the work and findings of the Investigation;
- the eight points of the terms of reference (Annex 3) are met, even if in some cases delivery is the responsibility of other parties;
- information is made public in a timely way, but subject to legal considerations.

Part 2 Background

2.1 Site description

54 Buncefield Oil Storage Depot is a large strategically important fuel storage site (known as a tank farm) operated by a number of companies. Figure 5 shows the layout of the site and its immediate surroundings.

55 The Depot receives petrol, aviation fuel, diesel and other fuels by pipeline. It stores and then distributes these fuels by pipeline and road tanker to London and South-East England, including to Heathrow Airport. The UK Petroleum Industry Association (UKPIA) reports that, prior to the events of 11 December 2005, Buncefield handled 8% of overall UK oil supplies into the market, including 20% of supply to consumers in the South East. The terminal acted as a main pipeline transit point to meet 40% of Heathrow's demand for aviation fuel. On 11 December the site held over 35 million litres of petrol, diesel and aviation fuel.

56 The Depot contains three sites which are so-called 'top-tier' sites under the COMAH Regulations (see Part 2.2 of this report on regulation of high-hazard sites), although the HOSL and BP sites did not acquire top-tier status until changes were made to the Regulations in July 2002. This required submission of safety reports for these sites by July 2003:

- Hertfordshire Oil Storage Ltd (HOSL) – a joint venture between Total UK Ltd (60%) and Texaco Ltd (40%). This site is in two sections, HOSL East and HOSL West. HOSL West was at the centre of the fire. The site had consent to store 34 000 tonnes of motor spirit and 15 000 tonnes of kerosene. The COMAH safety report assessment process had not been completed.
- British Pipeline Agency Ltd (BPA) – a joint venture between Shell and BP that operates the site and the pipeline system, while the assets are owned by UK Oil Pipelines Ltd (UKOP). This site is split between the 'North' (or 'Cherry Tree Farm') section and the main section. It was substantially damaged by fire. It had consent to store 70 000 tonnes of motor spirit and other fuels. The COMAH safety report assessment process had been completed.
- BP Oil Ltd. The BP facility to the south of the Depot was furthest from the fire and appears to have escaped with superficial damage. It is out of operation while the full extent of damage is assessed. It has consent to store 75 000 tonnes of motor spirit, all product being received from the BPA site pipelines. The COMAH safety report assessment process had been completed.

57 The fuels arrive at the sites in batches through a system of three pipelines, namely:

- One 10" diameter pipeline ('FinaLine') from Lindsey Oil Refinery, Humberside, terminating in the HOSL West site.
- One UKOP 10" diameter pipeline ('Mersey-Buncefield') from Stanlow refinery, Merseyside terminating in the BPA North site
- One UKOP 14" diameter pipeline ('Thames-Buncefield') from Shell Haven and Coryton Refinery terminating in the BPA main site.

58 After separation of the multi-fuel product entering the sites from the pipelines, the fuel is stored in tanks individually dedicated to specific product types. Product then leaves the sites either by road tanker or, in the case of aviation jet fuel, via two dedicated 6" and 8" pipelines from the BPA site into the West London Walton Gatwick pipeline system. Fuel leaving the site by road is loaded by dedicated vehicle loading facilities at HOSL West, BP and to a lesser extent BPA.

59 There are also fire-fighting facilities on site, some of which are shared. The site water treatment is operated by BPA, collecting run-off water from the whole site into a water treatment plant in the north-east corner of the Depot.

60 For land use planning purposes the Depot is surrounded by a consultation distance of 190 metres (see page 22). The local planning authority must consult HSE about developments within that distance, but not those outside it.

Site conditions at the time of the incident

61 Information provided by HOSL indicates that during the hours leading up to the explosion, the HOSL site was importing unleaded petrol through the FinaLine pipeline from the Lindsey Oil Refinery. In addition, unleaded petrol was being imported through the Thames pipeline and diesel through the Mersey line. Unleaded petrol was being exported from the site by filling road tankers at the gantry on the HOSL West site.

Weather conditions

62 Meteorological Office records have been obtained for two sites at Luton Airport (13 km to the east-north-east) and Northolt (24 km to the south). These indicate that during the early morning of 11 December 2005 the weather was calm, cold, stable and humid. Atmospheric stability at Northolt was stable (Pasquill stability category F). The relative humidity was recorded as 99%. The air temperature was -1.7°C at Northolt and 1°C at Luton. There was no wind recorded at Northolt, while Luton recorded an average wind speed of 6 knots (approximately 3 metres per second) during the 10 minutes before 06:00 GMT. The average wind direction was recorded as 280 degrees measured from true north (this is the direction from which the wind was blowing).

63 At Luton there was a light wind west to east. Further south there was no wind.

Geology

64 The Buncefield Depot and the immediate surrounding area are positioned on a variable layer of clay with flints over Upper Chalk. The clay with flints layer is classified as a low permeability surface deposit and is believed to be present at a variable thickness of between 2 m and 10 m. This layer should inhibit the vertical and lateral migration of contaminants and protect the chalk aquifer below where present in sufficient depth.

65 The Upper Chalk is classified as a major aquifer, which provides water supplies regionally. The Depot is located within the catchment of a ground water abstraction point located to the south and east of the Depot. Ground water is present typically at a depth of 45 metres below ground level and flow is generally towards the south-east. Natural holes in the chalk which allow quicker water flow than normal may be present, but none have been positively identified in the immediate area.

66 Within the Depot site boundary a layer of made-ground, comprising a sand clay dominated soil mixture, overlies the clay.

Water

67 A local ground water abstraction point that is used as cooling water is located approximately 500 m south of the Depot.

68 The River Gade is located approximately 3 km to the south-west and the River Ver approximately 3.5 km east of the Depot.

69 During normal operation, surface water from the Depot drains to the Depot effluent treatment plant. It is then pumped into the public surface water system at Pratts Dell to the north-west of the Depot. This in turn drains to the surface water-balancing pond at Redbourne Road and subsequently to the River Red, a tributary of the River Ver.

70 Maylands pond is another surface water-balancing pond situated to the south-west of the Depot. It was used as a source of fire-fighting water during the incident.

General background

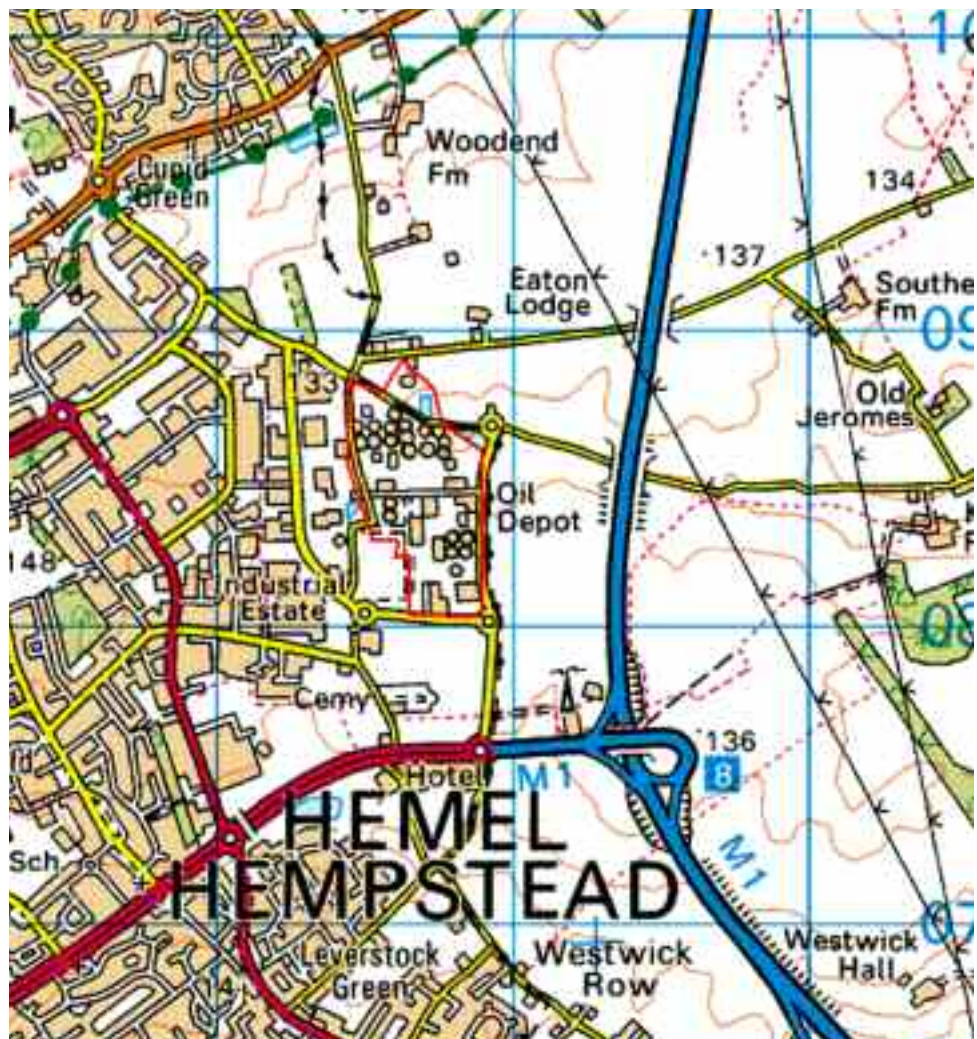
71 Land to the west and north of the Depot is largely used for the growing of arable crops.

72 There are no listed buildings within 1 km of the Depot and no recorded monuments within 500 m of the Depot.

73 The Depot is not located within a 100-year flood plain as defined by the EA flood maps.

74 There are no sites of special scientific interest within 2 km of the Depot and the nearest site designated under the Habitats Directive is Ashridge Common Special Area of Conservation, approximately 8 km north-west of the Depot.

Figure 8 Buncefield Oil terminal - Immediate surroundings of the complex



2.2 Regulation of high-hazard sites

75 The regulatory framework for sites, such as Buncefield, which pose potential major accident hazards comprises requirements imposed on the site operators under both health and safety and environmental legislation, complemented by the requirements of planning law. In particular the COMAH Regulations apply.

Health and safety law

76 Operators in the process industries are subject to the requirements of the Health and Safety at Work etc Act 1974 (HSW Act) and the Management of Health and Safety at Work Regulations 1999 (MHSWR) which require, respectively, safety policies and risk assessments covering the whole range of health and safety risks.

Control of Major Accident Hazards Regulations 1999 (COMAH)

77 COMAH's main aim is to prevent and mitigate the effects of those major accidents involving dangerous substances, such as chlorine, liquefied petroleum gas, and explosives which can cause serious damage/harm to people and/or the environment. The COMAH Regulations treat risks to the environment as seriously as those to people. They apply where threshold quantities of dangerous substances identified in the Regulations are kept or used. There are two thresholds, known as 'lower-tier' and 'top-tier'. Annex 1 gives a brief background to the origins of these Regulations. The requirements of COMAH are fully explained in *A guide to the Control of Major Accident Hazards Regulations 1999 (COMAH). Guidance on Regulations* L111 HSE Books 1999 ISBN 0 7176 1604 5.

78 The COMAH Regulations are enforced by a joint Competent Authority (CA) comprising HSE and EA in England and Wales, and HSE and the Scottish Environment Protection Agency (SEPA) in Scotland. Operators will generally receive a single response from the CA on all matters to do with COMAH. The CA operates to a Memorandum of Understanding which sets out arrangements for joint working.

79 The COMAH Regulations require operators of top-tier sites to submit written safety reports to the CA. Operators of top-tier sites must prepare adequate emergency plans to deal with the on-site consequences of possible major accidents and to assist with off-site mitigation. Local authorities for areas containing top-tier sites must prepare adequate emergency plans to deal with the off-site consequences of possible major accidents, based on information supplied by site operators.

80 The COMAH Regulations place duties on the CA to inspect activities subject to the Regulations and prohibit the operation of an establishment if there is evidence that measures taken for prevention and mitigation of major accidents are seriously deficient. The CA also has to examine safety reports and inform operators about the conclusions of its examinations within a reasonable time period.

Environmental legislation

81 Some of the establishments regulated under the COMAH Regulations are also regulated by EA and SEPA (the Agencies) under the Pollution Prevention and Control Act 1999 (PPC) or Part I of the Environmental Protection Act 1990 (EPA 90). The regime under EPA 90 is gradually being replaced by the PPC regime and will be fully replaced by 2007.

82 While the purpose of the COMAH Regulations (the prevention of major accidents) differs from that of IPC/PPC or LAPC (the prevention of pollution), the means to achieve them are almost identical. They require industry to have good management systems to control risk. PPC includes a specific duty to prevent and mitigate accidents to the environment which is complementary to the main COMAH duty. The Agencies manage this overlap between their different regimes following the principle that accident prevention work on COMAH sites is generally more significant because of the greater risks.

Land use planning

83 The land use planning aspects of the Seveso II Directive are given effect in the UK by the Planning (Hazardous Substances) Regulations 1992. Under these Regulations the presence of hazardous chemicals above specified thresholds requires consents from the Hazardous Substances Authority (HSA), usually the local planning authority. HSE is a statutory consultee on such occasions. The role of HSE is to consider the hazards and risks which would be presented by the hazardous substances to people in the vicinity, and on the basis of this advise the HSA whether or not consent should be granted. HSE will also supply a consultation distance around the site. Any future developments in these zones require HSE to be consulted.

84 The aim of health and safety advice relating to land use planning is to mitigate the effects of a major accident on the population in the vicinity of hazardous installations, by following a consistent and systematic approach to provide advice on applications for planning permission around such sites.

85 Historically, HSE has based its land use planning advice on the presumption that site operators are in full compliance with the HSW Act. Section 2 of the Act places a duty on an employer to ensure, so far as is reasonably practicable, the health and safety of his employees. There is a corresponding duty in Section 3 to ensure, so far as is reasonably practicable, that others (which includes the public) are not exposed to risks to their health and safety. These duties are goal-setting and operators are expected to determine the most appropriate means to comply with them, without the need for detailed approval from HSE.

86 Annex 2 sets out HSE's current approach to land use planning advice.

87 Under the General Development Procedure Order 1995, both HSE and EA are statutory consultees for:

- the development of a new major accident hazard site; or
- developments on an existing site which could have significant repercussions on major accident hazards; or
- other developments in the vicinity of existing establishments, where the siting or development is such as to increase the risk or consequences of a major accident.

Annex 1

Background to the COMAH Regulations

1 Certain industrial activities involving dangerous substances have the potential to cause accidents that give rise to serious injury to people or damage to the environment both close to and further away from the site of the accident. Such activities are known as major accident hazards.

Flixborough

2 In Great Britain, a disastrous explosion at a chemical plant at Flixborough in 1974 profoundly influenced the approach to regulating major hazards. There were 28 workers killed, the plant was destroyed and there was extensive damage to property off site. Following that accident, a committee of experts, the Advisory Committee on Major Hazards (ACMH), was appointed by the Health and Safety Commission to consider the problems of major accident hazards and make recommendations. They proposed a three-part strategy:

- (a) identification of the sites;
- (b) control measures to prevent major accidents; and
- (c) mitigatory measures to limit the effects of any accidents which do occur.

European Union Directive

3 Other major accidents occurred in Europe during the 1970s, the most significant of which took place in Seveso, Italy in 1976. Here, the accidental production and release of a dioxin as an unwanted by-product from a runaway chemical reaction led to widespread contamination. Such incidents, and the recognition of the differing standards of controls over industrial activities within the European Community, led the European Commission to propose a Directive on the control of major industrial accident hazards. The three-part strategy proposed in the UK was highly influential in shaping the Directive. The Directive on the Major Accident Hazards of Certain Industrial Activities (82/501/EEC) was adopted on 24 June 1982, and is generally known as the Seveso Directive.

4 Following a complete review of the Directive by the European Commission a new one, now known as Seveso II, was adopted in 1996. The Seveso II Directive retained the basic principles of major accident hazard controls set out in the original Seveso Directive but addressed some weaknesses and omissions. The new Directive followed a review carried out by the European Commission in conjunction with the Committee of Competent Authorities for the Seveso Directive (made up of representatives of all Member States' governmental bodies enforcing the Seveso Directive). It came into force on 3 February 1997 and was implemented in Great Britain on 1 April 1999 by the COMAH Regulations, except for land use planning requirements (article 12) which were implemented by changes to planning legislation.

5 An amending Directive in 2003 was implemented by changes to the COMAH Regulations. These came into force on 30 June 2005.

Annex 2

HSE's current approach to land use planning

Policy and practice

- 1 Under the Planning (Hazardous Substances) Regulations, the presence of hazardous chemicals above specified threshold quantities requires consent from the Hazardous Substances Authority (HSA), which is usually also the local planning authority (LPA). HSE is a statutory consultee on all hazardous substances consent applications. HSE's role is to consider the hazards and risks which would be presented by the hazardous substance(s) to people in the vicinity, and on the basis of this to advise the HSA whether or not consent should be granted.
- 2 In advising on consent, HSE may specify conditions that should be imposed by the HSA, over and above compliance with statutory health and safety requirements, to limit risks to the public (eg limiting which substances can be stored on site, or requiring tanker delivery rather than on-site storage). HSAs should notify HSE of the outcome of all applications for consent and where consent has been granted should supply copies of the site plans and conditions.
- 3 HSE uses the information contained in consent applications to establish a consultation distance (CD) around the installation. This usually comprises three zones (or 'risk contour areas') – see paragraph 6. The CD is based on the maximum quantity of hazardous substance(s) that the site is entitled to have under its consent. HSE notifies the LPAs of all CDs in their areas. The General Development Procedure Order 1995 requires the LPA to consult HSE about certain proposed developments (essentially those that would result in an increase in population) within any CD.
- 4 HSE advises the LPA on the nature and severity of the risks presented by the installation to people in the surrounding area so that those risks are given due weight by the LPA when making its decision. Taking account of the risks, HSE will advise against the proposed development or simply note that it does not advise against it. This advice balances the ACMH principle of stabilising and not increasing the numbers at risk, with a pragmatic awareness of the limited land available for development in the UK.
- 5 HSE's role in the land use planning system is advisory. It has no power to refuse consent or a planning application. It is the responsibility of the HSA or LPA to make the decision, weighing local needs and benefits and other planning considerations alongside HSE advice, in which case they should give HSE advance notice of that intention. LPAs may be minded to grant permission against HSE's advice. In such cases HSE will not pursue the matter further as long as the LPA understands and has considered the reasons for HSE's advice. However HSE has the option, if it believes for example that the risks are sufficiently high, to request the decision is 'called in' for consideration by the Secretary of State, in England and Wales (a very rare situation). In Scotland, if the planning authority is minded to grant permission they have to notify the Scottish Ministers who can decide to call in the application.

Consultation distances and risk contours

- 6 Using consent information, HSE undertakes a detailed assessment of the hazards and risks from the installation and produces a map with three risk contours representing defined levels of risk or harm which any individual at that contour

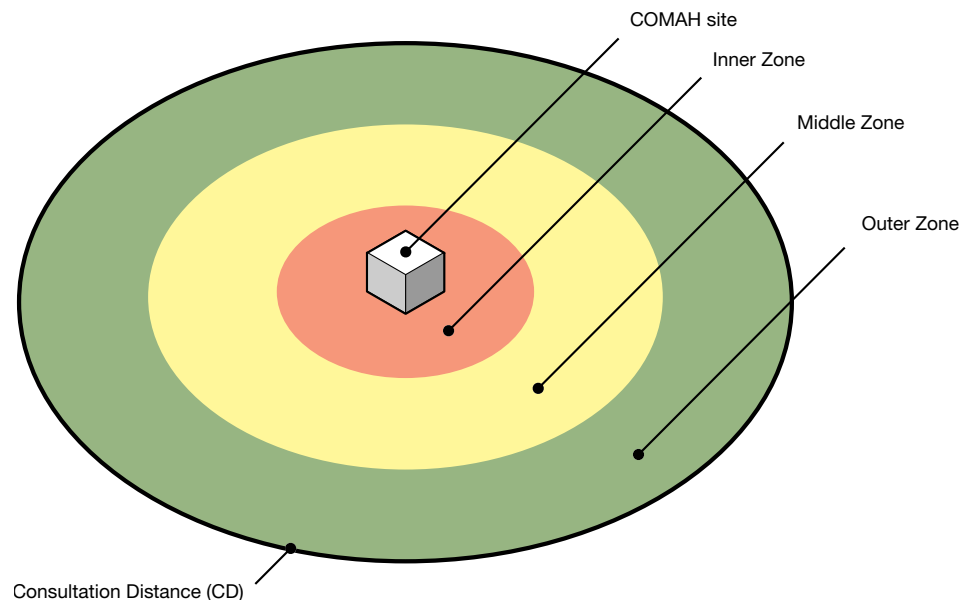
would be subject to. The risk of harm to an individual is greater the closer to the installation. In each case the risk relates to an individual sustaining the so-called 'dangerous dose' (see Figure 9) or specified level of harm. The three contours represent levels of individual risk of 10 cpm (chances per million), 1 cpm and 0.3 cpm per year respectively of receiving a dangerous dose or defined level of harm. The contours form three zones (see left), with the outer contour defining the CD around major hazard sites. The LPA consults HSE on relevant proposed developments within this CD.

Figure 9

Dangerous dose would lead to:

- severe distress to all;
- a substantial number requiring medical attention;
- some requiring hospital treatment; and
- some (about 1%) fatalities.

Figure 10



How HSE gives advice

7 When consulted, HSE firstly identifies which of the three defined zones the proposed development is in. Secondly, the proposed development is classified into one of four 'Sensitivity Levels'. The main factors that determine these levels are the number of people at the development, their sensitivity (vulnerable populations such as children, old people) and the intensity of the development. With these two factors known, a simple decision matrix is used to give a clear 'Advise Against' (AA) or 'Do not Advise Against' (DAA) response to the LPA, as shown below:

The 'PADHI' system

8 The decision matrix above was developed taking into account the experience of 30 years of HSE advice on land use planning. It is built into a software tool known as PADHI (Planning Advice for Developments near Hazardous Installations) introduced in late 2002. PADHI deals with the vast majority of consultations and is operated by staff in local HSE field offices, significantly speeding up responses from previous arrangements which required some specialist HSE resource.

Figure 11

Level of sensitivity	Development in Inner zone	Development in Middle zone	Development in Outer zone
1	DAA	DAA	DAA
2	AA	DAA	DAA
2	AA	AA	DAA
4	AA	AA	AA

Sensitivity level 1	<i>Example</i>	Factories
Sensitivity level 2	<i>Example</i>	Houses
Sensitivity level 3	<i>Example</i>	Vulnerable members of society eg primary schools, old people's homes
Sensitivity level 4	<i>Example</i>	Football ground/large hospital

DAA means Do not Advise Against the development
AA means Advise Against the development

Technical assumptions underpinning HSE methodology for land use planning

9 The installation The quantities and properties of hazardous substances, and the descriptions of storage and process vessels, are assumed to be in accordance with the 'hazardous substances consent' entitlement for the site since this represents a duty holder's declaration of their entitlement to store such substances which could be introduced at any time. For each type of development HSE's advice to planning authorities will take account of the maximum quantity of a hazardous substance permitted by a hazardous substances consent and any conditions attached to it. Best cautious, but not pessimistic, assumptions concerning substances, locations, operating conditions and surroundings are used. For operations not described in the consent (eg numbers and sizes of road tanker operations, pipework diameters, pumps and other fittings) site-specific values are obtained as necessary.

10 Hazardous events All foreseeable major accidents are considered and a representative set of events which describe a set of circumstances which, for that installation, could lead to an accidental release of hazardous substances.

11 Consequences The previously described 'dangerous dose' concept is generally used to describe the extent of the impact of any hazardous event on the surrounding population. Protection provided to people by being sheltered within buildings is generally taken into account by the approach, as is the likelihood of people being outdoors at the time of the incident.

12 Ambient conditions Local weather data is used to provide wind and stability information around the installation. Further, the surroundings are generally assumed to be flat although ground roughness can be taken into account where circumstances require it.

13 Risk assessment The calculations produce contours of the frequency that a typical house resident would be exposed to a dangerous dose or worse. This is generally expressed in terms of 'chances per million per annum' or cpm for short, eg 10 cpm, 3 cpm and 0.3 cpm.

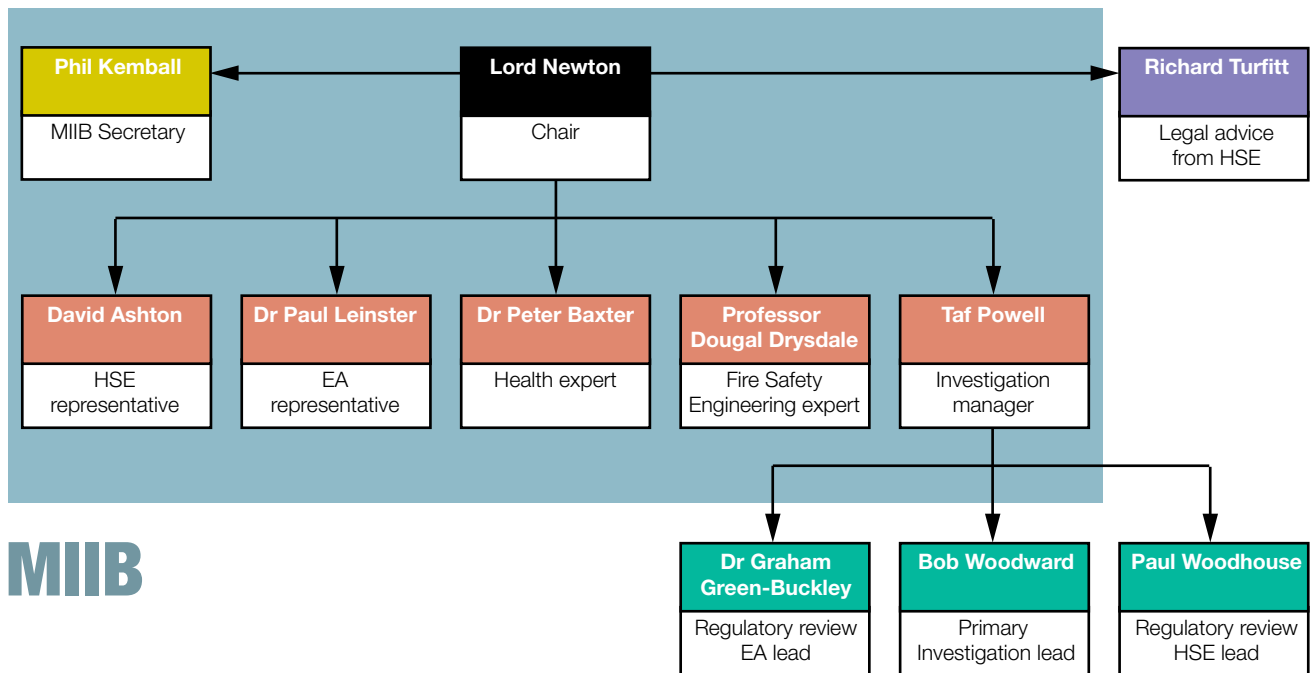
Annex 3

Investigation terms of reference

- 1 To ensure the thorough investigation of the incident, the factors leading up to it, its impact both on and off site, and to establish its causation including root causes.
- 2 To identify and transmit without delay to duty holders and other appropriate recipients any information requiring immediate action to further safety and/or environmental protection in relation to storage and distribution of hydrocarbon fuels.
- 3 To examine the Health and Safety Executive's and the Environment Agency's role in regulating the activities on this site under the COMAH Regulations, considering relevant policy guidance and intervention activity.
- 4 To work closely with all relevant stakeholders, both to keep them informed of progress with the investigation and to contribute relevant expertise to other inquiries that may be established.
- 5 To make recommendations for future action to ensure the effective management and regulation of major accident risk at COMAH sites. This should include consideration of off-site as well as on-site risks and consider prevention of incidents, preparations for response to incidents, and mitigation of their effects.
- 6 To produce an initial report for the Health and Safety Commission and the Environment Agency as soon as the main facts have been established. Subject to legal considerations, this report will be made public.
- 7 To ensure that the relevant notifications are made to the European Commission.
- 8 To make the final report public.

Annex 4

Major Incident Investigation organogram



Annex 5

Further information

Useful links

Dacorum Borough Council
www.dacorum.gov.uk
Tel: 01442 228000

St Albans District Council
www.stablans.gov.uk
Tel: 01727 866100

Hertfordshire County Council
www.hertsdirect.org
Tel: 01483 737555

Hertfordshire Chamber of Commerce
www.hertschamber.com
Tel: 01727 813680

Government links

Government Office for the East of England
www.go-east.gov.uk

Environment Agency
www.environment-agency.gov.uk

Department of Trade and Industry – Oil and Gas Directorate
www.og.dti.gov.uk

Health and Safety Executive
www.hse.gov.uk

Industry links

United Kingdom Petroleum Association (UKPIA)
www.ukpia.com
Tel: 020 72400289

Chemical Industries Association
www.cia.org.uk
Tel: 020 78343399

Useful sources of information

Dacorum Borough Council Digest newsletter, available monthly

Dacorum Borough Council Buncefield Update Newsletter

Glossary

The Health and Safety Commission (HSC) is responsible for health and safety regulation in Great Britain. The Health and Safety Executive (HSE) (and local authorities) are the enforcing authorities who work in support of the HSC. Both are statutory bodies, established under the Health and Safety at Work etc Act 1974 (the HSW Act).

HSC's statutory functions include conducting and sponsoring research; promoting training; providing an information and advisory service; and submitting proposals to Ministers for new or revised regulations and approved codes of practice. HSC has a chair plus nine members nominated by organisations representing employers, employees, local authorities and others. They are appointed by the Secretary of State for Work and Pensions.

HSE is a body of three people appointed by HSC with the Secretary of State's approval. HSE advises and assists HSC and has specific statutory responsibilities of its own, notably for enforcing health and safety law. HSE's staff of around 4000 (inspectors, policy advisors, technologists, scientific and medical experts etc) is collectively known as HSE.

HSE regulates health and safety in factories, farms, mines, nuclear installations, offshore installations, hospitals, schools and many other sectors. Local authorities are responsible for enforcement in offices, shops and other services.

The Environment Agency (EA) is the lead regulator in England and Wales with responsibility for protecting and enhancing the environment. It was set up by the Environment Act 1995 and is a non-departmental public body, largely sponsored by the Department for Environment, Food and Rural Affairs (DEFRA) and the National Assembly for Wales (NAW). EA's prime responsibilities include flood risk management, tackling pollution incidents, reducing industry's impact on the environment, restoring and improving rivers, coastal waters, contaminated land, and wildlife habitats.

EA also advises on sustainable drainage, water conservation and management, planning issues, nature conservation and waste management.

The Control of Major Accident Hazards Regulations (COMAH) are enforced by a joint Competent Authority (CA) comprising HSE and EA in England and Wales, and HSE and the Scottish Environment Protection Agency (SEPA) in Scotland.

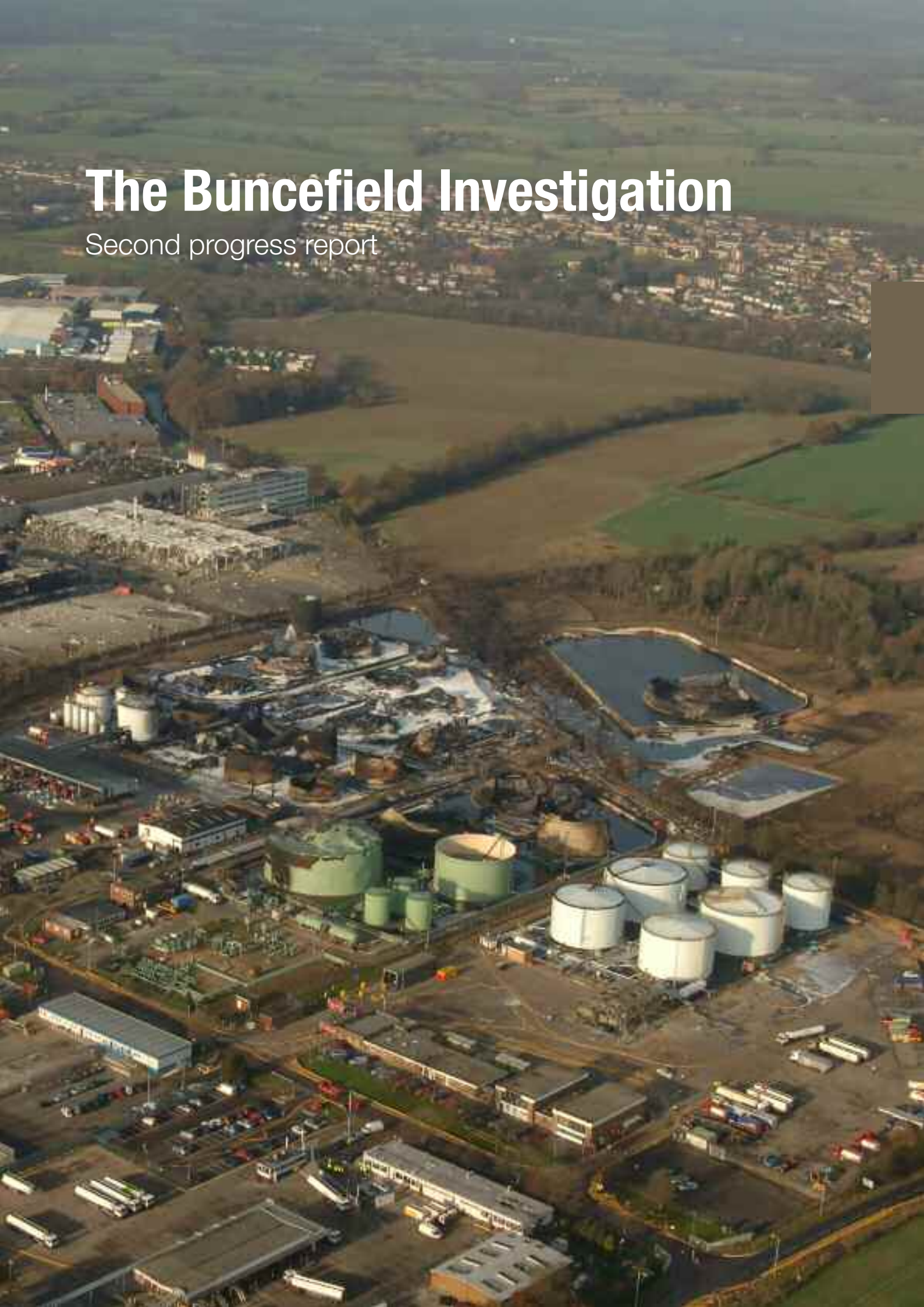
3-com	A business whose premises were effected by the Buncefield incident
ACMH	Advisory Committee on Major Hazards
Aquifer	A water-bearing stratum of porous rock, gravel or sand
BAA	BAA plc operate airports, including London Heathrow
Boreholes	A cylindrical shaft drilled into the ground, often for geological exploration or extraction of resources
Bund	An enclosure designed to contain fluids should they escape from the tank or vessel inside the bund
Catherine House	A building effected by the Buncefield incident

COMAH Regulations	The Control of Major Accident Hazards Regulations 1999 (COMAH). See annex 1
COMAH sites	A site to which the COMAH Regulations apply
Competent Authority	The COMAH Regulations are enforced by a joint Competent Authority (CA) comprising HSE and EA in England and Wales, and HSE and the Scottish Environment Protection Agency (SEPA) in Scotland. The CA operates to a Memorandum of Understanding which sets out arrangements for joint working
dangerous dose	A dose large enough to lead to: severe distress to all; a substantial number requiring medical attention; some requiring hospital treatment; and some (about 1%) fatalities
dioxin	Toxic chemical by-products of incineration and some industrial processes that use chlorine
duty holder	In the context of this report, any person or organisation holding a legal duty – in particular those placed by the HSW Act, the MHSWR, and the COMAH Regulations
fire water	Water stored for use during, and used during, fire-fighting operations
foam concentrate	In the context of this report, a concentrate used during operations to extinguish hydrocarbon fires
Fuji	A business whose premises were effected by the Buncefield incident
hazard	Anything with the potential to cause harm
human factors	HSE has defined human factors (also known as Ergonomics) as the environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work
hydrocarbon	An organic chemical compound of hydrogen and carbon. There are a wide variety of hydrocarbons such as crude oil (basically a complex mixture of hydrocarbons), methane, propane, butane, etc. They are often used as fuels
Northgate	A business whose premises were effected by the Buncefield incident
on- and off-site and emergency plans	Operators of top-tier COMAH sites must prepare adequate emergency plans to deal with the on-site consequences of possible major accidents and to assist with off-site mitigation. Local authorities for areas containing top-tier COMAH sites must prepare adequate emergency plans to deal with the off-site consequences of possible major accidents, based on information supplied by site operators
particulates	Fine particles (liquid or solid) suspended in the air such as dust, smoke, fumes, and so on

Pasquill stability category	A category within a classification scheme used to describe the degree of atmospheric turbulence
pollution dispersion model	A model used to describe the transport and diffusion of pollutants in the atmosphere
Prohibition Notice	Issuing improvement or prohibition notices are some of the range of means which enforcing authorities use to achieve the broad aim of dealing with serious risks, securing compliance with health and safety law and preventing harm. A prohibition notice stops work in order to prevent serious personal injury
responder	Under the Civil Contingencies Act 2004, EA is a Category 1 responder, and HSE is a Category 2 responder. These categories define the roles played by each body in response to a major incident
risk	The likelihood that a hazard will cause a specified harm to someone or something
RO	A business whose premises were effected by the Buncefield incident
run-off	Uncontained liquid, either deposited on-site as rain, or in the context of the Buncefield incident, fuel and/or fire water not contained as part of the operation to control the incident
safety reports	The COMAH Regulations require operators of top-tier sites to submit written safety reports to the Competent Authority
tier	The COMAH Regulations apply where threshold quantities of dangerous substances identified in the Regulations are kept or used. There are two thresholds, known as 'lower-tier' and 'top-tier'. Annex 1 gives a brief background to the origins of these Regulations
volatile	A substance which evaporates readily, even below its boiling temperature
watercourses	A natural or man-made channel along which water flows

The Buncefield Investigation

Second progress report



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Foreword

I present a second progress report that focuses mainly on the environmental impact on land, surface water and ground water of the fuel and fire water that escaped from the Buncefield site. It is important, in my view, that the vital work being done by the Environment Agency and others is brought to public attention.

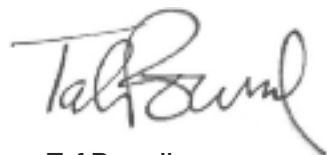
My report also contains for completeness a brief update on progress with the investigation into how fuel escaped, thereby breaching the primary containment barriers. It reveals that cloning of a number of important computer records has been successful and that vapour formation modelling is underway. Although briefly stated, this is important new information – it was quite possible that these disks would be too badly damaged for the information on them to be recovered.

The report is, as I say, mainly a description of loss of containment of fuel and fire water from bunds (secondary containment) and from the site itself (tertiary containment).

There are important early observations that sealant used in some bund walls was not capable of withstanding fires and/or the hydraulic pressure in bunds or adjacent tanks. Bund performance during the incident forms an important but as yet inconclusive aspect of the investigation.

There was massive loss of containment at the site boundaries and fuel and fire water escaped from the site to the surrounding lands. The report describes the monitoring work by the Environment Agency and others to identify whether or not short and long-term pollution of watercourses and ground waters has or is likely to occur, particularly potential contamination of the important chalk aquifer that underlies Buncefield. The pathways for pollutants are still being investigated. It is important to emphasise that if contamination of the aquifer occurs from the Buncefield incident, it could take months or years to materialise. However, we have been reassured by Three Valleys Water Company and the Drinking Water Inspectorate that drinking water is of a high quality and has not been affected by this incident.

A further report to the Board on the means of escape of the fuel and the formation of flammable vapours is suggested as possible within a month of this report, provided we are able to continue the good rate of progress that the investigation is making.



Taf Powell

Buncefield Investigation Manager and Member of Buncefield Major Incident Investigation Board

Part 1 Progress with the primary investigation

1.1 Loss of containment of fuel and contaminants

Background

1 Fuel depots such as Buncefield are strategic centres for the distribution of liquid fuels such as diesel, unleaded petrol and aviation fuel. Fuel comes to depots via pipelines from refineries and is stored according to fuel type before being distributed to other places (typically points of use, such as petrol stations and airports) either by road tanker, by rail, or by dedicated pipeline.

2 Fuel depots are designed to keep fuel within the vessels and pipework that store and distribute them. Should fuel escape, there needs to be provision for ensuring that fuels, and the contaminants associated with any emergency response to a fuel escape or fire, are prevented from running off site so as to protect the surrounding environment. The provisions for keeping escaped fuel and other contaminants within the site (referred to as containment) is described in the safety report that operators of large sites such as Buncefield must submit to the Environment Agency (EA) and the Health and Safety Executive (HSE) (the 'Competent Authority').

3 There are typically three levels of containment. **Primary containment** relates to the equipment and facilities that have direct contact with the products (eg tanks and pipework), and their operation and management.

4 **Secondary containment** relates to both the control of the product in the primary containment facilities (eg the provision of tank high-level alarms to prevent loss through overfilling) and any contingency provisions for the failure of the primary containment. The most important of these provisions are bunds, which are enclosures capable of holding liquids that may escape from the vessels and pipes within the bund wall.

5 There are a number of types of bunds across the Buncefield Depot, ranging from earth banks with earth bases to concrete walls with concrete bases. In the area most affected by the fire, the bunds were predominantly of concrete construction, although some had concrete walls and clay floors.

6 **Tertiary containment** relates to the site surface and associated drainage, boundary walls, roads, kerbs and any features such as road humps that can provide some retention of liquids. Proper design of drainage systems will limit loss of product out of the site and prevent lost product permeating into the ground with the potential risk that it can migrate to ground water, or contaminate surface waters and land.

7 At Buncefield, the site slopes downwards in a north-easterly direction towards Cherry Tree Lane, a public road running between the main site and the British Pipeline Agency Ltd (BPA) tank 12, at the north of the depot. There is a general slope from west to east. Cherry Tree Lane has a depression about half way along its length near to the BPA's tank 12 area, before sloping away to the east and the junction of Green Lane and Hogg End Lane.

Loss of fuel from vessel(s)

8 The first *progress report*¹ noted that the explosions and fires on 11 December 2005 were the result of a massive escape of fuel in the vicinity of bund A on the Hertfordshire Oil Storage Ltd (HOSL) West part of the site. This escaped fuel formed

¹ www.buncefieldinvestigation.gov.uk



Figure 1 Site map showing bunds

a flammable mixture with the air. Little was known about how primary containment was lost or how the escaping fuel formed into a flammable mixture. (Figure 1 shows a schematic of the bunds.)

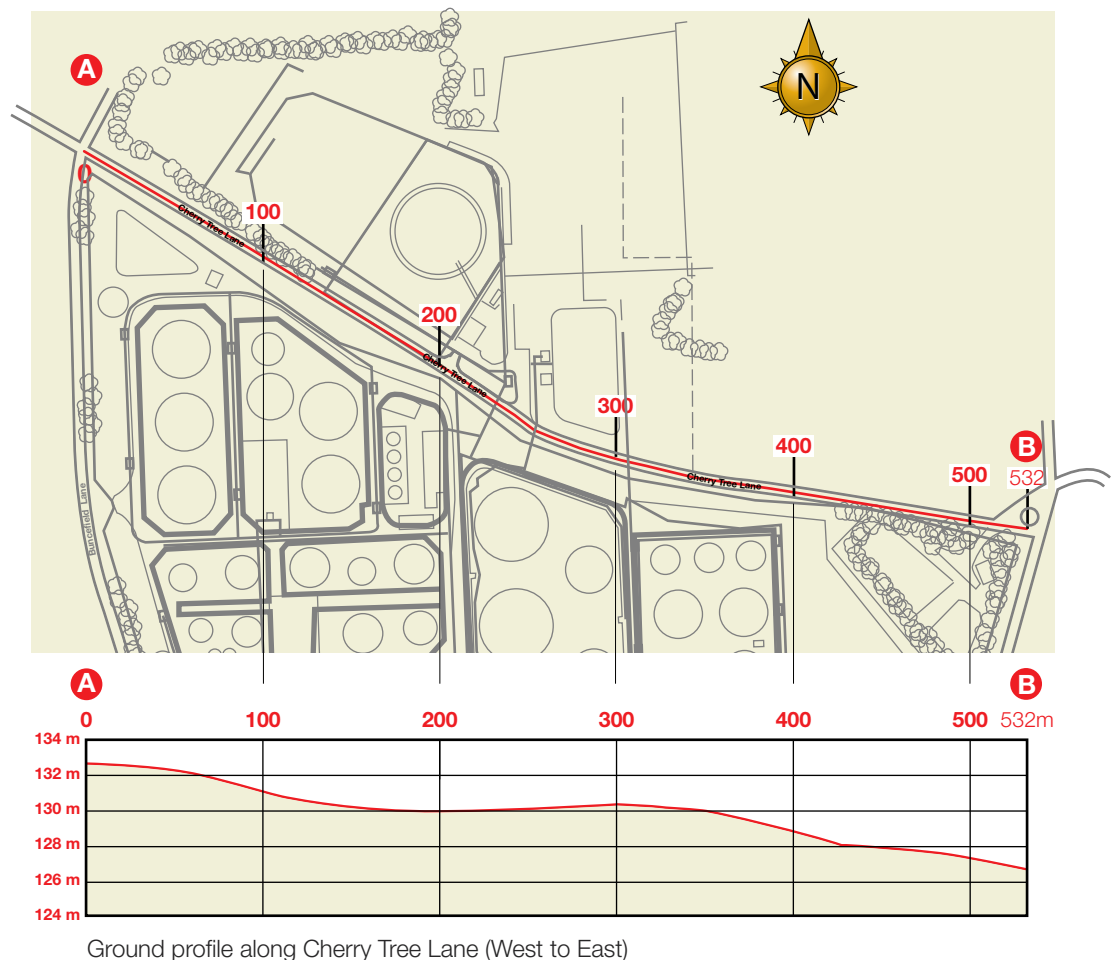
9 Progress has been made in determining the main source of escaped fuel. CCTV recordings recovered from the south side of the BPA site show the visible mist, associated with the loss of containment of the fuel, drifting eastwards onto the site from the adjacent HOSL West site shortly before the first explosion. This is consistent with the evidence obtained from other CCTV coverage and detailed in

the first *progress report*, and appears to confirm that the initial escape of fuel was from the HOSL West site. CCTV records from the Northgate building provide further confirmation of the spread of the flammable cloud away from the HOSL West site. This information also supports the initial forensic conclusions about the extent of the flammable cloud in this vicinity.

10 A significant amount of information has now been obtained from the extensive electronic equipment used to control and monitor the operations on site. Much of the equipment was housed in damaged buildings and great care had to be taken to ensure its safe removal and subsequent restoration and examination. This has revealed important information on key parameters such as fuel levels in tanks, flow rates and valve positions. Work is continuing to extract this information and to examine it in detail so as to conclude with confidence how the fuel escaped. It is hoped this work will be completed within five weeks of this report.

11 A key aspect of the investigation is to determine how the escaping fuel vaporised so rapidly. Work has been commissioned from the Health and Safety Laboratory (HSL) to assist with this. The work is being carried out as quickly as possible to enable feedback to the investigation team within the next month. In particular, priority is being given to the composition of the fuel and to modelling how the escaping fuel could have been vapourised under the prevailing weather conditions. This work should provide a link between the possible release events indicated by the control and instrumentation records and the clear evidence of mist formation coming from witness statements and CCTV records.

Figure 2 Schematic of topography at Cherry Tree Lane



12 In parallel with the work on vapour cloud formation, HSL is helping to determine the exact nature and composition of the flammable mixture and to determine the precise mechanism for generating such a violent explosion within an apparently unconfined vapour cloud. This work is supported by analysing other incidents from around the world and assimilating technical information from them.

13 Good progress on damage assessment, both on and off site, has given added momentum to the work to explain the high level of blast damage caused by the explosion.

14 A systematic fuel sampling programme is being carried out to confirm the composition of products being stored and transferred on site in tanks or pipes. This programme has had to be fitted into the remediation work being carried out on site by the operators, under the control of two Prohibition Notices issued by HSE.

Loss of fuel and contaminants from bunds

15 There was significant loss of secondary containment related to the bunds on the HOSL West and BPA sites. Investigators have not been able to gain access to every part of the sites, in particular to some of the bunded areas, because of continuing safety concerns. It has been possible, however, to identify some key issues related to the condition of the bunds after the fire. A more systematic examination of the bunds will be completed only when it is safe to do so, following final removal of product from a number of pipework sections.

16 While the bunds substantially remained standing throughout the incident, their ability to fully contain the fuel and fire waters was lost as a result of the explosion and subsequent fires. Figure 3 shows the damage caused to bund walls as a consequence of the incident. Pools of fuel were burning in the bunds as a result of loss of fuel from the tanks, along with fires from the tanks themselves. Figures 4 and 5 show a bund, where the concrete panels had been infilled with a joint sealant. This sealant has been lost as a result of the fire and/or hydraulic pressure within the bund.

Figure 3



Figure 4





Figure 5



Figure 6

17 Many of the bunds around the site have suffered varying degrees of sealant damage. Figure 6 shows fire water and product leaking from such a joint in the later stages of the incident.

18 Another two leakage mechanisms can be seen in Figure 7. Here a corner joint has opened up, releasing fire water and product. Visible along the lower edge of the bund wall, a 'tide mark' shows where liquids were seen to seep through the concrete itself.

19 Figure 8 shows the base of a bund where the concrete panels have undergone significant 'heave' which has resulted in the escape of product and fire water.

Figure 7



Figure 8



20 Figure 9 shows the inclusion of penetrating pipework in the construction. Here the sealing material surrounding the pipes has been lost.

Loss of contaminants from the site

21 There was extensive loss of tertiary containment and large amounts of contaminant went off site. The burning fuel formed an extensive plume of smoke. Ground and water contaminants include fuel and products of its degradation in the fire – hydrocarbons and polycyclic aromatic compounds (a group of chemicals commonly found in residues from burning coal, fuel and oil).

22 Some fire-fighting foam concentrate contains zinc (to act as a heat resistor) and a chemical called perfluorooctane sulphonate (PFOS), which is a surfactant to aid the spreading properties of the foam. Zinc and PFOS are useful tracers for the movement of fire-related contaminants off site.

23 There are lagoons on the site which provide a reserve of fire water for use in emergencies. One of the lagoons (to the north of bund A) shows evidence of significant damage to the lining that may have resulted from the explosion or the fire.

24 As a result of the breach to the lining, some of the liquids in the lagoon, which included contaminated run-off liquids from the bunds and fire fighting, may have escaped into the ground. The natural clay layer beneath the site would have helped to minimise the extent of any contamination of the ground from this source.

25 The pumphouse to the north of bund A, adjacent to the lagoon, was destroyed by the explosions. The control of water on the site was dependent on the use of the pumps located within the pump house. Because the initial explosions destroyed all of the fire-fighting equipment in the affected area, the lagoons were never brought into use and the fire services had to establish alternative arrangements.

Figure 9



Figure 10



26 During the incident, the internal roadways were submerged by fire water and fuel flowing to the lowest point. Fire water and fuels flowed through the site drainage and along the roads within the site perimeter. At the low point on the site perimeter the flows overtopped the road edge, which was not kerbed, and flowed into Cherry Tree Lane.

Figure 11 The three parallel bars show where the pumphouse stood before the incident



Figure 12



27 A large pool of liquid, consisting of fire water and fuels that escaped from tanks and pipes, collected in Cherry Tree Lane. It is estimated that this pool was 200 m in length and between 10 and 20 m wide. Road tankers removed the liquids in the pool by the first week in January this year.

28 The investigation has highlighted a number of potential pathways by which fuel and contaminated water could have entered the environment. Within the site, shallow boreholes of 4-5 m depth exist within the terminal, and a deep borehole is located in the Chevron/Texaco tanker park, directly due south of the HOSL and BPA sites that were on fire. This borehole is 42 m deep, extending into the chalk layer.

29 A number of places where contaminants could penetrate the ground have been found around the perimeter of the site: on the northern and southern verges of Cherry Tree Lane; on the western verge of Buncefield Lane; and the southern verge of Hogg End Lane. These drains and chambers were either submerged in fire water and fuel or had drains connected to them that delivered such contaminants.

30 Cherry Tree Lane has a number of road drains, some of which are connected to deep chambers. At the bottom of one appears to be a borehole at least 40 m deep penetrating the chalk aquifer. For a description of the local geology and aquifer, see paragraph 41.

Figure 13



1.2 Monitoring environmental impact

Air quality

31 Monitoring air quality impact of the incident was carried out by a number of organisations. The Health Protection Agency was chiefly responsible for organising the air quality monitoring in the vicinity of the Buncefield site. The Agency received the support of HSL and, via the Hertfordshire Fire Brigade, the London Fire Brigade Scientific Advisers. A Meteorological Office (Met Office)/Natural Environment Research Council aircraft also sampled the plume. This was supplemented by local monitoring organised by the Department for Environment, Food and Rural Affairs (DEFRA). DEFRA's Automatic Urban and Rural Network (AURN) and local authority air monitoring networks monitored the impact on air quality over the wider region of southern England, including London. French regional air networks monitored potential impacts in northern France. In addition, the Met Office carried out modelling of the plume and DEFRA's air quality information service published regular reports on air quality. The Environment Agency also carried out modelling of the short range impacts in support of the Met Office, which was used by the Health Protection Agency in part to develop the strategy for subsequent sampling of grass and soil.

32 DEFRA is planning to publish a report on *Air quality impact of the Buncefield Oil Depot explosion* in May. This report will describe the monitoring carried out in England and France during the incident, and assess the air quality impacts. It will also describe the modelling of the plume and estimate the emission of pollutants released in the fire. This will inform the considerations as to whether the Buncefield incident will be designated a major accident to the environment (MATTE) under COMAH as a result of the impact of the smoke plume.

33 DEFRA is keeping the Board informed of progress with its findings. DEFRA's website can be found at www.defra.gov.uk. The Health Protection Agency is also keeping the Board informed of progress of its findings. HPA's website can be found at www.hpa.org.uk.

Surface water

34 Extensive sampling of surface and ground waters around the site has been carried out to assess the environmental impact of the incident. Samples of liquids and contaminated soils have been sent to Environment Agency laboratories around the country for analysis.

35 Surface water monitoring has concentrated on the River Ver, as it receives surface water from the Buncefield site. Two balancing tanks (which provide buffers to prevent uncontrolled surges of water), the Maylands and Redbourn lagoons, receive surface water from the site and the surrounding area, and subsequently discharge into the River Ver.

36 The River Ver was monitored daily in the first two weeks after the incident. Two sites, one upstream and one downstream of the Maylands tank outfall, were tested. The balancing tanks and outfalls were also subject to daily sampling and analysis. The initial focus was on potential fuel and fire-fighting foam contamination which could impact on the ability of fish and other organisms to live in the river and on drinking water.

37 Two additional monitoring sites were added at the end of December, both on the River Colne, which is a tributary of the River Ver. These were both south of St Albans, 7 and 11 km downstream of the Maylands outfall. All of these points were sampled for PFOS.

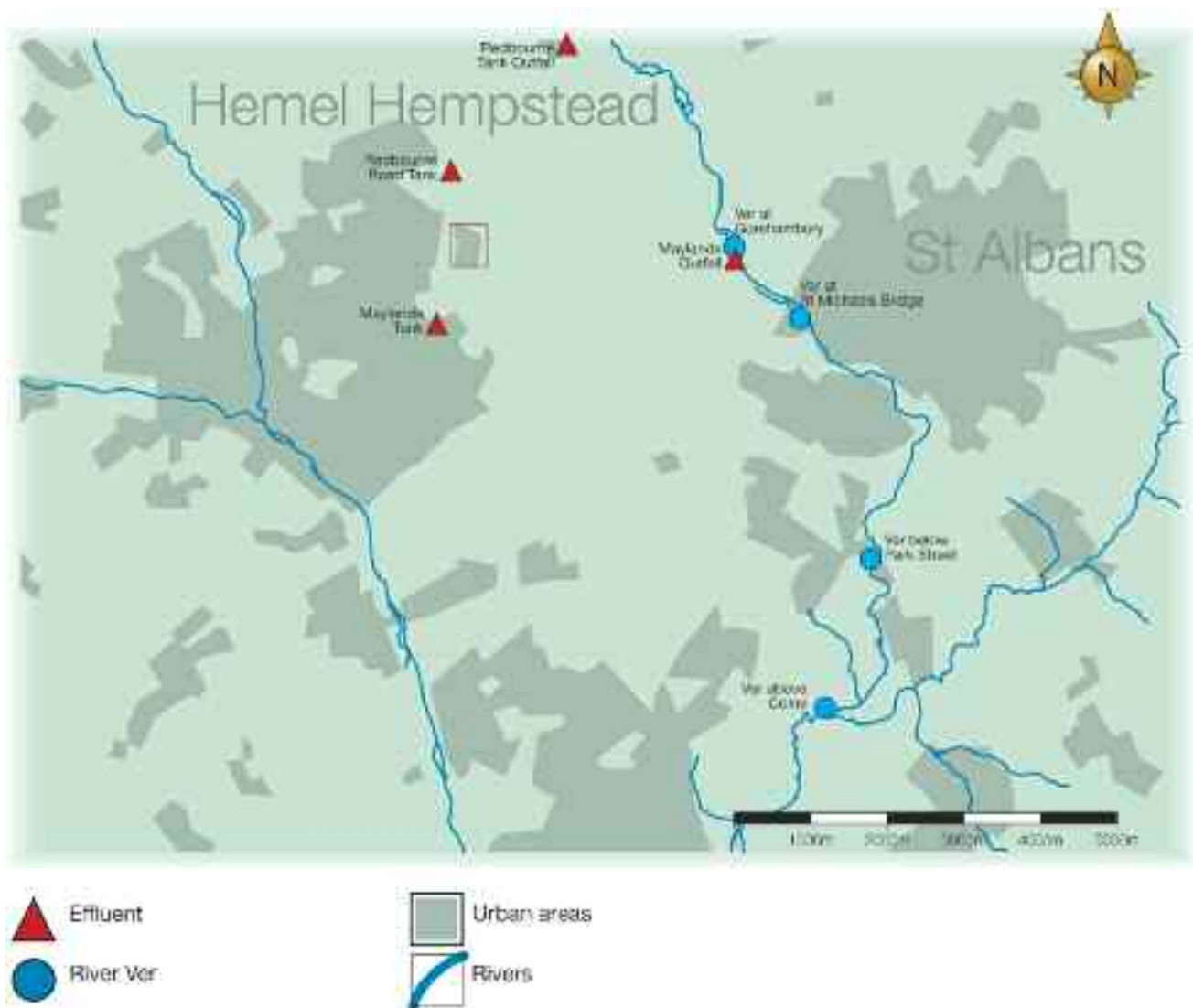


Figure 14

38 No direct impact of spills was found in the first days after the incident. By the third day of the incident, detectable but low concentrations of PFOS were noted in the balancing lagoons, at the Maylands outfall and in the River Ver downstream of the outfall. In addition, there was an increase in zinc above background concentrations.

39 PFOS was identified at all monitoring points, including in the River Colne. The PFOS concentrations, however, were less than the provisional water quality threshold concentration specified by the Drinking Water Inspectorate (DWI) and no identifiable environmental consequences have been observed in the river habitat.

40 Levels of PFOS started to drop in the River Ver in the middle of January, falling below detectable limits in February. The flow of water from the Maylands outfall stopped in February. However, the water that remains within this lagoon has low concentrations of PFOS.

Ground water

Geology

41 The Buncefield Depot and the immediate surrounding area are positioned on a variable layer of clay with flints over Upper Chalk. The clay with flints layer is classified as a low permeability surface deposit and is believed to be present at a variable thickness of between 2 and 10 m. This layer should inhibit the vertical and lateral migration of contaminants and protect the chalk aquifer below, where present in sufficient depth.

42 The Upper Chalk is classified as a major aquifer, which provides water supplies regionally. The Depot is located within the catchment of a ground water abstraction point located to the south and east of the depot. Ground water is present typically at a depth of 45 m below ground level and flow is generally towards the south-east. Natural holes in the chalk rocks, which allow quicker than normal water migration, may be present, but none have been positively identified in the Buncefield area. Ground water is water held naturally in the chalk rocks underground. This can be abstracted for drinking water and other purposes.

43 Regional ground water in the vicinity of the Buncefield site flows to the south east but there are possibly some local variations or preferential flow along dry valleys that may put Bow Bridge, Mud Lane/Holywell and Hunton Bridge pumping stations at a higher risk of contamination.

Monitoring

44 Ground water and ground water abstraction boreholes have been monitored up to 9 km surrounding the site. These include six pumping stations operated by Three Valleys Water Company, two private boreholes and a number of Environment Agency monitoring sites.

45 Three new observation boreholes have been drilled closer to the Buncefield site to provide early detection of any ground water pollution: Butlers Farm (between Buncefield and Bow Bridge Pumping Station); Breakspear House (south of Buncefield); and Hogg Lane (on the east boundary of Buncefield – see Figure 16). This is part of an ongoing monitoring regime that will provide further boreholes surrounding the site. They have each been sampled once, along with drinking water boreholes, and analysed for pollutants.

Figure 15 Picture of Maylands Tank outfall into River Ver



[illegible]

Abstract



Results of monitoring

46 It is too early to rule out potential contamination of the ground water, as it can take many months or years for water to drain through the ground into the chalk aquifer. Overall, the results received to date do not suggest any identifiable contamination pattern which is directly attributable to pollution from the incident.

47 A limited number of results have indicated the presence, at limits just above detection, of PFOS and other contaminants such as oil or polycyclic aromatic hydrocarbons. These results need to be considered in relation to the overall picture for the whole of the aquifer, especially as the ground-water flow has not been established.

48 The 42 m deep borehole located on the Chevron/Texaco lorry park on the Buncefield site, south of HOSL West has been sampled (see paragraph 28). Initial results indicate fuel is present at low concentrations. It is not yet known if this contamination is historic or a result of the incident. Investigations continue.

49 The four points of ground penetration around the perimeter of the site reported in paragraph 29 are being investigated. Some of the chambers and deep boreholes associated with these entry points may contain contaminants from the incident.

Drinking water

50 The closest drinking water abstraction point to the Buncefield site is the Bow Bridge pumping station approximately 3 km due east. Drinking water was not being pumped from here prior to the incident and the station remains out of operation as a precautionary measure. As a further safeguard, non-return valves have been fitted to prevent any possible backflow of water from the site. Changes have also been made to the supply arrangements to ensure drinking water supplies are maintained. The other drinking water abstractions are located in a ring around Buncefield at a distance of more than 5 km.

51 Water supply in the area is the responsibility of Three Valleys Water Company which has the detailed operational knowledge required to manage the local response. The regulation of drinking water quality is the responsibility of DWI.

52 Three Valleys Water Company and DWI are working closely together to ensure that drinking water supplies remain of the highest quality. Water companies treat and monitor the quality of water before it is distributed to the public as drinking water, thus providing reassurance of its quality.

Land investigations

53 Investigations to assess the extent of land contamination started in February 2006 along Cherry Tree Lane. Trial pits were excavated at points along the Lane and on site and a number of samples taken for laboratory analysis. The locations of the trial pits are indicated in Figure 18.

54 The initial findings indicate that the surface layer of the soils, the top 30 cm approximately, was contaminated with fuel and fire-fighting products. No visible free product was detected in any of the trial pits at depth. PFOS, hydrocarbons and polycyclic aromatic hydrocarbons have been reported in the laboratory analysis.

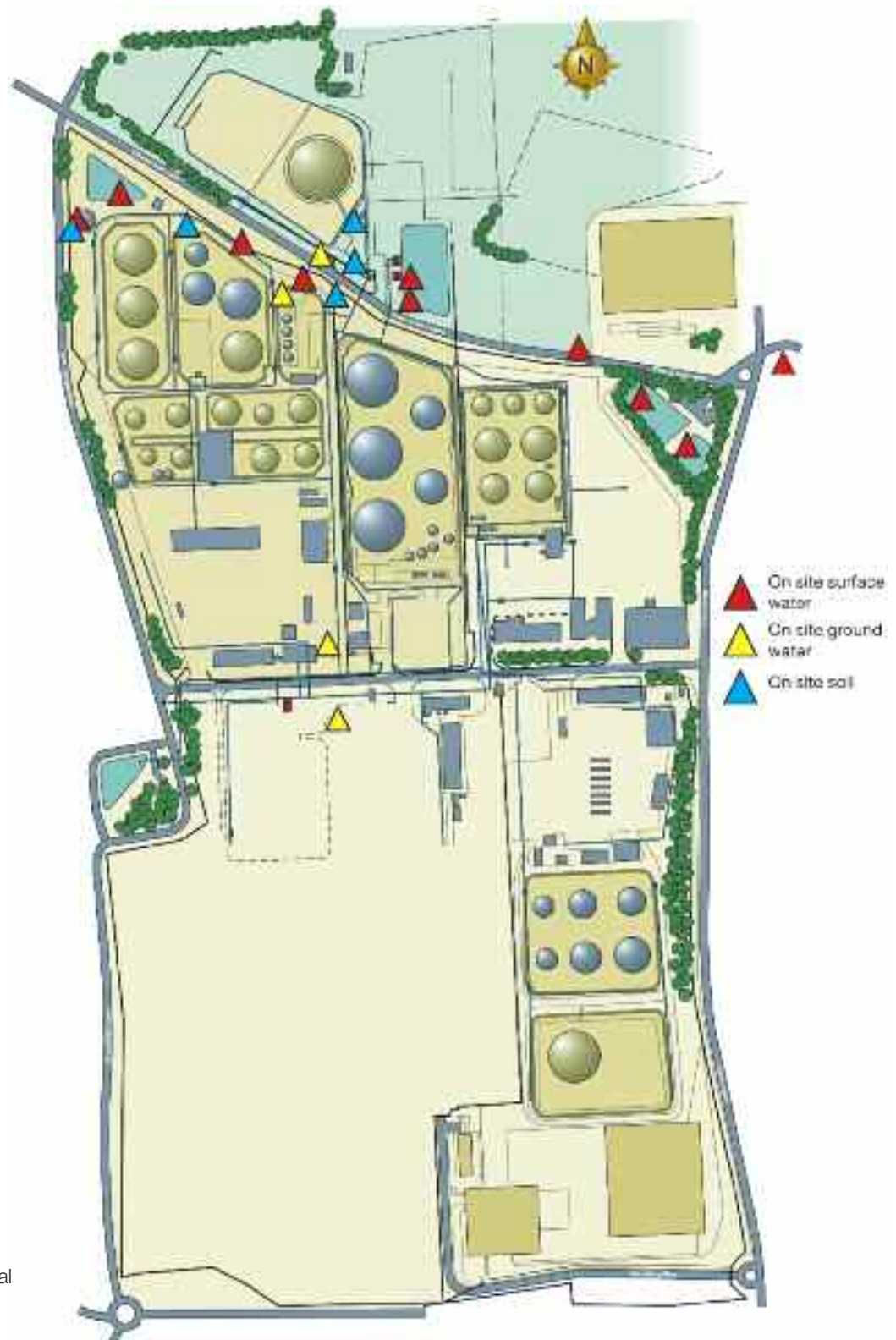


Figure 18 Location of trial pits

Disposal of fire water

55 All contaminated fire water has been removed from the site and is being safely and securely stored at a number of sites around the country. Thames Water holds the largest quantities. There are approximately twelve million litres at Maple Lodge Sewage Treatment works near Rickmansworth and four million litres at Blackbirds Treatment near Radlett.

56 The disposal of these fire waters is the responsibility of the oil companies. The Environment Agency await definitive risk assessments from the companies on their proposed best practicable disposal options to avoid risk of contamination of the environment.

57 Rainfall will give rise to more contaminated water within the Buncefield site. This will be contained on site before being safely removed.

1.3 Progress with other aspects of the major investigation

Acting on regulatory advice (Investigation term of reference two)

58 HSE issued an alert to fuel depot operators on 21 February 2006 in response to the first *progress report* to the Board, seeking a response from depot operators by Easter 2006. The Competent Authority has also begun a programme of depot inspections targeting the key findings in the first *progress report*. A report of the programme's findings is expected in late May. This will be of importance in improving the control of major hazards at fuel depots.

Working with others and communities (Investigation term of reference four)

59 Lord Newton has written to other agencies and authorities that may undertake reviews of the Buncefield incident. The investigation team is actively engaged with communities and businesses in the Buncefield area. See Part 2 of this progress report for further information on this aspect.

Report to the European Commission (Investigation term of reference seven)

60 A report has been sent to the European Commission by the Competent Authority to discharge a responsibility under the Control of Major Accident Hazards (COMAH) Regulations 1999.

Part 2 Current business and community issues

61 Four months on from the incident, the local community is still facing a variety of difficulties. In these challenging circumstances both individuals and businesses have demonstrated remarkable resilience.

62 The incident has had significant impact on some individuals' day-to-day lives, leading to changed circumstances, including in some cases unemployment. These factors contribute to heightened levels of stress and anxiety.

63 A number of properties that sustained significant structural damage are still being repaired, and in some cases residents are as yet unable to return home.

64 Many businesses forced to relocate away from Maylands Estate in the immediate aftermath of the incident are still facing challenges to deliver pre-incident levels of service. Some businesses based beyond Maylands have seen an associated drop in their levels of business.

65 The uncertain future of the Buncefield Oil Depot continues to cause concern to local businesses, employees and residents.

66 Dacorum Borough Council is working with community and voluntary sector organisations to provide a wide range of services, including advisory and training, to people affected by the incident. Business advice and support is being provided by both the Council and Hertfordshire Chamber of Commerce.

67 Board members have also met with local residents at Woodhall Farm and at Leverstock Green and will repeat the exercise at Adeyfield. A meeting with the Maylands business community will take place in April. The investigation team and Members of the Board have also met with representatives from Dacorum Borough Council, St Albans District Council and Hertfordshire County Council, as well as with Mike Penning (the local Member of Parliament), local councillors, Hertfordshire Police and Hertfordshire Fire and Rescue Service.

68 The investigation team and Dacorum Borough Council are working to ensure progress with the investigation is widely available to residents and businesses. Details of the first *progress report* were explained in Council newsletters to residents and business, such as *Dacorum Digest*, *Buncefield Update* and *Business Update*. The investigation team will continue to look for new and more effective means of communicating with people and businesses affected by the Buncefield incident.

69 An Investigation website contains useful information about the Investigation and the Board at www.buncefieldinvestigation.gov.uk.

70 Further meetings with residents and businesses in these areas will be arranged as the investigation progresses.

Part 3 Further work

3.1 Explosion and fire

71 The investigation priority is to establish how the fuel escaped from the vicinity of the HOSL site, and vapourised to form a flammable mixture that subsequently ignited with devastating results. Digital and other records, physical tracing of control systems, valve positions and other work on site, analysis of fuel samples and modelling of vapour formation under the prevailing conditions are therefore top priorities.

72 It is hoped that enough of the work will be completed within a month of publishing this second *progress report* to enable a further, third *progress report* to be made to the Board that describes with confidence how the fuel escaped and vapourised.

73 In parallel, further lines of investigation have been established. These include:

- pursuing information on other incidents of an apparently similar nature to Buncefield from around the world;
- completing an assessment of the extent of damage off site;
- modelling the ignition mechanism that generated massive overpressure from an apparently unconfined vapour cloud;
- modelling the dispersion of the flammable vapours; and
- development and propagation of the explosion.

74 Separately, work to ascertain why control of fuel was lost forms a continuing and key part of the primary investigation.

3.2 Environmental impact

75 The site drainage system was initially built when the site was commissioned in 1968 and has developed over the intervening years. A system of surface water drains and porous land-drains is evident but not yet fully mapped. A detailed examination of the site drainage system is underway. This will help to better define the flows during the incident.

76 Sampling of surface water will continue to monitor the potential effects of the Buncefield incident on surrounding watercourses (eg rivers and ponds).

77 Ground water monitoring by sampling of drains, subsurface chambers, pits and boreholes will continue. New boreholes will be sunk as further improved knowledge emerges of the drainage pathways from the site.

78 Analysis of fuel samples to get a 'fingerprint' has not yet been completed but it is one of the key steps in ascertaining whether contamination is a result of the incident (eg in determining whether the low-level contamination in the borehole sited in the lorry park south of the HOSL West site is new or historic).

79 Off-site, sampling of soil, sediment, and other materials, and CCTV examination of the drains around the perimeter of the Buncefield site is also continuing to develop a greater understanding of drainage and contamination.

80 DWI and Three Valleys Water Company will continue to work together to maintain supplies of high-quality drinking water.

81 The site operators are developing plans for the safe and environmentally sound disposal of fire water and other pollutants that have been removed to storage off site.

Annex 1 Further information

Useful links

Buncefield Investigation

Buncefield Major Incident Investigation
Marlowe Room, Rose Court
2 Southwark Bridge
London, SE1 9HS
Tel: 020 7717 6909
Fax: 020 7717 6082
E-mail: buncefield.inforequest@hse.gsi.gov.uk
Web: www.buncefieldinvestigation.gov.uk

Business support

Dacorum Business Contact Centre
Tel: 01442 867 805

Business Link Helpline
Tel: 01727 813 813

Hertfordshire Chamber of Commerce
Tel: 01727 813 680

Resident's support

Dacorum Community Trust Mayors' Fund
To apply, call the freephone helpline on 0800 131 3351. Lines are open from
9 am – 6 pm, 7 days a week.

Dacorum Borough Council
www.dacorum.gov.uk
Tel: 01442 228 000

Citizens Advice Bureau

Hemel Hempstead Citizens Advice Bureau, based in Hillfield Road, offers free, impartial, practical and confidential advice on a range of subjects.

Local authorities and emergency services

Dacorum Borough Council
www.dacorum.gov.uk
Tel: 01442 228 000

St Albans District Council
www.stablans.gov.uk
Tel: 01727 866 100

Hertfordshire County Council
www.hertsdirect.org
Tel: 01483 737 555

Hertfordshire Fire and Rescue Service
www.hertsdirect.org/yrccouncil/hcc/fire/buncefield

Hertfordshire Constabulary
www.herts.police.uk/news/buncefield/main.htm

Hertfordshire Chamber of Commerce
www.hertschamber.com
Tel: 01727 813 680

Government links

Office of the Deputy Prime Minister
Fire and Resilience Directorate: www.odpm.gov.uk

Government Office for the East of England
www.go-east.gov.uk

Environment Agency
www.environment-agency.gov.uk

Department of Trade and Industry
Oil and Gas Directorate: www.og.dti.gov.uk

Health and Safety Executive
Hazardous Installations Directorate: www.hse.gov.uk/hid
Control of Major Accident Hazards: www.hse.gov.uk/comah

Department for the Environment, Food and Rural Affairs
www.defra.gov.uk

Health Protection Agency
www.hpa.org.uk

Food Standards Agency
www.food.gov.uk

Drinking Water Inspectorate
www.dwi.gov.uk

Industry links

United Kingdom Petroleum Industry Association (UKPIA)
www.ukpia.com
Tel: 020 7240 0289

Chemical Industries Association
www.cia.org.uk
Tel: 020 7834 3399

Other useful sources of information

Dacorum Borough Council *Digest* newsletter, available monthly
Dacorum Borough Council *Buncefield Update* Newsletter

Annex 2 Investigation terms of reference

- 1 To ensure the thorough investigation of the incident, the factors leading up to it, its impact both on and off site, and to establish its causation including root causes.
- 2 To identify and transmit without delay to duty holders and other appropriate recipients any information requiring immediate action to further safety and/or environmental protection in relation to storage and distribution of hydrocarbon fuels.
- 3 To examine the Health and Safety Executive's and the Environment Agency's role in regulating the activities on this site under the COMAH Regulations, considering relevant policy guidance and intervention activity.
- 4 To work closely with all relevant stakeholders, both to keep them informed of progress with the investigation and to contribute relevant expertise to other inquiries that may be established.
- 5 To make recommendations for future action to ensure the effective management and regulation of major accident risk at COMAH sites. This should include consideration of off-site as well as on-site risks and consider prevention of incidents, preparations for response to incidents, and mitigation of their effects.
- 6 To produce an initial report for the Health and Safety Commission and the Environment Agency as soon as the main facts have been established. Subject to legal considerations, this report will be made public.
- 7 To ensure that the relevant notifications are made to the European Commission.
- 8 To make the final report public

Annex 3 Site maps



Glossary

The Health and Safety Commission (HSC) is responsible for health and safety regulation in Great Britain. The Health and Safety Executive and local authorities are the enforcing authorities who work in support of the HSC. Both are statutory bodies, established under the Health and Safety at Work etc Act 1974.

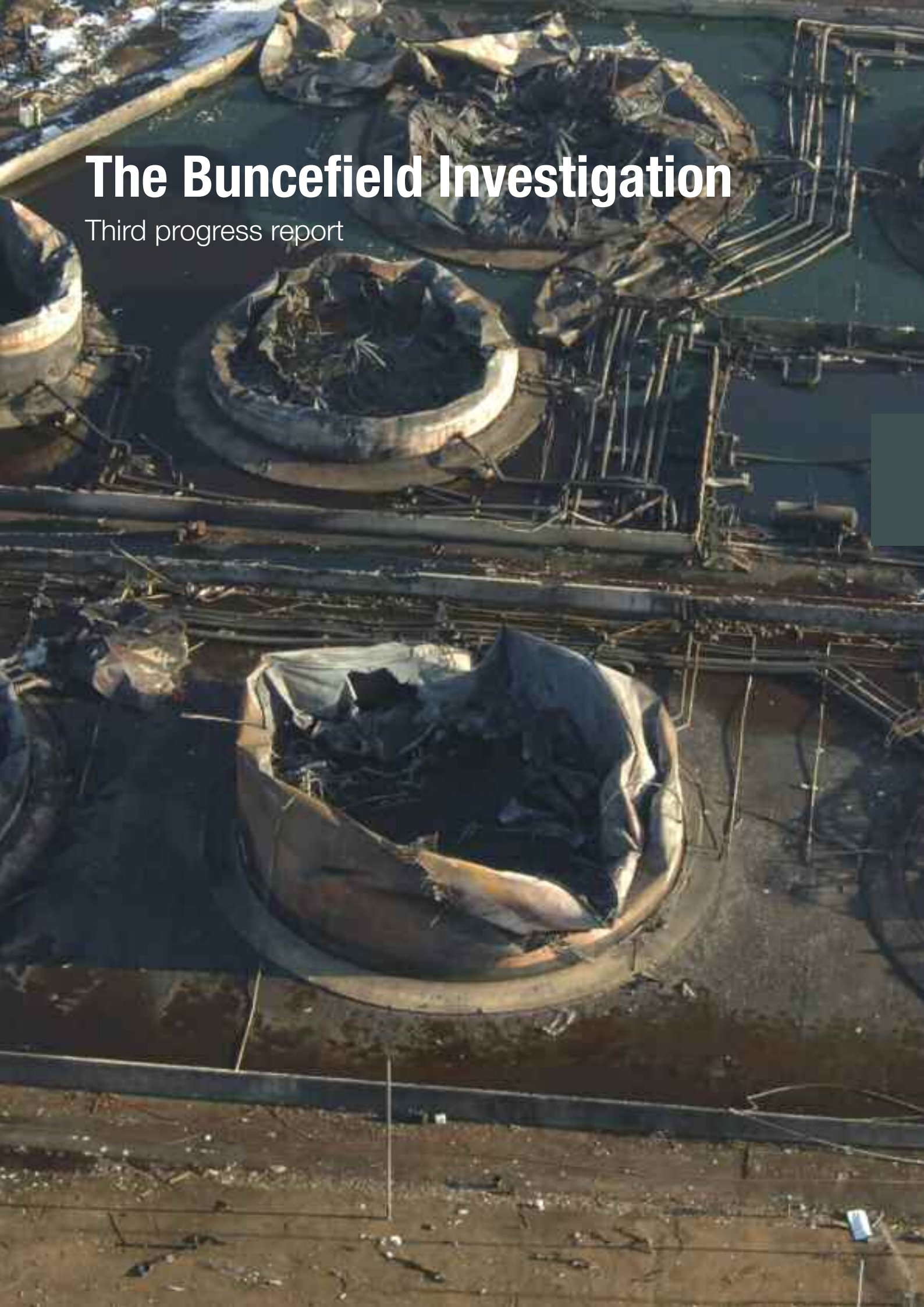
The Environment Agency is the lead regulator in England and Wales with responsibility for protecting and enhancing the environment. It was set up by the Environment Act 1995 and is a non-departmental public body, largely sponsored by the Department for Environment, Food and Rural Affairs (DEFRA) and the National Assembly for Wales (NAW). The Environment Agency's prime responsibilities include flood risk management, tackling pollution incidents, reducing industry's impact on the environment, restoring and improving rivers, coastal waters, contaminated land, and wildlife habitats. The Environment Agency also advises on sustainable drainage, water conservation and management, planning issues, nature conservation and waste management.

aquifer	A water-bearing stratum of porous rock, gravel or sand
borehole	A cylindrical shaft drilled into the ground, often for geological exploration or extraction
bund	An enclosure designed to contain fluids should they escape from the tank or vessel inside the bund
COMAH	The Control of Major Accident Hazards Regulations 1999 Regulations (COMAH). See Annex 1
COMAH sites	Sites to which the COMAH Regulations apply
Competent Authority	The COMAH Regulations are enforced by a joint Competent Authority comprising HSE and EA in England and Wales, and HSE and the Scottish Environment Protection Agency (SEPA) in Scotland. The Competent Authority operates to a Memorandum of Understanding which sets out arrangements for joint working
containment	Barriers which, in the event of a spill, can prevent spilled materials from reaching the environment
contaminants	Substances that have an adverse effect on air, water or soil
foam concentrate	In the context of this report, a concentrate used during operations to extinguish hydrocarbon fires
fire water	Water used during fire-fighting operations
hazard	Anything with the potential to cause harm
hydraulic pressure	Pressure exerted by water
hydrocarbon	An organic chemical compound of hydrogen and carbon. There are a wide variety of hydrocarbons such as crude oil (basically a complex mixture of hydrocarbons), methane, propane, butane, etc. They are often used as fuels

Northgate	A business whose premises were affected by the Buncefield incident
outfall	The point of discharge of water into a river, stream, pond, sea or other water body
PFOS	Abbreviation of perflourooctane sulphonate, a surfactant added to fire-fighting foam to aid it spreading
Polycyclic aromatic hydrocarbons and compounds	A group of chemicals commonly found in residues from burning coal, fuel and oil
pool fire	A fire over a pool of fuel and/or water or other liquids
primary containment	The equipment and facilities which have direct contact with the products under normal containment (eg tanks and pipe work), and their operation and management
Prohibition Notice	Issuing Improvement or Prohibition Notices are some of the range of means which enforcing authorities use to achieve the broad aim of dealing with serious risks, securing compliance with health and safety law and preventing harm. A Prohibition Notice stops work in order to prevent serious personal injury
risk	The likelihood that a hazard will cause a specified harm to someone or something
safety reports	The COMAH Regulations require operators of top-tier sites to submit written safety reports to the Competent Authority
secondary containment	The control of the product in the primary containment facilities (eg the provision of tank high-level alarms to prevent loss through overfilling) and any contingency provisions for the failure of the primary containment. The most important of these provisions are bunds
surface water	Water that sits or flows above land, including lakes, seas, rivers and streams
surfactant	A chemical added to fire-fighting foam which allows the foam to form a thin sealing film over the burning fuel
tertiary containment	The site surface and associated drainage, boundary walls, roads, kerbs and any features such as road humps that can provide some retention of liquids. Proper design of drainage systems will limit loss of product out of the site and prevent lost product permeating into the ground with the potential risk that it can migrate to ground water, or contaminate surface waters and land
watercourses	A natural or man-made channel along which water flows

The Buncefield Investigation

Third progress report



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Photograph on front cover shows Tank 912 and is courtesy of the Chiltern Air Support Unit

Foreword

This is my third progress report into the explosions, fires and aftermath at Buncefield. In this report I am able to explain with reasonable clarity and confidence that Tank 912 in bund A on the Hertfordshire Oil Storage Ltd (HOSL) West site overflowed at around 05.30 hours on 11 December while being filled at a high rate.

The environmental conditions, flow rate of fuel, and physical configurations of the tank top and wall provide a suitable mechanism for rapid formation of a fuel-rich vapour that flowed off site following the ground topography.

As the vapour flowed off site, driven by gravity and the formation of more vapour in bund A, it would have mixed with more air and by the time it reached the Fuji and Northgate car parks, may have become an almost ideal flammable mixture.

Several likely sources of ignition are discussed, a primary one on site and another in the Northgate car park. The explosion sequence is also discussed, but here there is far less confidence in the mechanism for the high overpressures seen and modelling of this may take some time. Nonetheless I believe the most important facts leading up to the explosions at Buncefield are known with reasonable confidence and they are presented below.

Updates are also given on environmental issues, and on further contacts with local businesses and residents, though the main focus is on the important information about how fuel escaped and vaporised leading to the explosions.

The ongoing investigation and other work are briefly described.



Taf Powell

Buncefield Investigation Manager and Member of Buncefield Major Incident Investigation Board

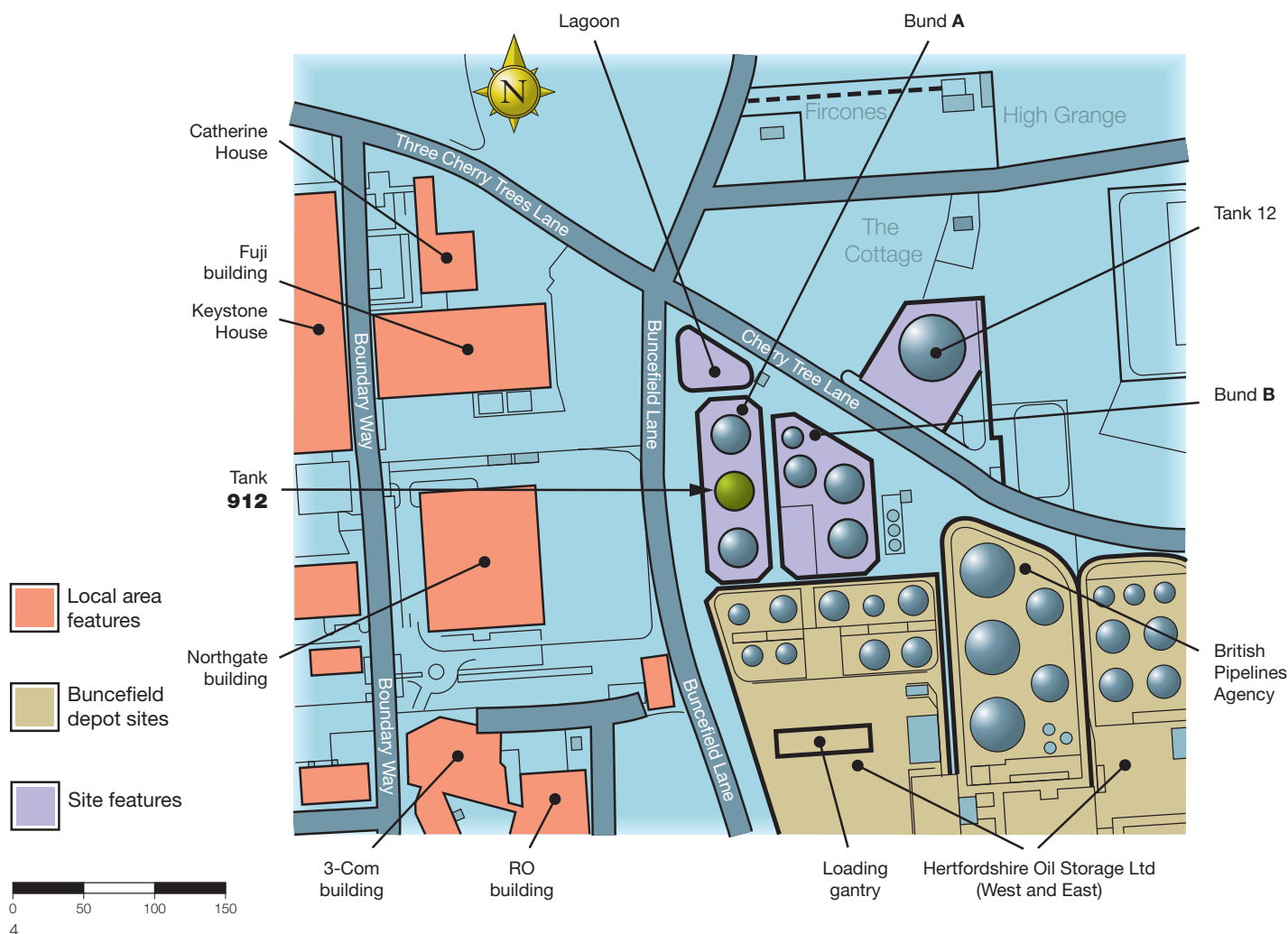
Introduction

1 This report describes where and how fuel escaped from storage at the Buncefield Oil Storage Depot on 11 December 2005 and how it vaporised, forming a flammable mixture that subsequently ignited at around 06.00 that morning with devastating consequences. It summarises the work carried out to analyse the electronic records that were recovered from site and experimental work undertaken by the Health and Safety Laboratory (HSL) to explain what happened to the fuel after it was released. So the heart of this report is a narrative, setting out the sequence of events leading up to the explosions.

2 For the complete picture of what is now known, this report should be read in conjunction with its predecessors, the details of which are not repeated here (see www.buncefieldinvestigation.gov.uk). The first progress report, published on 21 February, described in some depth the incident and emergency response. It concluded that the escape of fuel came from the area around bund A at the north west of the site and set out what was then known about the nature of the explosions and fire. The second progress report, published on 11 April, focused mainly on the environmental impact of the incident, and reported on the failure of some of the bunds to contain the fuel, foam and fire run-off water. It also set out the measures in hand to monitor any potential pollution levels.

3 The values and other data presented in this report are subject to ongoing rechecking as is usual in an investigation of this kind. They are presented as indicative and should be used in that context.

Figure 1 Layout of depot and surroundings



Timeline of events

10 December 2005

Around 19.00, Tank 912 in bund A at the HOSL West site started receiving unleaded motor fuel from the T/K South pipeline, pumping at about 550 m³/hour (flow rates are variable within limits).

11 December 2005

At approximately midnight, the terminal was closed to tankers and a stock check of products was carried out. When this was completed at around 01.30, no abnormalities were reported.

From approximately 03.00, the level gauge for Tank 912 recorded an unchanged reading. However, filling of Tank 912 continued at a rate of around 550 m³/hour.

Calculations show that at around 05.20, Tank 912 would have been completely full and starting to overflow. Evidence suggests that the protection system which should have automatically closed valves to prevent any more filling did not operate.

From 05.20 onwards, continued pumping caused fuel to cascade down the side of the tank and through the air, leading to the rapid formation of a rich fuel/air mixture that collected in bund A.

At 05.38, CCTV footage shows vapour from escaped fuel start to flow out of the north-west corner of bund A towards the west. The vapour cloud was about 1 m deep.

At 05.46, the vapour cloud had thickened to about 2 m deep and was flowing out of bund A in all directions.

Between 05.50 and 06.00, the pumping rate down the T/K South pipeline to Tank 912 gradually rose to around 890 m³/hour.

By 05.50, the vapour cloud had started flowing off site near the junction of Cherry Tree Lane and Buncefield Lane, following the ground topography. It spread west into Northgate House and Fuji car parks and towards Catherine House.

At 06.01, the first explosion occurred, followed by further explosions and a large fire that engulfed over 20 large storage tanks. The main explosion event was centred on the car parks between the HOSL West site and the Fuji and Northgate buildings. The exact ignition points are not certain, but are likely to have been a generator house in the Northgate car park and the pump house on the HOSL West site.

At the time of ignition, the vapour cloud extended to the west almost as far as Boundary Way in the gaps between the 3-Com, Northgate and Fuji buildings; to the north west it extended as far as the nearest corner of Catherine House. It may have extended to the north of the HOSL site as far as British Pipelines Agency (BPA) Tank 12 and may have extended south across part of the HOSL site, but not as far as the tanker filling gantry. To the east it reached the BPA site.

Part 1 Loss of fuel containment

1.1 Overview of Buncefield operations

4 Fuel products were supplied by three discrete pipeline systems:

- 10" pipeline (FinaLine) from Lindsay Oil Refinery on Humberside, which terminates in the HOSL West site;
- 10" pipeline from Merseyside via Blisworth, (M/B North), which terminates in the BPA's Cherry Tree Farm site;
- 14" pipeline from Thameside via a tee junction close to the site – the Hemel Tee (T/K South), which terminates in the BPA main site.

5 The three pipelines all operated in a similar way by transporting fuel oils and motor spirit in discrete batches, of known volume, under pressure. These batches were separated by an interface or buffer, which are small amounts of mixed product. The volume of this interface mix varies dependant on the flow rate and operating conditions prevalent while the product batches are being transported through the pipeline.

6 On arrival at site, the batches of product were diverted into dedicated tanks for each product type. The interface mix when it entered the site system, being a mix of two products, was either re-injected in small quantities into the large tanks of specific product if the product specification allowed, or it was transported back to a refinery as 'slops' for reprocessing.

7 The fuel stored in the tanks at Buncefield was then either transported off site in road tankers for distribution, or in the case of the majority of aviation fuel, via two BPA-operated 6" pipelines to London airports.

1.2 The escape of fuel

8 Evidence from CCTV footage reported in the first progress report pointed clearly to the vapour mist emanating from bund A on the HOSL West site. The investigation has therefore concentrated on finding out how the site was operating in the crucial period leading up to the explosion and what was happening in the vicinity of bund A.

9 At the time of the incident, approximately 06.00 on 11 December 2005, the pipelines were transporting the following products into the HOSL West site:

- FinaLine was delivering unleaded petrol at a flow rate of approximately 220 m³/hour into Tank 915 at HOSL West (also in bund A);
- M/B North line was delivering diesel oil at a flow rate of approximately 400 m³/hour into Tank 908 in bund D;
- T/K South line was delivering unleaded petrol at a flow rate of approximately 890 m³/hour into Tank 912.

10 All reasonable avenues of investigation have been and continue to be explored but information obtained to date allows stating with some confidence that the initial loss of containment occurred from Tank 912 in bund A, and that this was most likely due to an overfill of unleaded petrol.

11 In order to appreciate the way the fuel escaped, it is important to understand how the tank and its control and instrumentation systems functioned at the time.

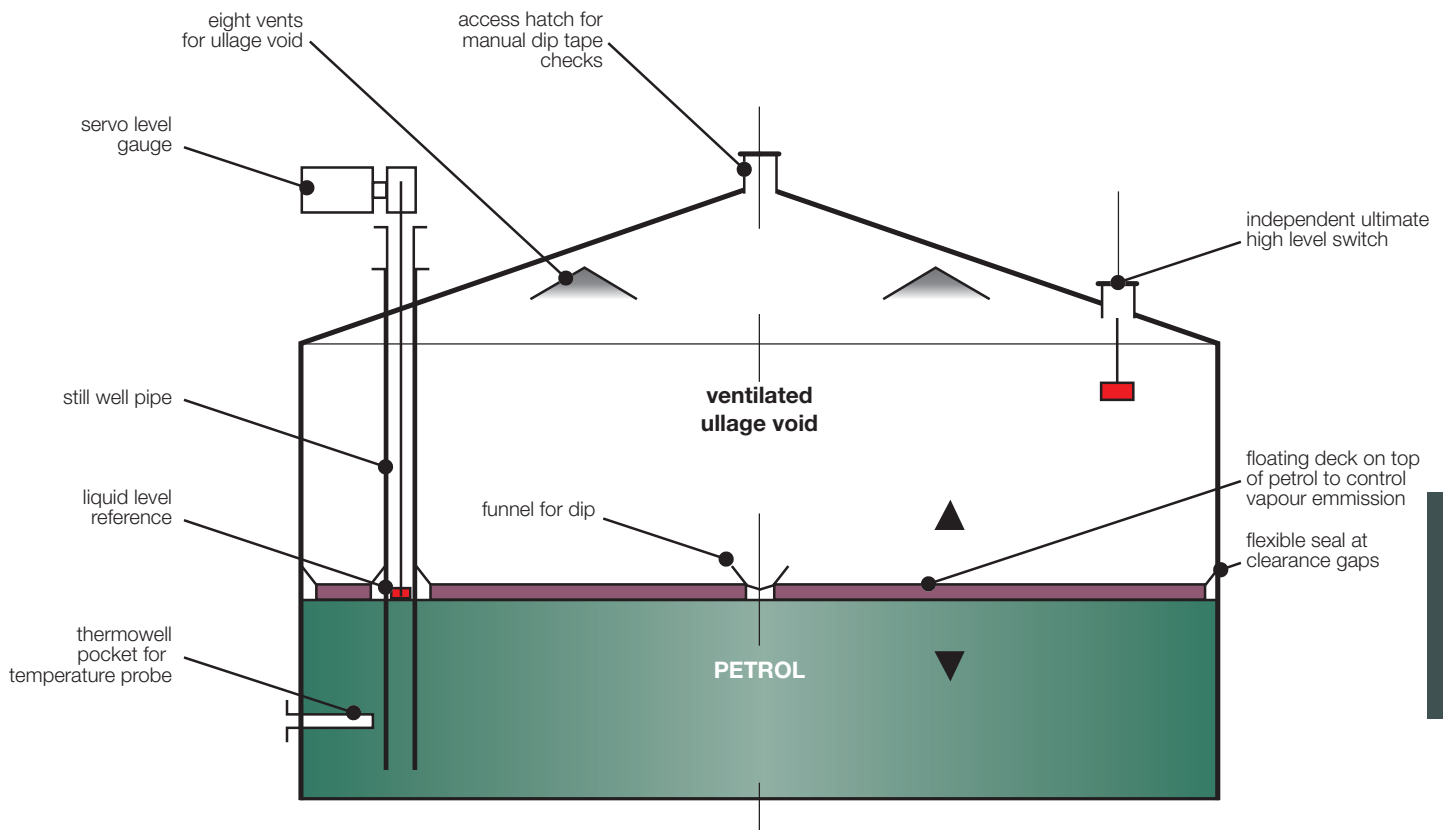


Figure 2 Basic layout of Tank 912

12 Figure 2 depicts the basic layout of Tank 912. This was a floating deck tank whereby in addition to the fixed roof, there is a deck inside the tank which floats on the fuel, thus minimising the emission of vapour from the fuel surface.

1.3 Instrumentation and control systems

13 Tank 912 was fitted with instrumentation that (among other things) measured and monitored levels and temperatures of the liquid in the tank. The instruments were connected to an automatic tank gauging (ATG) system in common with all the other tanks on the site. Tank levels were normally controlled from a control room using the ATG system.

14 A servo level gauge measured the liquid level. The temperature of liquid in Tank 912 was measured using a temperature sensor.

15 The ATG system enabled the operator to monitor levels, temperatures and tank valve positions, and to initiate the remote operation of valves all from the control room on HSOL West site. The ATG system was also able to trend data and had an event logging system, integrated with the alarm system. The ATG contained a large database which recorded levels, temperatures, alarms, valve positions, and other related information indexed against times and dates for a user-configurable period, which can be several months. The records from this database are providing valuable information for the investigation.

16 The tank also had an independent safety switch, which provided the operator with a visual and audible alarm in the control room when the level of liquid in the tank reached its specified maximum level (the 'ultimate' high level). This alarm also initiated a trip function to close valves on relevant incoming pipelines. The ultimate high level safety switch on the tank sensed when the liquid reached its specified maximum level, should all other alarms and controls fail to prevent this. Its purpose was to provide an alarm to operators in the control room and to initiate automatic shutdown of delivery once the maximum level was reached. The switch was intended to alert the control room operator via a flashing lamp (one for each tank) and an audible buzzer. In addition, the ultimate high level safety switch alarm signal from any overflowing tank in HOSL West would be sent to computer control and instrumentation relating to both the FinaLine and BPA pipelines.

17 When the BPA site received an alarm/trip signal from the HOSL West site, the BPA computer control system should have closed the relevant pipeline manifold valve feeding in product to the tank(s) on the HOSL West site. BPA also had a high-level supervisory control and data acquisition (SCADA) system, which had the facility for alarm and event logging both locally at Buncefield and remotely at the BPA control centre at Kingsbury, Warwickshire.

18 An override keyswitch in the HOSL West control room could be used to inhibit the alarm/trip signal to BPA during testing of the ultimate high level safety switches. Putting the keyswitch in the override position would illuminate a red lamp on the annunciator panel.

1.4 Evidence from control systems records

19 Examination of the records for Tank 912 from the ATG system suggest an anomaly. A little after 03.00 on 11 December, the ATG system indicated that the level remained static at about two thirds full. This was below the level at which the ATG system would trigger alarms.

20 However, the printouts from the BPA SCADA systems indicate that the T/K South line was delivering a batch of 8400 m³ of unleaded petrol, starting around 19.00 the previous evening (10 December). The delivery was being split between Tank 912 at the HOSL West site and BPA's site at Kingsbury, giving a flow rate to Tank 912 of around 550 m³/hour. These SCADA printouts further indicate that approximately seven minutes before the incident, the Kingsbury line was closed, leading to a sharp increase in the flow rate to Tank 912 to around 890 m³/hour.

21 At the time of the incident, automatic shutdown did not take place.

22 Examination of the valve positions shown by the ATG database confirm that the inlet valve to Tank 912, which was connected to the BPA petrol manifold, was open at the time of the incident. Based on this evidence, it is concluded that Tank 912 was still filling after 03.00.

23 Temperature records also provide evidence that the inflowing fuel was warmer than the tank contents. Records for Tank 912 show the tank temperature continuing to rise after 03.00, supporting the above conclusion that the product was still feeding into the tank from the pipeline.

24 The evidence to date is consistent with continued filling of Tank 912 after 03.00, despite the ATG system showing a static level reading. On the basis of calculations, Tank 912 would have been completely full at approximately 05.20, overflowing thereafter. This timing is entirely consistent with CCTV evidence and eyewitness accounts reporting on a dense vapour cloud at various times between 05.38 and 06.00. The overflow of unleaded petrol would therefore have been in the order of over 300 tonnes by 06.00.

1.5 Alarm systems testings

25 Simulation of the ultimate high level tank alarms (from the relevant electrical substation on site) and tests on the annunciator panel and the link to BPA prove that they worked normally. Tests on the override switch found that it had no effect on the audible and visual alarms from the annunciator, but it did, when switched to override, inhibit the alarm/trip signals being sent to BPA.

26 Information from the BPA SCADA system indicates that no ultimate high level alarm was received from HOSL West, but it has not been possible to test the ultimate high level safety switch or intervening wiring between Tank 912 and the substation, as they have been damaged in the fire. However, the switch has very recently been located, but it has not yet been possible to recover it. When it is, it will be subject to forensic examination.

Part 2 Creation of the vapour cloud

2.1 Liquid behaviour during overfilling

27 The investigation considered the effect of the floating deck arising from overfilling of Tank 912. This deck is constructed from relatively lightweight alloy tubes. It is unlikely that the integrity of the tank would have been breached when this floating deck became pressed up against the top of the tank by the rising liquid. Drawings of it show several places where fluid could flow upwards through it with minimal backpressure. These locations include freely hinged man-ways, the dip-tube diaphragm and the accommodation plate around the level gauge pipe.

28 Therefore overfilling of Tank 912 would have resulted in flow from the breather holes at the top of the tank. There were eight of these, each triangular in section with an area of 0.07 m^2 , as can be seen in Figure 3 which is a photograph of one of the tanks in bund A taken shortly after construction.

Figure 3 Tank top details before the incident



29 CCTV records from the HOSL West site show the first appearance of a mist from Bund A at about 05.38, supporting the view that the overflow began at around 05.20. For most of the time between the onset of loss of containment and ignition, the flow rate from vents would have been around 550 m³/hour. Approximately seven minutes before the incident, shutting down of the flow from the BPA line to Kingsbury led to a sharp increase in the rate of delivery to Buncefield with a corresponding increase in the overflow rate.

30 To simulate a loss of containment from Tank 912, a full-scale model of one eighth of the whole tank top, including one of the breather vents, has been built at HSL in Buxton, Derbyshire (see Figure 4). It includes a 'deflector plate' at the edge of the tank top, visible in the third and fourth pictures in Figure 4. The original plate was designed to direct water from sprinklers on the top of the tank onto the sides of the tank to provide cooling in the event of fire engulfment. Liquid running off the top of the tank strikes this plate and is directed back onto the side of the tank.

31 Considerable work has been carried out on this model, pumping water through the breather hole at a flow rate equivalent to 550 m³/hour for an entire tank top. These flows are sufficiently high that differences in viscosity and surface tension between water and petrol will make little difference to the results as regards observing initial flow behaviour.

Figure 4a-d Liquid flow from the breather holes on the tank top



Figure 4a



Figure 4b

32 These tests demonstrate that the deflector plate was effective in channelling the majority but not all of the liquid onto the tank wall, but only spread it laterally over approximately one third of the wall. Images captured from video records are shown in Figure 4.

2.2 Generation of hydrocarbon-rich vapour

33 The differences in physical characteristics between water and petrol become more important for processes of droplet formation and additional work with petrol will be needed to investigate the subsequent behaviour of the escaped fuel. These tests are therefore a less reliable indicator of behaviour. However, it seems likely that the proportion of the liquid flowing over the top of the deflector plate will not reattach to the wall. This free cascade of liquid will naturally divide into small droplets.

34 Much of the liquid directed back to the wall by the deflector plate will hit the wind girder which can be seen running round the tank about a third of the way down in Figure 3. It is likely that this liquid flow will be further fragmented on impact with this girder to form a second free cascade.

35 There would be an impact zone in the bund where there is further splashing of falling liquid. There is also likely to have been a vigorous mixing of the heavy downward vapour flow with air.



Figure 4c



Figure 4d

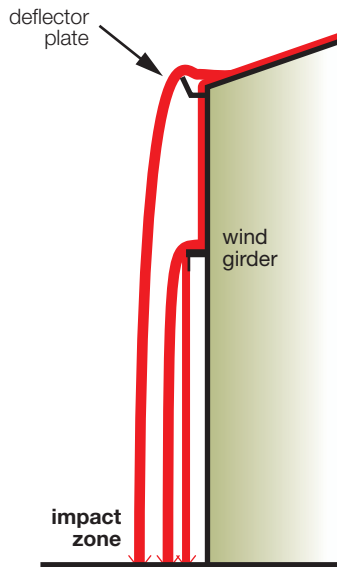


Figure 5 Liquid flow during overfilling of a tank with deflector plate and wind girder

36 The general features of these processes during an overflow are illustrated schematically in Figure 5.

37 The conclusion of this work is that the flow is likely to be very efficiently fragmented, and would create relatively small droplets falling freely through air around the tank. These conditions would promote the evaporation of the lighter chemical components of petrol, eg butanes, pentanes and hexanes.

38 The free fall of fuel droplets through the air also leads to entrainment of air and mixing between the air and fuel vapour. Calculations based on a simplified composition of unleaded petrol suggest that the ambient air already at 0 °C and fully saturated with water vapour, would have cooled below zero by a further 7-8 °C from fuel evaporation. As a result, roughly half the initial water content of the air would precipitate as an ice mist, and this mist would persist even as the vapour is diluted. This is consistent with the cloud of mist highly visible on CCTV cameras. It supports the contention that the mist can be used as an indicator for determining the size of the fuel/air vapour mixture created by the overfilling and how it was dispersed.

2.3 Dispersion of vapour

39 Aerial pictures of the site have confirmed preliminary conclusions about the extent of the burn damage shown in Figure 5 of the first progress report. This is also shown by the dotted line in Figure 6. This is indicative of the extent of the flammable vapour cloud.

40 As described in the first progress report, eyewitness accounts and CCTV footage show a white mist or thick fog on the north and west sides of the HOSL West site, spreading out from bund A (around Tanks 910, 912 and 915). By the time of the main explosion, the edge of this cloud had almost reached Boundary Way to the west of bund A and wisps of mist had just started to arrive at the tanker loading gantry to the south. To the north, it had flowed beyond Cherry Tree Lane. To the east, the mist can be seen on CCTV at the BPA site, but not further east at the

Figure 6 Extent of burn damage (indicated by dotted line)



HOSL East site. This is a little way beyond the extent of the burn damage shown in Figure 6. According to witnesses, the depth of the visible mist varied from about 1 m in the area between bund A and the loading gantry to between 5 and 7 m in Three Cherry Trees Lane.

41 In addition to defining the overall extent and location of the flammable vapour cloud, dispersion modelling is being used to analyse how concentrations of hydrocarbons vary within the cloud. In the meantime some features of dispersion of the hydrocarbon-rich vapour can be deduced from observations of burn damage at the site. Figures 7 and 8 illustrate this.

42 The telegraph pole shown in Figure 7 is in Buncefield Lane relatively close to the wall of bund A containing Tank 912. The bottom part of the pole shows soot blackening, characteristic of objects exposed to burning of a very rich vapour mixture. Video records of the fire confirm that this area was not affected by the smoke plume during the fire.

43 The tree trunk in the Northgate car park shown in Figure 8 is much further from the site and has been exposed to an explosion propagating in a more dilute vapour mixture with a composition close to the optimum for complete combustion. There is no soot on exposed surfaces but the left-hand side facing the camera has been deeply abraded by grit driven into it at high speed by the explosion. Examples of this kind of damage were found across most of the area covered by the Northgate and Fuji car parks.

44 Such observations of burn damage support the conclusion that additional air mixed with the rich vapour as it flowed out across the Northgate and Fuji car parks. This reduced the vapour concentration to the point where it could support an explosion.

Figure 7 A telegraph pole in Buncefield Lane, showing sooting on lower half



Figure 8 Part of a tree trunk in the Northgate car park showing abrasion



Part 3 The explosions

3.1 Description

45 From analysis of seismic records, the British Geological Survey (BGS) has calculated that the main explosion occurred at 06.01:32. Eyewitness accounts and media reports refer to a very large explosion followed by a number of lesser ones. The other explosions were not detected seismically, confirming that they were significantly smaller than the main explosion. Because of this it is not possible to say how many smaller explosions occurred, or much about their timing. The first of the smaller subsequent explosions was probably some minutes after the main explosion and probably all occurred within about half an hour. It cannot be ruled out that there were one or more smaller explosions immediately before the main explosion.

46 The delay of some minutes between the main and subsequent explosions suggests the latter were more likely to be due to internal tank explosions or further release of fuel from damaged tanks and pipework, rather than further explosions of parts of the vapour cloud.

47 For instance, part of a tank roof believed to come from Tank 910 in bund A was found in the Northgate car park. This is consistent with an internal explosion in the tank. It is understood that this tank was empty of liquid fuel and not in use at the time. Internal explosions in other empty tanks or tank ullage spaces could have accounted for the remaining explosions.

3.2 Ignition sources

48 The dispersion of vapour mixture is described earlier in Part 2.3. The extent of the visible mist cloud by the time of the main explosion very closely matches the extent of visible burning to vulnerable surfaces. Within this extensive area of about 80 000 m² there would have been a number of potential ignition sources. It is not possible to identify the ignition source for this explosion with any degree of certainty, because of the resulting destruction of evidence. However, there are some potential candidates.

49 There is some evidence of an internal explosion in the fire pump house, located on the east side of the lagoon on the HOSL West site. This is indicated by the doors, which are the only remaining part of the cladding. The left-hand door has been blown open, and the top half of the right-hand door folded outwards. It is believed that the pumps should have started when the emergency fire alarm was activated just before the explosion occurred.

50 There is also evidence of an internal explosion in the emergency generator cabin located on the south side of the Northgate Building. It is understood that there were thermostatically controlled heaters in the cabin and the air intakes for the diesel generator would have allowed vapour to enter the cabin. If the heaters were switched on, the spark generated at any electrical contacts would have been capable of igniting a surrounding flammable atmosphere. Like the pump house, the venting of an internal explosion within the generator cabin would have also been a very powerful ignition source.

51 Car engines are another potential source. A number of witnesses describe how their cars began to run erratically. For at least one vehicle in Three Cherry Trees Lane, the engine continued to race even after the ignition had been turned off and the driver had left the vehicle.

52 Other sources of ignition cannot be ruled out, given that off site there would have been no precautions in place to control ignition sources. There is also the possibility that there were near-simultaneous ignitions at a number of locations.

3.3 Explosion development and magnitude

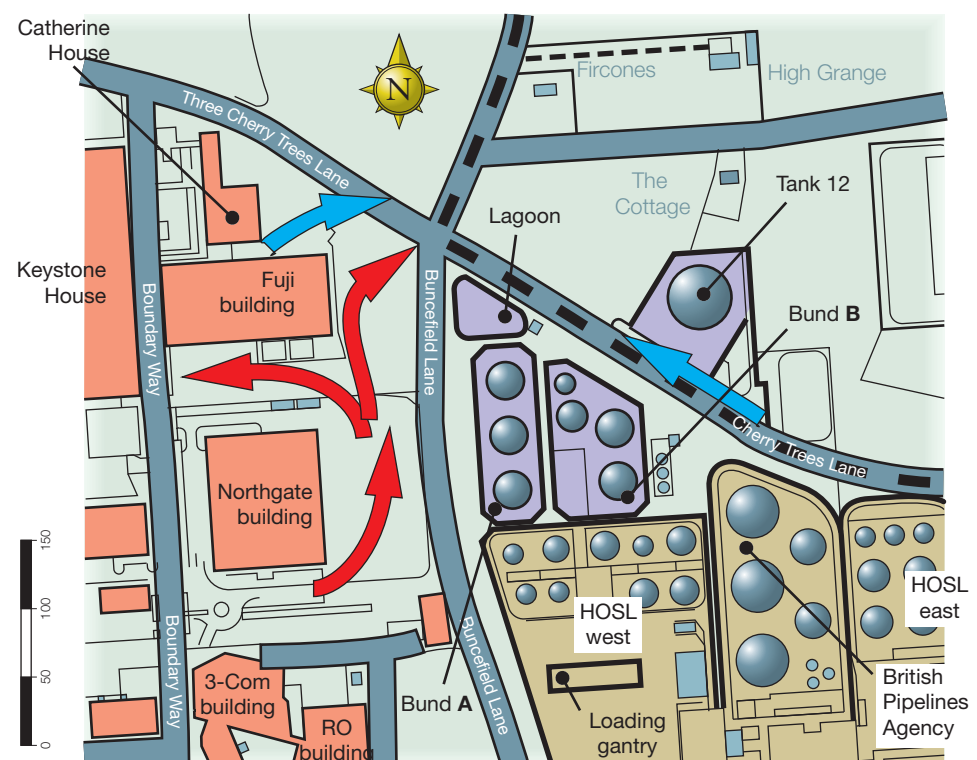
53 A preliminary assessment of the blast damage has been carried out. Estimates have been made of the overpressures required to cause the observed damage, based on the published tables derived from wartime bomb damage and solid explosive and nuclear bomb testing. Due to the very different characteristics of a blast wave produced by a vapour cloud explosion, there is considerable uncertainty in the estimated overpressures, and work is ongoing to resolve these uncertainties. But it is clear from a purely qualitative assessment of the damage that the highest overpressures were generated in the area of the Northgate and Fuji car parks.

54 Subject to these uncertainties, the current best estimates of the overpressures are of the order of:

- 700–1000 mbar in the Northgate and Fuji car parks, leading to extensive damage to adjacent buildings;
- decaying to 7–10 mbar at 2 km distant, causing breakage of some windows in local homes and premises.

55 The magnitude of the overpressures generated in the open areas of the Northgate and Fuji car parks is not consistent with current understanding of vapour cloud explosions. For example, a method in current usage would predict overpressures in this sort of environment of 20–50 mbar. The investigation has, so far, been unable to establish why the ignition of the vapour cloud and the explosion propagation in the relatively uncongested environment of the adjacent car parks caused significant overpressures that produced the severe damage to property.

Figure 9 Showing main and secondary explosion propagation



56 Furthermore there is evidence, from erosion/abrading on just one side of posts and tree trunks, of a powerful explosion having propagated northwards across the Northgate and Fuji car parks, as shown in Figure 8. The movement of objects like fence posts, tree branches etc indicate explosions of lesser magnitude having propagated through other areas bordering on the Buncefield site. The directions of explosion propagation are shown on Figure 9. The main explosion propagation is shown in red with secondary effects in blue.

Part 4 Environmental monitoring

4.1 Air quality and health surveillance

57 The second progress report explained that the Department for Environment, Food and Rural Affairs (DEFRA) is planning to publish a report on *Initial review of air quality aspects of the Buncefield Oil Depot explosion* in May, and this is still the case. The Health Protection Agency (HPA) is also closely involved with this work. DEFRA and HPA are continuing to keep the Investigation Board informed of progress with their findings.

4.2 Water quality monitoring

58 In the period from 12 December 2005 and up until 19 April, 125 river water samples and 76 ground water samples have been taken as part of a monitoring programme. On site, 190 solid and liquid samples from bunds, tanks, boreholes, lagoons and outfalls have been taken.

59 These samples were monitored for fuels and fire-fighting foam, or other chemicals which act as indicators for them. The indicators for foam include fluoro-surfactants including perfluorooctane sulphonate (PFOS) and zinc.

4.3 Ground water monitoring

60 Ground water and ground water abstraction boreholes have been monitored up to 9 km from the site, including six pumping stations operated by Three Valleys Water Company. Private boreholes have been sampled in a wider survey of the ground water for contamination, but not as part of the routine programme.

61 Three new observation boreholes have been drilled closer to the Buncefield site to provide an early detection of any ground water pollution: Butlers Farm (between Buncefield and Bow Bridge pumping station); Breakspear House (south of Buncefield) and Hogg End Lane (on the east boundary of Buncefield). This is part of an ongoing regime of monitoring that will provide further boreholes in the vicinity of the site.

62 In addition to the observation boreholes, two new ones have been installed in the vicinity of Tank 12, in the northern part of the site, to determine the level of ground water and any contamination. The first of these has been installed adjacent to the Cherry Tree Lane deep road drain. A second new borehole has been installed to the north west of Tank 12, which is believed to be upstream of the Cherry Tree Lane road drain.

63 The location of the monitoring borehole network was provided in the second progress report.

Results of ground water monitoring

64 Some results from the samples, taken from the ground water monitoring network, have shown very low levels of PFOS. Follow-up samples however, have not always shown PFOS to be still present. It is therefore not possible to draw conclusions as to the extent and origin of the PFOS. Further monitoring is continuing to establish if the results are directly attributable to the incident.

65 The Drinking Water Inspectorate (DWI) has established an advisory level for PFOS in drinking water of no greater than 3 micrograms/litre. This advice follows consultation with health professionals at HPA. HPA has stated that: 'It appears unlikely that a lifetime's consumption of drinking water containing concentrations up to 3 micrograms/litre would harm human health'. In all cases, the levels at which PFOS has been detected has been below this advisory level.

66 Fuel products, fuel-related contaminants and surfactants have been detected in soakaways, boreholes and chambers in the verges of Cherry Tree Lane.

67 Latest results suggest that the fuels and fire waters that formed a large pool in Cherry Tree Lane during the incident have passed into the deep road drain, and from there into the underlying water table. The extent of the movement of this pollution off the site will be the focus for the continuing investigations.

68 Work is continuing to characterise the contaminants found to establish if they relate to the loss of containment during this incident.

4.4 Surface water

69 Extensive sampling of surface water around the site continues to assess the environmental impact of the incident. The samples have been sent to Environment Agency laboratories around the country for analysis.

70 Monitoring of surface water has concentrated on the River Ver as it received surface water from the Buncefield site. Two balancing tanks which provided a buffer to prevent uncontrolled surges of water, known as the Maylands and Redbourn lagoons, received surface water from the site and the surrounding area. These tanks subsequently discharged into the River Ver and River Red respectively.

71 The River Ver was monitored daily in the first two weeks after the incident. Two sites were tested, one upstream and one downstream of the Maylands' tank outfall. Additionally, the balancing tanks and outfalls were subject to daily sampling and analyses. The initial focus was directed to oil contamination and fire-fighting foam, which could have caused oil pollution and as the foam degraded, oxygen depletion. This could have impacted on the ability of fish and other organisms to live in the river.

72 Two additional monitoring sites were sampled routinely on the River Ver at the end of December, downstream of St Albans, 7 and 11 km downstream of the Maylands' outfall.

73 These sites were sampled for oils and fluoro-surfactants such as PFOS.

Results of surface water monitoring

74 No direct impact of the loss of containment was found in the first days after the incident. By the third day of the incident, low concentrations of PFOS were noted in the balancing lagoons, at the Maylands' outfall and in the River Ver downstream of the outfall. In addition, there was an increase in zinc levels above background concentrations (zinc is often used together with PFOS in fire-fighting foams).

75 PFOS concentrations started to drop in the River Ver in the middle of January, one month after the incident, to below detectable levels in February. Occasionally, low concentrations of surfactants are found in the River Ver. The flow of water from the Maylands' outfall stopped in February. The Redbourn outfall started to flow in February, with low concentration of PFOS, feeding into the River Ver. The Maylands' tank contains low PFOS concentrations. Results to date indicate the levels to be generally below the DWI advisory limit (3 micrograms/litre).

76 PFOS has been identified at all monitoring points, including during a survey on the River Colne. The PFOS concentrations, however, have not exceeded the DWI advisory limit and no identifiable environmental consequences have been observed in the river habitat. More recently, fluoro-surfactants (other than PFOS), which may be associated with fire-fighting foam, have been detected in the river at low concentrations.

4.5 Impact on the environment and drinking water

77 Although there have been elevated levels of surfactants and other contaminants found in the surface waters in the proximity of the Buncefield site, there has been no evidence (to date) of an adverse impact to the environment. The results from the monitoring to date are below levels that would cause concern to the health of humans or wildlife. Monitoring will continue for the foreseeable future.

78 Public drinking water supply in the area is the responsibility of Three Valleys Water Company, which has the detailed operational knowledge required to manage the local response. The regulation of public drinking water quality is the responsibility of DWI. Both Three Valleys Water Company and DWI are working closely together to ensure that drinking water supplies remain of the highest quality.

79 The monitoring boreholes that have shown evidence of fuel and fire water contamination are not used to abstract water for drinking water purposes. The nearest drinking water abstraction point operated by Three Valleys Water Company, some 3 km from the Buncefield site, has not been used for abstraction since the incident in December.

80 The purpose of the Environment Agency monitoring is to determine the severity and extent of ground water contamination and advise on any remediation that may be necessary. The Environment Agency is in regular contact with Three Valleys Water Company and should there be evidence that pollution is migrating towards any of its abstraction boreholes, the Environment Agency will advise Three Valleys Water Company so that they can put in place appropriate measures to safeguard the quality of drinking water supplies.

4.6 Disposal of contaminated fire waters

81 The contaminated fire waters have been removed from the site and are being safely stored at a number of sites around the country. The largest single storage site is at the Thames Water Maple Cross Sewage Treatment Works.

82 The fire waters are a mixture of water, oils and fire-fighting foam.

83 The oil companies are responsible for the safe disposal of the fire waters. They are continuing to investigate suitable techniques. The Environment Agency is responsible for ensuring that any proposals will provide proper protection of the environment.

84 The current storage does not present a significant environmental risk and measures are in place to protect the environment.

85 In response to the significant loss of primary and secondary containment after the incident, the Environment Agency issued specific advice to its officers to ensure that operators have assessed and provided suitable containment, primarily bunding (secondary containment) at fuel depots over the next three months. Some of these investigations will take place at the same time as Competent Authority (HSE and Environment Agency) investigations, following the safety alert issued to industry by HSE following publication of the first progress report (see www.buncefieldinvestigation.gov.uk). A copy of the Environment Agency advice is at Annex 1.

Part 5 Continuing business and community issues

86 Both local residents and businesses affected by the incident continue to face a variety of difficulties.

87 At this time a number of residents have still not been able to return to their homes. The continuing uncertainty about the future of the depot is a cause of anxiety and stress to those living in the area. Businesses and residents are also concerned to know the root causes of the explosions and fires as soon as possible.

88 Investigation Board members met the Maylands Business Network in April, to listen to views and concerns of the local business community. Some businesses continue to have challenging operating conditions and face difficult decisions about whether to reinstate their premises.

89 According to a recent report, around 100 official redundancies have occurred since December, although it is likely that further jobs have been lost but have been unreported. A variety of agencies are working towards the recovery of the area. The Maylands Task Force, a group of key business leaders and local agencies, is seeking to rejuvenate and develop the area. A number of high profile companies have committed to remain while longer-term decisions about whether to rebuild their previous buildings are made.

90 In late May, Board members will be meeting with local residents in Adeyfield, and follow-up meetings with residents at Woodhall Farm and Leverstock Green will be arranged in the near future. In June, Board members will be represented at the Young People's Forum to hear the views and concerns of local school children.

Part 6 The continuing Investigation

91 The investigation team will continue investigation of the computer records and testing and examination of the wiring and instrumentation circuits that remain after the fire. In particular, the team wish to establish why the safety switch and associated trip instrumentation of Tank 912 did not prevent an overfill. The team will then be looking at factors that may have contributed to any underlying causes to the incident.

92 Additional work will be carried out at HSL to measure what proportion of the liquid flows over the deflector plate and what proportion is brought back to the wall, and to investigate other factors associated with vapour cloud formation and dispersion.

93 Further detailed work is still being considered in order to ascertain why the ignition of the vapour cloud and explosion propagation in the relatively uncongested environment of the adjacent car parks caused significant overpressures that produced the severe damage to property.

94 Investigations into the loss of control of the fuel in Tank 912 continue apace.

95 The evidence obtained to date supports the initial conclusions regarding the physical process and the mechanisms that led to the explosions, while not yet understanding why the main explosion was so violent. Term of Reference 5 requires recommendations to be made for future action to ensure the effective management and regulation of major accident risk at COMAH sites. The investigation is in a position, subject to ongoing inquiries, to direct attention to the effective management and regulation of both the on-site and off-site major accident risks presented by such sites. This work will include the prevention of incidents, preparation for response to incidents, and mitigation of their effects. The investigation will pursue those issues in order to assist the Investigation Board to make its Initial Report to the Health and Safety Commission and the Environment Agency in line with its Terms of Reference.

Annex 1

Memo to Area PIR Team Leaders from Martin Bigg, Head of Industry Regulation, Environment Agency dated 10 April 2006

BUNCEFIELD INVESTIGATION UPDATE – 11 April 2006
ENVIRONMENT REVIEW AT OIL/FUEL STORAGE SITES

Introduction

On 11 April 2006 the Buncefield Major Incident Investigation Board (BMIIIB) will publish its second progress report on the investigation. This memo identifies actions to be taken by Environment Agency staff with responsibility for the regulation of oil/fuel storage sites under the COMAH Regulations.

At this stage nothing can be said in relation to the causes leading to the loss of primary containment. Some information relating to issues of secondary and tertiary containment will be made available, though it is recognised that not all the details, which would be normally be used to inform inspections, will be available.

Given this situation, at this stage, our actions should be limited to a basic risk assessment of the secondary and tertiary containment measures across the sector, with the aim of identifying those sites with obvious basic deficiencies. This basic risk screening will inform further inspection and actions when conclusions from the Buncefield investigation are known.

Second progress report

In summary the BMIIIB second progress report raised the following points regarding secondary and tertiary containment:

Secondary containment

- While the concrete bunds substantially remained standing, their ability to contain fuel and fire water was lost due to damage to the sealant in the construction and expansion joints;
- sealant around penetrating pipework was also lost resulting in leakage;
- seepage through the walls of the concrete bunds also occurred; and
- the concrete panels forming the floor of the bunds underwent significant heave, opening up holes and cracks which acted as a pathway for fuel and fire water into the environment.

Tertiary containment

- Following loss of containment, fuel and fire water found numerous pathways into the environment. These included a number of shallow boreholes and one deep borehole within the site and flow across site roadways and overtopping of kerbs onto public roads and consequent escape via surface water gullies.

Implications for the programme of sector inspections

The key issues to be addressed by Environment Agency staff within the next three months are listed below. Where inspections have already taken place, either by joint teams of inspectors from the HSE and the Environment Agency or unilaterally by either, please review the findings of these inspections against the key issues.

- Are the tanks holding oil/fuel within a bund or bunds of such integrity that they would contain any leak of the tank and fire water, and prevent loss including into the ground?

- Is the bund capacity at least 110% of largest tank in the bund or at least 25% of all the tanks in the bund?
- Is the bund capable of holding the significant volumes of imported fire water used during an incident for either direct fire fighting and/or cooling of adjacent tanks?
- Is the bund design sufficiently robust to remain serviceable following a pool fire that may last for a considerable period of time? This assessment should take account of whether sealants¹ and waterstops² have been used as part of the construction and expansion joints.
- Is there any pipework penetrating the bund which could cause the containment to fail including when subject to fire?
- Given that pumps and powered valves will be lost if site power is lost due to fire or explosion, the behaviour of liquids flowing under gravity should be considered. This includes the loss of liquids from secondary containment. Has a study been made of the directions and volumes of flow and are provisions in place to contain these liquids within the boundaries of the site?
- Has an assessment been made of drainage paths to the environment and are the plans available to the off-site emergency response teams? This should include all on-site and near-off-site drainage and its relationship to the surface water systems, geology and hydrogeology.

Please contact Mark Maleham (Tel: 0117 914 2813) if clarification is required.

Martin G Bigg

Head of Industry Regulation

- 1 British Standard BS 6213: 2000 *Selection of construction sealants. Guide* (First published May 1982 Second edition July 2000) British Standards Institution ISBN 0 580 33168 7
- 2 Waterstops are preformed strips of durable impermeable material that are wholly or partially embedded in the concrete during construction. BS 8007: 1987 *Code of practice for design of concrete structures for retaining aqueous liquids* British Standards Institution ISBN 0 580 16134 X

Annex 2 Further information

Useful links

Buncefield Investigation

Buncefield Major Incident Investigation
Marlowe Room, Rose Court
2 Southwark Bridge
London, SE1 9HS
Tel: 020 7717 6909
Fax: 020 7717 6082
E-mail: buncefield.inforequest@hse.gsi.gov.uk
Web: www.buncefieldinvestigation.gov.uk

Business support

Dacorum Business Contact Centre
Tel: 01442 867 805

Business Link Helpline
Tel: 01727 813 813

Hertfordshire Chamber of Commerce
Tel: 01727 813 680

Residents' support

Dacorum Community Trust Mayors' Fund
To apply, call the freephone helpline on 0800 131 3351. Lines are open from
9.30 am – 4.30 pm, Monday to Friday.

Dacorum Borough Council
www.dacorum.gov.uk
Tel: 01442 228 000

Citizens Advice Bureau

Hemel Hempstead Citizens Advice Bureau, based in Hillfield Road, offers free, impartial, practical and confidential advice on a range of subjects.

Local authorities and emergency services

Dacorum Borough Council
www.dacorum.gov.uk
Tel: 01442 228 000

St Albans District Council
www.stablans.gov.uk
Tel: 01727 866 100

Hertfordshire County Council
www.hertsdirect.org
Tel: 01483 737 555

Hertfordshire Fire and Rescue Service
www.hertsdirect.org/yrccouncil/hcc/fire/buncefield

Hertfordshire Constabulary
www.herts.police.uk/news/buncefield/main.htm

Hertfordshire Chamber of Commerce
www.hertschamber.com
Tel: 01727 813 680

Government links

Office of the Deputy Prime Minister
Fire and Resilience Directorate: www.odpm.gov.uk

Government Office for the East of England
www.go-east.gov.uk

Environment Agency
www.environment-agency.gov.uk

Department of Trade and Industry
Oil and Gas Directorate: www.og.dti.gov.uk

Health and Safety Executive
Hazardous Installations Directorate: www.hse.gov.uk/hid
Control of Major Accident Hazards: www.hse.gov.uk/comah

Department for the Environment, Food and Rural Affairs
www.defra.gov.uk

Health Protection Agency
www.hpa.org.uk

Food Standards Agency
www.food.gov.uk

Drinking Water Inspectorate
www.dwi.gov.uk

Industry links

United Kingdom Petroleum Industry Association (UKPIA)
www.ukpia.com
Tel: 020 7240 0289

Chemical Industries Association
www.cia.org.uk
Tel: 020 7834 3399

Other useful sources of information

Dacorum Borough Council *Digest* newsletter, available monthly
Dacorum Borough Council *Buncefield Update* Newsletter

Annex 3 Investigation terms of reference

- 1 To ensure the thorough investigation of the incident, the factors leading up to it, its impact both on and off site, and to establish its causation including root causes.
- 2 To identify and transmit without delay to duty holders and other appropriate recipients any information requiring immediate action to further safety and/or environmental protection in relation to storage and distribution of hydrocarbon fuels.
- 3 To examine the Health and Safety Executive's and the Environment Agency's role in regulating the activities on this site under the COMAH Regulations, considering relevant policy guidance and intervention activity.
- 4 To work closely with all relevant stakeholders, both to keep them informed of progress with the investigation and to contribute relevant expertise to other inquiries that may be established.
- 5 To make recommendations for future action to ensure the effective management and regulation of major accident risk at COMAH sites. This should include consideration of off-site as well as on-site risks and consider prevention of incidents, preparations for response to incidents, and mitigation of their effects.
- 6 To produce an initial report for the Health and Safety Commission and the Environment Agency as soon as the main facts have been established. Subject to legal considerations, this report will be made public.
- 7 To ensure that the relevant notifications are made to the European Commission.
- 8 To make the final report public.

Annex 4 Site maps



Glossary

The Health and Safety Commission (HSC) is responsible for health and safety regulation in Great Britain. The Health and Safety Executive and local authorities are the enforcing authorities who work in support of the HSC. Both are statutory bodies, established under the Health and Safety at Work etc Act 1974.

The Environment Agency is the lead regulator in England and Wales with responsibility for protecting and enhancing the environment. It was set up by the Environment Act 1995 and is a non-departmental public body, largely sponsored by the Department for Environment, Food and Rural Affairs (DEFRA) and the National Assembly for Wales (NAW). The Environment Agency's prime responsibilities include flood risk management, tackling pollution incidents, reducing industry's impact on the environment, restoring and improving rivers, coastal waters, contaminated land, and wildlife habitats. The Environment Agency also advises on sustainable drainage, water conservation and management, planning issues, nature conservation and waste management.

ATG	Automatic tank gauging system
bund	An enclosure designed to contain fluids should they escape from the tank or vessel inside the bund
COMAH Regulations	The Control of Major Accident Hazards Regulations 1999 (COMAH)
COMAH sites	Sites to which the COMAH Regulations apply
Competent Authority	The COMAH Regulations are enforced by a joint Competent Authority comprising HSE and EA in England and Wales, and HSE and the Scottish Environment Protection Agency (SEPA) in Scotland. The Competent Authority operates to a Memorandum of Understanding which sets out arrangements for joint working
containment	Barriers which, in the event of a spill, can prevent spilled materials from reaching the environment
contaminants	Substances that have an adverse effect on air, water or soil
fire waters	A mix of waters, oils and fire-fighting foam
hazard	Anything with the potential to cause harm
hydrocarbon	An organic chemical compound of hydrogen and carbon. There are a wide variety of hydrocarbons such as crude oil (basically a complex mixture of hydrocarbons), methane, propane, butane etc. They are often used as fuels
Northgate	A business whose premises were affected by the Buncefield incident
Overpressure	For a pressure pulse (or blast wave), the pressure developed above atmospheric pressure is called the overpressure
PFOS	Perfluorooctane sulphonate

Prohibition Notice	Issuing Improvement or Prohibition Notices are some of the range of means which enforcing authorities use to achieve the broad aim of dealing with serious risks, securing compliance with health and safety law and preventing harm. A Prohibition Notice stops work in order to prevent serious personal injury
risk	The likelihood that a hazard will cause a specified harm to someone or something
safety reports	The COMAH Regulations require operators of top-tier sites to submit written safety reports to the Competent Authority
SCADA system	High-level supervisory control and data acquisition system
servo level gauge	Measures the liquid level in tanks
ullage	The volume in the tank between the normal maximum operating volume and when the tank is completely full of liquid
wind girder	Structural stiffening ring attached to the tank side wall

BUNCEFIELD MAJOR INCIDENT INVESTIGATION

Initial Report to the Health and Safety Commission and the Environment Agency of the investigation into the explosions and fires at the Buncefield oil storage and transfer depot, Hemel Hempstead, on 11 December 2005

Buncefield Major Incident Investigation Board

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Initial Report to the Health and Safety Commission and the Environment Agency of the investigation into the explosions and fires at the Buncefield oil storage and transfer depot, Hemel Hempstead, on 11 December 2005

Buncefield Major Incident Investigation Board

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Executive summary

The terms of reference of the Investigation directed by the Health and Safety Commission into the explosions and fires at the Buncefield oil storage and transfer depot, Hemel Hempstead, on 11 December 2005 require an initial report to be produced for the Health and Safety Commission and the Environment Agency when the main facts of the incident have been established.

The independent Board set up to supervise the Investigation has previously published three Progress Reports submitted to the Board by the Investigation Manager. The Initial Report presents the Board's view that enough of the facts have been established, as described in the Progress Reports, to set out with reasonable confidence the sequence of events leading to the incident on 11 December. This also allows the Board to identify several issues of concern for the effective regulation of fuel storage sites such as Buncefield.

Summary of the incident and subsequent investigation

The Initial Report summarises and updates material from the Progress Reports on the nature of operations at Buncefield, the timeline of key events, the emergency response and the progress of the Investigation. Evidence shows that the main explosion probably resulted from the ignition of a vapour cloud emanating from Tank 912 in Bund A in the Hertfordshire Oil Storage Limited West site, most likely resulting from an overfill of unleaded petrol. The probable mechanism for the creation of the vapour cloud is described, though uncertainty remains about why the explosion was so violent.

Main findings since the publication of the Third Progress Report relate to the functioning of the systems used to shut down fuel delivery when a tank is full; the likely composition of the fuel released from Tank 912; and the ongoing monitoring of the environmental impact of the incident, particularly in relation to groundwater contamination. In this last regard, the incident has now been declared a Major Accident to the Environment (MATTE). The Investigation continues.

Issues of concern arising from the Investigation to date

Though knowledge of the Buncefield incident is still incomplete, enough is known for the Board to draw broad conclusions about the need for action in three areas:

- ▼ Design and operation of storage sites.
- ▼ Emergency response to incidents.
- ▼ Advice to planning authorities.

Design and operation of storage sites

The Buncefield incident involved failures of the means provided to contain fuel and water used in fire-fighting (known as 'fire-water') at three levels: primary, secondary and tertiary. The paramount need is to ensure the integrity of the primary means of containment, ie to make sure that fuel does not escape from the vessels in which it is normally contained. Further precautions need to be considered to prevent this happening and, should it still occur, to inhibit the formation of a flammable vapour.

This does not however lessen the need for effective secondary and tertiary containment (bunds and drains, mainly) that prevent pollutants from escaping the site and contaminating the environment should primary containment be lost.

Emergency response to incidents

Overall, the response to the incident was very impressive. The incident has highlighted the need to have effective emergency arrangements, both on and off site, in the event of a major incident of this kind. Lessons from Buncefield provide a very important opportunity to bring about improvements in emergency preparedness of resilience groups throughout Britain, and further afield. There are a number of reviews into the effectiveness of the emergency response to Buncefield being carried out by the agencies concerned, and the Board intends to return to this important area in the future.

Advice to planning authorities

The Buncefield incident poses fundamental questions about residential and commercial developments around sites like Buncefield. Continuing uncertainty in this area creates serious problems for local communities, particularly those directly affected by the Buncefield incident. This is a complex issue requiring a balance to be made between the risks and benefits of development. The Board intends to address these issues in detail once the preliminary conclusions of HSE's current review of its advice to planning authorities are known.

A measured approach is justified since the likelihood of a similar explosion remains low, and should be made lower still by a programme of actions designed to increase the reliability of primary containment. In our view, the importance of reaching conclusions that are considered, costed and sustainable greatly outweighs any benefit that might be derived from coming to summary judgements.

Introduction

1 This report is the ‘initial report’ required by the terms of reference of the Investigation into the explosions and fires at the Buncefield oil storage and transfer depot, Hemel Hempstead, Hertfordshire on 11 December 2005.¹ The Investigation was directed by the Health and Safety Commission (HSC) using its powers under section 14(2)(a) of the Health and Safety at Work etc Act 1974.

2 The Investigation is being carried out jointly by the Health and Safety Executive (HSE) and the Environment Agency. HSC appointed an independent Investigation Board, chaired by Lord Newton of Braintree, to supervise this investigation.² This report has been prepared by the Investigation Board, based on information arising from the continuing HSE/Environment Agency Investigation. Throughout the Investigation, the Board has been supplied with Progress Reports from the Investigation Manager, Taf Powell, which the Board has published.³

3 This report does not repeat all the material contained in the Progress Reports, which should be read for a fuller understanding of the Investigation up to May 2006. Part 1 summarises, and updates where necessary, key points of the Investigation for completeness and to aid in understanding the Investigation Board’s initial conclusions set out in Part 2. The Board has included significant new findings from the Investigation that have emerged since the publication of the Third Progress Report on 9 May. Other new material is contained in the annexes to this report.

4 The Investigation terms of reference require an initial report to be submitted to HSC and the Environment Agency as soon as the main facts of the incident have been established. The Investigation is still continuing. Nevertheless, the Investigation Board considers that, with publication of the Third Progress Report in May, enough facts have been established to set out with reasonable confidence the sequence of events leading to the incident on 11 December. In particular, enough is known for the Board to be able to identify several issues of concern for the effective regulation of fuel storage sites such as Buncefield. As well as the main facts of the incident, the Board has included in Part 2 of this report its emerging thoughts about future action to address these issues of concern.

5 The Investigation Board plans to give further consideration to these issues.

¹ The full terms of reference are reproduced in Annex 1. Term of reference 6 requires an initial report.

² The Members of the Investigation Board are listed in Annex 2.

³ Details of the three published Progress Reports are contained in Further information.



Part 1 - Summary of the incident and subsequent investigation

6 This section summarises information contained in the three Progress Reports to the Board published between February and May 2006. Full details can be found in the reports, which are available on the Investigation website.⁴ Where necessary, this information has been updated in this report and supplemented by new findings from the Investigation. Other new information is contained in the annexes, referenced as appropriate in the text below.

Overview of Buncefield operations

7 The Buncefield oil storage and transfer depot is a large tank farm occupied by three companies. These are: Hertfordshire Oil Storage Limited, a joint venture between Total UK Limited and Chevron Limited; United Kingdom Oil Pipelines Limited and West London Pipeline and Storage Limited, whose site is operated by British Pipeline Agency Limited; and British Petroleum Oil UK Limited.⁵ Each site is classified as a ‘top-tier’ site under the Control of Major Accident Hazards (COMAH) Regulations 1999.⁶

8 Figure 1 shows the layout of the Buncefield depot and its surroundings. The Buncefield depot forms part of a national petroleum refinery, pipeline and storage system, described in Annex 4. Fuel products were supplied to Buncefield by three pipeline systems:

- ▼ 10” pipeline (FinaLine) from Lindsey Oil Refinery on Humberside, terminating in the Hertfordshire Oil Storage Limited West site;
- ▼ 10” pipeline from Merseyside to Buncefield (M/B pipeline), terminating in the British Pipeline Agency Limited-operated Cherry Tree Farm site;
- ▼ 14” pipeline from Thames (Coryton) to Kingsbury, Warwickshire, with a spur line to Buncefield (T/K pipeline), terminating in the British Pipeline Agency Limited-operated main site.

9 The three pipelines all transported fuel products in discrete batches, separated by an interface or buffer of mixed product. At the terminal, the operators monitored the arrival of the various grades of fuel and separated them out into dedicated tanks by fuel type. The interface of mixed fuel was diverted to special small tanks to be reinjected into the main large storage tanks, if the fuel specification allowed, or transported back to the refinery as ‘slops’ for re-refining.

⁴ Details of the three published Progress Reports are contained in Further information. These reports have not been revised to take account of more recent findings.

⁵ Texaco Limited became Chevron Limited on 3 July 2006.

⁶ The regulatory framework for high hazard sites, including the main requirements of COMAH, is summarised in Annex 8.

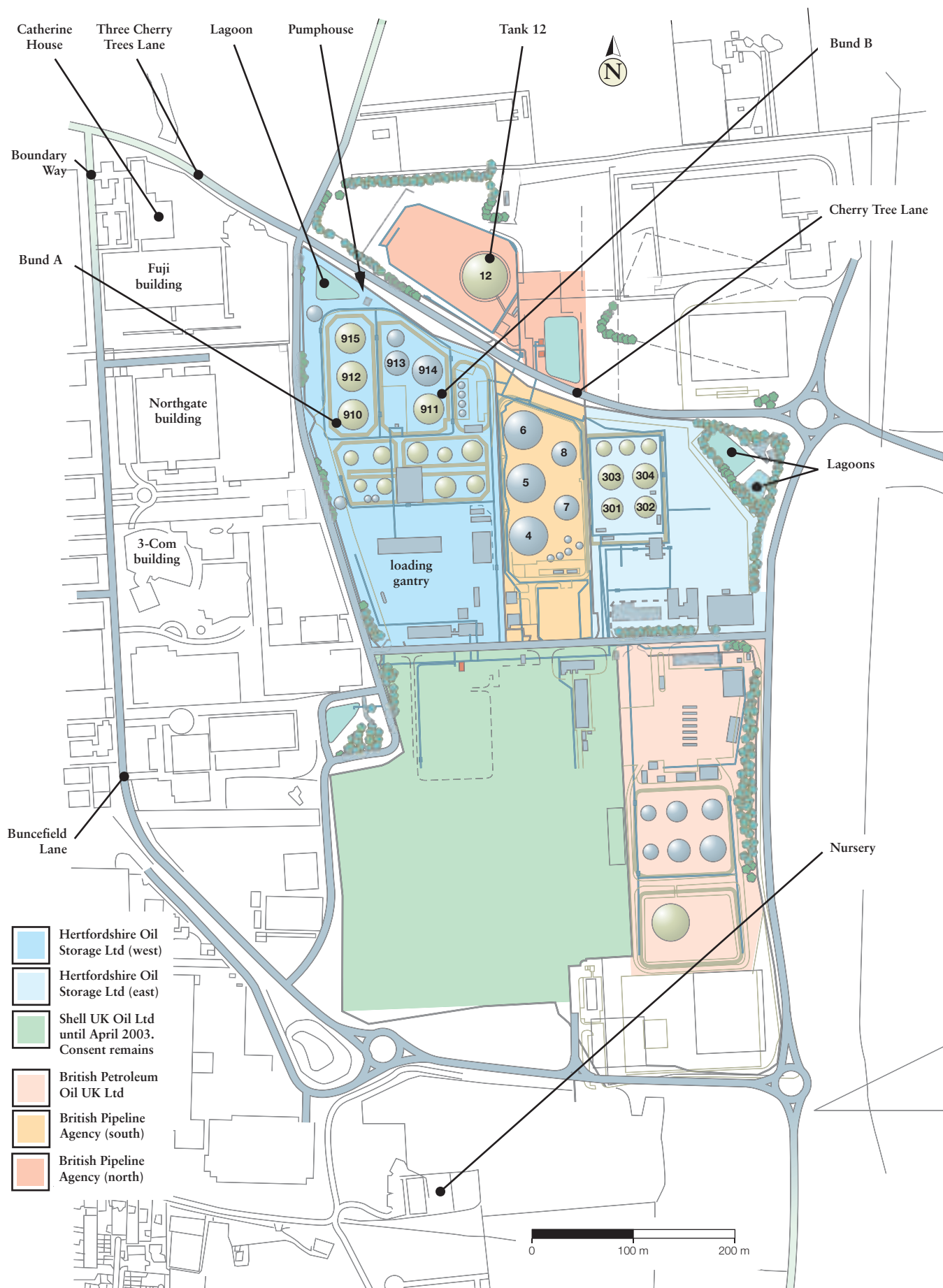


Figure 1 Pre-incident layout of Buncefield depot and immediate surroundings

10 The separated products left the depot either by road tanker or, in the case of the majority of aviation fuel, via two dedicated pipelines from the British Pipeline Agency Limited main site into the West London Pipeline system, which supplies Heathrow and Gatwick Airports. Tankers operating from Buncefield were of 44 or 18 tonnes capacity and were increasingly operated by specialised transport operators.

Timeline of key events

10 December 2005

- ▼ Around 19.00, Tank 912 in Bund A at the Hertfordshire Oil Storage Limited West site started receiving unleaded motor fuel from the T/K pipeline, pumping at about 550 m³/hour (flow rates are variable within limits).

11 December 2005

- ▼ At approximately **midnight (00.00)** the terminal was closed to tankers and a stock check of products was carried out. When this was completed at around 01.30, no abnormalities were reported. From approximately 03.00, the level gauge for Tank 912 recorded an unchanged reading. However, filling of Tank 912 continued at a rate of around 550 m³/hour.
- ▼ Calculations show that at around 05.20 Tank 912 would have been completely full and starting to overflow. Evidence suggests that the protection system which should have shut off the supply of petrol to the tank to prevent overfilling did not operate. From this time onwards, continued pumping caused fuel to cascade down the side of the tank and through the air, leading to the rapid formation of a rich fuel/air mixture that collected in Bund A.
- ▼ At 05.38 vapour from the escaping fuel is first visible in CCTV footage from a camera looking down the western edge of Bund A, flowing out of the north-west corner of Bund A towards the west.⁷
- ▼ At 05.46 the vapour cloud had thickened to a depth of about 2 m and was flowing out of Bund A in all directions.
- ▼ By 05.50 the vapour cloud had started flowing off site near the junction of Cherry Tree Lane and Buncefield Lane, following the ground topography. It spread west into Northgate House and Fuji car parks and towards Catherine House.
- ▼ Between 05.50 and 06.00 the pumping rate down the T/K pipeline to Hertfordshire Oil Storage Limited West, and onwards to Tank 912, gradually rose to around 890 m³/hour.
- ▼ By 06.01 the vapour cloud extended to the west almost as far as Boundary Way in the gaps between the 3-Com, Northgate and Fuji buildings; to the north-west it extended as far as the nearest corner of Catherine House. It probably extended to the north of the Hertfordshire Oil Storage Limited site as far as Tank 12, operated by British Pipelines Agency Limited, and probably extended south across part of the Hertfordshire Oil Storage Limited site, but not as far as the tanker filling gantry. To the east it reached the British Pipeline Agency Limited site.
- ▼ At 06.01 the first explosion occurred, followed by further explosions and a large fire that engulfed over 20 large storage tanks. The main explosion event appears to have been centred on the car parks between the Hertfordshire Oil Storage Limited West site and the Fuji and Northgate buildings.

⁷ Timings deduced from CCTV footage have been corrected for any inaccurate setting of the CCTV timers.

- ▼ At 06.08 an emergency services major incident was declared and operational command and control was set up near the incident site within minutes.
- ▼ At 09.00 Strategic Co-ordinating Group ('Gold' command') convened for the first time.
- ▼ An extensive plume of smoke from the burning fuel dispersed over southern England and beyond.⁸ The plume could be seen from many kilometres away, and was also clearly identified in satellite images.

12 December 2005

- ▼ **Noon.** Peak of the fire. 25 Hertfordshire pumps were on site with 20 support vehicles and 180 fire-fighters.
- ▼ There was some loss of secondary containment, as the bunds were unable to fully contain the escaped fuel and water used in fire-fighting (known as 'fire-water'), which 'overtopped' (ie spilled over the top of) the bund walls.

14 December 2005

- ▼ HSE assumed control of the Investigation from Hertfordshire Constabulary.
- ▼ Damage to bunds caused by the intense heat of the fire caused significant loss of secondary containment on the Hertfordshire Oil Storage Limited West and British Pipeline Agency Limited sites. There was also extensive loss of tertiary containment at the site boundaries and large amounts of contaminated liquids escaped off site. The fire service recovered as much of the contaminated run off as possible, but was unable to prevent contamination of groundwater and surface water.

15 December 2005

- ▼ 'Fire all out' declared by the Fire Service.
- ▼ 786 000 litres of foam concentrate and 68 million litres of water (53 million 'clean' and 15 million recycled) were used overall to contain the incident during the period of fire-fighting operations.
- ▼ Strategic Co-ordinating Group ('Gold' command) convened for the last time.

16 December 2005

- ▼ The on-site investigation started (the preliminary planning and information gathering had commenced earlier). HSE issued notices to secure the site, to ensure both that evidence was left undisturbed and that clean up operations were conducted safely. Key parts of the site remained too dangerous for investigators to access for weeks or months.

18 December 2005

- ▼ Hertfordshire Oil Storage Limited started surveying roads and buildings on the site.

⁸ Monitoring by the Meteorological Office showed that the visible plume was mainly black carbon (soot). Full details of the plume and related air quality monitoring arrangements are given in the Department for the Environment, Food and Rural Affairs' *Initial review of the air quality aspects of the Buncefield oil depot explosion*, available at www.defra.gov.uk/environment/airquality/buncefield/index.htm.

20 December 2005

- ▼ HSC formally directed HSE and the Environment Agency to investigate the incident and to make a special report. HSE appointed Taf Powell, Director of HSE's Offshore Division, to be the Investigation Manager. HSC also announced the appointment of an independent Board to supervise the Investigation.
- ▼ The control room on the Hertfordshire Oil Storage Limited West site was sufficiently structurally sound to allow entry for gathering records and other evidence.

23 December 2005

- ▼ The Investigation team, with assistance from Hertfordshire Constabulary and Hertfordshire Fire and Rescue Service, recovered computers from damaged offices and placed them in safe storage.

5 January 2006

- ▼ Hertfordshire Fire and Rescue Service handed control of the site over to the Investigation team. Hertfordshire Constabulary and Hertfordshire Fire and Rescue Service continued to give invaluable support to the Investigation team that was working to gather and secure evidence.

12 January 2006

- ▼ HSC appointed Lord Newton of Braintree to chair the independent Board.

February 2006

- ▼ All fire-water had been removed from site and stored, pending safe disposal. The area around the loading gantry had been made safe for access and tankers, which were present at the time of the incident, were removed.
- ▼ Investigating personnel gained access to Bund A for the first time.
- ▼ Internal roadways were cleared and limited work started on removing debris from Bund A. Sampling of fuel in pipework was carried out prior to safe disposal. As fuel residues still remained in interconnecting pipework and damaged tanks, monitoring for flammable vapour was routinely carried out.

Emergency response to the Buncefield incident

11 The co-ordination and management framework at any incident identifies three levels of interlinked leadership and co-ordination.⁹ They are:

- ▼ Strategic - Gold
- ▼ Tactical - Silver
- ▼ Operational - Bronze

12 The emergency services (primarily the Fire and Rescue Service and the police) led the initial response to the incident and its immediate aftermath. Representation of all agencies deployed to resolve the Buncefield incident was established through a meeting process known as the Strategic Co-ordinating Group, also known as Gold command. This included the Environment Agency as a Category 1 responder under the Civil Contingencies Act 2004.¹⁰ The Strategic Co-ordinating Group made decisions to ensure that the implementation of strategic aims was delivered by the tactical (Silver) and operational (Bronze) commands.

13 The Strategic Co-ordinating Group had its first multi-agency meeting at 09.00 on 11 December at Hertfordshire Police Headquarters, chaired by the Police Strategic Co-ordinating Group Commander. A decision was made at this meeting to evacuate those with damaged homes and workplaces, and to tell everyone in the immediate vicinity to shelter – ‘go in, stay in, tune in’.

14 The Strategic Co-ordinating Group remained in place until 18:30 on Thursday 15 December.

Disposal of fire-water

15 The contaminated fire-water was removed from the site during the first three weeks following the fire, although an unknown quantity contaminated the surface waters and groundwater. Following the event, further contaminated water resulting from rainfall or cleaning operations was removed from the site by tanker and stored along with the fire-water in a number of locations around the country.

16 The fire-water remains in temporary storage, and it is important for this matter to be resolved. The Board understands that the decontamination of fire-water on such an unprecedented scale may require the use of several processes to render the water suitable for its return to the environment. The oil companies are developing options to achieve this, which will be assessed by the Environment Agency to ensure that they have the minimum impact possible on the environment.

17 On 21 June 2006, the Environment Agency was informed that some 800 000 litres of this contaminated water had been released inadvertently from storage into a sewage treatment plant and thereafter into the River Colne, a tributary of the River Thames. The Environment Agency launched an investigation with the assistance of Thames Water Utilities Limited, who operate the storage facility and associated sewage treatment works. This investigation has yet to be concluded.

⁹ *UK Resilience. Management and co-ordination of local operations*, available at www.ukresilience.info/ccact/errpdfs/err_chap_04.pdf.

¹⁰ Other Category 1 responders included the Health Protection Agency (HPA) and the Strategic Health Authority. The Environment Agency’s role was to minimise the risks of environmental damage. HSE is a Category 2 responder, so during the early phase of the incident stood ready to provide advice and expertise on request.

The Investigation

18 Progress Reports 1-3 detail four key aspects of the Investigation, briefly summarised below:

- ▼ Loss of fuel containment.
- ▼ Formation of the vapour cloud.
- ▼ The explosions.
- ▼ Environmental monitoring.

Loss of fuel containment

19 The first Progress Report indicated that the explosion probably resulted from ignition of a vapour cloud emanating from the vicinity of Bund A in the Hertfordshire Oil Storage Limited West site. The Investigation Manager was sufficiently confident in the investigation findings to state in the Third Progress Report that the initial loss of containment which created the vapour cloud occurred from Tank 912 in Bund A, most likely resulting from an overfill of unleaded petrol.

20 To understand how the fuel escaped, the Investigation examined how Tank 912 and its instrumentation and control systems functioned at the time. This examination suggested further lines of inquiry, involving aspects of the automatic tank gauging system, and the high-level alarm system. Investigators wanted to ascertain how the gauging system performed and why automatic shutdown of delivery did not take place as intended when the tank's 'ultimate high level' (ie the specified maximum capacity) was reached.

21 The Third Progress Report detailed findings about instrumentation and control systems on Tank 912. These include the product monitoring systems both for level and temperature, and the 'ultimate high-level switch', which was part of the system to prevent overfilling of the tank. As the Third Progress Report explained, from about three hours before the incident, the level gauge remained static, although the tank continued to fill.

22 The ultimate high-level switch should, if triggered, cause an alarm to sound and shut down the supply of fuel to the tank. Since publication of the Third Progress Report, most of the ultimate high-level switch from Tank 912 has been recovered, along with other parts of the instrumentation systems on this and other tanks, for examination.

23 Further investigation into the design of the ultimate high-level switch indicated that the position of a test lever or plate fitted to the switch is critical to ensure continued effective operation. While the relevance of this feature to the Buncefield incident has still to be determined, one of the issues that has arisen from these enquiries relates to the reliance on this type of switch at many similar installations throughout the UK and worldwide.

24 The Competent Authority has taken action to bring this issue to the urgent attention of operators of similar sites in the UK through a Safety Alert.¹¹ The Alert applies to a particular kind of switch used in ultimate high-level alarm systems. Improvement Notices have also been issued, requiring the suppliers to contact users or installers of these switches to alert them to this issue and provide revised instructions and labelling on the safe use, setting, cleaning and maintenance of the switches. The Board notes the continuing co-operation of the suppliers in that process.

¹¹ Sites like Buncefield are regulated by a 'Competent Authority', as detailed in Annex 8. The full text of the Safety Alert can be found on HSE's website at www.hse.gov.uk/comah/alerts/sa0106.htm.

Formation of the vapour cloud

25 The Third Progress Report described extensive tests undertaken to model the behaviour of fuel escaping from Tank 912 during overfilling. Tank 912 was fitted with a deflector plate, installed to direct water from sprinklers on the tank's top to its sides to provide cooling in the event of fire. The tests demonstrated that the deflector plate channelled some of the escaped fuel onto the tank wall, but the rest ran over the top of the plate, fragmenting into droplets that cascaded through the air. Most of the fuel running down the wall hit a wind girder (a structural stiffening ring) and detached from the tank wall, creating a second cascade of droplets.

26 These conditions would promote the evaporation of the lighter components of petrol, eg butanes, pentanes and hexanes. The free-fall of droplets leads to entrainment of air and mixing between the air and fuel vapour, and the formation of a rich fuel/air mixture. Cooling of the surrounding air, already saturated with water vapour by the evaporation, would cause some of the water content to precipitate as an ice mist, which is consistent with the cloud of mist visible on

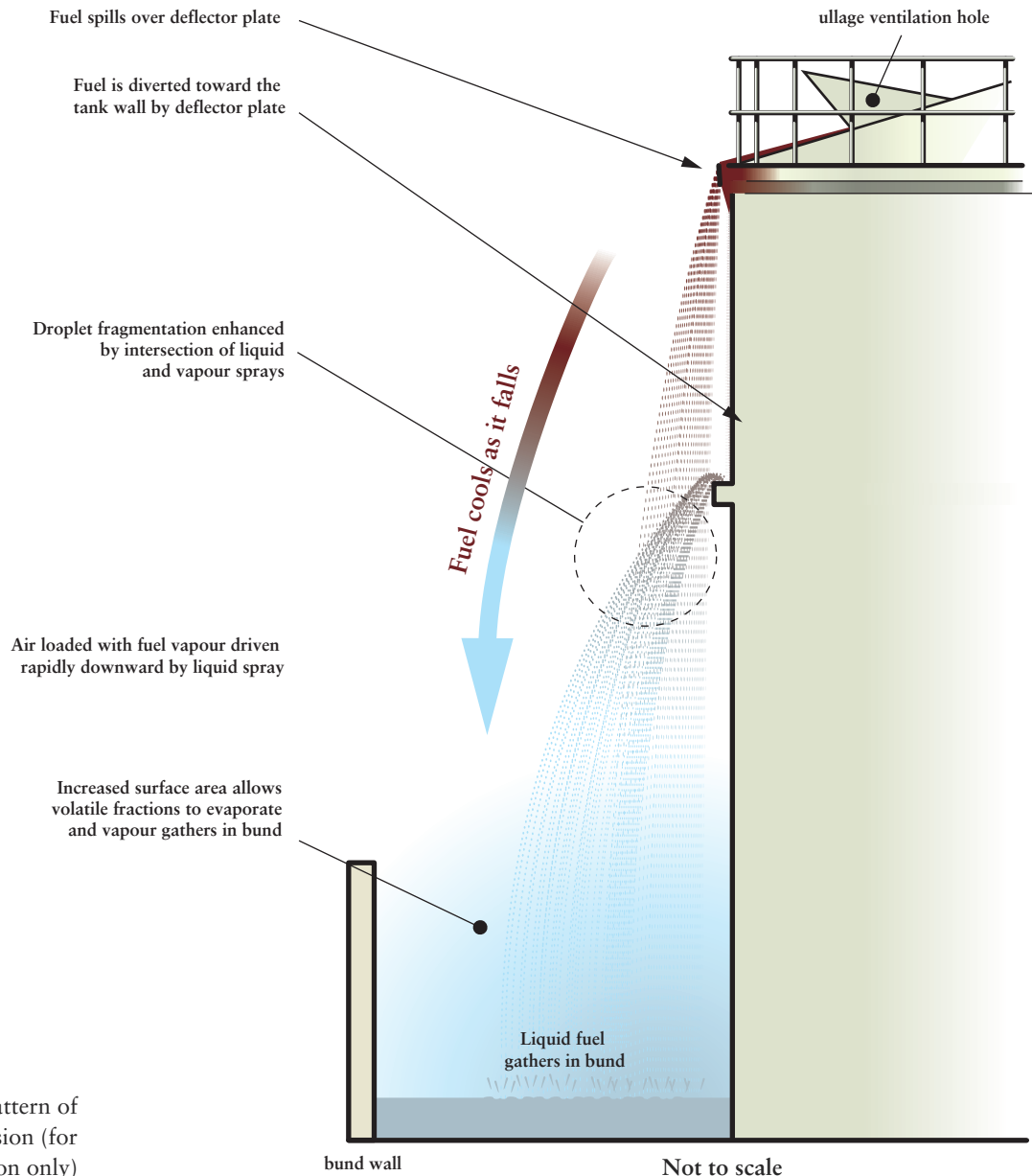


Figure 2 The pattern of fuel dispersion (for illustration only)

CCTV. The fuel/air mixture and its accompanying ice mist were heavier than air and so were initially contained within the bund. As the volume of the mixture grew from the continuing overfilling of the tank, it flowed out of the bund, dispersing and flowing off site. Further mixing with the air would have reduced the vapour concentration to the point where significant volumes of the mixture could support an explosion.¹²

27 Since publication of the Third Progress Report, further work to simulate the overflow of liquid from the full height of Tank 912 has confirmed the pattern of fuel dispersal and vaporisation shown in Figure 2.

The explosions

28 The Third Progress Report described a number of potential ignition sources of the main explosion that occurred at 06.01 on 11 December. The prime candidate appears to be an explosion within the emergency generator cabin on the south side of the Northgate building; this is consistent with the site of the main explosion event. However, further study of the CCTV evidence shows a sudden illumination of the east face of the Fuji building, consistent with an explosion or a flash fire at the location of the pumphouse to the east of the lagoon on the Hertfordshire Oil Storage Limited West site. This illumination was recorded by a camera before it was destroyed by the overpressure, suggesting that this explosion or flash fire occurred before the main explosion at 06.01. The pumphouse is the subject of continuing forensic investigation.

29 Much uncertainty remains about why the explosion was so violent, generating overpressures of a magnitude much greater than current understanding of vapour cloud explosions would predict. For example, a method in current use would predict overpressures of 20-50 millibar (mbar) in the open areas of the Northgate and Fuji car parks. The current best estimates of the overpressures that actually occurred in these areas are of 700-1000 mbar, leading to extensive damage to adjacent buildings. Annex 6 describes the mechanics of fire and explosion hazards from fuels such as petrol, as currently understood.

30 Continuing work relevant to gaining a better understanding of the explosion has included extensive sampling to identify the composition of the released fuels, as well as to verify the product distribution throughout the depot. It shows that the released fuel probably had a butane content of 10% and consequently would have had a high vapour pressure, ie it would be capable of evaporating rapidly to produce a flammable vapour. The total butane content is specified in the standard, and depends on whether the product is winter or summer grade. For winter grade petrol the vapour pressure limits are defined as 70-100 kiloPascals (kPa) and for summer they are reduced to 45-70 kPa. See Annex 7 for further information about standards and fuel composition.

31 Further research is needed to try to discover the actual mechanism for generating the unexpectedly high overpressures seen at Buncefield. The Board refers to this again in paragraph 76, and in relation to terms of reference 1 and 5 in Annex 1.

32 The number and severity of injuries at Buncefield was low compared to some other major incidents involving explosions, and there were no fatalities. Annex 6 provides more information about explosion overpressures, and includes tables which show the levels of damage or injury that would normally be expected to result from different overpressures.

¹² The explosive properties of petrol, including the significance of vapour concentrations, are explained in Annex 6.

Environmental monitoring

Air quality

33 An initial report on the results of the air quality monitoring and the impact of the plume on human health and vegetation was published by the Department for the Environment, Food, and Rural Affairs (DEFRA) in May 2006.¹³ Overall, the report concluded ‘there are unlikely to have been widespread air quality impacts at ground level due to pollutants emitted from the Buncefield fires.’ It went on to say that ‘overall it was concluded that the fire at Buncefield Oil Depot did not result in substantial pollution of soil and grasses’ and ‘that pollutant levels were, in general, unexceptional and typical of UK urban environments.’

34 The prevailing meteorological conditions at the time of the incident and the high buoyancy of the smoke plume from the fire resulted in most of the plume material reaching a high altitude in the atmosphere. It then dispersed over a wide area with minimal mixing down to ground level.

Land investigations

35 Trial pits were excavated starting in February on and surrounding the site to assess the impact on land. The initial findings indicate that the surface layer is contaminated with fuel and fire-fighting products.

36 The extent and degree of the contamination of the land within the Buncefield depot is continuing to be established. Many trial pits have been excavated to investigate the soil beneath the concrete hardstanding and under the bases of the bunds. All of this information will inform the continuing Investigation and allow the Environment Agency to assess the oil companies proposed remediation of the contamination when that is formally submitted to the Competent Authority.

Surface water and groundwater monitoring

37 Extensive surface water monitoring immediately following the incident was carried out at a number of locations, as detailed in the Second Progress Report. Monitoring will continue for the foreseeable future at these locations to determine any long-term effects on the aquatic environment.

38 The Environment Agency started to monitor the groundwater under and around the Buncefield site soon after the incident. This monitoring has shown that there is contamination of the groundwater by fire-fighting products, fuels, and fuel-related products. This has been reported in the previous Progress Reports and on the Environment Agency website.

39 Following the detection of contamination, the Environment Agency reviewed the sampling locations for the existing groundwater monitoring network (details of which were reported in the Second Progress Report) and concluded that further monitoring boreholes were required at specified locations. Some of the new boreholes are already installed.

¹³ This report presents and summarises the air quality measurements made during the Buncefield incident, and includes results obtained from targeted local monitoring, measurements from long-term monitoring networks, the modelling undertaken by the Meteorological Office, and emissions estimates of the pollutants from the fire. See Further information for further details.

40 The new monitoring boreholes will ensure that the extent of pollution is understood. Also, the increased groundwater monitoring network will improve the understanding of flow and contaminant transport within the chalk aquifer.

41 In addition to the extensive sampling that is currently underway, the Environment Agency is developing a groundwater conceptual model to assist in understanding the movement of pollutants within the groundwater and aquifer so that it may assess the likely extent of contamination. This model is a conceptual representation of the environment (in this case an aquifer) and the interactions within it.

42 All of the above will aid the assessment of the impact of the contamination on the environment and to human health. It will also assist in determining the best solutions for the clean up of the groundwater and the aquifer.

Perfluorooctane sulphonates (PFOS)

43 Perfluorooctane sulphonates are a group of chemicals, collectively identified as PFOS, which have been shown to be hazardous (persistent, bioaccumulative and toxic). PFOS chemicals have been used in a diverse range of applications, including as an additive to aid the spreading properties of fire-fighting foam. PFOS does not appear to degrade in the natural environment. Due to this stability, it has now become widespread both in humans and in the environment. Annex 9 describes the environmental hazards presented by PFOS and the current approach to its regulation.

44 PFOS was not routinely monitored and analysed in any surface water or groundwater in the UK prior to the Buncefield incident. Sampling and analysis for PFOS are not straightforward and until very recently there has been no recognised recommended limit for PFOS levels in groundwater or drinking water against which to assess any results.

45 PFOS was present in some of the foam used to combat the Buncefield fire. At the start of the Buncefield incident, PFOS in the fire-water was recognised as an important potential contaminant for land, surface water and groundwater. The Environment Agency and others have sampled groundwater and surface water extensively for PFOS and other contaminants both on and off site from soon after the explosion. The Board notes that it is the responsibility of the local water company to monitor the quality of drinking water (as opposed to groundwater and rivers), and that the Drinking Water Inspectorate (DWI) regulates the activities of water companies in relation to drinking water quality.

Results of monitoring

46 PFOS was detected in the Rivers Ver and Colne in the days immediately following the incident, however, these levels dropped below the lowest threshold detectable by the Environment Agency after a short period. Ongoing testing still shows sporadic detection of PFOS in the rivers. No direct impact has been detected either at the time or in the intervening months on fish or other aquatic species in these waters. Only long-term monitoring will identify if there has been a lasting environmental consequence of the presence of PFOS and its associated fluorinated compounds.

47 Results to date (six months since the incident) of groundwater monitoring have shown the presence of fuels, fuel-related products and residues from the fire-fighting foams in groundwater at a number of locations, but they are most prevalent under and close to the site.

48 Although PFOS above the level of three microgrammes per litre (which is the advisory level set by the DWI for PFOS in drinking water) has been detected in environmental monitoring samples, these levels have not been detected in samples of drinking water.

49 It could be many months before the full extent of the contamination of the groundwater is known. The Environment Agency is working with DWI and the local water supply companies to ensure that they are fully aware of sampling results, and are able to act appropriately to safeguard public water supplies.

Further monitoring

50 In view of the apparent widespread occurrence of trace quantities of PFOS around the Hemel Hempstead area, some apparently unconnected with Buncefield, the Environment Agency is conducting a targeted national groundwater sampling exercise to investigate the wider prevalence of PFOS and related compounds in groundwater.

51 The initial monitoring programme is being carried out in the period April to July 2006. Groundwater is being sampled at selected sites on the Environment Agency's national groundwater monitoring network. A range of sites have been selected in rural, urban and industrial areas. Some sites are where fire-fighting foams may have been used, eg fire stations, airbases etc, while others are where such use is not suspected. Approximately 150 sites will be sampled as a part of this programme.

52 If perfluorosurfactant compounds are detected in groundwater, repeat sampling will be carried out to verify the initial results and to investigate persistence. If widespread detection occurs, the programme will be extended beyond July and, if necessary, selected compounds added to the routine monitoring programme. A similar sampling exercise is planned for surface waters to take place over the period July to December 2006.

Notification to the European Commission

53 The Competent Authority (at Buncefield, jointly HSE and the Environment Agency) is required under regulation 21(1) and (2) of the COMAH Regulations to inform the European Commission of any major occurrence on a COMAH site. HSE, on behalf of the Competent Authority, issued a short report on 10 March 2006 for inclusion on the Major Accident Reporting System. As further information of international significance becomes known, the Competent Authority will also pass this on to the European Commission and hence the international community.

54 DEFRA has established threshold criteria defining a Major Accident To The Environment (MATTE), based on Schedule 7 (part 1) of the COMAH Regulations. The Environment Agency, using these criteria, has determined that the Buncefield incident is a MATTE, and the Competent Authority has recently reported this to the European Commission. This determination is based on the results of Environment Agency monitoring of groundwater beneath and in the vicinity of the Buncefield site, which has been shown to be contaminated with fuels and fire-fighting foam by-products. This area of contamination is deemed to extend over the one hectare threshold described in the Regulations. The reporting of this MATTE to the European Commission has no impact on the continued monitoring and remediation programme that is already taking place.

The continuing Investigation

55 Work continues on the Investigation to ensure that all reasonable lines of enquiry are followed. Evidence continues to be gathered from different sources. The emerging information contributes to a greater understanding of the underlying root causes, and will allow the Investigation team to refine its enquiries further and to bring into focus elements such as wider management systems and organisational factors.

56 Almost all the plant and equipment required for forensic examination has been recovered from the Buncefield site, which will allow the operators to demolish buildings, tanks and bunds. However, further investigation work will be carried out on the integrity of the floors of the bunds together with environmental monitoring of the ground underneath, in particular where tanks were located.

57 The Investigation has also considered previous incidents which may have similarities to the events at Buncefield. These are summarised in Annex 5. Work is in hand to identify other incidents that may be relevant.

Part 2 - Issues of concern arising from the Investigation to date

58 Knowledge of the Buncefield incident is still incomplete, but enough is known to draw some broad conclusions about actions which might be taken to improve health, safety and environmental protection at or near oil storage sites, including areas where further work is needed. The Board does not intend to make any comment at this stage on possible legal proceedings. The initial observations set out here concern broader issues. The Board will continue to ensure that information is made publicly available, either through its own reports or via the Competent Authority, where it is necessary to ensure continued safety, while also attempting to preserve the integrity of any future criminal proceedings that might be brought by the relevant enforcing authorities.

59 The Board's observations and conclusions at this stage fall into three areas, which are considered further below:

- ▼ Design and operation of storage sites.
- ▼ Emergency response to incidents.
- ▼ Advice to planning authorities.

60 We believe these, together with our examination of HSE's and the Environment Agency's roles in regulating the activities on the Buncefield site, will form the broad scope of our further work.

Design and operation of storage sites

61 The Buncefield incident involved failures of primary, secondary and tertiary means to contain fuel and associated fire-waters.

- ▼ **Primary** means are the tanks, pipes and vessels that hold liquids, and the devices fitted to them to allow them to be safely operated.
- ▼ **Secondary** means are enclosed areas around storage vessels (often called bunds), created usually by concrete or earth walls. Their purpose is to hold any escaping liquids and any water or chemicals used in fire-fighting.
- ▼ **Tertiary** means are things such as drains designed to limit the passage of chemicals off site, raised kerbs to prevent liquids that have breached the bunds from escaping into the general area around the site, etc.

62 The Board has already seen sufficient information from the Investigation to be able to express an obvious, but nonetheless important opinion that safety, health and environmental protection are of paramount importance at sites like Buncefield. We would expect this point to be uppermost in the mind of the industry-chaired task group recently convened by HSE to pursue improvements to safety and environmental protection at fuel depots.

63 The occurrence of a massive fuel vapour explosion confirms the overriding need to ensure the integrity of the primary means of containment; in other words, to make sure that liquid does not escape from the vessels in which it is normally meant to be confined.

64 Safety and planning assumptions at fuel depots like Buncefield have until now been based upon fires in pools of escaped liquid, held in check by bunds while the emergency services establish control. The formation of a huge vapour cloud from tank storage was not considered a sufficiently credible scenario for land use planning purposes.¹⁴ One particular lesson from the Buncefield incident is therefore that such a cloud can form while a highly flammable liquid such as unleaded petrol is escaping from primary containment in a storage tank, and where the path of escape involves cascading, fragmenting and dispersing the liquid from height (eg from the vents in the top of a tank that is being overfilled).

65 The Investigation has demonstrated that ‘overtopping’ a tank with highly flammable fuel is more likely to produce a potentially explosive mixture than pooling from a lower level escape, such as may result from a tank failure. The Investigation has also shown that the design of the tank itself may have contributed to the vapour formation at Buncefield. This suggests that design and construction of tanks and pipework that could be favourable to the formation of flammable vapours should be discouraged.

66 Secondary and tertiary means of containment are vital for environmental protection. However, the secondary containment provided by bunds around tanks is of lesser value where there is rapid formation of vapour that will fairly quickly overflow the bund wall. Tertiary containment also has little effect against a cloud of vapour, as it is intended to intercept and hold liquid flowing along the ground. It is the Board’s view that the ineffectiveness of customary means of secondary and tertiary containment against migration of large volumes of vapour re-emphasises that the most urgent focus of attention should be on preventing loss of primary containment and, should that occur, inhibiting rapid large-scale vaporisation and any subsequent dangerous migration of a flammable vapour.

67 The Investigation also revealed that the fire pumphouse that provided the means to distribute cooling water for the whole Buncefield site was immediately adjacent to, and downhill from, Bund A. As described in paragraph 28, recent CCTV analysis has identified this pumphouse as a likely source of one of the early ignitions of the flammable vapour. The loss of the pumphouse, probably from an internal explosion of vapour that had entered from the surrounding cloud, immediately rendered inoperative the fire-fighting provisions for the site. It is foreseeable that flammable vapour in an enclosure could, if ignited, cause damage within that enclosure. The risk of flammable vapour reaching fire pumps increases the closer the pumps are to tanks containing volatile flammable liquids. The industry-chaired task group may want to review whether current guidance related to the siting and/or means of protection of emergency response facilities is suitable at sites such as Buncefield.

68 Following publication of the Investigation Manager’s first Progress Report in February 2006, the Competent Authority (HSE with the Environment Agency in England and Wales, and with the Scottish Environment Protection Agency in Scotland) began a programme of site inspections to ensure operators reviewed key design and operational aspects of their sites, a process supported by the findings of subsequent Progress Reports.

¹⁴ At Buncefield, the formation of a flammable vapour cloud at the tanker loading gantry, as opposed to the tank storage areas, was considered by the Competent Authority and site operators, but the level of off-site hazard this would pose was judged to be lower than a large pool fire originating from the tank storage area.

69 The preliminary findings of the Competent Authority programme were published on 13 June 2006.¹⁵ As a result of the programme, three Improvement Notices have been served. The Board welcomes this initiative and looks forward to the publication of the detailed findings of the Competent Authority programme of inspection this autumn. The Board notes the industry's efforts in working with the Competent Authority to review the findings from both the Investigation and the Safety Alert review, and to make recommendations to the joint industry/regulator task group regarding action needed to improve risk control. In particular, the Board notes that part of this work will be to review and revise published guidance on handling flammable liquids at storage sites by mid-2007, and expects this work to be pursued with vigour.

70 That guidance should be the culmination and record of a substantial effort by the industry, working with the regulators, and begun at once, to develop and implement better methods for handling flammable liquids at storage sites, particularly where volatile fuels are handled, with the principal aim of safely confining them in the vessels intended for that purpose. By 'methods' the Board means the plant, equipment, management systems, operational procedures and working practices provided to achieve safe operation and the ongoing verification by operators, supported by the Competent Authority, that all these control measures are effective.

71 In summary, the Investigation has revealed a number of matters concerning the design and operation of sites such as Buncefield where improvements to maintaining primary containment must be considered by the industry, working closely with the Competent Authority. These matters include:

- ▼ the electronic monitoring of tanks and pipework, and associated alarms that warn of abnormal conditions;
- ▼ the detection of flammable vapours in the immediate vicinity of tanks and pipework;
- ▼ the response to the detection of abnormal conditions, such as automatic closure of tank inlet valves and incoming pipeline valves;
- ▼ the extent to which the exterior construction of tanks (eg tank top design) inhibits, or contributes to, flammable vapour formation;
- ▼ the siting and/or means of protection of emergency response facilities; and
- ▼ the recording of monitoring, detection and alarm systems and their availability (eg off site) for periodic review of the effectiveness of the control measures by the operator and the Competent Authority, as well as in root cause analysis should there be an incident.

72 Where a need for additional systems is identified, HSC and the Competent Authority should satisfy themselves that current legal requirements are robust enough, and supported with sufficient resources, to ensure that these systems are provided and maintained at every fuel storage site where the risks require them, without relying upon voluntary compliance. It has not been established whether changes in the law or in the resources available to the Competent Authority are required to achieve this end. The Board is, however, clear that the severity of the Buncefield incident makes a compelling case for any such changes to be made as a matter of very high legislative priority, should the need be identified.

¹⁵ The full report is available on HSE's website at www.hse.gov.uk/comah.

73 As well as ensuring the effectiveness of primary containment, the industry, working with the Competent Authority, should embark on a review of the purpose, specifications, capacity, construction and maintenance of secondary and tertiary containment, and in particular the bunds around tanks. This work should lead to revised guidance, either as part of that referred to in paragraphs 69 and 70, or produced separately – but on at least as rapid a timescale. Again, the necessary standards should be capable of being insisted upon by law.

74 The Board is clear that it will wish to offer further advice when the Investigation is further advanced. This might deal with, for instance, the human and organisational factors that contribute to the safe operation of a major hazard site such as a fuel storage depot. Such factors include, for example, job organisation, management of organisational change, monitoring and supervision, training and control room layout.

75 In the longer term, it may prove necessary to consider additional standards for the overall layout of storage sites.

76 The system for delivering fuel safely around the country depends on good communications between those responsible for delivery and those responsible for receiving the delivered batches, to ensure sites receiving fuel are able to accept deliveries safely. The adequacy of existing safety arrangements, including communications, may also need to be reviewed. The Board expects to return to these and other matters in due course.

77 Further work is needed to research the actual mechanism for generating the unexpectedly high explosion overpressures seen at Buncefield. This is a matter of keen international interest, and participation from a broad range of experts, as well as the industry, is essential to ensure the transparency and credibility of any research programme. The Board will consider further recommendations about the nature and scope of such work.

Emergency response to incidents

78 Improving the arrangements to prevent fires and explosions in no way lessens the need to have effective emergency arrangements in the event of an incident. This covers both planning for emergencies and the effectiveness of the response. Operators of top-tier COMAH sites are required by law to prepare adequate emergency plans to deal with the on-site consequences of possible incidents, and they must also provide local authorities with information to enable them to prepare emergency plans to deal with the off-site consequences. The adequacy of these plans depends, among other things, on a full appreciation of the potential for major accidents. In the light of the emerging findings:

- ▼ Operators of oil storage depots should review their on-site emergency plans and the adequacy of information they supply to local authorities to ensure they take full account of the potential for a vapour cloud explosion, as well as fires. From the ‘forthwith actions’ taken by depot operators and the Competent Authority in response to the Competent Authority’s Safety Alert of 21 February 2006, responsible operators should have already undertaken such reviews. The Competent Authority must ensure that this is the case and work with the industry to ensure that all learning is fully shared.

- ▼ The public health implications of potential vapour cloud explosions must be considered in both on-site and off-site emergency plans. Though the public health impact of Buncefield appears to have been minimal, this may not necessarily have been the case under different conditions.¹⁶
- ▼ As with on-site protective systems, HSC and the Competent Authority bodies should satisfy themselves that legal requirements are robust enough to ensure any necessary changes to emergency plans are duly made.

79 Several separate reviews are looking at the effectiveness of the emergency response to Buncefield. The emergency services, particularly the fire and police services, responded impressively and on a massive scale that was almost certainly unprecedented in modern times. Inevitably there are lessons to be learned from such an exceptional event. This is particularly important given the newness of the local, regional and national resilience arrangements tested at Buncefield. The Board intends to return to this topic when more information is available from those reviews. Meanwhile the Board has the following observations:

- ▼ Given the huge cost of the Buncefield incident, it is essential not to miss any of the lessons it has provided for emergency response. Like the response itself, this is a multi-agency task that requires a clear lead. It will be part of the Board's ongoing work to establish a clear picture of the lead provided by central Government for first responders.
- ▼ The public health impacts of Buncefield appear to have been minimal. Nevertheless, the incident has revealed the importance of prompt, useful advice to early responders such as the Fire and Rescue Services, and to the public. There may also be scope to improve the co-ordination of sampling and monitoring activities, particularly in the early stages of major incidents. The Board welcomes the establishment of a Health Protection Agency-led working group aiming to establish frameworks and agreed working practices for any future post-incident environmental sampling, and awaits with interest the results of this work. The Board also welcomes the steps being taken by the Health Protection Agency to draw to the attention of regional resilience fora in Britain the immediate lessons of Buncefield for the provision of health protection advice during a major incident.
- ▼ The local residential and business communities have interests to be considered, eg the maintenance of employment and support in effecting a rapid return to social normality. This appears to be both a regional and, on the scale of Buncefield, a national issue. It is not clear to the Board how far emergency planning arrangements have taken account of this aspect in the past. The Secretary of State for Communities and Local Government, through the Government Office for the East of England, recently established a task force to investigate options for Government support to businesses and local economies in the period following an exceptional disaster. This initiative is very welcome and the Board hopes swift progress will be made in this work.

¹⁶ The low impact on public health of the Buncefield incident is an initial conclusion of the Health Protection Agency. Their review of the health effects of the Buncefield fire is available at www.hpa.org.uk/explosions/hemel.htm.

Advice to planning authorities

80 One of the starkest issues raised by the Buncefield explosion is the location of sites with such major hazard potential alongside neighbouring commercial and residential development. The situation poses the fundamental planning question that all parties have to address – quite simply, what to do about such development.

81 The Board is acutely aware of the problems that planning uncertainties cause for local communities, particularly those directly affected by the Buncefield incident. Decisions about rebuilding businesses near the Buncefield depot – crucial to the livelihood of those who work in those businesses and to the local economy in general – hinge on decisions about rebuilding the whole of the area, including the depot itself.

82 A key element of the land use planning process for developments around Buncefield and many similar sites is the advice HSE provides to planning authorities. The Board, in its statement of 9 May on publishing the Third Progress Report, indicated its view that enough information had emerged at that stage to enable HSE to review as a matter of urgency the basis and standard of the advice it provides. The Board notes that HSE has acted on that challenge and expects to produce some preliminary conclusions in the autumn of this year.

83 The Board recognises that this is a complex issue for which there are no simple solutions. There is a need to balance the risks and benefits of development – a judgement made no easier by technical and scientific uncertainties. This is illustrated by the fact that HSE's advice on this site was based on a representative 'worst credible scenario' of a major liquid fuel pool fire. A vapour cloud explosion was initially considered, but arising from tanker loading operations and not tank storage. A pool fire was assessed as presenting the greater off-site hazard. The Buncefield incident brings into question the assessment policy for many oil/fuel depot sites, and the zone setting method which it informs.

84 The Board intends to address these issues in more detail, but not before seeing the preliminary conclusions of HSE's review. A measured approach is justified since the likelihood of a similar explosion remains low, and should be made lower still by a programme of actions designed to increase the reliability of primary containment. In our view, the importance of reaching conclusions that are considered, costed, and sustainable greatly outweighs any benefit that might be derived from coming to summary judgements.

85 We will be interested to know HSE's views on the desirability and feasibility of an approach to advise on developments around sites like Buncefield based more on consideration of risk. Under such an approach, the likelihood of major incidents, taking into account all the measures in place against them, would play a more explicit part than hitherto in determining planning advice.

86 The Board has also noted the incremental development around Buncefield (and presumably other sites).¹⁷ Given that most planning advice currently focuses on specific developments subject to planning approval, this could mean that in the future, more attention should be paid to the total population at risk from a major hazard site. The Board welcomes the Ministerial Statement laid in the House of Commons on 15 May, which referred to cross-Government work on this issue currently being co-ordinated by the Cabinet Office, and to which HSE is making an important contribution, and looks forward to the consultation with stakeholders expected later this year.

¹⁷ The history of development within a 3 km radius of the Buncefield depot site between 1966 and 2005 is shown in Figure 5, Annex 3.

Annex 1

Terms of reference and progress

This annex sets out the eight terms of reference for the Investigation and explains the progress that is being made towards accomplishment of each of them.

1 To ensure the thorough investigation of the incident, the factors leading up to it, its impact both on and off site, and to establish its causation including root causes

The Board has published three Progress Reports from the Investigation Manager. These have revealed the main facts of the incident, but have not speculated on why control of the fuel was lost. The explosion mechanism, ie the means by which unexpectedly high overpressures were generated, is subject to significant further investigation. This may require wider expert consultation and research.

The criminal investigation is pursuing all reasonable lines of inquiry into the facts and causes of the incident to enable the Competent Authority (HSE and the Environment Agency) to take a view on legal proceedings.

2 To identify and transmit without delay to duty holders and other appropriate recipients any information requiring immediate action to further safety and/or environmental protection in relation to storage and distribution of hydrocarbon fuels

The Competent Authority issued a Safety Alert to around 1100 COMAH duty holders on 21 February 2006. Special attention was paid to 108 fuel depot owners storing COMAH quantities of fuel in Great Britain, seeking a review of arrangements for detecting and dealing with conditions affecting containment of fuel. Most duty holders responded to the alert by the Easter deadline. Meanwhile, the Competent Authority visited all 108 depots to follow up the alert. An interim report was published on 13 June and is available at www.hse.gov.uk/comah/alert.htm.

The Environment Agency issued further advice to its inspectors to investigate secondary (bundling) and tertiary (drains and barriers) containment at depots in England and Wales in response to the Second Progress Report. The Environment Agency is expected to publish a report in the summer. The Environment Agency also continues to monitor the effects of Buncefield on the surrounding environment and to issue updates on its website, www.environment-agency.gov.uk. The initiative is being handled separately for Scotland by the Scottish Environment Protection Agency, with joint inspections undertaken with HSE covering primary, secondary and tertiary containment, and management systems. However, it is intended that an overall view of the situation in Britain will be available this summer.

On 16 June investigators served two Improvement Notices on the manufacturers of the high-level alarm switch installed on Tank 912, having identified a potential problem at other sites related to the setting of the switch for normal operations following testing. This was followed up by a Safety Alert from HSE on 4 July alerting operators relying on such switches of the potential problem.

The Chairman of the Buncefield Board wrote to the Chief Executive of the Health Protection Agency on 3 July enquiring into progress with informing regional resilience groups of early lessons learned from Buncefield, focusing on public health issues in the immediate aftermath of a major airborne incident.

3 To examine the Health and Safety Executive's and the Environment Agency's role in regulating the activities on this site under the COMAH Regulations, considering relevant policy guidance and intervention activity

Work is progressing steadily on both parts of the review, concerning respectively HSE's and the Environment Agency's prior regulatory activities at Buncefield. The full findings of the review will be incorporated into the Board's final report (see term of reference 8). Any immediate important lessons from the examination of the Competent Authority's prior role will be incorporated into the lessons learned programme under term of reference 5.

4 To work closely with all relevant stakeholders, both to keep them informed of progress with the Investigation and to contribute relevant expertise to other inquiries that may be established

The ongoing impact on residents and businesses of the Buncefield incident has been reported in all three Progress Reports. The Board has maintained an active interest in releasing as much new information as possible to the community and its representatives, such as the local MP Mike Penning, to assist in understanding the events of 11 December 2005, and to maintain public confidence that progress is being made with the Investigation. Residents and businesses have shown remarkable resilience in great adversity. Dacorum Borough Council in particular, but also St Albans and Hertfordshire Councils, have performed extremely effectively in very difficult circumstances, and have supported the Board in its engagement with residents and businesses, as has Mike Penning MP.

The Board has also kept key Government stakeholders informed of the Investigation's progress, and has maintained its interest in developments that have taken place since Buncefield to help manage the aftermath and support a return to normality for residents and businesses.

The Board has engaged with all the public sector agencies involved in the emergency response to Buncefield and has met with a number of the key agencies, particularly the Category 1 (Gold) responders. This is not an issue in which the Board has primary responsibility but, as reported in this Initial Report, the Board is giving further consideration to emergency response and emergency preparedness issues, and will say more on this later.

The Buncefield Major Incident Investigation made presentations to two multi-agency debriefing sessions on 21 and 28 June to inform regional resilience groups around Britain of the response to the Buncefield incident.

5 To make recommendations for future action to ensure the effective management and regulation of major accident risk at COMAH sites. This should include consideration of offsite as well as onsite risks and consider prevention of incidents, preparations for response to incidents, and mitigation of their effects

HSE, the Environment Agency and the Health Protection Agency are contributing to this work to assist the Board to make sensible, practical and affordable recommendations for improvements in the light of the Buncefield incident. Key workstreams are in environmental protection; land use planning; fire and explosion mechanisms; control and instrumentation; human and organisational factors; health; emergency response and preparedness; and regulatory impact.

HSE has convened an industry-chaired task group that includes the Environment Agency and the Scottish Environment Protection Agency, to consider design and operation issues. The Board is considering how to make suitable arrangements for further research and modelling of explosion mechanisms in flammable vapour clouds. HSE has begun work on changes to land use planning advice and is working closely with a Cabinet Office-led team on applying new knowledge of risks to society in the planning system. The Health Protection Agency is consulting key agencies to improve public health advice and support during significant pollution events.

6 To produce an initial report for the Health and Safety Commission and the Environment Agency as soon as the main facts have been established. Subject to legal considerations, this report will be made public

This element is discharged by the publication of this report.

7 To ensure that the relevant notifications are made to the European Commission

A report from the Environment Agency and HSE was made to the European Commission on 10 March. Subsequently, the Environment Agency declared Buncefield a Major Accident To The Environment (MATTE), and the Competent Authority has recently reported this to the European Commission.

8 To make the final report public

The timing for the publication of the final report remains uncertain and is of course linked to progress on the main terms of reference and to any decision on any criminal proceedings that might be considered. The possibilities include a further interim report or reports; decisions must necessarily depend on the timing of developments and consideration of the public interest.

Annex 2

Members of the independent Board

The Rt. Hon. Lord Newton of Braintree has been a life peer since 1997 after spending 23 years as a Conservative Member of Parliament for Braintree, Essex. From 1982 to 1988 he held ministerial positions at the Department of Health and Social Security. In 1988 he joined the Cabinet as Chancellor of the Duchy of Lancaster and Minister at the DTI. He then held the post of Secretary of State for Social Security from 1989 to 1992 when he was appointed Leader of the House of Commons, which he held until 1997. In 2002 he chaired the Committee that reviewed the operation of the Anti-Terrorism, Crime and Security Act 2001.

Professor Dougal Drysdale is one of the leading international authorities in Fire Safety Engineering. He was the Chairman of the International Association of Fire Safety Science until September 2005 and is currently the editor of the leading scientific journal in the field, Fire Safety Journal. His wide range of research interests includes the ignition characteristics of combustible materials, flame spread and various aspects of fire dynamics. He is a Fellow of the Royal Society of Edinburgh and a Fellow of both the Institution of Fire Engineers and the Society of Fire Protection Engineers.

Dr Peter Baxter is a Consultant Physician in Occupational and Environmental Medicine at Cambridge University and Addenbrooke's Hospital, Cambridge. In the past he has advised the Government on the impacts on public health relating to air quality standards, major chemical incidents, natural disasters and climate change.

Taf Powell is Director of HSE's Offshore Division. He graduated in Geology and Chemistry from Nottingham University. His oil field career has been split between working in the UK and abroad in offshore exploration and development and regulation of the sector in licensing, well operations, policy and safety regulation. In 1991 he joined HSE's Offshore Division from BP and started work to develop the new offshore regulatory framework, one of Lord Cullen's recommendations following his inquiry into the Piper Alpha disaster. As HSE's Operations Manager, based in Aberdeen, he then led inspection teams and well engineering specialists responsible for enforcing the new regulations until 2000 when he took up his current role.

Dr Paul Leinster is Director of Operations at the Environment Agency. Up until March 2004 he was the Director of Environmental Protection, having joined the Agency in 1998. Prior to this he was the Director of Environmental Services with SmithKline Beecham. Previous employers also include BP International, Schering Agrochemicals and the consultancy firm Thomson-MTS where he was Managing Director. Paul has a degree in Chemistry, a PhD in Environmental Engineering from Imperial College and an MBA from the Cranfield School of Management. Paul has worked for 30 years in the health and safety and environmental field.

David Ashton is Director of HSE's Field Operations North-West and Headquarters Division. He joined HSE in 1977 as an inspector in the west of Scotland where he dealt with a wide range of manufacturing and service industries, including construction, engineering and the health services. In 1986 he joined Field Operations HQ to deal with machinery safety. He then held the post of Principal Inspector of manufacturing in Preston for two years, before being appointed as a management systems auditor to examine offshore safety cases in the newly formed Offshore Division. In 1993 he became Head of HSE's Accident Prevention Advisory Unit, looking at the management of health and safety in organisations. Between 1998 and 2003 David was HSE's Director of Personnel, before being appointed to his current position.

Annex 3

Planning history of Buncefield site and neighbouring developments

1 Planning permission was granted in 1966 to Shell Mex and BP Limited, Regent Oil Co Limited, Mobil Oil Co Limited, and Petrofina (GB) Limited to develop 91 acres of land at Buncefield for the construction of a storage and distribution depot for petroleum products. St Albans Rural District Council initially refused the application on the grounds that it was an inappropriate development in the Green Belt and would have a detrimental effect on the amenity of the locality. On appeal, the Minister of Housing and Local Government granted permission subject to a number of conditions relating to design of the site, tree planting and restrictions on the size of office premises.

2 At the time that the terminal was built in 1968, the site was well screened by hedges and trees, but there were about nine dwellings on the periphery of the site to the north whose amenities were affected by the site, and a farm to the south. One of the nine dwellings to the north was converted in 2000 to create five separate properties. Since 1968 there has been general encroachment and development of adjacent land. This can be seen on the map in Figure 5. The majority of this building development took place during the period from the mid 1960s to the early 1980s, comprising the construction or redevelopment of residential properties and a number of schools and industrial premises to the west of the site, all of which fell within a 3 km radius as shown on the map. Between 1990 and 2006, a few additional industrial premises were built around the site.

3 Dacorum Borough Council is the principal planning authority for the site, but a small section to the north of Cherry Tree Lane falls to St Albans District Council.

4 The local planning authority decides whether developments can go ahead. But arrangements have existed since 1972 for local planning authorities to obtain consultee advice from HSE and its predecessors about the safety implications for developments from risks associated with major hazards. Between 1991 and 2005, 28 applications were passed to HSE for advice relating to a variety of commercial or residential developments around the Buncefield site. HSE advised against four of these proposals and advised that seven others could be allowed subject to certain conditions. As far as is known, the local authority followed HSE's advice in these cases.

5 In addition to these specific developments on which HSE was a statutory consultee, HSE is from time to time consulted on other matters. For example, HSE was consulted on four local structure plan revisions.

6 The complex began operations in 1968 after a pipeline was constructed to link two Shell refineries at Stanlow at Ellesmere Port in Cheshire and Shell Haven on the Thames Estuary at Stanford-le-Hope in Thurrock. The depot operated originally under licence given under the Petroleum (Consolidation) Acts 1928 and 1936. The Planning (Hazardous Substances) Act 1990 and subsequent statutory provisions, the Planning (Hazardous Substances) Regulations 1992 (PHS Regulations) and later the Planning (Control of Major Accident Hazards) Regulations 1999 introduced new procedures for consent to be sought from the hazardous substances authority to store hazardous substances.

7 The consent identifies the hazardous substances and their location on site and defines certain conditions of use such as maximum size, temperature and pressure of storage vessels. Figure 6 contains some details of consents obtained for the Buncefield depot. The consents for Shell UK Oil Limited have been included in this table as they have not been revoked, although Shell no longer operates from this site.

HSE's role in land use planning

8 HSE's specific role in land use planning is twofold:

- ▼ Under the PHS Regulations, the presence of hazardous chemicals above specified threshold quantities requires consent from the local hazardous substances authority, which is usually also the local planning authority. HSE is a statutory consultee on all hazardous substances consent applications. Its role is to consider the hazards and risks which would be presented by the hazardous substance(s) to people in the vicinity, and on the basis of this to advise the hazardous substances authority whether or not consent should be granted. In advising on consent, HSE may specify conditions that should be imposed by the hazardous substances authority, over and above compliance with statutory health and safety requirements, to limit risks to the public (eg limiting which substances can be stored on site, or requiring tanker delivery rather than on-site storage). Hazardous substances authorities should notify HSE of the outcome of all applications for consent, and where consent has been granted should supply copies of the site plans and conditions.
- ▼ HSE uses the information contained in consent applications to establish a consultation distance around the installation. This usually comprises three zones or risk contour areas. The consultation distance is based on the maximum quantity of hazardous substance(s) that the site is entitled to have under its consent. HSE notifies the local planning authorities of all consultation distances in their areas. The General Development Procedure Order 1995 requires the local planning authority to consult HSE about certain proposed developments (essentially those that would result in an increase in population) within any consultation distance. HSE advises the local planning authority on the nature and severity of the risks presented by the installation to people in the surrounding area so that those risks are given due weight by the local planning authority when making its decision. Taking account of the risks, HSE will advise against the proposed development or simply note that it does not advise against it.

9 HSE's approach to land use planning is set out in more detail in Annex 2 of the first Progress Report. Some of this process is now being devolved to certain local planning authorities.

10 The consultation distance represents the furthest distance at which HSE wishes to be consulted about developments near hazardous installations/major accident hazard pipelines. This does not mean that there is no risk beyond the consultation distance, just that the predicted risks are sufficiently low that they need not be part of a planning decision.

11 Within the consultation distance, HSE undertakes an assessment of the hazards and risks from the installation and produces a map with three contours representing defined levels of harm or risk which any individual at that contour would be subject to, based on information relating to the hazardous substances consent. The harm or risk to an individual is greater the closer to the installation.

The contours form three zones, with the outer contour defining the consultation distance around major hazard sites. The local authority consults HSE on relevant proposed developments within this consultation distance.

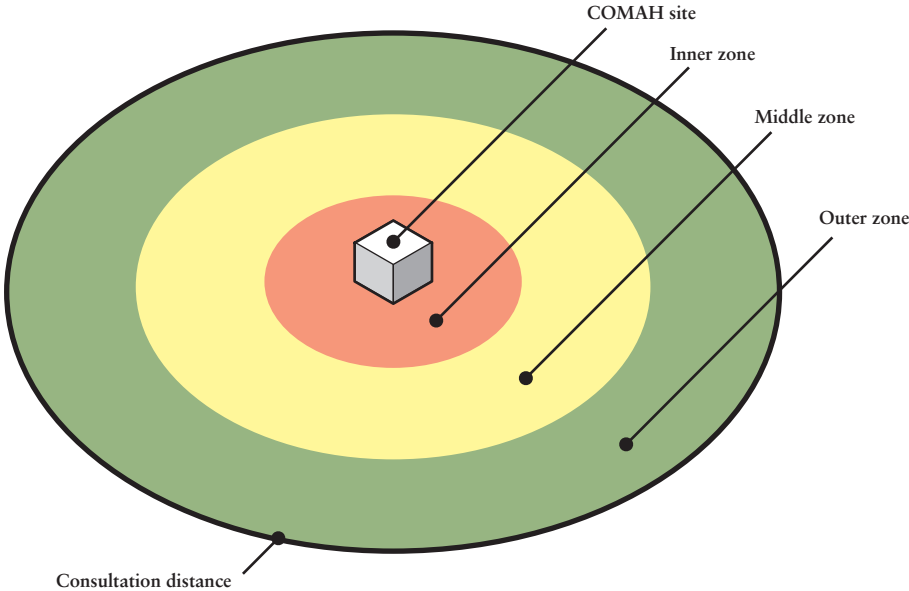


Figure 3 Consultation distance and zones

12 When a planning application is received, HSE or the local planning authority first identifies in which of the three zones the proposed development is located. Secondly, the proposed development is classified into one of four ‘sensitivity levels’. The main factors that determine these levels are the number of people at the development, their sensitivity (vulnerable populations such as children, old people) and the intensity of the development. With these two factors known, a simple decision matrix is used to give a clear ‘Advise Against’ or ‘Do not Advise Against’ response to the local planning authority, as shown below:

Level of sensitivity	Development in inner zone	Development in middle zone	Development in outer zone
1	DAA	DAA	DAA
2	AA	DAA	DAA
3	AA	AA	DAA
4	AA	AA	AA
Sensitivity level 1	Example	Factories	
Sensitivity level 2	Example	Houses	
Sensitivity level 3	Example	Vulnerable members of society eg primary schools, old people’s homes	
Sensitivity level 4	Example	Football ground/large hospital	
DAA means Do not Advise Against the development			
AA means Advise Against the development			

Figure 4 Land use planning ‘sensitivity levels’ and decision matrix

13 More comprehensive guidance on the allocation of sensitivity levels is given on the Planning Advice for Developments near Hazardous Installations website (www.hse.gov.uk/landuseplanning/padhi.pdf).

History of the consultation distance around the Buncefield site

14 HSE has had arrangements with local planning authorities for consultation around developments in the vicinity of major hazards since the early 1970s, although it was not until the implementation of the Notification of Installations Handling Hazardous Substances Regulations 1982 (NIHHS Regulations) in 1983 that HSE first received notification from Shell Mex and BP of the terminal as a major hazard. A generic non-site specific consultation distance of 250 m from the boundary of the site was set for consultation purposes and the relevant local planning authority was notified. At that time it was customary to issue a generic consultation distance without performing a site-specific assessment. This consultation distance was based upon the assumption that the main hazard was from thermal radiation following a major fire within the bund.

15 In 1992 the site expanded and Mobil and Shell sent another notification and application for consent to store certain amounts of flammable material. The existing consultation distance was maintained at a generic 250 m from the site boundary. There are no records of the technical assessments that were performed when the local planning authority sought advice on developments within the vicinity of the site, but early assessments were based then, as now, upon a pool fire following loss of containment of a substantial quantity of flammable liquid. However, for tanks that were banded there was a continuing assumption that any subsequent fire would be within the confines of the bund.

16 In 1996 a site-specific reassessment was performed based upon consented amounts of flammable material, and the consultation distance was reduced from 250 m to 190 m. The original 250 m was set in the early days of HSE giving land use planning advice, to ensure that all developments that might be advised against would be subject to consultation. By 1996, technical policy and methodology had been reviewed. In addition, three-zone maps were now being produced so that development control advice could be given more quickly and efficiently. The new policy assumed that the bund would not be able to contain the full contents of a tank following a sudden, catastrophic failure. It was assumed that the bund would be overtopped and the resulting pool fire would extend beyond the confines of the bund.

17 In July 2001 another consultation distance was calculated due to an extensive reassessment of the hazards from the site following the submission of a batch of new consent applications from the oil companies. The regulations requiring consent to store flammable substances were changed in 1999 to include additional flammable materials. The consultation distance was reduced from 190 m to 185 m. This was unchanged following a further consent application on 8 July 2005 from BP. The presence of the additional material did not alter the main basis of the calculation which assumed the worst-case event was the catastrophic failure of the largest tank containing gasoline. The consultation distance was reduced slightly owing to a slight change to the inputs in the model used to perform the calculations. See Figure 7 for a representative plan of the site showing the consultation distance since July 2001.

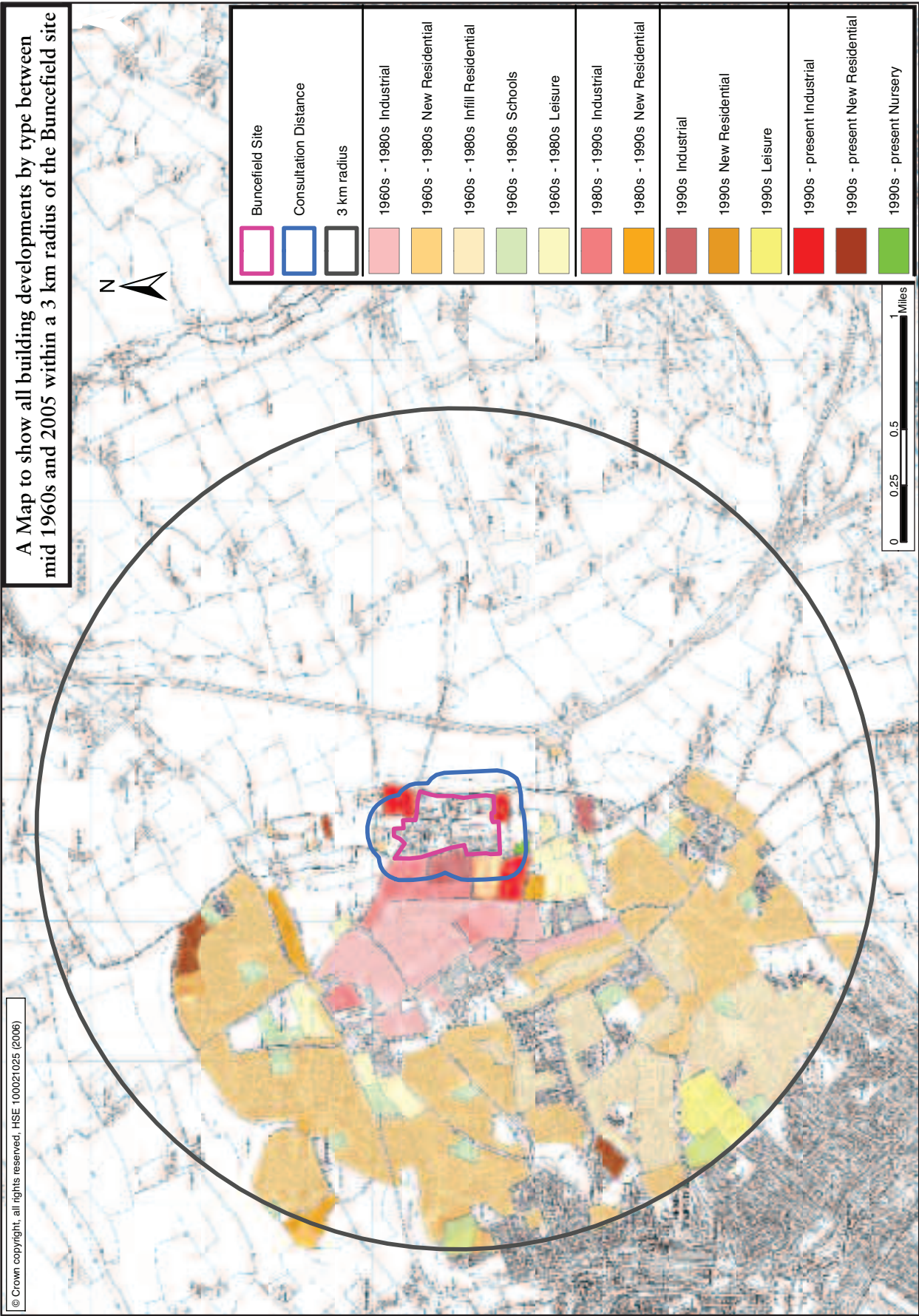


Figure 5 Developments within 3 km of the Buncefield site between 1966 and 2005

Some details of hazardous substances consents issued for the Buncefield oil storage and transfer depot

Operator	Hazardous Substances Consent applications
Texaco Limited	19 September 1983*: 10 571 tonnes motor spirit
Mobil Oil Co Limited	8 November 1983*: 17 650 tonnes petrol
Hertfordshire Oil Storage Limited	30 November 1992: 34 020 tonnes motor spirit 18 October 1999: 15 314 tonnes kerosene
BP Oil UK Limited petroleum spirits	18 November 1992: 17 650 tonnes gasoline in name of Mobil Oil Co Limited 26 October 1999: 15 080 tonnes automotive petrol and other 21 October 2003: 15 200 tonnes automotive petrol and 10 522 tonnes petroleum products classified as dangerous for the environment (most likely to be gasoline or diesel) 3 May 2005: 26 900 tonnes automotive petrol and 10 522 tonnes petroleum products classified as dangerous for the environment (most likely to be gasoline or diesel)
British Pipeline Agency Limited	26 October 1999: 70 000 tonnes automotive petrol and other petroleum spirits
Shell UK Oil Limited	19 September 1983*: 37 397 tonnes HFLs Class 4 and 42 561 tonnes kerosene and white oils 30 November 1992: 34 013 tonnes petroleum spirit and 39 000 tonnes diesel, gas oil and kerosene 1999: 33 000 tonnes motor spirit and 17 000 tonnes kerosene

Figure 6 Hazardous substances consents issued

** Note: The first applications for 'consent' were in 1992, before then different arrangements were in place, ie these were notifications under NIHHS and consent was not required.*



Figure 7 Plan representing the hazardous substances consents and consultation area around the Buncefield depot since July 2001 (for illustration only)

Annex 4

UK petroleum refinery, pipeline and storage system

Refineries

1 Petroleum products in the UK are predominantly supplied from nine refineries where crude oil is refined into liquefied petroleum gas (LPG), petrol, diesel, aviation fuel, gas oil, heating oil and residual bitumen. From a typical barrel of North Sea crude oil, approximately 3% becomes LPG, 37% petrol, 25% diesel, 20% kerosene (aviation fuel/heating oil) and 12% fuel oil (for power generation). Figure 8 shows the location of the refineries. They are sited on the coast or on estuaries so that they can receive crude oil by ship.



Figure 8 UK oil refinery and pipeline network

2 Storing, moving and delivering these fuels to the end user are important elements of the UK economy. Each year approximately 75 million tonnes of petroleum products are moved around the UK.

3 All nine main refineries in the UK have substantial storage for finished products coming out of the refinery. However, given the location of refineries, there are also large storage terminals around the country, generally near major conurbations. These terminals are mainly supplied from the refineries by pipeline, rail and sea. Often they are run as joint ventures between a number of oil companies. Commercial arrangements are commonly negotiated between companies to draw products on exchange from another company's terminal. This avoids the need to transport products over long distances from one terminal to another. Figure 9 shows the place of oil storage and transfer depots in the UK oil distribution system.

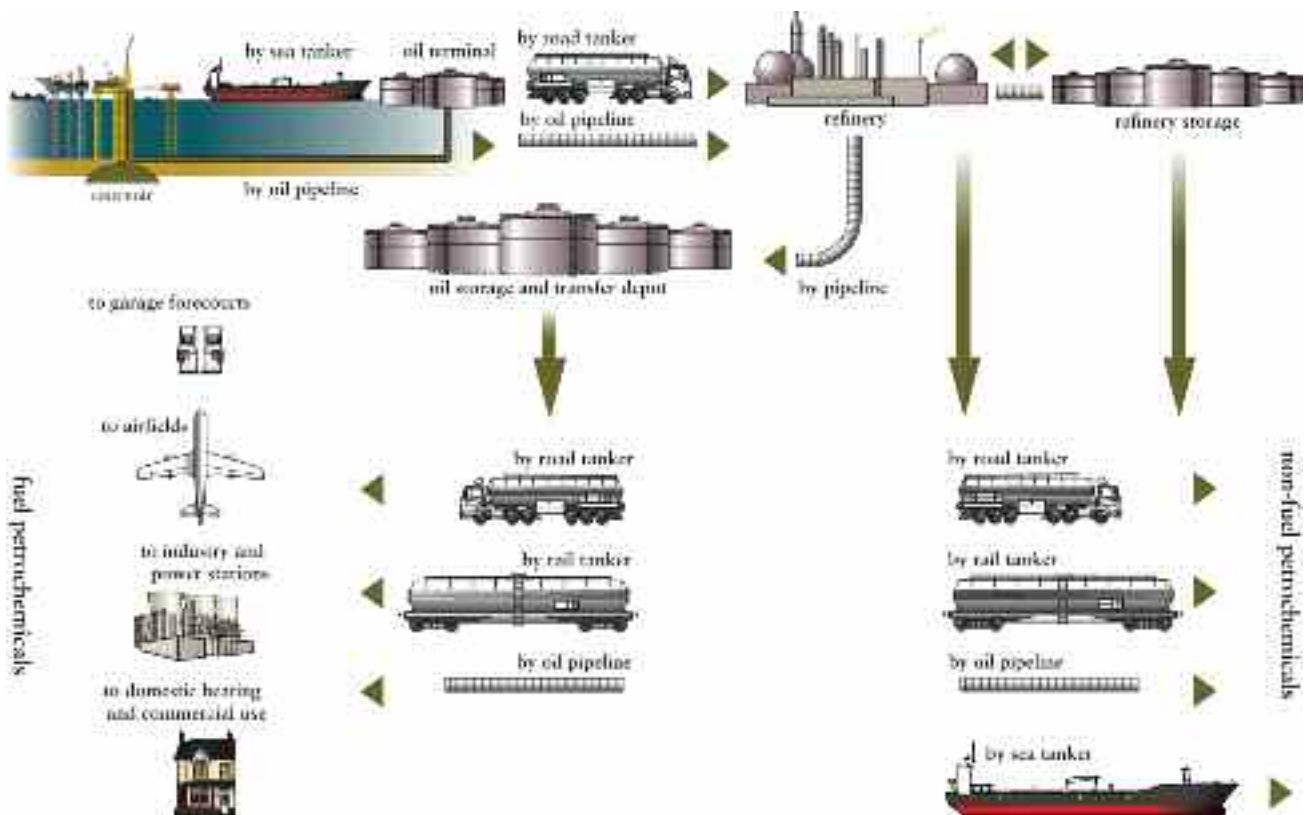


Figure 9 The UK oil distribution system

Petroleum pipelines

4 The UK mainland has a network of approximately 1500 miles of petroleum pipelines. Some of them are owned by individual oil companies dedicated to supplying their own terminals, and some are owned by joint ventures such as United Kingdom Oil Pipelines Limited (UKOP). Others belong to the Government. Once installed, underground pipelines offer substantial environmental and safety benefits, not least from the elimination of road tanker journeys or transportation by rail or sea.

5 These pipelines are used to transport a variety of fuels, including petrol, diesel, heating oil and aviation fuel. After a batch of predetermined volume of one fuel has been delivered through the pipeline, a different fuel may be transported. As the fuels travel along the pipeline, a relatively small degree of mixing will occur at the interface. As this volume of mixed fuels has to be reprocessed, the pipeline operator manages the flow rates continually to minimise these interfaces to reduce wastage. Around 30 million tonnes of fuel are moved around the UK in this way in a year.

Annex 5

Incidents that have similarities with the Buncefield incident

Location	Date and time	Comments – background	Comments – explosion	Ref <i>see over</i>
1 Houston, Texas, USA	April 1962	‘Severe leak’ from a gasoline tank. Almost windless conditions. Ignition near adjacent highway.	Described as a ‘blast’, but no details are available.	1
2 Baytown, Texas, USA	27 January 1977	Overfilling of a ship with gasoline.	Few details are available, but it is likely that there would have been congestion.	1
3 Texaco, Newark, New Jersey, USA	7 January 1983 After 00.00 hrs	Overfilling of a tank containing unleaded gasoline. 114-379 m ³ (80-265 tonnes) of gasoline released. Slight wind, ignition source 300 m away.	Relatively uncongested area. High overpressures reported, but not quantified. Three minor explosions preceded the main blast.	2
4 Naples Harbour, Italy	21 December 1985	Overfilling of a tank containing unleaded gasoline. 700 tonnes escaped. Low wind speed (2 m/s).	Relatively congested area. The tank overtopped 1.5 hours before ignition. Various overpressures estimated from damage analysis, but they are minimum values (eg >48 kPa).	3
5 St Herblain, France	7 October 1991 04:00 hours	Leak of gasoline from a transfer line into a bund. Wind <1 m/s. 20 minutes delay, ignition in car park c. 50 m away. Volume of flammable cloud est. 23 000 m ³ .	Presence of parked petrol tankers may have been sufficient to generate turbulence. High overpressures produced, but not quantified.	4
6 Jacksonville, Florida, USA	2 January 1993 03:15 hours	Overfilling of a tank containing unleaded gasoline. 50 000 gallons (190 m ³ , 132 tonnes) released.	High overpressure produced, but not quantified.	5
7 Laem Chabang, Thailand	2 December 1999 23:25 hours	Overfilling of a gasoline tank. Few details.	High overpressure produced, but not quantified. Relatively low congestion in the area.	6

Note: The root cause of each of the above incidents was the spillage (loss of containment) of a large quantity of gasoline (eg >100 tonnes) due to overfilling of a tank, or failure of pipework inside a bund. In each case, the windspeed was very low, or zero, and a significant vapour cloud was able to form. The feature of the Buncefield explosion that appeared unique was the apparent lack of obstacles which could induce turbulence and thereby lead to rapid flame propagation, sufficient to produce the high overpressures recorded. Accordingly, incidents 2, 4 and 5 may not be relevant. As the ‘lack of confinement’ cannot be quantified, the relevance of the other incidents might be superficial. More information is required. Work is in hand to identify other incidents that may be relevant.

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- 6 *THAIOIL Fire: A whiff of oil, then a thundering explosion* Witness Accounts, Bangkok Post (FBKP) 5 December 1999 Page 1

Annex 6

Fire and explosion hazards from petrol

Introduction

1 This annex sets out a general explanation of the fire and explosion hazards from fuels such as petrol, as currently understood. It is not limited to the circumstances of the Buncefield incident.

Flashpoint

2 The physical properties of highly flammable liquids, such as petrol, are such that if they are mishandled or released they present a significant risk of fire or explosion. In this context, perhaps the most important property of petrol is its high volatility. At normal ambient temperatures, the vapour released by simple evaporation from the fuel surface can readily be ignited as it mixes with air. It is classified legally as a Highly Flammable Liquid, ie it has a flashpoint (measured in a 'closed cup' apparatus) below 32 °C.

3 'Flashpoint' is used to define the hazard associated with liquid fuels and to help determine safe working conditions. The flashpoint is defined as the minimum temperature at which a liquid fuel produces sufficient vapour to form a flammable or ignitable mixture with air. Petrol has a flashpoint of around minus 40 °C, well below normal (ambient) temperatures, and can be ignited very easily. It is the vapour that 'burns', releasing heat, some of which is transferred to the surface of the fuel, thus increasing the rate of evaporation that supplies the flame with fuel vapour. Paragraph 7 of this annex provides more information about fuel fires.

4 Not all concentrations of fuel vapour in air are flammable, ie capable of being ignited by a small ignition source such as a spark or a flame. Ignition can only occur if the mixture of flammable vapour in air falls within certain concentrations, known as the lower and upper explosion (or flammability) limits. For petrol vapour, concentrations below 1.4% in air are too lean to burn, while those above 7.6% are too rich.¹⁸ At all concentrations between these two limits, known as the flammable range, the mixtures will burn, in that a flame will propagate away from the ignition source.

5 The flash point and the flammable range are determined by standard test methods.

6 Whether an ignition can give rise to a fire, an explosion or a combination of both depends on a number of factors, including the conditions prevailing at the time and the immediate surroundings of the release, but particularly on the amount of vapour present and how it is able to mix or diffuse with air.

Fires

7 In a fire, the vapour evolved from spilt or released material is ignited and continues to burn above the fuel surface where the vapour mixes with the surrounding air. This type of flame is known as a diffusion flame as the fuel vapour

¹⁸ The concentration of petrol vapour in a partially full petrol tank is above the upper explosive limit and therefore too rich to burn.

and air mix by diffusion, and it is the type of flame associated with fires involving liquid and solid fuels. Heat transferred from the flame to the fuel provides the energy required to maintain the flow of fuel vapours that support the flame. The flames associated with a liquid pool fire will completely cover the surface and will continue to burn as long as there is fuel remaining. The flames of a petrol pool fire will extinguish when all the petrol is consumed, or if air can be excluded from the flames, or if the vapour release can be prevented or inhibited (as happens when the liquid surface is completely covered with a layer of fire-fighting foam).

8 With large hydrocarbon pool fires such as those at Buncefield, the flames are so large that mixing of fuel vapour and air is not efficient. This leads to the formation of species within the flame that cause the release of copious amounts of black smoke. The immediate precursors of the smoke are minute soot particles which radiate, producing the characteristic yellow colour associated with almost all diffusion flames. The hazards arising from such fires are due to heat transfer by radiation to neighbouring surfaces and to the hot fire products (rich in smoke and toxic gases) carried aloft by buoyancy. Pressure effects are negligible and could not cause structural damage, but heat transfer to structures immersed in the flames will cause weakening and eventual collapse.

Explosions

9 For an explosion involving petrol vapour to occur, the vapour/air mixture must be within its flammable range when it encounters a potential source of ignition. A flame will propagate rapidly, spreading spherically from the ignition source throughout the entire flammable mixture. The heat released as the fuel is consumed causes the gases to expand as a result of the associated temperature rise. If confined, eg if the mixture is contained within a building, the gases cannot expand freely and the pressure will rise until parts of the confining structure (such as the windows of a building) fail and relieve the pressure. This is normally a violent event and may produce a shock wave that can cause remote damage.

10 High temperature effects from the explosion are transient, but they will ignite highly flammable liquids and can ignite lightweight combustible solids (eg tissue paper). Some can be left burning after the explosion has passed. The flame created by an explosion of petrol vapour in air is blue or very pale yellow, depending on the fuel/air mixture. It is known as a premixed flame as the fuel vapour and air are mixed before ignition occurs. The amount of smoke produced is negligible compared to that produced in a fire.

11 In general terms, overpressures are not developed if an unconfined petrol vapour/air mixture is ignited because the gases can expand freely. However, the speed at which the flame travels through the flammable mixture can vary considerably, depending on a number of different factors. If the flame speed is very high, some overpressure will be created as the expansion cannot occur rapidly enough, despite the (apparent) lack of confinement. Factors that affect the speed with which a flame will travel through a flammable mixture include:

- ▼ composition of the mixture;
- ▼ amount of vapour and size of the flammable cloud;
- ▼ strength of the ignition source;
- ▼ degree of confinement within the flammable cloud ('partial confinement');
- ▼ turbulence created within the mixture as the flame front forces the unburnt mixture through a partially confined space.

12 The term ‘partial confinement’ is used to describe a situation in which obstacles lie in the path of the advancing flame. As the (as yet) unburnt mixture is forced past these obstacles, turbulence is produced. The flame will travel much more rapidly through a turbulent mixture than through a quiescent one.

13 The flame speed may vary from a few metres per second (m/s) to sonic velocities (340 m/s). Under certain conditions, supersonic velocities may be reached. If the velocity is subsonic the propagating flame is termed a deflagration. If the flame speed is greater than the speed of sound the explosion is termed a detonation. The faster a flame travels, the greater the overpressure produced. A cloud of petrol vapour in the open without any turbulence creating obstructions, such as complex pipe racks or congested plant, would on ignition produce a deflagration with a relatively slow flame speed (eg 10 m/s). Such an event would give rise to overpressures of about 0.2 psi (14 mbar). For a flame to accelerate beyond this and create higher overpressures, some or all of the factors mentioned above would have to play a part. A flame would not accelerate to detonation unless it was confined in a long narrow structure such as a pipeline.

14 As indicated above, if a flammable mixture is ignited within an item of enclosed plant or equipment, the pressure will build up until the plant either fails or a purpose-built vent or explosion relief panel opens. Storage tanks, for example, are normally designed with a weak roof joint so that in the event of an internal explosion, the explosive forces are vented upwards without the rest of the tank failing. Without any venting, and provided that the item of plant does not fail, an internal deflagration from hydrocarbon vapours could theoretically give a maximum pressure rise of approximately 130 psi (8.9 bar).

Flash fires

15 A flash fire can occur if a vapour rich cloud spreads from its release point, undergoing some dilution at the interface between the cloud and the surrounding air so that a flammable mixture exists only at the interface. The cloud still has a fuel-rich core. Upon ignition the flame front will rapidly propagate through the flammable regions of the cloud and the fuel-rich region will burn more slowly as it mixes with air. The flames will eventually become established as an ordinary diffusion flame at the point of origin. Flash fires do not usually generate any appreciable overpressure effects.

Overpressure

16 The pressure wave created by an explosion can have an effect on people, plant or property, in addition to the harmful effects from the burning vapour. The greatest effects from the pressure wave will be at the closest point to the explosion. Previous work to categorise the damage from blast overpressure has mainly considered the effects from conventional explosives and nuclear bomb tests, rather than the type of incident that occurred at Buncefield. Explosions are often classified according to their TNT equivalent, with an ‘efficiency factor’ used to compensate for the lower efficiency of an igniting vapour cloud in converting chemical energy into blast energy.

17 Another difference is that the blast from a conventional explosive has a high peak pressure over a short period of time, when compared to a hydrocarbon cloud which generates a lower peak pressure but of longer duration. The longer duration creates a higher impulse and therefore a different damaging effect than the same energy release from a high explosive. A further problem with using this information to analyse vapour cloud explosion events is the fact that conventional explosives have a point source, whereas a vapour cloud occupies a large volume.

18 The following table lists commonly accepted damage figures from blast overpressure and can be used for comparative purposes. However, care has to be taken in using this data as it does not take into account the duration of the pressure wave.

Commonly accepted damage figures from blast overpressure

Pressure (psi)	Pressure (millibar)	Damage
0.02	1.4	Annoying noise, if of low frequency
0.10	7	Breakage of small windows under strain
0.15	10	Typical pressure for glass failure
0.30	21	Damage to some ceilings
0.40	28	Minor structural damage
0.5-1.0	34-70	Large and small windows shattered, damage to window frames
0.75	52	Minor damage to houses, 20-50% of tiles displaced
0.9	63	Roof damage to oil storage tanks
1.0	70	Houses made uninhabitable
1.0-2.0	70-140	Asbestos cladding shattered, fastenings of corrugated steel panels fail, tiled roof lifted and displaced
2.0	140	Partial collapse of walls and roofs of houses, 30% of trees blown down
3.0	210	90% of trees blown down, steel framed buildings distorted and pulled away from foundations
3.0-4.0	210-280	Rupture of oil tanks
4.0-5.0	280-350	Severe displacement of motor vehicles
5.0	350	Wooden utility poles snapped
7.0-9.0	490-630	Collapse of steel girder framed buildings
8.0-10	560-700	Brick walls completely demolished
>10	>700	Complete destruction of all unreinforced buildings
70	4900	Collapse of heavy masonry or concrete bridges

Source: HSE Specialist Inspector Report Number 37 – Simplified calculations of blast induced injuries and damage

Commonly accepted figures for direct harm to people from blast overpressure

Pressure (psi)	Pressure (millibar)	Direct harm to people
2	138	Threshold for eardrum rupture
1.5-2.9	103-200	People knocked down or thrown to the ground
10-15	690-1035	90% probability of eardrum rupture
12-15	830-1035	Threshold of lung haemorrhage
30-34	2068-2400	Near 100% fatality from lung haemorrhage

19 HSE uses the following levels of overpressure for providing land use planning advice around hazardous installations. These are based on estimates of fatalities within occupied buildings.

Pressure (psi)	Pressure (millibar)	Direct harm to people
8.6	600	50% fatalities for a normal population
2	140	Threshold of fatality (1-5%) for a normal population
1	70	Threshold of fatality (1-5%) for a vulnerable population

Annex 7

Product composition at Buncefield

1 Extensive sampling of the various petroleum products at the Buncefield depot has been carried out to verify the product distribution through the site from the different supply pipelines, and also to identify the composition of the released materials. The majority of the samples were taken from the Hertfordshire Oil Storage Limited site but samples were also taken from the two pipelines feeding unleaded petrol to the site, the United Kingdom Oil Pipelines Limited T/K pipeline and the FinaLine pipeline from the Lindsey refinery.

2 As a release of unleaded petrol is considered to be the initiating event for the explosion and subsequent fire, all petrol samples have been tested against the standard BS EN 228 for automotive fuels, together with a full chemical analysis by an independent accredited test house.¹⁹ Samples of other products handled on site including diesel, aviation fuel and gas oil have been subject to simple laboratory tests to confirm their identity.

Product identification

3 The test results from the samples taken on site are consistent with the product type identified from the site plans or by the company as being contained or held within any particular plant or section of pipework. Many of the samples showed degradation or contamination caused by heat-damaged plant or open pipework as a result of the incident. This degradation is particularly noticeable by the loss of the more volatile components, including butane, from many of the samples.

4 The loss of volatile components from the samples has made a direct comparison of their analytical results and subsequent tracking of the different product sources through the site extremely difficult. In addition representative samples from Tank 912 after the incident are not available as this tank completely burnt out, and only fire-damaged residues consisting mainly of water could be extracted from the tank bottom. The samples of the material feeding Tank 912, taken by the operator prior to the incident and retained on site, were destroyed during the incident.

Product composition

5 The evidence to date is consistent with the release of petrol from Tank 912 while it was being fed from the British Pipeline Agency Limited manifold. Petrol is a blend of many different hydrocarbons, each of which will have an impact on the vapour pressure. The British Pipeline Agency Limited manifold feeding Tank 912 was being supplied by a parcel of unleaded petrol from the British Petroleum PLC oil refinery at Coryton, Essex. That in turn was made up from the feed from four separate tanks. No sample of the parcel is available as the part-batches from the feeder tanks are not blended and tested as a composite batch before being pumped from site. British Petroleum PLC has provided the Conformity Certificates for the individual feeder tanks showing their analysis against the British Standard. The British Standard is a performance specification and only details specific limits for

¹⁹ BS EN 228: 2004 *Automotive fuels. Unleaded petrol. Requirements and test methods*. Available online at www.bsonline.bsi-global.com.

the chemicals lead and benzene. By way of example, the standard does not specifically limit the content of butane, which comprises a mixture of butanes and butenes, and therefore the presence and levels of these individual components are not routinely determined. The total butane content, however, will affect the vapour pressure and this is specified in the standard depending on whether the product is marketed as winter or summer grade. For winter grade petrol the vapour pressure limits are defined as 70-100 kPa and for summer they are reduced to 45-70 kPa.

6 The Conformity Certificates show that the vapour pressure for the four part-batches were all at or very close to 100 kPa. This was corroborated by evidence obtained from the British Pipeline Agency Limited site after the incident. This corresponded to a total butane content of 10.0%. By contrast, other samples of petrol taken from the site after the incident and which had been degraded by exposure to the fire were found to have lower vapour pressures and correspondingly lower butane levels. Therefore the product released on site was at the top end of the winter grade limit for vapour pressure. A reasonable estimate of the butane content of the released material is 10% by weight.

Annex 8

Regulatory framework for high hazard sites

1 The regulatory framework for sites such as Buncefield, which present potential major accident hazards, comprises requirements imposed on the site operators under both health and safety and environmental legislation, complemented by the requirements of planning law. In particular, the Control of Major Accident Hazards Regulations 1999 (COMAH) apply.

Health and safety law

2 Operators in the process industries are subject to the requirements of the Health and Safety at Work etc Act 1974 (the HSW Act) and the Management of Health and Safety at Work Regulations 1999 which require, respectively, safety policies and risk assessments covering the whole range of health and safety risks.

Control of Major Accident Hazards Regulations 1999 (COMAH)

3 COMAH's main aim is to prevent and mitigate the effects of those major accidents involving dangerous substances, such as chlorine, liquefied petroleum gas and explosives which can cause serious damage/harm to people and/or the environment. The COMAH Regulations treat risks to the environment as seriously as those to people. They apply where threshold quantities of dangerous substances identified in the Regulations are kept or used. There are two thresholds, known as 'lower-tier' and 'top-tier'. The requirements of COMAH are fully explained in *The requirements of COMAH are fully explained in A guide to the Control of Major Accident Hazards Regulations 1999 (COMAH). Guidance on Regulations L111 HSE Books 1999 ISBN 0 7176 1604 5.*

4 The COMAH Regulations are enforced by a joint Competent Authority comprising HSE and the Environment Agency in England and Wales, and HSE and the Scottish Environment Protection Agency (SEPA) in Scotland. Operators will generally receive a single response from the Competent Authority on all matters to do with COMAH. The Competent Authority operates to a Memorandum of Understanding, which sets out arrangements for joint working.

5 The COMAH Regulations require operators of top-tier sites to submit written safety reports to the Competent Authority with the purpose, among others, of demonstrating that major accident hazards have been identified and that the necessary measures have been taken both to prevent such accidents and to limit any consequences. Operators of top-tier sites must also prepare adequate emergency plans to deal with the on-site consequences of possible major accidents, and to assist with off-site mitigation. Local authorities for areas containing top-tier sites must prepare adequate emergency plans to deal with the off-site consequences of possible major accidents, based on information supplied by site operators.

6 The COMAH Regulations place duties on the Competent Authority to have in place a system of inspections for establishments subject to the Regulations, and to prohibit the operation of an establishment if there is evidence that measures taken for prevention and mitigation of major accidents are seriously deficient. The Competent Authority also has to examine safety reports and inform operators about the conclusions of its examinations within a reasonable time period.

7 The inspection plan for a particular establishment is drawn up by inspectors from the Competent Authority based on previous interventions at the site and on information gained from the assessment of the safety report. The inspection programme requires input from a range of inspectors with specialist knowledge and identifies and prioritises issues. The focus of the programme is to ensure that the key risk control measures for preventing and mitigating major hazards are maintained.

8 The adequacy of this process and its application at Buncefield by HSE and Environment Agency inspectors is subject to a review under term of reference 3.

Environmental legislation

9 Some of the establishments regulated under the COMAH Regulations are also regulated by the Environment Agency and SEPA (the Agencies) under the Pollution Prevention and Control Act 1999 (PPC) or Part I of the Environmental Protection Act 1990 (EPA 90). The regime under EPA 90 is gradually being replaced by the PPC regime and will be fully replaced by 2007.

10 While the purpose of the COMAH Regulations (the prevention of major accidents) differs from that of PPC, the means to achieve them are almost identical. They require industry to have good management systems to control risk. PPC includes a specific duty to prevent and mitigate accidents to the environment which is complementary to the main COMAH duty. The Agencies manage this overlap between their different regimes following the principle that accident prevention work on COMAH sites is generally more significant because of the greater risks.

Supporting guidance and standards

11 The legal requirements are supported by a large body of guidance and standards that set out recognised good practice in the control of major accident hazards. This includes national and international standards, industry guidance and guidance published by the Competent Authority. Examples of the latter are *Reducing error and influencing behaviour* HSG48 (Second edition) HSE Books 1999 ISBN 0 7176 2452 8 and *Successful health and safety management* HSG65 (Second edition) HSE Books 1997 ISBN 0 7176 1276 7.

Land use planning

12 The land use planning aspects of the Seveso II Directive are given effect in the UK by the Planning (Hazardous Substances) Regulations 1992, as amended in 1999. Under these Regulations the presence of hazardous chemicals above specified thresholds requires consent from the hazardous substances authority, usually the local planning authority. HSE is a statutory consultee on such occasions. The role of HSE is to consider the hazards and risks which would be presented by the hazardous substances to people in the vicinity, and on the basis of this advise the hazardous substances authority whether or not consent should be granted. HSE will also supply a consultation distance around the site. Any future developments in these zones require HSE to be consulted.

13 The aim of health and safety advice relating to land use planning is to mitigate the effects of a major accident on the population in the vicinity of hazardous installations, by following a consistent and systematic approach in providing advice on applications for planning permission around such sites.

14 Historically, HSE has based its land use planning advice on the presumption that site operators are in full compliance with the HSW Act. Section 2 of the Act places a duty on an employer to ensure, so far as is reasonably practicable, the

health and safety of his employees. There is a corresponding duty in section 3 to ensure, so far as is reasonably practicable, that others (including the public) are not exposed to risks to their health and safety. These duties are goal-setting and operators are expected to determine the most appropriate means to comply with them, without the need for detailed approval from HSE.

15 Under the General Development Procedure Order 1995, both HSE and the Environment Agency are statutory consultees for:

- ▼ the development of a new major accident hazard site; or
- ▼ developments on an existing site which could have significant repercussions on major accident hazards; or
- ▼ other developments in the vicinity of existing establishments, where the siting or development is such as to increase the risk or consequences of a major accident.

Annex 9

Regulation of perfluorooctane sulphonates (PFOS)

1 Perfluorochemicals are a family of chemicals used in products designed to repel dirt, grease and water, including kitchenware, carpet treatments, food wrappers, sprays for leather and other clothing, paints and cleaning products.

2 A group of these substances, perfluorooctane sulphonates (collectively identified as PFOS), has been shown to be hazardous (persistent, bioaccumulative and toxic). PFOS has been used in a diverse range of applications, from fire-fighting foam additives to use as a mist suppressant in chromium plating. PFOS was also used in common household anti-soil treatments often referred to by the trade name 'Scotchgard' (a trademark of 3M PLC).

3 The UK Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment (COT), an independent scientific committee that provides advice to the Food Standards Agency, the Department of Health and other Government Departments and Agencies on matters concerning the toxicity of chemicals - is currently evaluating PFOS, most recently in May 2006.²⁰

4 On the basis of the preliminary COT discussions, the Health Protection Agency advised the Drinking Water Inspectorate in March 2006 that, 'It appears unlikely that a lifetime's consumption of drinking water containing concentrations up to three microgrammes (of PFOS) per litre would harm human health' and that 'drinking-water concentrations of PFOS should not exceed three microgrammes per litre.' The Health Protection Agency will review its advice when COT has finalised its assessment of PFOS.

5 In the light of current Health Protection Agency advice, the Drinking Water Inspectorate's view (29 March 2006) is that to safeguard human health, PFOS should not be present in drinking water supplies above three microgrammes/litre (µg/l).

6 PFOS does not appear to undergo any degradation in the natural environment. Due to this extreme stability it has now become widespread both in man and the environment. The biological persistence of PFOS in living organisms is high, with an estimated elimination half-life for humans of the order of four to eight years.

7 These concerns resulted in the principal manufacturer of PFOS (3M) announcing a voluntary phase-out of PFOS manufacture from 2001 onwards. PFOS, however, continues to be produced by some companies and is used in some industrial processes, for example semiconductor production and chromium plating. PFOS was used as an ingredient in some AFFF Class B fire-fighting foam concentrates until a few years ago. These concentrates have a shelf life of at least ten years and remaining stocks will therefore continue to be available for use on oil fires.

8 DEFRA consulted on a national action to restrict the use of PFOS and substances that may degrade to PFOS in October 2004. This included proposals to phase out the use of PFOS in fire-fighting foams. In December 2005, the European Commission issued a proposal for a Directive restricting the marketing and use of PFOS. In this draft Directive PFOS used in fire-fighting foams as well as

²⁰ The COT minutes and background working paper are available from www.food.gov.uk/science/ouradvisors/toxicity/cotmeets/cot2006/334454.

photolithography, photographic coats, chromium plating and hydraulic fluids for aviation would be allowed to continue.

9 The Environment Agency has conducted a national environmental risk assessment of PFOS.²¹ This concluded that there was an environmental risk for all PFOS uses. For now, the drive to minimise PFOS in the environment and drinking water has to be reconciled with its continued use in some industrial sectors.

10 The risk reduction strategy proposed by DEFRA would have phased out PFOS use in chrome plating two years after the legislation came into force, and in fire-fighting foam and most other applications five years after the legislation came into force. The draft EU Directive (December 2005) on PFOS does not phase out the use of PFOS in these applications. The EU has now prohibited the UK from imposing unilateral restrictions on the use of PFOS and any action to restrict the use of PFOS will now proceed at an EU level.

The Environment Agency's approach

11 The Environment Agency's policy aim is to progressively reduce and ultimately phase out the discharge of PFOS to controlled waters. However, the Environment Agency does not regulate all users and, due to its widespread presence, it is not feasible to prevent all discharges of PFOS into controlled waters. When calculating acceptable concentrations of PFOS in consented effluent discharges to surface water the Environment Agency will aim to prevent detectable emissions where possible. As PFOS is a List I substance under the Groundwater Directive, the Environment Agency cannot authorise its disposal to groundwater.

²¹ Brooke D, Footitt A and Nwaogu TA *Environmental risk evaluation report: perfluorooctane sulphonate (PFOS)* Research Contractor: Building Research Establishment Ltd. Risk and Policy Analysts Ltd.

Annex 10

Legal considerations

Prosecution decision making

1 The Board is aware that the process of making enforcement decisions is complex. Every duty holder and situation is unique. The prosecution decision can only be considered once the criminal investigation is fully complete, ie all reasonable lines of enquiry have been followed (in line with the Code of Practice issued pursuant to the Criminal Procedure and Investigations Act 1996). In the case of HSE, the HSC Enforcement Policy Statement sets out the approach to be followed, in accordance with the aims of the Government's 'Principles of Good Enforcement' and requires HSE to apply the Code for Crown Prosecutors (The Code).

2 The Environment Agency has its own Enforcement and Prosecution Policy, which also relies on those principles and commits the Agency to take account of the Code. Each case is unique and will be considered on its own merits. Any prosecution decision requires a careful balancing of individual factors present in that particular case and will be taken by a lawyer who is independent of the Investigation.

3 The Code states that the decision-maker (prosecutor) must be fair, independent and objective. It is their duty to review cases and to ensure that the law is properly applied, that all relevant evidence is put before the court and that obligations of disclosure are complied with. The prosecutor will also ensure that the investigators have identified any material that might undermine the prosecution case or assist the defence, and that they have acted in compliance with the Human Rights Act 1998. The more complex the circumstances of a case and/or the technical evidence, the longer this process may take.

Evidential stage

4 There is a strict order in which the prosecutor must apply the two stages which form the Full Code Test under the Code. The prosecutor must first consider the evidential stage. If there is not the required level of evidence then no prosecution can go ahead, no matter how important the case or how strong the public interest is in favour of prosecution. The prosecutor must be satisfied that the evidence is admissible to meet the evidential test.

5 To pass the evidential stage the Approval Officer must be satisfied that there is enough evidence to form 'a realistic prospect of conviction' against each defendant on each charge. This is a different test to the one that magistrates or juries have to apply. This is not simply a case of percentages. The evidential stage is met if there is 'sufficient evidence to ensure that a jury or bench of magistrates, with a correct understanding of the law, is more likely than not to convict the defendant of the alleged charge.'

6 The prosecutor's considerations will include:

- ▼ Is there any evidence which might support or detract from the reliability of an admission?
- ▼ What explanation has the suspect given?
- ▼ Is the character of any of the witnesses likely to weaken their evidence?
- ▼ Does the witness have a motive that might influence his or her evidence?
- ▼ Is there any concern over the accuracy or credibility of a witness? If so, what is the basis for that concern?

Public interest stage

7 If the case meets the standard required by the evidential stage, only then can the prosecutor consider whether a prosecution is required in the public interest. The prosecutor has to balance the factors for and against prosecution very carefully. The decision must not be affected by improper or undue pressure from any source.

8 For HSE, the HSC Enforcement Policy Statement sets out the common health and safety public interest factors, which, if one or more is present, HSC expects should lead to a prosecution, eg where:

- ▼ death was a result of the breach of legislation;
- ▼ the gravity of an alleged offence, taken together with the seriousness of any actual or potential harm, or the general record and approach of the offender, warrants it;
- ▼ there has been a reckless disregard for health and safety requirements, repeated breaches which give rise to significant risk, or persistent and significant poor compliance;
- ▼ work has been carried out in serious non-compliance with an appropriate licence or safety case;
- ▼ a duty holder's standard of managing health and safety is found to be far below what is required by health and safety law and to be giving rise to significant risk;
- ▼ there has been a failure to comply with an improvement or prohibition notice, or there has been a repetition of a breach that was subject to a formal caution;
- ▼ false information has been supplied wilfully, or there has been an intent to deceive, in relation to a matter which gives rise to significant risk;
- ▼ inspectors have been intentionally obstructed in the lawful course of their duties.

9 The list is not exhaustive. The Enforcement Policy Statement acknowledges that there may be occasions where these factors may be present but that the public interest does not require a prosecution.

10 The Environment Agency will consider the environmental effect of the alleged offence, the foreseeability of the offence or the circumstances leading to it, the intent of the offender, any history of offending, the attitude of the offender, whether a prosecution is required in order to ensure deterrence, and the personal circumstances of the offender. Again the list is not exhaustive.

11 There is a presumption that the Environment Agency will prosecute where one or more of the following are present:

- ▼ Incidents or breaches that have significant consequences for the environment, or which have the potential for such consequences.
- ▼ Operations have been carried out without a licence.
- ▼ There have been excessive or persistent breaches of regulatory requirements.
- ▼ There has been a failure to comply or to comply adequately with formal remedial requirements.
- ▼ There has been reckless disregard for management or quality standards.
- ▼ There has been a failure to supply information without reasonable excuse, or knowingly or recklessly supplying false or misleading information.
- ▼ Agency staff have been obstructed.
- ▼ There has been an attempt to impersonate Agency staff.

12 The Code for Crown Prosecutors also lists other relevant factors for and against prosecution, which again are not exhaustive. The prosecutor balances the factors for and against prosecution.

Views of the victim(s) (part of the public interest stage)

13 The prosecutor will also take into account the consequences for the victim of the decision to prosecute or not to prosecute, and any views expressed by the victim or the bereaved. While the prosecutor will ‘take into account’ their views, neither enforcement authority is bound to follow those views when reaching the final decision on enforcement.

Glossary

ambient temperature The temperature of the surrounding air

aquifer A water-bearing stratum of porous rock, gravel or sand

bar and millibar Although a bar is not a measure in the International System of Units (SI), it is one of the units used in meteorology when describing atmospheric pressure. The SI unit for measuring pressure is the pascal (Pa). A millibar is equal to 1/1000 of a bar, or 100 pascals (a hectopascal)

bioaccumulative Literally, to accumulate in a biological system. It is commonly taken to measure the uptake over time of toxic substances that can stay in a biological system

borehole A cylindrical shaft drilled into the ground, often for geological exploration or extraction of resources

Bronze command The working name for the operational command level during a Major Incident

bund An enclosure designed to contain fluids should they escape from the tank or vessel inside the bund, as well as any additional materials added to the container area such as fire-fighting water and foam, etc

COMAH See Control of Major Accident Hazards Regulations 1999

COMAH sites A site to which the Control of Major Accident Hazards Regulations 1999 apply

Competent Authority The Control of Major Accident Hazards Regulations (COMAH) are enforced by a joint Competent Authority comprising the Health and Safety Executive (HSE) and the Environment Agency in England and Wales, and HSE and the Scottish Environment Protection Agency in Scotland

Control of Major Accident Hazards Regulations 1999 The main aim of these Regulations is to prevent and mitigate the effects of those major accidents involving dangerous substances, such as chlorine, liquefied petroleum gas, and explosives which can cause serious damage/harm to people and/or the environment. The Regulations treat risks to the environment as seriously as those to people. They apply where threshold quantities of dangerous substances identified in the Regulations are kept or used. See also Seveso II

duty holder In the context of this report, any person or organisation holding a legal duty – in particular those placed by the HSW Act, the Management Regulations, and the COMAH Regulations

Environment Agency The Environment Agency is the lead regulator in England and Wales with responsibility for protecting and enhancing the environment. It was set up by the Environment Act 1995 and is a non-departmental public body, largely sponsored by the Department for Environment, Food and Rural Affairs and the National Assembly for Wales

fire-water Water stored for use during, and used during, fire-fighting operations

foam In the context of this report, a foam used during operations to extinguish hydrocarbon fires

forthwith action The Investigation terms of reference require the Investigation team and Board to ‘identify and transmit without delay to duty holders and other appropriate recipients any information requiring immediate action to further safety and/or environmental protection in relation to storage and distribution of hydrocarbon fuels.’ This is referred to as ‘forthwith’ action for both the Investigation, the Competent Authority, and duty holders

Gold command The working name for the strategic command centre during a Major Incident - also known as the Strategic Co-ordinating Group

groundwater All water below the water-table, as opposed to ‘ground waters’, which include groundwater but also sub-surface water above the water-table. The term ‘ground water’, where used in the previous progress reports, should normally have read ‘groundwater’

hazard Anything with the potential to cause harm

Health and Safety Commission The Health and Safety Commission is a statutory body, established under the Health and Safety at Work etc Act 1974, responsible for health and safety regulation in Great Britain

Health and Safety Executive The Health and Safety Executive is a statutory body, established under the Health and Safety at Work etc Act 1974. It is an enforcing authority working in support of HSC. Local authorities are also enforcing authorities under the Health and Safety at Work etc Act 1974

HSC See Health and Safety Commission

HSE See Health and Safety Executive

hydrocarbon An organic chemical compound of hydrogen and carbon. There are a wide variety of hydrocarbons such as crude oil (basically a complex mixture of hydrocarbons), methane, propane, butane etc. They are often used as fuels

Improvement Notice Improvement Notices are one of a range of means which enforcing authorities use to achieve the broad aim of dealing with serious risks, securing compliance with health and safety law and preventing harm. An Improvement Notice allows time for the recipient to comply

kiloPascal Pascals (Pa) are the unit of pressure in the International System of Units (SI). A kiloPascal (kPa) is equal to 1000 Pa. Although bar are not units within SI, they are sometimes used as units to measure atmospheric pressure. 1 kPa = 10 bar. See also bar and millibar

kPa See kiloPascal

lower-tier See tier

Major Accident To The Environment DEFRA has established threshold criteria defining a ‘Major Accident To The Environment’ (MATTE), based on Schedule 7 (part 1) of the Control of Major Accident Hazards Regulations 1999. The Environment Agency, using these criteria, has determined that the Buncefield incident is a MATTE, and the Competent Authority has recently reported this to the European Commission

MATTE See Major Accident To The Environment

millibar See bar and millibar

overpressure For a pressure pulse (or blast wave), the pressure developed above atmospheric pressure

perfluorooctane sulphonates A group of chemicals, collectively identified as PFOS, which have been shown to be hazardous (persistent, bioaccumulative and toxic). PFOS chemicals have been used in a diverse range of applications, including as an additive to aid the spreading properties of fire-fighting foam

perfluorosurfactant In the context of the Buncefield incident, a surfactant is a chemical added to fire-fighting foam which allows the foam to form a thin sealing film over the burning fuel. Perfluorosurfactants are a type of surfactant

PFOS See perfluorooctane sulphonates

pool fire A fire over a pool of fuel and/or water or other liquids

primary containment The tanks, pipes and vessels that normally hold liquids, and the devices fitted to them to allow them to be safely operated

pumphouse In the context of this report, the structure enclosing the pumping equipment used to move water around the Buncefield site prior to the incident. It principally stored water intended for fire-fighting operations

risk The likelihood that a hazard will cause a specified harm to someone or something

run off Uncontained liquid, either deposited on site as rain, or in the context of the Buncefield incident, fuel and/or fire-water not contained as part of the operation to control the incident

Safety Alert Where the Competent Authority considers that an issue poses significant risk, it can choose to issue a Safety Alert to operators of COMAH sites informing them of the issue and possibly requiring them to undertake certain activity

SCG See Strategic Co-ordinating Group

Scottish Environment Protection Agency The public body which is responsible for the protection of the environment in Scotland

secondary containment Enclosed areas around storage vessels (often called bunds), created usually by concrete or earth walls. Their purpose is to hold any escaping liquids and any water or chemicals used in fire-fighting

SEPA See Scottish Environment Protection Agency

Seveso II In 1976, a major accident occurred in Seveso, Italy, where the accidental production and release of a dioxin as an unwanted by-product from a runaway chemical reaction led to widespread contamination. A number of such incidents, and the recognition of the differing standards of controls over industrial activities within the European Community, led the European Commission to propose a Directive on the control of major industrial accident hazards. The Directive on the Major Accident Hazards of Certain Industrial Activities (82/501/EEC) was adopted on 24 June 1982, and is generally known as the Seveso Directive. Following a complete review of the Directive by the European Commission a new one, now known as Seveso II, came into force on 3 February 1997 and was implemented in Great Britain on 1 April 1999 by the Control of Major Accident Hazards Regulations 1999, except for land use planning requirements, which were implemented by changes to planning legislation

Silver command The working name for the tactical command centre during a Major Incident

Strategic Co-ordinating Group Representation of all agencies deployed to resolve the Buncefield incident was established through a meeting process known as the Strategic Co-ordinating Group, also known as Gold Command

surface water Water that sits or flows above land, including lakes, seas, rivers and streams

tank farm A facility where hazardous substances, very often petroleum products, are stored in tanks

tertiary containment The site surface and associated drainage, boundary walls, roads, containment kerbs and any features such as road humps that can provide some retention of liquids. Proper design of drainage systems will limit loss of product out of the site and prevent lost product permeating into the ground with the potential risk that it can migrate to groundwater, or contaminate surface waters and land

tier The Control of Major Accident Hazards Regulations 1999 apply where threshold quantities of dangerous substances identified in the Regulations are kept or used. There are two thresholds, known as ‘lower-tier’ and ‘top-tier’, and COMAH sites fall into one or other of these

topography The physical configuration of the surface of the land, including its elevation, slope, and orientation

top-tier See tier

ultimate high-level switch Part of the system to prevent overfilling of the tank, the ultimate high-level switch is an independent mechanism which should be triggered when the ‘ultimate high level’ (ie the specified maximum capacity) is reached in a tank to which it is fitted, both causing an alarm to sound and shutting down the supply of fuel to the tank

vapour pressure A measure of the tendency of a material to form a vapour. The higher the vapour pressure, the higher the potential vapour concentration

volatility The readiness of a substance to evaporate

wind girder Structural stiffening ring attached to the tank side wall

Further information

Useful links

Buncefield Major Incident Investigation

Marlowe Room, Rose Court

2 Southwark Bridge

London, SE1 9HS

Tel: 020 7717 6909

Fax: 020 7717 6082

E-mail: buncefield.inforequest@hse.gsi.gov.uk

Web: www.buncefieldinvestigation.gov.uk

Community/Business support

Dacorum Business Contact Centre

Tel: 01442 867 805

Business Link Helpline

Tel: 01727 813 813

Hertfordshire Chamber of Commerce

Tel: 01727 813 680

Dacorum Community Trust Mayor's Fund

To apply, call the freephone helpline on 0800 131 3351.

Lines are open 9.30 am-4.30 pm, Monday to Friday

Dacorum Borough Council

Tel: 01442 228 000

Web: www.dacorum.gov.uk

Hemel Hempstead Citizens Advice Bureau

19 Hillfield Road, Hemel Hempstead HP2 4AA

Tel: 01442 213368

Local authorities and emergency services

Dacorum Borough Council

Tel: 01442 228 000

Web: www.dacorum.gov.uk

(Dacorum Borough Council Digest newsletter, available monthly

Dacorum Borough Council Buncefield Update Newsletter)

St Albans District Council

Tel: 01727 866 100

Web: www.stalbans.gov.uk

Hertfordshire County Council

Tel: 01483 737 555

Web: www.hertsdirect.org

Hertfordshire Fire and Rescue Service

Web: www.hertsdirect.org/yrccouncil/hcc/fire/buncefield

Hertfordshire Constabulary

Web: www.herts.police.uk/news/buncefield/main.htm

Hertfordshire Chamber of Commerce

Tel: 01727 813 680

Web: www.hertschamber.com

Government links

Department for Communities and Local Government

Fire and Resilience Directorate

Web: www.communities.gov.uk

Government Office for the East of England

Web: www.go-east.gov.uk

Environment Agency

Web: www.environment-agency.gov.uk

Department of Trade and Industry

Oil and Gas Directorate

Web: www.og.dti.gov.uk

Health and Safety Executive

Hazardous Installations Directorate

Web: www.hse.gov.uk/hid

Control of Major Accident Hazards

Web: www.hse.gov.uk/comah

Department for the Environment, Food and Rural Affairs

Web: www.defra.gov.uk

Health Protection Agency

Web: www.hpa.org.uk

Food Standards Agency

Web: www.food.gov.uk

Drinking Water Inspectorate

Web: www.dwi.gov.uk

Industry links

United Kingdom Petroleum Industry Association (UKPIA)

Tel: 020 7240 0289

Web: www.ukpia.com

Chemical Industries Association

Tel: 020 7834 3399

Web: www.cia.org.uk

Three Valleys Water

Tel: 0845 782 3333

Web: www.3valleys.co.uk

Investigation reports

Buncefield Major Incident Investigation:

- ▼ Progress Report, published 21 February 2006
- ▼ Second Progress Report, published 11 April 2006
- ▼ Third Progress Report, published 9 May 2006

Available from www.buncefieldinvestigation.gov.uk

DEFRA: Initial review of Air Quality aspects of the Buncefield Oil Depot Explosion

www.defra.gov.uk/environment/airquality/buncefield/buncefield-report.pdf

Hertfordshire Fire and Rescue Service's Report into the 'Fire Response' – to be published in November 2006

Angus Fire, Buncefield Oil Terminal Incident December 2005: Review of part played by Angus Fire and lessons learned

www.angusfire.co.uk

Other related reports/information

East of England Development Agency – report by SQW, Economic Developments Consultants on: *The Buncefield Oil Depot Incident: Economic and Business Confidence Impact Study*, June 2006

www.eeda.org.uk

Swiss Fire Service: *Quick Look Report – Buncefield Fire 11 December 2005*

Contract research reports for HSE

- ▼ W.S. Atkins Science and Technology: Derivation of fatality probability functions for occupants of buildings subject to blast loads Phases 1, 2, & 3 - 147/1997 and Phase 4 - 151/1997
- ▼ Biomedical Sciences Chemical and Biological Defence Sector Defence Evaluation and Research Agency: Review of blast injury data and models 192/1998

Available from: www.hsebooks.com

Government Advisory Bodies

- ▼ Committee on mutagenicity of chemicals in food, consumer products and the environment (COM)
- ▼ Committee on carcinogenicity of chemicals in food, consumer products and the environment (COC)
- ▼ Committee on toxicity of chemicals in food, consumer products and the environment (COT)

www.advisorybodies.doh.gov.uk/coc/

Recommendations on the design and operation of fuel storage sites



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Figure 1 An overview of an oil storage depot on the east coast of England.

Introduction

1 This report sets out recommendations to improve safety in the design and operation of fuel storage sites. We make these recommendations as the independent Investigation Board, chaired by Lord Newton of Braintree, set up to supervise the investigation into the explosions and fires at the Buncefield oil storage and transfer depot, Hemel Hempstead, Hertfordshire on 11 December 2005. The investigation was directed by the Health and Safety Commission (HSC) using its powers under section 14(2)(a) of the Health and Safety at Work etc Act 1974.

2 Item 5 of the investigation's terms of reference requires us to 'make recommendations for future action to ensure the effective management and regulation of major accident risk at COMAH¹ sites. This should include consideration of off-site as well as on-site risks and consider prevention of incidents, preparations for response to incidents, and mitigation of their effects.'

3 Our initial report, published on 13 July 2006, identified four principal workstreams that would form the basis for our continuing work and developing recommendations. Those workstreams are:

- ▼ design and operation of storage sites;
- ▼ emergency preparedness for, and response to, incidents;
- ▼ advice to planning authorities; and
- ▼ examination of the Health and Safety Executive's (HSE's) and the Environment Agency's roles in regulating the activities on the Buncefield site.

4 This report concentrates on the first of these – design and operations. Future reports will make recommendations on other areas, though we anticipate some overlap as the workstreams are closely related. Improving control measures goes hand in hand with improving emergency arrangements and with considering the potential impacts of major incidents on local communities. This report builds on the broad conclusions set out in paragraphs 61-77 of our initial report, which in turn reflect the findings of the investigation, as summarised in the initial report and in the three progress reports preceding it. That material is referenced, but not repeated, in this report. In preparing this report we have also considered information from other sources, such as the Buncefield Standards Task Group,² the Competent Authority³ and the Baker report (see paragraph 15). Our broad aim in making these recommendations is to catalyse improvement in the fuel storage sector so that it is continually alert to the major hazard potential of its operations.

¹ The Control of Major Accident Hazards Regulations 1999. These Regulations are enforced by a joint Competent Authority comprising HSE and the Environment Agency in England and Wales and HSE and the Scottish Environment Protection Agency in Scotland.

² The joint Competent Authority/Industry Standards Task Group set up to review safety and environmental protection standards at fuel storage sites following the Buncefield incident. The Task Group published its initial recommendations on 12 October 2006.

³ See footnote 1. The Competent Authority issued Safety Alerts in February and July 2006.

The Board's approach

5 Our starting point in developing these recommendations is the importance of primary containment,⁴ as expressed in paragraph 63 of our initial report:

The occurrence of a massive fuel vapour explosion confirms the overriding need to ensure the integrity of the primary means of containment; in other words, to make sure that liquid does not escape from the vessels in which it is normally meant to be confined.

6 Recommendations 1-16 therefore emphasise the need to increase the protection provided by primary containment systems. The Buncefield incident highlighted the need for high integrity systems for this purpose. Notwithstanding the importance of primary containment, there remains a need for effective means of preventing environmental pollution in the event of a failure of primary containment. While implementing our recommendations should significantly reduce the likelihood of such a failure, the potential for failure remains. Recommendations 17-18 therefore deal with improvements to secondary and tertiary containment.⁵

7 Recommendations 1-18 essentially deal with technological matters and their management. However, paragraph 74 of our initial report noted that human and organisational factors are also important and these are covered in Recommendations 19-22. Finally, Recommendations 23-25 deal with broader strategic objectives relating to sector leadership and culture, essential to ensure that the benefits of the more detailed recommendations are fully realised.

8 In several areas work is already underway that has the potential to meet these recommendations, in response both to the Buncefield Standards Task Group report^(ref 1) and to Safety Alerts issued by the Competent Authority. We understand that the Task Group is also working on other aspects of design and operation, including aspects recommended in our initial report. We welcome the initiative of the sector and the Competent Authority in taking this forward. However, the Task Group is a temporary body set up to deliver a specific project of improvements (a so-called 'task-and-finish' group). Without implying any criticism of the Task Group, this is not a suitable arrangement for leadership of the sector. As we indicate in paragraphs 34-36 of this report, the Board believes that the sector, in consultation with the Competent Authority, needs to build on its work to put in place continuing arrangements for comparable leadership in relation to operating and safety standards on a long-term basis. In our view action to improve sector leadership will be the key to facilitate implementation of our recommendations and to provide a focus for continuous improvement.

⁴ Primary means of containment are the tanks, pipes and vessels that hold liquids and the devices fitted to them to allow them to be operated safely.

⁵ Secondary means of containment are enclosed areas around storage vessels (often called bunds), created usually by concrete or earth walls. Their purpose is to hold any escaping liquids and any water or chemicals used in firefighting. Tertiary means are features such as drains designed to limit the passage of chemicals off site, or raised kerbs to prevent liquids that have breached the bunds from escaping into the general area around the site.

Scope of the recommendations

9 As a minimum the recommendations in this report address Buncefield-type sites as defined in the Buncefield Standards Task Group report,⁶ ie depots that store and transfer petroleum products on a large scale. We use the term ‘the sector’ to denote these sites collectively, except where the context clearly indicates otherwise. Some recommendations will also apply to a wider range of fuel storage facilities. In some cases, although we have not studied the wider chemical industry, we consider that relevant lessons for fire and explosion risks can be applied beyond fuel storage and distribution. We indicate in the text some obvious areas where our recommendations may apply beyond the sector, as defined above. More generally, we encourage the chemical industry, working with the Competent Authority, to consider the broader relevance of our findings so far.

10 The recommendations are addressed to those in the sector who have the legal duties to prevent and control major accidents.⁷ Primarily this means operators of Buncefield-type sites as described in paragraph 9, but also includes designers, suppliers and contractors, as well as professional institutions or trade associations where appropriate. In practice this will require close working with the regulators (the Competent Authority), who will also need to ensure the recommendations are implemented.

Status of the recommendations

11 In making these recommendations we recognise that work continues, including the work to investigate explosion mechanisms mentioned in paragraphs 16-19 and work in the Buncefield Standards Task Group. Further recommendations will follow in relation to other areas of interest mentioned in paragraph 3.

12 We expect our recommendations to be put into practice throughout the sector. Unless the context indicates otherwise, we envisage the Competent Authority will adopt the recommendations as the minimum necessary to comply with legal requirements. For example, where the recommendations call for higher standards to be incorporated in revised guidance, those standards should be capable of being insisted upon by law. The recommendations do not specifically call for changes to the law on the assumption that the existing legal framework is sufficient to ensure that necessary improvements are put in place. However, if this proves not to be the case in any respect, HSC and the Department for Environment, Food and Rural Affairs (DEFRA) should draw up proposals for the necessary legal changes.

⁶ The Task Group initial recommendations apply to petrol stored at COMAH top and lower tier sites in vertical, cylindrical, non-refrigerated, above ground storage tanks with side walls greater than 5 metres in height and where the filling rate is greater than 100 cubic metres/hour.

⁷ COMAH requires operators of major hazard sites subject to the Regulations to take all measures necessary to prevent major accidents and limit their consequences to persons and the environment. Operators of top tier COMAH sites (like Buncefield) are also required to submit written safety reports to the Competent Authority; and to prepare emergency plans to deal with the consequences of a major accident. Operators and others (including contractors, designers, suppliers) also have relevant duties under the Health and Safety at Work etc Act 1974 and related regulations and under environmental legislation.



13 Where the recommended improvements are self evidently necessary or where the sector is already intent on their implementation we expect the recommendations to be implemented without undue delay. Some recommendations, particularly those involving large-scale engineering improvements, will be easier to implement in new sites than in existing sites. Other recommendations, such as those needing cultural and leadership changes, should be addressed immediately, though their effects may not be apparent in the short term. It is essential to have clear timescales, understood both by the industry and the Competent Authority, against which progress can be measured and reported. We therefore ask the Competent Authority to start without delay a programme of reviews with operators of Buncefield-type sites of their response to these recommendations, leading to site-specific timed action plans.

14 Where commitments have already been made (eg through the Buncefield Standards Task Group) or the need for action is self-evident, we have not made detailed cost-benefit assessments. In most cases we consider the costs will be reasonable and the benefits, in preventing another Buncefield incident, beyond argument. We are exploring further the costs and other implications of some recommendations relative to their perceived benefits, though we expect this to confirm our belief that the improvements we recommend are affordable. In agreeing priorities for the action plans we call for in paragraph 13, the Competent Authority will need to take account of cost, as described in paragraph 31.

The Baker report

15 We have noted with interest the recent report of the BP US Refineries Independent Safety Review Panel by James Baker's panel in the United States.^(ref 2) Some of the recommendations and findings in that report align with our thinking arising from the Buncefield investigation. In particular the Baker report's recommendations relating to process safety leadership, process safety culture, performance indicators, independent monitoring and industry leadership are relevant. The Baker panel's findings regarding the implementation of good engineering practices, safety knowledge and competence also align with our views.



Figure 3 Damage to property on the Maylands estate adjacent to Buncefield

Further work to investigate explosion mechanism

16 Current explosion models do not predict the blast damage that occurred at Buncefield. Paragraph 77 of our initial report said:

Further work is needed to research the actual mechanism for generating the unexpectedly high explosion overpressures seen at Buncefield. This is a matter of keen international interest, and participation from a broad range of experts, as well as the industry, is essential to ensure the transparency and credibility of any research programme. The Board will consider further recommendations about the nature and scope of such work.

17 Towards the end of 2006 we appointed an advisory panel to assist us in formulating proposals for a programme of work. The panel is chaired by Professor Dougal Drysdale who is a member of the Board. The panel is considering the evidence currently available in respect of potential explosion mechanisms of a flammable vapour cloud that could cause the type and extent of damage seen at Buncefield.

18 We have asked the panel to advise us whether research is justified and if so the scope of such research, likely methods of funding it, and its governance arrangements, to ensure a satisfactory outcome. We have asked the panel to present its findings to us shortly after Easter and we shall make our recommendations known soon afterwards.

19 The advisory panel experts are:

Professor Dougal Drysdale, University of Edinburgh (Chair)
Professor Derek Bradley, University of Leeds
Professor Geoffrey Chamberlain, Shell Global Solutions
Dr Laurence Cusco, Health and Safety Laboratories
Mike Johnson, Advantica
Professor Hans Michels, Imperial College London
Professor Vincent Tam, BP Exploration

The recommendations

20 Our recommendations are grouped under the following six headings:

- ▼ Systematic assessment of safety integrity level requirements (Recommendation 1)
- ▼ Protecting against loss of primary containment using high integrity systems (Recommendations 2-10)
- ▼ Engineering against escalation of loss of primary containment (Recommendations 11-16)
- ▼ Engineering against loss of secondary and tertiary containment (Recommendations 17-18)
- ▼ Operating with high reliability organisations (Recommendations 19-22)
- ▼ Delivering high performance through culture and leadership (Recommendations 23-25)

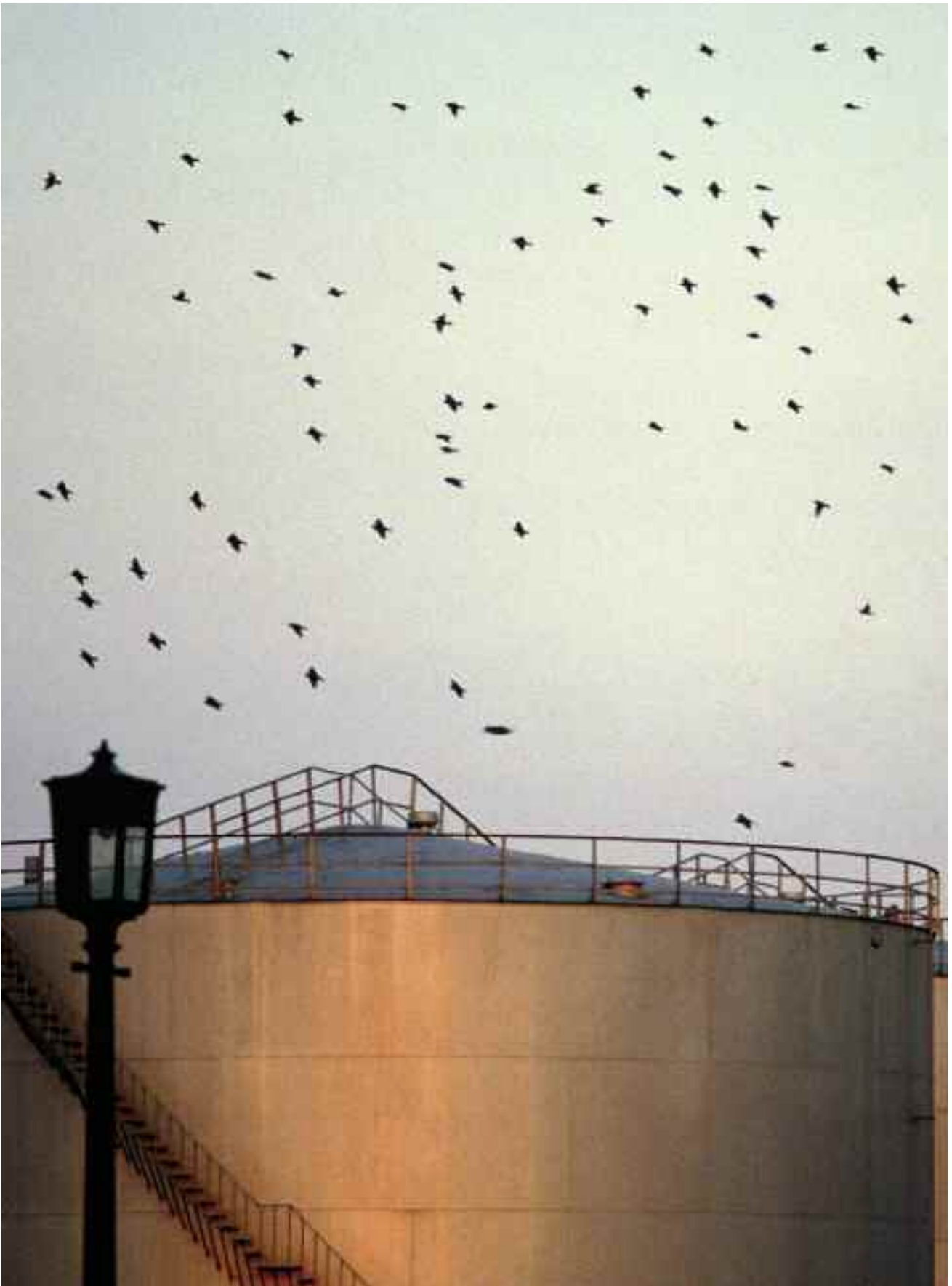


Figure 4 Tops of a tank farm in South London

Systematic assessment of safety integrity level requirements

21 The recommendations under this and the next two headings are based on the conclusions set out in paragraphs 61-77 of our initial report and on the findings of the first and third progress reports. The Buncefield incident highlighted the need for high integrity systems, which we discuss further in the next section. However, our firm belief is that before protective systems are installed there is a need to determine the appropriate level of integrity that such systems are expected to achieve. The sector currently lacks a common methodology to ensure a systematic approach to this determination process. Several methodologies exist, but there is no consistency. A common methodology would provide greater assurance.

22 Recommendation 1 is in line with work now underway following the Buncefield Standards Task Group's initial recommendations relating to tank overfill protection, particularly paragraph 9, which states *'The overall systems for tank-filling control must be of high integrity – with sufficient independence to ensure timely and safe shutdown to prevent tank overflow. Site operators should meet the latest international standards.'*

Recommendation 1 The Competent Authority and operators of Buncefield-type sites should develop and agree a common methodology to determine safety integrity level (SIL)⁸ requirements for overfill prevention systems in line with the principles set out in Part 3 of BS EN 61511.^(ref 3) This methodology should take account of:

- ▼ the existence of nearby sensitive resources or populations;
- ▼ the nature and intensity of depot operations;
- ▼ realistic reliability expectations for tank gauging systems; and
- ▼ the extent/rigour of operator monitoring.

Application of the methodology should be clearly demonstrated in the COMAH safety report submitted to the Competent Authority for each applicable site. Existing safety reports will need to be reviewed to ensure this methodology is adopted.

⁸ A SIL is a measure of the safety system performance, in terms of the probability of failure on demand. There are four discrete integrity levels, SIL 1-4. The higher the SIL level, the higher the associated safety level and the lower the probability that a system will fail to perform properly.



Figure 5 General view of fuel storage tanks with associated pipework and instrumentation

Protecting against loss of primary containment using high integrity systems

23 Paragraph 21 notes that the Buncefield incident highlighted the need for high integrity systems to prevent breaches of primary containment. The background is summarised in paragraphs 61-77 of our initial report, based on the findings of the third progress report. In particular, paragraph 63 of our initial report emphasised the overriding need to ensure the integrity of the primary means of containment. The following recommendations, particularly Recommendations 2-8, are closely related and need to be considered as a whole. Our recommendations for automatic systems, that do not depend on the need for human intervention, are not intended to override the risk-based approach of Recommendation 1 but to act as a starting point.

24 Recommendations 3-5 reflect our firm view that to ensure integrity the sector must move towards installing independent overfill prevention systems at sites handling large quantities of highly flammable liquids⁹ such as petrol. We welcome indications that API Code 2350^(ref 4) is also moving in this direction. In many respects Recommendations 3-5 align with work underway to implement paragraphs 8-11 of the Buncefield Standards Task Group's initial report, except that the Task Group stopped short of recommending automatic overfill prevention systems. Annex 1 to this report sets out our arguments for installing automatic overfill prevention systems (Recommendation 3). This would be a significantly higher standard than that generally installed in this sector. These changes will need to be carefully planned to consider up-stream implications and phased in to avoid undue disruption to the UK fuel supply.

25 Recommendations 6 and 7 follow up paragraph 76 of our initial report, which referred to the need for good communication between the parties responsible for transferring fuel safely around the country. We indicated that the adequacy of existing safety arrangements for transferring fuel between sites, eg between refineries and Buncefield-type sites, may need to be reviewed. In returning to this, we firmly believe that such a review is necessary given the number of responsible parties in a typical system – refinery operator, pipeline operator, and depot operator.

26 The safety report for any given depot or refinery (gasoline pipelines are not currently subject to COMAH, though we may return to this in our next report) does not deal specifically with the relationship between the transmitter and the receiver of hazardous products. Therefore we welcome the recommendation at paragraph 7 in the Buncefield Standards Task Group's first report relating to improving the communications between site operators and operators of pipeline transfers. This does not, however, go so far as to require site operators to have ultimate control to stop receiving fuel into tanks to prevent an overfill. We believe it is essential for such a hierarchy of control to be established, at the same time dealing with any upstream consequences.

⁹ A liquid fuel is classified under the Planning (Control of Major Accident Hazards) Regulations 1999 according to its flashpoint, defined as *'The minimum temperature at which a liquid, under specific test conditions, gives off sufficient flammable vapour to ignite momentarily on the application of an ignition source'*. A highly flammable liquid is defined as one with the flashpoint below 21°C. As petrol has a flashpoint in the region of c -40°C, it is therefore classified as a highly flammable liquid.

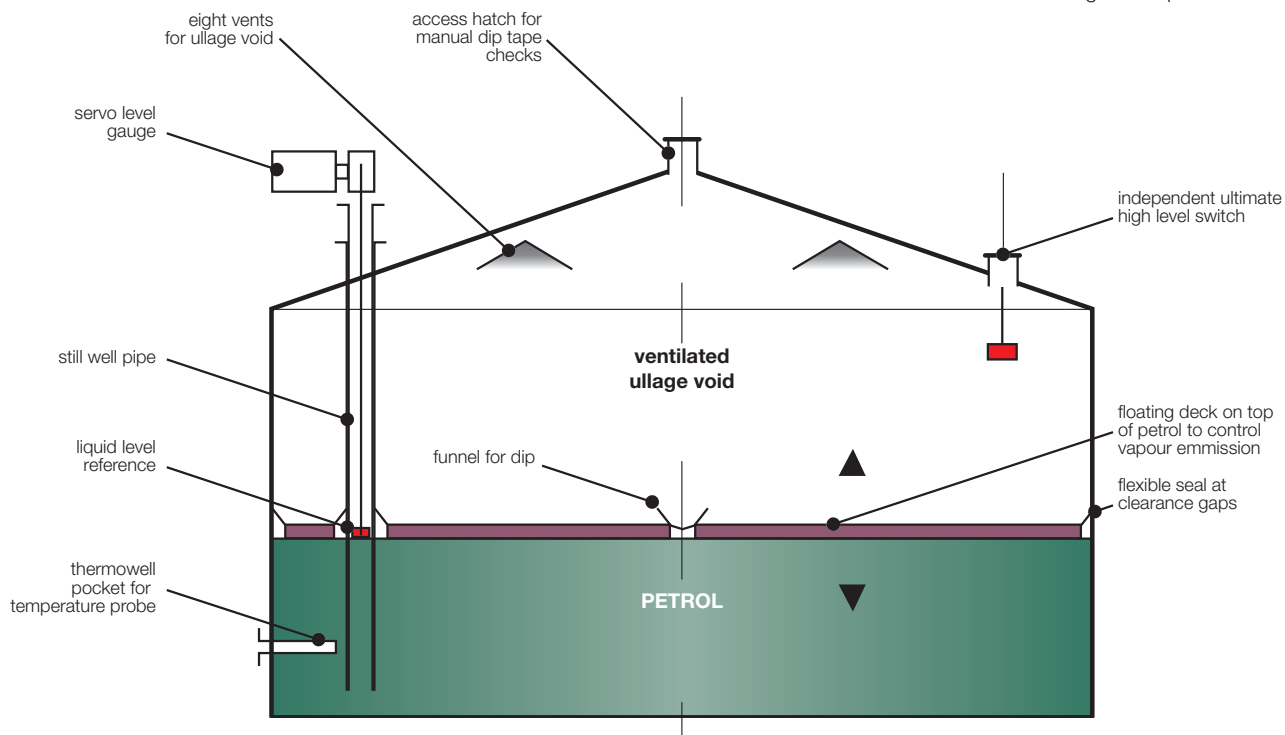


Figure 6 General schematic of a typical internal floating roof tank

27 Annex 2 to this report sets out our arguments for developing improved components and systems (Recommendation 8). Recommendations 9 and 10 are needed to help monitor and review the effectiveness of improved control measures.

Recommendation 2 Operators of Buncefield-type sites should, as a priority, review and amend as necessary their management systems for maintenance of equipment and systems to ensure their continuing integrity in operation. This should include, but not be limited to reviews of the following:

- ▼ the arrangements and procedures for periodic proof testing of storage tank overfill prevention systems to minimise the likelihood of any failure that could result in loss of containment; any revisions identified pursuant to this review should be put into immediate effect;
- ▼ the procedures for implementing changes to equipment and systems to ensure any such changes do not impair the effectiveness of equipment and systems in preventing loss of containment or in providing emergency response.

Recommendation 3 Operators of Buncefield-type sites should protect against loss of containment of petrol and other highly flammable liquids by fitting a high integrity, automatic operating overfill prevention system¹⁰ (or a number of such systems, as appropriate) that is physically and electrically separate and independent from the tank gauging system.

Such systems should meet the requirements of Part 1 of BS EN 61511 for the required safety integrity level, as determined by the agreed methodology (see Recommendation 1). Where independent automatic overfill prevention systems are already provided, their efficacy and reliability should be reappraised in line with the principles of Part 1 of BS EN 61511 and for the required safety integrity level, as determined by the agreed methodology (see Recommendation 1).

¹⁰ The factors that determine the type of independent automatic system required will include the effects on the upstream system, for example if filling from a refinery process, a ship or a railway vessel. For all systems the outcome required is the same, ie automatically stopping supply to the dangerously full tank by means that are fully independent of the tank gauging system.

Recommendation 4 The overfill prevention system (comprising means of level detection, logic/control equipment and independent means of flow control) should be engineered, operated and maintained to achieve and maintain an appropriate level of safety integrity in accordance with the requirements of the recognised industry standard for ‘safety instrumented systems’, Part 1 of BS EN 61511.

Recommendation 5 All elements of an overfill prevention system should be proof tested in accordance with the validated arrangements and procedures sufficiently frequently to ensure the specified safety integrity level is maintained in practice in accordance with the requirements of Part 1 of BS EN 61511.

Recommendation 6 The sector should put in place arrangements to ensure the receiving site (as opposed to the transmitting location) has ultimate control of tank filling. The receiving site should be able to safely terminate or divert a transfer (to prevent loss of containment or other dangerous conditions) without depending on the actions of a remote third party, or on the availability of communications to a remote location. These arrangements will need to consider upstream implications for the pipeline network, other facilities on the system and refineries.



Figure 7 General view of fuel terminal in Aberdeen's harbour area

Recommendation 7 In conjunction with Recommendation 6, the sector and the Competent Authority should undertake a review of the adequacy of existing safety arrangements, including communications, employed by those responsible for pipeline transfers of fuel. This work should be aligned with implementing Recommendations 19 and 20 on high reliability organisations to ensure major hazard risk controls address the management of critical organisational interfaces.

Recommendation 8 The sector, including its supply chain of equipment manufacturers and suppliers, should review and report without delay on the scope to develop improved components and systems, including but not limited to the following:

- ▼ alternative means of ultimate high¹¹ level detection for overfill prevention that do not rely on components internal to the storage tank, with the emphasis on ease of inspection, testing, reliability and maintenance;
- ▼ increased dependability of tank level gauging systems through improved validation of measurements and trends, allowing warning of faults and through using modern sensors with increased diagnostic capability; and
- ▼ systems to control and log override actions.

Recommendation 9 Operators of Buncefield-type sites should introduce arrangements for the systematic maintenance of records to allow a review of all product movements together with the operation of the overfill prevention systems and any associated facilities. The arrangements should be fit for their design purpose and include, but not be limited to, the following factors:

- ▼ the records should be in a form that is readily accessible by third parties without the need for specialist assistance;
- ▼ the records should be available both on site and at a different location;
- ▼ the records should be available to allow periodic review of the effectiveness of control measures by the operator and the Competent Authority, as well as for root cause analysis should there be an incident;
- ▼ a minimum period of retention of one year.

Recommendation 10 The sector should agree with the Competent Authority on a system of leading and lagging performance indicators for process safety performance. This system should be in line with HSE's recently published guidance on *Developing process safety indicators* HSG254.^(ref 5)

¹¹ Also commonly known as 'high high' level alarms.

Engineering against escalation of loss of primary containment

28 The recommendations under this heading follow on from our earlier arguments about the importance of primary containment – see paragraph 23 above. The Buncefield incident demonstrated the potential for a vapour cloud to form from a loss of primary containment of a highly flammable liquid such as petrol. We have adopted a precautionary approach in drawing up these recommendations as we believe they are appropriate in the light of the Buncefield incident, notwithstanding that the investigation into the severity of the explosion continues. Recommendation 12, in particular, anticipates our coming recommendations on emergency response arrangements.

Recommendation 11 Operators of Buncefield-type sites should review the classification of places within COMAH sites where explosive atmospheres may occur and their selection of equipment and protective systems (as required by the Dangerous Substances and Explosive Atmospheres Regulations 2002^(ref 6)). This review should take into account the likelihood of undetected loss of containment and the possible extent of an explosive atmosphere following such an undetected loss of containment. Operators in the wider fuel and chemicals industries should also consider such a review, to take account of events at Buncefield.

Recommendation 12 Following on from Recommendation 11, operators of Buncefield-type sites should evaluate the siting and/or suitable protection of emergency response facilities such as firefighting pumps, lagoons or manual emergency switches.

Recommendation 13 Operators of Buncefield-type sites should employ measures to detect hazardous conditions arising from loss of primary containment, including the presence of high levels of flammable vapours in secondary containment. Operators should without delay undertake an evaluation to identify suitable and appropriate measures. This evaluation should include, but not be limited to, consideration of the following:

- ▼ installing flammable gas detection in bunds containing vessels or tanks into which large quantities of highly flammable liquids or vapour may be released;
- ▼ the relationship between the gas detection system and the overfill prevention system. Detecting high levels of vapour in secondary containment is an early indication of loss of containment and so should initiate action, for example through the overfill prevention system, to limit the extent of any further loss;
- ▼ installing CCTV equipment to assist operators with early detection of abnormal conditions. Operators cannot routinely monitor large numbers of passive screens, but equipment is available that detects and responds to changes in conditions and alerts operators to these changes.

Recommendation 14 Operators of new Buncefield-type sites or those making major modifications to existing sites (such as installing a new storage tank) should introduce further measures including, but not limited to, preventing the formation of flammable vapour in the event of tank overflow. Consideration should be given to modifications of tank top design and to the safe re-routing of overflowing liquids.

Recommendation 15 The sector should begin to develop guidance without delay to incorporate the latest knowledge on preventing loss of primary containment and on inhibiting escalation if loss occurs. This is likely to require the sector to collaborate with the professional institutions and trade associations.

Recommendation 16 Operators of existing sites, if their risk assessments show it is not practicable to introduce measures to the same extent as for new ones, should introduce measures as close to those recommended by Recommendation 14 as is reasonably practicable. The outcomes of the assessment should be incorporated into the safety report submitted to the Competent Authority.



Figure 8 View of fuel tank set in earth bund

Engineering against loss of secondary and tertiary containment

29 While we emphasise the priority that should be given to preventing a loss of primary containment, adequate secondary and tertiary containment remains necessary for environmental protection in the event of a loss of primary containment of hazardous substances. Paragraphs 66 and 73 of our initial report and, in particular, the second progress report, described the failure of secondary and tertiary containment at Buncefield to prevent a major accident to the environment (MATTE).

30 Significant improvements to primary containment¹² will have implications for environmental protection systems. A fundamental review of the whole system of containment, taking account of site-specific conditions, will provide the greatest assurance for the safety and environmental protection of the site and its neighbourhood. As well as Buncefield-type incidents, other causes of primary containment failure such as sudden or undetected creeping loss of tank or pipework integrity can give rise to serious environmental consequences. This underlines the importance of maintaining high bunding standards.

31 Though there is a need for an integrated approach to containment, the recommendations below are segmented for convenience. Operators should adopt a risk-based approach and draw up plans for phased investment and improvement. They should be able to demonstrate to the Competent Authority why it is not practicable to meet fully improved standards, if that is so. We stress that the overflow of highly flammable liquid which led to the Buncefield explosions is only one foreseeable cause of a MATTE. Industry should therefore include improvements against those other foreseeable events in its remedial programme to secondary and tertiary containment, taking the same risk-based and phased approach.

¹² For example, in preventing tank overfilling, structural failure and loss of integrity (eg gasket failure) of pipework and valve joints.

Recommendation 17 The Competent Authority and the sector should jointly review existing standards for secondary and tertiary containment with a view to the Competent Authority producing revised guidance by the end of 2007.

The review should include, but not be limited to the following:

- ▼ developing a minimum level of performance specification of secondary containment (typically this will be bunding);
- ▼ developing suitable means for assessing risk so as to prioritise the programme of engineering work in response to the new specification;
- ▼ formally specifying standards to be achieved so that they may be insisted upon in the event of lack of progress with improvements;
- ▼ improving firewater management and the installed capability to transfer contaminated liquids to a place where they present no environmental risk in the event of loss of secondary containment and fires;
- ▼ providing greater assurance of tertiary containment measures to prevent escape of liquids from site and threatening a major accident to the environment.

Recommendation 18 Revised standards should be applied in full to new build sites and to new partial installations. On existing sites, it may not be practicable to fully upgrade bunding and site drainage. Where this is so operators should develop and agree with the Competent Authority risk-based plans for phased upgrading as close to new plant standards as is reasonably practicable.



Figure 9 A modern process control room

Operating with high reliability organisations

32 The need for high reliability organisations¹³ was not addressed directly in our initial report or in the Buncefield Standards Task Group's interim recommendations, though many of the issues below are being considered in the Task Group's continuing work. The need follows from the preceding recommendations relating to technological improvements in hardware. Such improvements are vital in improving process safety and environmental protection, but achieving their full benefit depends on human and organisational factors such as the roles of operators, supervisors and managers. Paragraph 74 of our initial report indicated our interest in this area.

33 The recommendations are more broadly applicable than Buncefield-type sites, but are intended to apply to those sites as a minimum.

Recommendation 19 The sector should work with the Competent Authority to prepare guidance and/or standards on how to achieve a high reliability industry through placing emphasis on the assurance of human and organisational factors in design, operation, maintenance, and testing. Of particular importance are:

- ▼ understanding and defining the role and responsibilities of the control room operators (including in automated systems) in ensuring safe transfer processes;
- ▼ providing suitable information and system interfaces for front line staff to enable them to reliably detect, diagnose and respond to potential incidents;
- ▼ training, experience and competence assurance of staff for safety critical and environmental protection activities;
- ▼ defining appropriate workload, staffing levels and working conditions for front line personnel;
- ▼ ensuring robust communications management within and between sites and contractors and with operators of distribution systems and transmitting sites (such as refineries);
- ▼ prequalification auditing and operational monitoring of contractors' capabilities to supply, support and maintain high integrity equipment;
- ▼ providing effective standardised procedures for key activities in maintenance, testing, and operations;
- ▼ clarifying arrangements for monitoring and supervision of control room staff; and
- ▼ effectively managing changes that impact on people, processes and equipment.

¹³ That is, robust organisations with a strong safety culture that have a high probability of achieving safe and reliable performance. More detail is given in Annex 5.

Recommendation 20 The sector should ensure that the resulting guidance and/or standards is/are implemented fully throughout the sector, including where necessary with the refining and distribution sectors. The Competent Authority should check that this is done.

Recommendation 21 The sector should put in place arrangements to ensure that good practice in these areas, incorporating experience from other high hazard sectors, is shared openly between organisations.

Recommendation 22 The Competent Authority should ensure that safety reports submitted under the COMAH Regulations contain information to demonstrate that good practice in human and organisational design, operation, maintenance and testing is implemented as rigorously as for control and environmental protection engineering systems.



Figure 10 Maintenance worker inspecting a tank top

Delivering high performance through culture and leadership

34 Culture and leadership were not addressed directly in our initial report or in the Buncefield Standards Task Group's first report, but are necessary prerequisites to achieving full compliance with the preceding recommendations. We have set the sector several tasks which we acknowledge to be very challenging:

- ▼ to substantially strengthen safety standards at Buncefield-type sites;
- ▼ to identify analogous sites where the same high level of engineered safety is necessary and to install it;
- ▼ to continue with and extend a programme of revision of guidance and standards to ensure more consistent responses to broadly similar risks than are the case today; and
- ▼ to bring about a wide range of cultural and behavioural changes.

35 Implementing our recommendations will require the sector to show clear leadership in setting high standards of process safety and environmental protection and in pursuing excellence in operations. At paragraph 8 we indicated our support for the work done thus far by the Buncefield Standards Task Group. We see the Task Group as continuing to play a key role. However, the scale of the improvements that we believe the sector needs to make can only come about through sector leadership at the highest level. We welcome the sector's acknowledgement of the need for more consistent responses to broadly similar risks. However, some fifteen months have passed since Buncefield, and we believe that the sector will face deserved criticism if clear and energetic progress is not now made on our recommendations.

36 The recommendations below require collaboration across the sector, as will several of our earlier recommendations in practice (eg Recommendation 19). Collaboration in turn requires leadership and vision. We make no specific recommendations about the form of leadership structures or the precise arrangements for taking forward implementation. These are matters for the sector to determine if it is to embrace the arrangements fully. They could build on existing arrangements, but need to engage and motivate all parts of the sector, including the workforce. Leadership should also embrace the important relationship between site operators and the surrounding communities, businesses and the local authorities.¹⁴ This needs to be characterised by openness and transparency. The recommendations can also be applied to other sectors. The Competent Authority should actively encourage and support the development of robust arrangements for continuing leadership in the sector, and other sectors as necessary.

¹⁴ We intend to return to this point in our recommendations for emergency preparedness and response.

Recommendation 23 The sector should set up arrangements to collate incident data on high potential incidents including overfilling, equipment failure, spills and alarm system defects, evaluate trends, and communicate information on risks, their related solutions and control measures to the industry.

Recommendation 24 The arrangements set up to meet Recommendation 23 should include, but not be limited to, the following:

- ▼ thorough investigation of root causes of failures and malfunctions of safety and environmental protection critical elements during testing or maintenance, or in service;
- ▼ developing incident databases that can be shared across the entire sector, subject to data protection and other legal requirements. Examples¹⁵ exist of effective voluntary systems that could provide suitable models;
- ▼ collaboration between the workforce and its representatives, dutyholders and regulators to ensure lessons are learned from incidents, and best practices are shared.

Recommendation 25 In particular, the sector should draw together current knowledge of major hazard events, failure histories of safety and environmental protection critical elements, and developments in new knowledge and innovation to continuously improve the control of risks. This should take advantage of the experience of other high hazard sectors such as chemical processing, offshore oil and gas operations, nuclear processing and railways.

¹⁵ Such as HSE's Offshore Hydrocarbon Releases Database and the Rail Safety and Standards Board's National Incident Reporting System, NIR-Online.

Annex 1

Terms of reference and progress

This annex sets out the eight terms of reference for the Investigation and explains the progress that is being made towards accomplishment of each of them.

1 To ensure the thorough investigation of the incident, the factors leading up to it, its impact both on and off site, and to establish its causation including root causes

The Board has published three progress reports from the Investigation Manager. This was followed by the Board's initial report on 13 July 2006, which summarised the three preceding reports and set out the Board's four main areas of concern. These have revealed the main facts of the incident, but have not speculated on why control of the fuel was lost. The explosion mechanism, ie the means by which unexpectedly high overpressures were generated, is subject to significant further investigation. Wider expert consultation has been undertaken on whether and what further research may be required and this is explained in this report.

The criminal investigation is pursuing all reasonable lines of inquiry into the facts and causes of the incident to enable the Competent Authority (HSE and the Environment Agency) to take a view on legal proceedings.

2 To identify and transmit without delay to dutyholders and other appropriate recipients any information requiring immediate action to further safety and/or environmental protection in relation to storage and distribution of hydrocarbon fuels

The Competent Authority issued a Safety Alert to around 1100 COMAH dutyholders on 21 February 2006. Special attention was paid to 108 fuel depot owners storing COMAH quantities of fuel in Great Britain, seeking a review of arrangements for detecting and dealing with conditions affecting containment of fuel. Most dutyholders responded to the alert by the Easter deadline. Meanwhile, the Competent Authority visited all 108 depots to follow up the alert. An interim report was published on 13 June 2006 and is available at www.hse.gov.uk/comah/alert.htm.

The Environment Agency issued further advice to its inspectors to investigate secondary (bunding) and tertiary (drains and barriers) containment at depots in England and Wales in response to the Second progress report. The Environment Agency continues to monitor the effects of Buncefield on the surrounding environment and to issue updates on its website, www.environmentagency.gov.uk. The initiative is being handled separately for Scotland by the Scottish Environment Protection Agency, with joint inspections undertaken with HSE covering primary, secondary and tertiary containment, and management systems. However, it is understood that an overall view of the situation in Britain will be available following the publication of this report by the Buncefield Board.

On 16 June 2006 investigators served two Improvement Notices on the manufacturers of the high level alarm switch installed on Tank 912, having identified a potential problem at other sites related to the setting of the switch for normal operations following testing. This was followed up by a Safety Alert from HSE on 4 July 2006 alerting operators relying on such switches of the potential problem.

The Chairman of the Buncefield Board wrote to the Chief Executive of the Health Protection Agency on 3 July 2006 enquiring into progress with informing regional resilience groups of early lessons learned from Buncefield, focusing on public health issues in the immediate aftermath of a major airborne incident, following up with a meeting December 2006. HPA is assisting the Board with its recommendations for improving emergency preparedness and response to major incidents which is likely to be the subject of the next report from the Board.

3 To examine the Health and Safety Executive's and the Environment Agency's role in regulating the activities on this site under the COMAH Regulations, considering relevant policy guidance and intervention activity

Work is progressing steadily on both parts of the review, concerning respectively HSE's and the Environment Agency's prior regulatory activities at Buncefield. The full findings of the review will be incorporated into the Board's final report (see term of reference 8). Immediate important lessons from the examination of the Competent Authority's prior role will be incorporated as appropriate into the lessons learned programme under term of reference 5.

4 To work closely with all relevant stakeholders, both to keep them informed of progress with the Investigation and to contribute relevant expertise to other inquiries that may be established

The ongoing impact on residents and businesses of the Buncefield incident has been reported in the three progress reports and in the initial report in which, in Part 2, the Board set out its main areas of concern. The Board has maintained an active interest in releasing as much new information as possible to the community and its representatives, such as the local MP Mike Penning, to assist in understanding the events of 11 December 2005, and to maintain public confidence that progress is being made with the Investigation. As has been reported previously, residents and businesses continue to show remarkable resilience in the difficult aftermath to the Buncefield incident. Dacorum Borough Council in particular, but also St Albans and Hertfordshire Councils, have performed extremely effectively in very difficult circumstances, and have supported the Board in its engagement with residents and businesses, as has Mike Penning MP.

The Board has also kept key Government stakeholders informed of the Investigation's progress, and has maintained its interest in developments that have taken place since Buncefield to help manage the aftermath and support a return to normality for residents and businesses.

The Board has engaged with all the public sector agencies involved in the emergency response to Buncefield and has met with a number of the key agencies, particularly the Category 1 (Gold) responders. This is not an issue in which the Board has primary responsibility but, as reported in this Initial Report, the Board is giving further consideration to emergency response and emergency preparedness issues, and will say more on this in its report on emergency preparedness and response.

The Buncefield Major Incident Investigation made presentations to two multiagency debriefing sessions on 21 and 28 June 2006 to inform regional resilience groups around Britain of the response to the Buncefield incident.

5 To make recommendations for future action to ensure the effective management and regulation of major accident risk at COMAH sites. This should include consideration of off-site as well as on-site risks and consider prevention of incidents, preparations for response to incidents, and mitigation of their effects

Staff seconded from HSE, the Environment Agency and the Health Protection Agency are assisting the Investigation Manager and the Board to make sensible, practical and affordable recommendations for improvements in the light of the Buncefield incident. Key workstreams are in environmental protection; land use planning; fire and explosion mechanisms; control and instrumentation; human and organisational factors; health; emergency response and preparedness; and regulatory impact.

This report, making recommendations for the design and operation of Buncefield-type sites, is the first report under this term of reference. HSE has convened an industry chaired task group (the Buncefield Standards Task Group) that includes the Environment Agency and the Scottish Environment Protection Agency, to also consider design and operation issues in parallel with the Board's work. This initiative has been welcomed by the Board in this report.

Work is advanced in producing recommendations on emergency preparation for, and response to, extreme events such as Buncefield. This work is supported by an immense amount of work undertaken by other agencies such as Hertfordshire Resilience, Hertfordshire Fire and Rescue Service, and the Health Protection Agency. The Board intends to join together the many strands of this subject, including issues concerning support to communities and businesses in the aftermath of an extreme incident.

The Board is close to recommending suitable arrangements for further research and modelling of explosion mechanisms in flammable vapour clouds.

HSE has completed its initial work on changes to land use planning advice and has issued a public consultation document seeking views by 22 May 2007 (see <http://hse.gov.uk/consult/condocs/cd211.htm>). The Board will be setting out its own views to the consultation document in due course. HSE is also working closely with a Cabinet Office led team on applying new knowledge of risks to society in the planning system. The Health Protection Agency is consulting key agencies to improve public health advice and support during significant pollution events.

6 To produce an initial report for the Health and Safety Commission and the Environment Agency as soon as the main facts have been established. Subject to legal considerations, this report will be made public

This element is discharged by the publication of the Board's initial report on 13 July 2006.

7 To ensure that the relevant notifications are made to the European Commission

A report from the Environment Agency and HSE was made to the European Commission on 10 March 2006. Subsequently, the Environment Agency declared Buncefield a major accident to the environment (MATTE), and the Competent Authority has recently reported this to the European Commission.

8 To make the final report public

The timing for the publication of the final report remains uncertain and is of course linked to progress on the main terms of reference and to any decision on any criminal proceedings that might be considered. The possibilities include a further interim report or reports; decisions must necessarily depend on the timing of developments and consideration of the public interest.

Annex 2

Members of the independent Board

The Rt. Hon. Lord Newton of Braintree has been a life peer since 1997 after spending 23 years as a Conservative Member of Parliament for Braintree, Essex. From 1982 to 1988 he held ministerial positions at the Department of Health and Social Security. In 1988 he joined the Cabinet as Chancellor of the Duchy of Lancaster and Minister at the DTI. He then held the post of Secretary of State for Social Security from 1989 to 1992 when he was appointed Leader of the House of Commons, which he held until 1997. In 2002 he chaired the Committee that reviewed the operation of the Anti-Terrorism, Crime and Security Act 2001.

Professor Dougal Drysdale is one of the leading international authorities in Fire Safety Engineering. He was the Chairman of the International Association of Fire Safety Science until September 2005 and is currently the editor of the leading scientific journal in the field, Fire Safety Journal. His wide range of research interests includes the ignition characteristics of combustible materials, flame spread and various aspects of fire dynamics. He is a Fellow of the Royal Society of Edinburgh and a Fellow of both the Institution of Fire Engineers and the Society of Fire Protection Engineers.

Dr Peter Baxter is a Consultant Physician in Occupational and Environmental Medicine at Cambridge University and Addenbrooke's Hospital, Cambridge. In the past he has advised the Government on the impacts on public health relating to air quality standards, major chemical incidents, natural disasters and climate change.

Taf Powell is Director of HSE's Offshore Division. He graduated in Geology and Chemistry from Nottingham University. His oil field career has been split between working in the UK and abroad in offshore exploration and development and regulation of the sector in licensing, well operations, policy and safety regulation. In 1991 he joined HSE's Offshore Division from BP and started work to develop the new offshore regulatory framework, one of Lord Cullen's recommendations following his inquiry into the Piper Alpha disaster. As HSE's Operations Manager, based in Aberdeen, he then led inspection teams and well engineering specialists responsible for enforcing the new regulations until 2000 when he took up his current role.

Dr Paul Leinster is Director of Operations at the Environment Agency. Up until March 2004 he was the Director of Environmental Protection, having joined the Agency in 1998. Prior to this he was the Director of Environmental Services with SmithKline Beecham. Previous employers also include BP International, Schering Agrochemicals and the consultancy firm Thomson-MTS where he was Managing Director. Paul has a degree in Chemistry, a PhD in Environmental Engineering from Imperial College and an MBA from the Cranfield School of Management. Paul has worked for 30 years in the health and safety and environmental field.

David Ashton is Director of HSE's Field Operations North-West and Headquarters Division. He joined HSE in 1977 as an inspector in the west of Scotland where he dealt with a wide range of manufacturing and service industries, including construction, engineering and the health services. In 1986 he joined Field Operations HQ to deal with machinery safety. He then held the post of Principal Inspector of manufacturing in Preston for two years, before being appointed as a management systems auditor to examine offshore safety cases in the newly formed Offshore Division. In 1993 he became Head of HSE's Accident Prevention Advisory Unit, looking at the management of health and safety in organisations. Between 1998 and 2003 David was HSE's Director of Personnel, before being appointed to his current position.

Annex 3

Rationale for Recommendation 3 – Independent and automatic storage tank overflow prevention

1 It is common practice to employ an ultimate high level detection system to detect when the liquid in a storage tank has reached a level beyond which any further filling is likely to result in an overspill of liquid unless suitable averting action is taken. The benefit of such a system being independent of the tank gauging system is recognised in the current standards and guidance for storage tank operations.^(refs 4,7,8) However, the current standards and guidance (other than in the case of reference 2 for unattended facilities only) do not require the overfill prevention system to be automatic.

2 Nevertheless, the benefit of an automatic overfill prevention system is recognised by the Energy Institute^(ref 7) which says that ‘where tank filling operations are complex, such as with tanks fed by cross-country pipelines, consideration should be given to the fitting of high level alarms and devices for automatically cutting off the supply. Ideally automatic cut-off devices should be high integrity and independent of any normal measuring alarm or system.’ We also note that a draft revision to API Code 2350 considers requiring automatic independent shutdown systems to control filling of tanks at Buncefield type sites.

3 The benefit of an automatic overfill prevention system stems from the diversity that such a system provides in combination with the tank gauging system. Without such diversity the combination of the systems is vulnerable to common cause failures as they would both rely on human operators. For example, abnormal events may distract or disable the operators such that they fail to properly control the tank gauging system and then also fail to respond to the ultimate high liquid level alarm in time to prevent overfilling. Such common cause failures can significantly degrade the overall integrity of the gauging and overfill prevention systems such that the likelihood of an overspill is much higher than would be evaluated by considering the systems as being independent.

4 It is our considered view, having consulted with experts in the industry, that the assurance for the overall integrity of containment provided by the diversity of manual and automatic systems justifies overfill prevention systems being automatic in Buncefield like sites. This is particularly so given the potentially high consequences for both safety and the environment, together with the associated societal concern, that may result from a substantial overspill of petrol or similar substance in such sites.

5 We consider that a further benefit of an automated overfill prevention system stems from the greater confidence in testing, inspection, verification and auditing that competently engineered arrangements allow for, compared with that afforded by manually operated systems.

6 However, even with such an approach it remains vital that both the gauging system and the overfill prevention systems are maintained in effective working order. It also remains important to properly evaluate the required safety integrity level (SIL) for the automated overfill prevention system, taking into account the associated risks in line with Recommendation 1 of this report. This will ensure a low enough level of residual risk taking into account a realistic view of the reliability of the systems.

7 We consider that the preferred way of achieving automated overfill prevention will include the use of positively isolating valves such as remotely operated shut-off valves (ROSOVs) or emergency shutdown valves (ESDVs).^(ref 9) Such valves are designed to achieve and maintain rapid isolation of plant items and thereby prevent further movement of liquid that could result in overfilling of a tank. However, we recognise that the use of ROSOVs or ESDVs may not be appropriate in some applications, such as filling from a ship or train, or from a refinery process. In such applications it may be more appropriate to employ other or additional control arrangements such as automatic diversion of flow and/or shutdown of a pump. Whatever system is selected, the safety integrity level required for that site must not be compromised.

8 In all applications, the desired outcome must be the same. Namely, if petrol (or similar flammable substance) filling at a Buncefield-type site continues after the system has warned operators to take action, but action has not been taken or is not effective, then means that require no further human intervention (ie automatic) should safely stop the tank filling before overflow occurs.

9 We further recognise that certain applications may require the industry, working with the joint Competent Authority, to resolve some practical and technical considerations to achieve what we have stipulated.

Annex 4

Background and supporting material for ‘improved components and systems’ (Recommendation 8)

Alternative means of ultimate high level detection

1 The detection of ultimate high liquid level in storage tanks often relies on a switch mounted on the roof of the tank (or on the uppermost level of the tank wall). This is commonplace within the industry. For example it is illustrated in API RP 2350.^(ref 4) However, the arrangement suffers from a number of disadvantages with regard to safety, namely:

- ▼ the operation of the switch cannot be tested fully in situ other than by raising the liquid level in the tank to the ultimate high level. Any other means of testing will leave a number of potential failure modes uncovered and so leave the switch in a faulty state unbeknown to the operator or maintenance staff. However, such testing itself introduces the possibility of overfilling so must be undertaken under strict supervision. There is often a reluctance to undertake such testing;
- ▼ simple switches do not benefit from ‘on line’ diagnostics. More advanced sensors (such as those based on tuning fork or thermocouple technology) incorporate diagnostics so that all foreseeable failure modes are detected as they occur.

2 The recommendation is intended to encourage the industry to move away from the use of simple level switches for ultimate high level indication and towards the use of more advanced sensors that incorporate ‘on line’ diagnostics and can therefore be considered to be ‘fail safe’. Such sensors are in widespread use and a number are available that have been certified for use in SIL2/3 applications in accordance with BS EN 61511.

3 The second part of this recommendation is that the means of ultimate high level detection should not rely on components ‘internal to the storage tank’. Reliance on such internal components will always be problematic from a safety viewpoint as access to the inside of the tank for inspection and maintenance will be very limited. It also means that a ‘wet test’ of the switch can only be carried out by filling the tank to the ultimate high level. While such a test could possibly be carried out safely under controlled conditions, there would be significant difficulties in ensuring safety at all times with such an approach.

4 A reasonably practicable alternative solution may be the use of a small external tank tapped into the main tank through a small bore pipe at the ultimate high level. The ultimate high level sensor would be fitted to this external tank such that the ‘overspill’ from the main tank is sensed. Initial considerations suggest that such an approach is feasible. It appears to offer a number of significant benefits. The setting of the ultimate high level would be determined by the physical position of the tapping. This would not be vulnerable to unintended changes. Access to the tank, especially if fitted adjacent to the existing stairway, would be relatively easy and wet testing of the level sensor would be possible without the need to overfill the main tank. These are significant benefits and worthy of further consideration. The practicalities of fitting such an external tank and the associated instrumentation and cabling will also need to be considered. It may be that the

tapping could be made without the need to empty the main tank, although this would need to be confirmed. This would significantly reduce the installation costs. The potential benefits on the face of it justify a recommendation to encourage the industry to explore this approach further.

Increased dependability of tank level gauging systems

5 Tank gauging systems often employ mechanical servo gauges to sense the liquid level. However, such gauges appear to be vulnerable to a number of potential failure modes.

6 This recommendation is intended to encourage the industry to make effective use of the facilities provided in state-of-the-art tank gauging systems to reconcile the indications of product level in tanks with all available information such as product movement requests, pipeline flow measurements, temperature, etc. In this way it may be arranged that the failure of a single element of the system, such as a servo gauge, is detected and the operators alerted before a hazardous situation develops or before a demand is placed on the overfill prevention system.

7 A further contribution to enhanced dependability may result from the use of modern electronic gauge sensors, for example based on radar technology. Electro-mechanical servo gauges are intricate devices vulnerable to many failure modes. Electronic sensors eliminate the failure modes associated with mechanical components and may offer a higher reliability alternative. Such devices are readily available.

Annex 5

High reliability organisations (Recommendations 19-22)

1 A ‘high reliability organisation’ (HRO) is a robust organisation with a strong safety culture that has a high probability of achieving safe, reliable and quality performance over a long period of time.

Background

2 Since the early 1980s studies have been made of organisations that operate ‘high-hazard, low-risk’ technologies at very high levels of reliability;^(refs 10-13) examples are in the air traffic control sector, and on aircraft carriers. The manufacturing and banking sectors also contain examples of companies that have elected to build HROs that are significantly in advance of their peer groups. The studies show that safe operation is not just a matter of compliance with various regulations, codes and standards, but also crucially depends on organisational design and culture. HROs have developed a culture of reliability to drive the business (including high productivity), without sacrificing the drive for improvement or the capability to change.

Culture

3 The ethos of a HRO is based on the prevention of unplanned events (including accidents) through good organisational design and management. The culture of a HRO is one that expects its organisation and sub-systems to fail and works very hard to avoid failure and to minimise its impact. This preoccupation with the possibility of failure leads to a continual state of ‘mindfulness’ combined with a strong desire to be a ‘learning organisation’. High reliability organisations actively seek to know what they do not know, design systems to make all knowledge relating to a problem available to everyone in the organisation, learn quickly and efficiently, train staff to recognise and respond to system abnormalities, empower staff to act, and design redundant systems to catch problems early. Maintenance and proof testing are optimised to increase knowledge and to raise productivity to very high levels through avoidance of unplanned interruptions of which major accidents are the extreme examples.

Characteristics

4 Frequently cited characteristics of high reliability organisations include:

- ▼ **Extensive process auditing.** The organisation will have an established system for monitoring compliance with procedures, and also the efficacy of the procedures themselves. Audits will be designed to identify both expected and unexpected safety problems. There will be robust follow up on actions and problems identified in earlier audits. Regular safety drills and equipment testing will be part of the process auditing system.
- ▼ **Reward and recognition.** Organisational reward systems have powerful influences on the behaviour of individuals in them. HROs will have reward systems that drive the desired behaviours and value the contribution of all in the organisation. For instance full and accurate reporting of incidents, and exemplary care of work equipment will be valued more than ‘zero reported lost time incidents’ (which can encourage competitive under-reporting). They will also be aware that punitive measures may reward behaviour that hides results or redirects blame.

- ▼ **Higher quality standards.** HROs will maintain high quality standards and avoid quality degradation as core values. This will involve regular evaluation of the organisation's performance, capabilities and goals.
- ▼ **Perception of risk.** The HRO will be aware of all risks and, importantly, the significance of each key risk and suitable (but not excessive) control measures will be in place.
- ▼ **Command and control systems that will include:**
 - *Delegated decision-making.* Relevant competent staff will be integrated into the decision-making process.
 - *Redundancy.* Critical protection systems, process technology and personnel responsibilities are protected against predicted failure that can cause process interruptions and hazardous outcomes.
 - *Senior management involvement.* Top managers will be expected to understand and communicate the 'big picture' rather than being involved too much in the detail and 'micromanaging'.
 - *Formal rules and procedures.* Standard operating procedures (SOPs) will be set out and their implementation will be monitored. The SOPs will deal with all main processes, including response to hazards to personnel, the environment and capital assets. SOPs are updated as lessons are learned from abnormal events and systems failures.
 - *Competency.* Particular emphasis will be given to training in safety critical tasks and in continuous improvement in process efficacy.
 - *Needs of front line staff.* Operator training will incorporate hands-on simulation. Communications will be geared to awareness of adverse situations that can arise, and how to deal with them. Positive behaviours are encouraged. Unwanted behaviours are challenged.

Annex 6

BS EN 61511 Functional safety – Safety instrumented systems for the process industry sector

Background

1 BS EN 61511^(refs 14,15,16) is the process industry standard for ‘safety instrumented systems’. Such systems are widely used in the chemical and petrochemical process industries to measure and control process variables (such as liquid levels and temperatures or gas pressures) so as to ensure that the safe working limits of plant items are not exceeded and thereby avoid hazardous events such as loss of containment of flammable or toxic materials. Other common terms for safety instrumented systems (SIS) are ‘emergency shutdown (ESD) systems’, ‘trip systems’, ‘safety interlock systems’ or ‘safety shutdown systems (SSD)’.

2 The standard (comprising three parts) was first published by the International Electrotechnical Commission (IEC) as IEC 61511 in 2003. It was developed by an international working group comprising experts from the chemical and petrochemical industries. As such it represents the worldwide consensus view on how such systems should be engineered to ensure safety. It covers all aspects of the lifecycle of a system from initial specification and design through to installation, operation, maintenance and eventual decommissioning.

3 Member countries of the IEC agree to adopt IEC standards as national standards. IEC 61511 as adopted as the national standard for the UK when it was published by the British Standards Institution (BSI) as BS IEC 61511 in 2003. Subsequently, the standard was adopted by the European standardisation body for Electrotechnical matters, CENELEC, and is now published by BSI as BS EN 61511. The standard has similarly been adopted by all member countries of the IEC. For example, in the USA it is published as ANSI/ISA-84.00.01-2004.

Principles of BS EN 61511

4 The principles of BS EN 61511 were established by the generic standard for functional safety, BS EN 61508.^(ref 17) The overall aim is to ensure that the performance of a safety instrumented system, in terms of both the functions it provides and their integrity, is adequate to ensure safety. It defines four levels of safety integrity, SIL1, SIL2, SIL3 and SIL4. The higher the SIL level the higher the associated safety level and the lower the probability that the system will fail to perform properly. The required SIL is determined by a hazard and risk assessment taking into account any measures that reduce the risks associated with the hazard under consideration and the tolerable risk target for the specific application. Generally it is preferred to avoid sole reliance on SIS, particularly in high hazard applications. Consequently, most SIS in the chemical and petrochemical process industries in the UK are specified as SIL1 or SIL2.

Application of BS EN 61511 to overfill protection systems

5 BS EN 61511 has no specific requirements for storage tank overfill prevention systems. However, the principles of the standard are directly relevant and can be readily applied to such systems. Application of the standard will provide a risk-based design target for the SIL of an overfill protection system. It will ensure that the design and installation is adequate to achieve the required SIL and that sufficiently frequent periodic testing of the system is carried out to reduce, so far as is reasonably practicable, the risks of tank overfilling.

6 While the application of BS EN 61511 provides a risk-based target for the integrity of an overfill protection system (recommendation 1), and hence for the reliability of the constituent components, it does not require such systems to be automatic in operation. However, if the overfill protection system relies on human operation, the possibility of human failure remains resulting in common cause failure of both a tank gauging system and its overfill protection system. This possibility is very difficult to quantify but is likely to be a critical factor in determining the likelihood of overfilling. For this reason it is felt necessary to make the additional recommendation (recommendation 3) that overfill protection systems should be automated.

Annex 7

Examples of incidents that have involved loss of primary containment from storage tanks

Records of incidents of this type are held by the companies involved for purposes of monitoring the effectiveness of their health and safety policy. The following table gives some examples of such incidents to illustrate the fact that they should not be considered as ‘rare events’. Data have been compiled by a reputable operator in the USA that indicate that overfilling occurs once in every 3300 filling operations.

Location	Date	Fuel released	Consequence
Jacksonville, Florida, UK	1993	Unleaded petrol/gasoline	190 m ³ released. The spill ignited, leading to a major explosion and fire.
Coryton, UK	1997	Unleaded petrol/gasoline	81 m ³ released. Spill contained within bund – no ignition.
Belgium	2001	Hexene	Approx 90 m ³ released. Spill contained within bund – no ignition.
Sour Lake, Texas, USA	2003	Crude oil	80 m ³ released. Spill contained within bund – no ignition.
Torrance, California, USA	2004	Jet fuel	Approx 10 m ³ released. Contained in bund – no fire or explosion.
Bayonne, New Jersey, USA	2004	Fuel oil	825 m ³ released. Oil ‘contained on tank farm’ – no fire or explosion.
Casper, Wyoming, USA	2004	Unleaded petrol/gasoline	Up to 1270 m ³ released. Spill contained within bund – no ignition.
Rensselaer, NY, USA	2005	Unleaded petrol/gasoline	0.4–4 m ³ released. Spill contained within bund – no ignition.

Table 1 Examples of loss of primary containment from fuel storage tanks

Table 2 contains examples of situations in which the loss of primary containment created circumstances (actual or potential) for environmental damage.

Location	Date	Fuel released	Cause	Consequence
Fawley	1999	Crude oil (400 tonnes)	Corrosion of tank base.	No injuries or off-site effects. All of the oil was recovered from primary containment. ECRA* (major loss of inventory).
Milford Haven	2005	Kerosene (653 tonnes)	Leak from damaged sump escaped through permeable floor of bund.	No injuries, but nearby gardens, farmland, and stream contaminated. All wildlife killed in stream. ECRA (contamination of groundwater).
Antwerp, Belgium	2005	Crude oil (26 000 tonnes)	Catastrophic failure of storage tank as a result of corrosion.	Overtopping of bund wall occurred due to sudden release. No injuries. ECRA (major loss of inventory).
Plymouth Harbour	2005	Kerosene (tonnage uncertain)	Corrosion of the tank base and a permeable bund base.	No injuries. Kerosene entered into the ground.
Coryton	2006	Gas oil (121 tonnes)	Tank overfilled, oil escaped from bund by defective drain valve.	No injuries or harm to the environment.
Poole Harbour	2006	Diesel oil (19 tonnes)	Diesel escaped through damaged base plate and through cracks in concrete bund floor.	No injuries. Pollution of ground but not of the harbour.

* ECRA – European Commission Reportable Accident

Table 2 Loss of primary containment from fuel storage tanks, some with environmental consequences

References

- 1 Buncefield Standards Task Group – Initial Report 2006
(www.hse.gov.uk/comah/buncefield/bstg1.htm)
- 2 *Safety Review Panel ('The Baker Report')* BP US Refineries Independent Safety Review Panel 2007
- 3 BS EN 61511: 2004 *Functional safety. Safety instrumented systems for the process industry sector* British Standards Institution
- 4 API RP 2350 *Overfill protection for storage tanks in petroleum facilities* (Third edition) January 2005
- 5 *Developing process safety indicators: A step-by-step guide for chemical and major hazard industries* HSG254 HSE Books 2006 ISBN 978 0 7176 6180 0
- 6 *Dangerous Substances and Explosive Atmospheres Regulations* 2002 SI 2002/2776 The Stationery Office 2002 ISBN 978 0 11 042957 1
- 7 *Model Code of Safe Practice in the Petroleum Industry, Part 2, Design, Construction and Operation of Petroleum Distribution Installations* (Third edition) Energy Institute September 2005
- 8 *The storage of flammable liquids in tanks* HSG176 HSE Books 1998 ISBN 978 0 7176 1470 7
- 9 *Remotely operated shutoff valves (ROSOVs) for emergency isolation of hazardous substances: Guidance on good practice* HSG244 HSE Books 2004 ISBN 978 0 7176 2803 2
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- 13 Weick K and Sutcliffe K *Managing the unexpected: Assuring high performance in an age of complexity* Jossey-Bass, San Francisco 2001
- 14 BS EN 61511-1: 2004 *Functional safety – Safety instrumented systems for the process industry sector – Part 1: Framework, definitions, system, hardware and software requirements* British Standards Institution
- 15 BS EN 61511-2: 2004 *Functional safety – Safety instrumented systems for the process industry sector – Part 2: Guidelines for the application of BS EN 61511-1* British Standards Institution

16 BS EN 61511-3: 2004 *Functional safety – Safety instrumented systems for the process industry sector – Part 3: guidance for the determination of the required safety integrity levels* British Standards Institution

17 BS EN 61508-1: 2002 *Functional safety of electrical/electronic/programmable electronic safety-related systems* British Standards Institution

Glossary

API American Petroleum Institute. It is the American national trade association for the petroleum industry, but it has an increasingly collaborative stance with other bodies such as BSI. API produces a number of guides to standards and recommended practices. Of interest is API Recommended Practice 2350 *Overfill protection for storage tanks in petroleum facilities* which is currently being reviewed

BSI Formerly British Standards Institution, now the BSI Group, it was founded in 1901 as the Engineering Standards Committee, it is now diversified into making standards, certifying management systems, product testing and other engineering services related to quality

bund An enclosure designed to contain fluids should they escape from the tank or vessel inside the bund, as well as any additional materials added to the container area such as firefighting water and foam, etc

Buncefield Standards Task Group The joint Competent Authority/industry standards working group set up to review safety and environmental protection standards at fuel storage sites following the Buncefield incident. The Task Group published its initial recommendations on 12 October 2006

CENELEC European Committee for Electrotechnical Standardisation

COMAH See Control of Major Accident Hazards Regulations 1999

COMAH site A site to which the Control of Major Accident Hazards Regulations 1999 apply

Competent Authority The Control of Major Accident Hazards Regulations (COMAH) are enforced by a joint Competent Authority comprising the Health and Safety Executive (HSE and the Environment Agency in England and Wales, and HSE and the Scottish Environment Protection Agency in Scotland

Control of Major Accident Hazards Regulations 1999 The main aim of these Regulations is to prevent and mitigate the effects of those major accidents involving dangerous substances, such as chlorine, liquefied petroleum gas, and explosives which can cause serious damage/harm to people and/or the environment. The Regulations treat risks to the environment as seriously as those to people. They apply where threshold quantities of dangerous substances identified in the Regulations are kept or used

dutyholder In the context of this report, any person or organisation holding a legal duty – in particular those placed by the Health and Safety at Work etc Act, the Management of Health and Safety at Work Regulations, and the COMAH Regulations

Environment Agency The Environment Agency is the lead regulator in England and Wales with responsibility for protecting and enhancing the environment. It was set up by the Environment Act 1995 and is a non-departmental public body, largely sponsored by the Department for Environment, Food and Rural Affairs and the National Assembly for Wales

firefighting pumps The pumping equipment, normally permanently installed in a pumphouse to move water around the site during fire fighting operations

firewater Water stored for use during, and used during, firefighting operations

firewater lagoon An artificial pond that principally stores water intended for firefighting operations

flashpoint The lowest temperature at which a liquid gives off sufficient vapour to form a flammable mixture

hazard Anything with the potential to cause harm

Health and Safety Commission The Health and Safety Commission is a statutory body, established under the Health and Safety at Work etc Act 1974, responsible for health and safety regulation in Great Britain

Health and Safety Executive The Health and Safety Executive is a statutory body, established under the Health and Safety at Work etc Act 1974. It is an enforcing authority working in support of HSC. Local authorities are also enforcing authorities under the Health and Safety at Work etc Act 1974

high reliability organisations Robust organisations with a strong safety culture that have a high probability of achieving safe and reliable performance. More detail is given in Annex 5

high integrity systems Systems that are designed and maintained so that they have a high probability of carrying out their intended function. Safety instrumented systems having safety integrity levels in the range SIL1 to SIL4 are regarded as high integrity systems

HSC See Health and Safety Commission

HSE See Health and Safety Executive

IEC International Electrotechnical Commission

independent overfill protection system A system that detects when the liquid in a storage tank has reached a level where continued further filling will result in loss of containment and acts to prevent further filling in time to prevent such loss of containment. Where such systems are automatic they do not rely on any human operator action

kiloPascal Pascals (Pa) are the unit of pressure in the International System of Units (SI). A kiloPascal (kPa) is equal to 1000 Pa. Although bar are not units within SI, they are sometimes used as units to measure atmospheric pressure. 1 kPa = 10 bar

major accident to the environment DEFRA has established threshold criteria defining a 'major accident to the environment' (MATTE), based on Schedule 7 (part 1) of the Control of Major Accident Hazards Regulations 1999. The Environment Agency, using these criteria, has determined that the Buncefield incident is a MATTE, and the Competent Authority has recently reported this to the European Commission

manual emergency switches Simple and robust push switches that will initiate emergency action such as shutting down pumps or interrupting process operations, and which are located at strategic and accessible locations around the site

MATTE See major accident to the environment

overpressure For a pressure pulse (or blast wave), the pressure developed above atmospheric pressure

primary containment The tanks, pipes and vessels that normally hold liquids, and the devices fitted to them to allow them to be safely operated

pumphouse In the context of this report, the structure enclosing the pumping equipment used to move water around the Buncefield site prior to the incident. It principally stored water intended for firefighting operations

risk The likelihood that a hazard will cause a specified harm to someone or something

Safety Alert Where the Competent Authority considers that an issue poses significant risk, it can choose to issue a Safety Alert to operators of COMAH sites informing them of the issue and possibly requiring them to undertake certain activity

safety integrity level (SIL) A safety integrity level (SIL) is a measure of safety system performance, in terms of the probability of failure on demand. There are four discrete integrity levels, SIL 1-4. The higher the SIL level, the higher the associated safety level and the lower the probability that a system will fail to perform properly

Scottish Environment Protection Agency The public body that is responsible for the protection of the environment in Scotland

secondary containment Enclosed areas around storage vessels (often called bunds), created usually by concrete or earth walls. Their purpose is to hold any escaping liquids and any water or chemicals used in firefighting

SEPA See Scottish Environment Protection Agency

tertiary containment The site surface and associated drainage, boundary walls, roads, containment kerbs and any features such as road humps that can provide some retention of liquids. Proper design of drainage systems will limit loss of product out of the site and prevent lost product permeating into the ground with the potential risk that it can migrate to groundwater, or contaminate surface waters and land

ultimate high level switch Part of the system to prevent overfilling of the tank, the ultimate high level switch is an independent mechanism which should be triggered when the 'ultimate high level' (ie the specified maximum capacity) is reached in a tank to which it is fitted, both causing an alarm to sound and shutting down the supply of fuel to the tank

Further information

Useful links

Buncefield Major Incident Investigation

Marlowe Room, Rose Court 2 Southwark Bridge London, SE1 9HS

Tel: 020 7717 6909 Fax: 020 7717 6082

E-mail: buncefield.inforequest@hse.gsi.gov.uk

Web: www.buncefieldinvestigation.gov.uk

Community/Business support

Dacorum Business Contact Centre Tel: 01442 867 805

Business Link Helpline Tel: 01727 813 813

Hertfordshire Chamber of Commerce Tel: 01727 813 680

Dacorum Community Trust Mayor's Fund

To apply, call the freephone helpline on 0800 131 3351. Lines are open 9.30 am to 4.30 pm, Monday to Friday

Dacorum Borough Council Tel: 01442 228 000

Web: www.dacorum.gov.uk

Hemel Hempstead Citizens Advice Bureau

19 Hillfield Road, Hemel Hempstead HP2 4AA

Tel: 01442 213368

Local authorities and emergency services

Dacorum Borough Council Tel: 01442 228 000

Web: www.dacorum.gov.uk

(Dacorum Borough Council Digest newsletter, available monthly Dacorum Borough Council Buncefield Update Newsletter)

St Albans District Council Tel: 01727 866 100

Web: www.stalbans.gov.uk

Hertfordshire County Council Tel: 01483 737 555

Web: www.hertsdirect.org

Hertfordshire Fire and Rescue Service

Web: www.hertsdirect.org/yrccouncil/hcc/fire/buncefield

Hertfordshire Constabulary

Web: www.herts.police.uk/news/buncefield/main.htm

Hertfordshire Chamber of Commerce Tel: 01727 813 680

Web: www.hertschamber.com

Government links

Department for Communities and Local Government
Fire and Resilience Directorate
Web: www.communities.gov.uk

Government Office for the East of England
Web: www.goeast.gov.uk

Environment Agency
Web: www.environmentagency.gov.uk

Department of Trade and Industry
Oil and Gas Directorate
Web: www.og.dti.gov.uk

Health and Safety Executive
Hazardous Installations Directorate
Web: www.hse.gov.uk/hid

Control of Major Accident Hazards
Web: www.hse.gov.uk/comah

Department for the Environment, Food and Rural Affairs
Web: www.defra.gov.uk

Health Protection Agency
Web: www.hpa.org.uk

Food Standards Agency
Web: www.food.gov.uk

Drinking Water Inspectorate
Web: www.dwi.gov.uk

Scottish Environment Protection Agency
Web: www.sepa.ork.uk

Buncefields Standards Task Group (BSTG)
Chair: Ken Rivers Tel: 0151 951 4078

Industry links

United Kingdom Petroleum Industry Association (UKPIA)
Tel: 020 7240 0289 Web: www.ukpia.com

Chemical Industries Association
Tel: 020 7834 3399 Web: www.cia.org.uk

Three Valleys Water
Tel: 0845 782 3333 Web: www.3valleys.co.uk

United Kingdom Onshore Pipeline Operators' Association (UKOPA)
Tel: 01773 852003 Web: www.ukopa.co.uk

Tank Storage Association
Tel: 01244 335627 Web: www.tankstorage.org.uk

Investigation reports

Buncefield Major Incident Investigation:

- ▼ Progress Report, published 21 February 2006
- ▼ Second Progress Report, published 11 April 2006
- ▼ Third Progress Report, published 9 May 2006
- ▼ Initial Report, published 13 July 2006

Available from www.buncefieldinvestigation.gov.uk

DEFRA: *Initial review of Air Quality aspects of the Buncefield Oil Depot Explosion*
www.defra.gov.uk/environment/airquality/buncefield/buncefieldreport.pdf

Buncefield: Hertfordshire Fire and Rescue Service's review of the fire response
 Hertfordshire Fire and Rescue Service November 2006 ISBN 978 0 11 703716 8

Angus Fire, Buncefield Oil Terminal Incident December 2005: Review of part played by Angus Fire and lessons learned www.angusfire.co.uk

Other related reports/information

East of England Development Agency – report by SQW, Economic Developments Consultants on: *The Buncefield Oil Depot Incident: Economic and Business Confidence Impact Study*, June 2006 www.eeda.org.uk

Swiss Fire Service: *Quick Look Report – Buncefield Fire 11 December 2005*

Buncefield social impact report Decorum Borough Council January 2007
www.decorum.gov.uk/default.aspx?page=4191

Contract research reports for HSE

WS Atkins Science and Technology: *Derivation of fatality probability functions for occupants of buildings subject to blast loads Phases 1, 2, & 3 147/1997 and Phase 4 151/1997*

Biomedical Sciences Chemical and Biological Defence Sector Defence Evaluation and Research Agency: *Review of blast injury data and models 192/1998*

Available from: www.hsebooks.com

Government Advisory Bodies

Committee on mutagenicity of chemicals in food, consumer products and the environment (COM)

Committee on carcinogenicity of chemicals in food, consumer products and the environment (COC)

Committee on toxicity of chemicals in food, consumer products and the environment (COT)

www.advisorybodies.doh.gov.uk/coc/



Recommendations on the emergency preparedness for, response to and recovery from incidents



Recommendations on the emergency preparedness for, response to and recovery from incidents

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Figure 1 An overview of the Buncefield site and adjacent business and residential communities before the incident

Introduction

1 This report sets out recommendations to improve both planning for emergencies and the effectiveness of the response to emergencies at Buncefield-like sites and other high-hazard industrial facilities regulated under the COMAH¹ regime. The recommendations are made by the independent Investigation Board, chaired by Lord Newton of Braintree, set up to supervise the investigation into the explosions and fires at the Buncefield oil storage depot, Hemel Hempstead, Hertfordshire on 11 December 2005. The Health and Safety Commission (HSC) directed the investigation using its powers under section 14(2)(a) of the Health and Safety at Work etc Act 1974.

2 Item five of the investigation's terms of reference required us to 'make recommendations for future action to ensure the effective management and regulation of major incident risk at COMAH sites. This should include consideration of off-site as well as on-site risks and consider prevention of incidents, preparations for response to incidents and mitigation of their effects'.

3 Our initial report,^(Ref 1) published on 13 July 2006, identified four principal workstreams that would form the basis for our continuing work and developing recommendations. Those workstreams are:

- ▼ design and operations;
- ▼ emergency preparedness for, and response to, incidents;
- ▼ advice to planning authorities; and
- ▼ examination of the Health and Safety Executive's (HSE's) and the Environment Agency's (EA's) roles in regulating the activities on the Buncefield site.

4 This report concentrates on the second of these – emergency preparedness and response. It builds on the broad conclusions set out in paragraphs 78–79 of our initial report. This report also draws together information from other sources, such as the recommendations and reviews by many organisations with experience of planning for and responding to the Buncefield incident. In several areas, work is already underway that has the potential to meet these recommendations. We understand that Hertfordshire Fire and Rescue Service, Hertfordshire Resilience Forum, the Health Protection Agency and the Buncefield Standards Task Group (among others) are working on aspects of emergency preparedness and response, including aspects recommended in our initial report. We welcome the initiative of the sector, the Competent Authority and responders in taking this forward.

5 We wish to ensure that their work and experiences are shared by the widest possible audience. Our broad aim in making these recommendations is therefore to ensure that the lessons of Buncefield are used to catalyse improvement in emergency planning, response and recovery arrangements throughout Britain. We well understand that devolved administrations exist elsewhere in the UK and these regimes differ from England in some respects in relation to their legislative and structural arrangements. We expect the recommendations in this report will be

¹ The Control of Major Accident Hazards Regulations 1999 (COMAH). These Regulations are enforced by a joint Competent Authority comprising HSE and the Environment Agency in England and Wales and HSE and the Scottish Environment Protection Agency in Scotland.

fully implemented throughout the UK and we anticipate the Competent Authority (CA) will ensure there is consistency of approach across the UK in the COMAH sector. Annex 3 attempts to explain some of the differences in the devolved administrations and we have reflected these in our recommendations as far as possible without sacrificing coherence.

6 The Buncefield incident caused no fatalities, perhaps fortuitously, but it had a huge impact on local residents and businesses, as well as on communities further away. The huge scale of the devastation, plus the extent of the work required to enable full recovery, highlights the need to learn all we can from the experience. Indeed, the incident also provides insights into what might have happened but did not, particularly in potential impacts on public safety and health, and on the environment.

The Board's approach

7 We recognise that the need to reduce the risk of a major incident at fuel storage sites is the first priority. For this purpose our report on design and operation of fuel storage sites made recommendations to 'catalyse improvement in the fuel storage sector so that it is continually alert to the major hazard potential of its operations'.^(Ref 2) Therefore Recommendation 1 calls upon site operators and the Competent Authority to ensure they have identified all foreseeable major hazard incidents and associated emergency scenarios. Recommendations 2–9 address the plans and arrangements to contain a developing incident on site, should primary containment be lost.

8 The second priority is to ensure that the emergency preparedness and response arrangements are effective, because however much improvement is made in preventive measures there can be no guarantee that a major hazard incident will not occur. The recommendations in this report therefore follow closely on our design and operation recommendations. Indeed there is some overlap between them, reflecting the close relationship between planning to prevent an incident and planning to deal with its potential consequences if it occurs. There may be further overlaps with the last two workstreams mentioned in paragraph 3, on which work continues.

9 The Buncefield incident was a major test for contingency planning and for the new national arrangements introduced under the Civil Contingencies Act 2004 (CCA) from September 2005. Recommendations 10–20 deal with planning and implementing an emergency response by those concerned. The impressive emergency response to Buncefield effectively relied on initiative and good working relations of the responders in dealing with an incident that had been unforeseen and therefore not planned for. The performance of the primary responders and support was outstanding and we commend all those involved in managing the incident response. Recommendations 21–26 address the primary response to major incidents, including setting up a means of assessing the public health implications.

10 We also acknowledge the efforts of many organisations in the response to Buncefield and the great resilience of the local community and businesses in the ongoing recovery effort to bring the affected local community back to social normality. Recommendations 27–32 address the recovery from a major incident with Buncefield-like consequences.

11 Our recommendations address the need to improve emergency arrangements at local, regional and national levels. An important element is to ensure that emergency arrangements to meet the requirements of COMAH are fully integrated with those established under the Civil Contingencies Act 2004. Recommendations 10–12 deal in particular with central government leadership in the planning for and early response to a major incident.

Scope of the recommendations

12 In our report on the design and operation of fuel storage sites we said that as a minimum, the recommendations would address Buncefield-type sites as defined by the Buncefield Standards Task Group,² ie depots that store and transfer petroleum products on a large scale. However, in most areas of emergency preparedness and response, we consider that many of the lessons from this incident can be applied beyond fuel storage and distribution, including matters that should be addressed at the national level. Certainly this report should be carefully considered by all those with a responsibility for COMAH sites with a potential for violent explosions or large complicated fires. More generally, we encourage high-hazard industries, the Competent Authority and Category 1 and 2 responders³ to consider the broader relevance of our findings so far.

13 Some of the recommendations are addressed to those who have legal duties to prevent and control major incidents.⁴ In practice this will require close working with the regulators (the Competent Authority), who will also need to ensure the recommendations are implemented. Other recommendations apply to organisations, including central or equivalent government and local authorities, responsible for planning for and responding to incidents and for the maintenance and restoration of social and economic well-being. This report is mainly written in terms of the UK approach to civil contingencies and COMAH, but in places refers to bodies or approaches which reflect the arrangements in England, or England and Wales. The Board expects that the equivalent administrations will respond as appropriate in line with their responsibilities.

² The task group comprises industry, members of the COMAH Competent Authority and primary responders. It was set up in the aftermath of Buncefield to respond to the incident and to the recommendations of the Buncefield Board.

³ Category 1 responders are organisations at the core of the response to most emergencies (eg emergency services, local authorities, NHS bodies). Category 1 responders are subject to the full set of civil protection duties under the Civil Contingencies Act 2004. Category 2 responders are other organisations that are likely to be involved in emergencies, such as utilities and transport companies.

⁴ COMAH requires operators of major hazard sites subject to the Regulations to take all measures necessary to prevent major accidents and limit their consequences to persons and the environment. Operators of top-tier COMAH sites (like Buncefield) are also required to submit written safety reports to the Competent Authority, and to prepare emergency plans to deal with the consequences of a major accident. Operators and others (including contractors, designers, and suppliers) also have relevant duties under the Health and Safety at Work etc Act 1974 and related regulations and under environmental legislation.

Status of the recommendations

14 In making these recommendations we recognise that work continues within industry, the Cabinet Office Civil Contingencies Secretariat (CCS), Hertfordshire Resilience Forum, the emergency services, the Health Protection Agency, the Environment Agency, the local authorities Dacorum and St Albans, and other Category 1 and 2 responders to improve the effectiveness of emergency preparedness and response. The Buncefield Standards Task Group has worked hard to identify and address issues in preparation for this report. Our recommendations are intended to support and complement these efforts.

15 We expect our recommendations to be implemented throughout the COMAH and (where necessary) the Civil Contingencies Act sectors and elsewhere as appropriate, and the emergency planning community. The Civil Contingencies Secretariat or its equivalents in Scotland, Wales and Northern Ireland should oversee this work, working with the Competent Authority (CA) as appropriate. We envisage that the CA and other emergency planners/responders will adopt the recommendations as the minimum necessary to comply with relevant legal requirements. The recommendations do not specifically call for changes to the law on the assumption that the existing legal framework is sufficient to ensure that necessary improvements are put in place. However, if this proves not to be the case in any respect, the relevant government departments/devolved administrations should draw up proposals for the necessary legal changes.

16 Where the recommended improvements are self-evidently necessary or where implementation is already intended, we expect the recommendations to be implemented without undue delay and for the relevant authorities to see this is the case. Arrangements should be made by both the Competent Authority and the relevant devolved administrations to ensure our recommendations are implemented consistently across both the Civil Contingencies Act and COMAH legislative regimes. Some recommendations call for reviews of existing arrangements and procedures and, particularly where this involves a multi-organisational approach, as in the work of the National Recovery Working Group,⁵ this may involve longer timescales before robust plans can be implemented. It is essential to have clear timescales, understood and committed to by industry, the relevant government ministers, agencies and authorities, and emergency planners, against which progress can be measured and reported.

17 Where commitments have already been made or the improvements are unquestionably necessary we have not undertaken detailed cost-benefit analysis. This applies to most of the recommendations, since many are already in hand by the relevant authority and the Buncefield Standards Task Group. We are exploring the costs and implications of some of the recommendations, and attempting to draw economic parallels with other serious explosion incidents that massively impacted the surrounding community. This includes the Danvers chemical plant explosion, Massachusetts, in November 2006, the Toulouse chemical explosion in September 2001 and the Enschede Fireworks disaster in May 2000 (see Annex 4). We are also examining the full economic costs of the Buncefield incident from the various sources available.

⁵ The National Recovery Working Group was established by the Secretary of State for Communities and Local Government led by Government Office for the North West. See Annex 5.

The recommendations

18 Our recommendations are grouped under the following four headings:

- ▼ Assessing the potential for a major incident (Recommendation 1)
- ▼ Managing a major incident on site (Recommendations 2–9)
- ▼ Preparing for and responding to a major incident off site (Recommendations 10–26)
- ▼ Recovering from a major incident (Recommendations 27–32)



Figure 2 Looking into part of the Buncefield site before the incident. Note the ground vehicles, large storage tanks, and occupied buildings. To the right are manifolds that distributed fuel around the site

Assessing the potential for a major incident

19 The recommendations under this and the next three headings are based on the conclusions set out in paragraphs 78–79 of our initial report and on the findings of the first^(Ref 3) and third^(Ref 4) progress reports. They have also been informed by our discussions with key responders to the Buncefield incident and by several reports and recommendations (listed in *References* and *Further information*) prepared by responders on their experiences. We endorse many of those recommendations. Our design and operation report^(Ref 2) set out recommendations to prevent the recurrence of incidents like that at Buncefield. Nevertheless, however much preventive standards are improved the possibility of a major incident remains. It is essential, therefore, to have in place effective emergency arrangements in the event of an incident occurring.

20 Operators of top-tier COMAH sites are required by law to prepare adequate emergency plans to deal with the on-site consequences of possible incidents and to provide information to enable local authorities to prepare emergency plans to deal with the off-site consequences. To be effective, these plans must be based on a full appreciation of the potential for major incidents. Before Buncefield a massive vapour cloud explosion at a tank farm was not deemed a credible major incident risk. Nor is it just a matter of vapour cloud explosions, as there is also the potential for significant fires affecting multiple storage tanks.

21 The key to both effective major hazard controls and to effective emergency arrangements is the adequacy of the operator's assessment of the major hazard potential of a site. Getting this right will be reflected in relevant documentation, such as the COMAH safety report and emergency plans, and in the arrangements themselves. Operators therefore need to take an integrated approach to assessing preventive and responsive needs.

Recommendation 1 Operators of Buncefield-type sites should review their emergency arrangements to ensure they provide for all reasonably foreseeable emergency scenarios arising out of credible major hazard incidents, including vapour cloud explosions and severe multi-tank fires that, before Buncefield, were not considered realistically credible. The Competent Authority should ensure that this is done.^(Ref 5: HRF Rec 2)

Managing a major incident on site

22 A key objective of the on-site plan should be to contain an incident on the site to minimise its effects, to limit damage and to protect people and the environment. Following the identification of all emergency scenarios arising out of credible incidents (Recommendation 1), the operator must put in place arrangements to respond to those scenarios. This includes preparing and putting into effect an on-site emergency plan to specify the response of those who work on the site in an emergency. In practice this work must be closely integrated with preparing the site safety report and with providing the local authority with the information it needs to prepare an off-site emergency plan.

23 Paragraph 78 of our initial report recommended operators to review their on-site emergency plans following Buncefield, where they had not already done so. Recommendations 2 and 3 build on this early response to the incident by asking the Competent Authority to support operators in improving the quality of their on-site plans. Currently, guidance to COMAH operators on preparing on-site emergency plans is not sufficiently aligned with the guidance to the Competent Authority for assessing the plans. Therefore, firstly a review of the existing COMAH guidance on emergency planning is required; and secondly plans should be reviewed in the light of the revised guidance.

24 Recommendation 4 asks operators to ensure they have fully competent staff available 24/7 to perform the requirements of the on-site plan and should bear in mind the nature and extent of any changes to the plans as a result of Recommendations 2 and 3. If sites are inaccessible out of hours, operators should have alternative means of getting on site, providing an inventory of what is on site and maintaining communications with the site if an incident occurs.⁶

Figure 3 Surface pipelines within an oil fuel depot



⁶ The Competent Authority has published a methodology to determine if the emergency preparedness on site is sufficient.^(Ref 6)

Recommendation 2 The Competent Authority should review the existing COMAH guidance on preparing on-site emergency plans.^(Ref 7) This guidance needs to reflect the HSE's Hazardous Installations Directorate (HID)⁷ Chemical Industries Division inspection manual used by inspectors to assess the quality of the on-site plan in meeting the COMAH Regulations. In particular, reference should be made to the need to consult with health advisors and emergency responders.^(Ref 5: HRF Rec 1)

Recommendation 3 For Buncefield-type sites, operators should review their on-site emergency plans to reflect the revised guidance on preparing on-site emergency plans as per Recommendation 2. The Competent Authority will need to check that this is done.

Recommendation 4 Operators should review and where necessary revise their on-site emergency arrangements to ensure that relevant staff are trained and competent to execute the plan and should ensure that there are enough trained staff available at all times to perform all the actions required by the on-site emergency plan.^{(Ref 2: Recs 6 and 19) (Ref 8: FRS Rec 10)}

25 The Buncefield incident exceeded the assessed worst-case event of a single tank fire. The two pump houses and their associated lagoons to the north and north-west of the site were rendered unavailable for use. Recommendation 5 therefore repeats Recommendation 12 of our design and operation report, for the sake of completeness. Recommendations 6 and 7 go further to ensure operators secure alternative arrangements in the event of primary response facilities being unavailable, for example, taking account of seasonal variations in available water supply.⁸ Where operators depend on local services (eg the local Fire and Rescue Service) to provide alternative resources, they need to consult the local provider to identify any limitations on the availability of services. Any such limitations should be considered and addressed within the site's emergency planning arrangements.

Recommendation 5 For Buncefield-type sites, operators should evaluate the siting and/or suitable protection of emergency response facilities such as the emergency control centre, firefighting pumps, lagoons or manual switches, updating the safety report as appropriate and taking the necessary remedial actions.^(Ref 2: Rec 12)

Recommendation 6 Operators should identify vulnerable critical emergency response resources and put in place contingency arrangements either on or off site in the event of failure at any time of the year and make appropriate amendments to the on-site emergency plan. This should include identifying and establishing an alternative emergency control centre with a duplicate set of plans and technical information.^(Ref 8: FRS Rec 10)

⁷ HID is responsible for regulating and promoting improvements in health and safety, contributing to the overall HSC/E aim of reducing and controlling the major hazard risks present across certain high-hazard industries and sectors.

⁸ The main water source for fighting the fires at Buncefield was the Breakspear Lagoon, which may not have held sufficient water in the summer months.

Recommendation 7 For COMAH sites, if the operator relies on an off-site Fire and Rescue Service to respond, the operator's plan should clearly demonstrate that there are adequate arrangements in place between the operator and the service provider. The Competent Authority will need to check that this is done.

Warning and informing the public

26 Communications to the local community are important to give adequate assurance that the site is well run and emergency preparations are realistic and reliable. Regulation 14 of COMAH requires the operator of an establishment to ensure that the public, in a public information zone (PIZ),⁹ is supplied with information on safety measures at the establishment and on what to do in the event of a major incident at the establishment. Communications with off-site communities are required at least every five years, while a review is required every three years. More frequent communications may be needed for larger communities or where the population is transient. It is important to pay adequate attention to this function in a consistent way. Recommendation 8 therefore asks operators to review their approach to communicating with the public, including making provision for joint communications with local authorities and others. Such joint communications would reassure the public that all parties are working together; that operators will do all they can to prevent an incident or contain it on site; and that if a major incident should occur and they are affected, the local authority has plans in place to help and support them. Where complaints or reports are made by the local community, the site operator should respond within a reasonable time. This recommendation is closely linked with Recommendation 20.

Figure 4 Inspectors discussing strategy and logistics



⁹ This area is determined by the Competent Authority by taking account of both the likelihood and effects of possible major incidents at the major hazard site. It is set on the basis that people outside it are not at significant immediate risk from major incidents (although they could be if the incident escalates). The PIZ does not cover areas where a major incident might cause only environmental damage.

27 Recommendation 9 supports this more integrated process by ensuring that the COMAH guidance on warning and informing the public^(Ref 7) is revised to give more advice on the frequency and form of communication, and that it is complemented by the CCA *Emergency preparedness* guidance on communicating with the public.^(Ref 9) This will encourage the actions of the operators to be integrated with those of Category 1 responders in their duty to warn and inform the public.

Recommendation 8 COMAH site operators should review their arrangements to communicate with residents, local businesses and the wider community, in particular to ensure the frequency of communications meets local needs and to cover arrangements to provide for dealing with local community complaints. They should agree the frequency and form of communications with local authorities and responders, making provision where appropriate for joint communications with those bodies.^(Ref 8: HRF Rec 3)

Recommendation 9 The Competent Authority should review the COMAH guidance to assist operators in complying with Recommendation 8 and should work with the Cabinet Office to integrate the COMAH guidance and the CCA *Communicating with the public*^(Ref 9) guidance, so that communications regarding COMAH sites are developed jointly by the site operator and the local emergency responders.



Figure 5 Firefighters train to assist casualties in the event of an emergency



Figure 6 An unusual shot of a section of the M1 evacuated and closed in the height of the emergency. This caused major, temporary transport disruption to this part of the UK

Preparing for and responding to a major incident off site

28 In spite of efforts to prevent a major incident or to contain an incident on site, the potential for an incident to have an impact beyond the site boundary remains. Given the scale of the Buncefield incident, the majority of our recommendations deal with the emergency response to and recovery from a major incident. Here the main focus is on the local authority, which has the legal responsibility to prepare emergency plans to deal with the off-site consequences of an incident at a top-tier COMAH site. However, other Category 1 responders under the Civil Contingencies Act 2004 – the Health Protection Agency, Health Protection Scotland (and equivalent health bodies), Regional Resilience Teams in Government Offices in the Regions, the Civil Contingencies Secretariat, equivalent administrations and the Competent Authority – also have key roles. To prepare an effective plan the local authority and others depend on accurate information from the operator about the nature of operations on site and their hazard potential. This underlines the importance of an integrated approach and close co-operation between the various parties involved.

29 The local authority also has wider emergency planning functions, particularly under the arrangements now being put in place to implement the CCA. These arrangements had a severe test at Buncefield and held up well, but there are numerous lessons to be learned on a national scale. Since incidents of this scale are rare, it is important to ensure that the learning from Buncefield is shared by everyone concerned. We are aware that several reviews have been made of the emergency response to Buncefield, but not all are widely known and there is a danger that some good points will be missed. We endorse many of these points in this report. The nationally applicable lessons of all these reviews must be brought together and made accessible to all. The Civil Contingencies Secretariat should consider publishing a consolidated summary of the lessons to emerge from major incidents of this sort and the steps that are being taken to address them.

30 Our recommendations deal mainly with the detailed planning for and implementation of emergency arrangements, including communications. First, however, Recommendations 10–12 consider general arrangements at national level. In our initial report we noted that to learn lessons on the emergency response requires input from a large number of organisations, and this work requires a clear lead if the maximum benefit from our and other recommendations is to be gained. We also said that it ‘will be part of the Board’s ongoing work to establish a clear picture of the lead provided by central [and devolved] Government for first responders’.

31 During the early days of the response to the Buncefield incident, there was a valuable ministerial role in providing a focus for informing Parliament about the progress of the response and giving public reassurance that all necessary resources were being deployed.^(Ref 10) There was, however, a perception – particularly among those directly affected – that once the spotlight had moved on, central government lost interest. This was not supported by our findings but, as different ministers became involved, it was unclear who had the responsibility to ensure that problems arising were addressed.

32 There is good sense in maintaining flexibility in central response arrangements, as well as in ministers generally stepping back from close operational involvement. We see benefit, however, in reviewing how the ministerial role may best assist and complement that of the direct responders – this is addressed in Recommendation 10.

As well as keeping Parliament informed and reassuring the public as provided for in the current arrangements, we see an important role for a minister in ensuring the response works as intended and in providing the authority to clear any bottlenecks. It is also important to ensure from the start that attention is given to the need to plan for the return to social normality, though this may mean working with a different minister who would be involved for a longer term (see Recommendation 27). Finally, while we acknowledge the efforts by many groups to implement recommendations made by other agencies, their task will be made easier if a minister is nominated to ensure that lessons arising from an emergency are implemented.

33 The CCA recognises that COMAH requires emergency response arrangements to be in place and sensibly does not duplicate these requirements. Unfortunately, we have indications that some see the arrangements to comply with the CCA and with COMAH as being separate. This was never intended and would lead to wasteful duplication and a possible loss of effectiveness. Just as emergency arrangements should be integrated with preventive measures, so should COMAH emergency arrangements be fully integrated with those under the CCA. The CCA framework and supporting guidance provides a valuable resource in preparing COMAH on- and off-site emergency plans. Recommendation 11 addresses this point.

Recommendation 10 The Cabinet Office should initiate a review of the arrangements to identify a minister (and their devolved counterparts) and their role to complement and support the emergency responders following a major incident to ensure national arrangements work as intended and there is continuity of government attention throughout the response and recovery phases. The review should include communications, public reassurance, the interface with planning for a return to social normality (Recommendation 27), and arrangements to ensure that recommendations made following major incidents are implemented.

Recommendation 11 The Civil Contingencies Secretariat, working with the Competent Authority, should ensure that COMAH emergency arrangements are fully integrated with those under the CCA with the aim of ensuring that major hazard events are dealt with consistently at all levels, from on site to national, in terms of planning, shared resources, and practical arrangements. The review should include, but not be limited to, confirmation that:

- ▼ response arrangements take account of devolved responsibilities;
- ▼ lead responsibility in government for ensuring emergency response arrangements at COMAH sites is dealt with consistently under COMAH and CCA;
- ▼ procedures and guidance are suitably aligned; and
- ▼ deployment of emergency equipment considers both COMAH and CCA sectors and sites.

34 The support to Buncefield from many parts of Britain was impressive, as was the donation of human and material resources. The firefighting, while led by the Hertfordshire Fire and Rescue Service, required a national response with a total of 32 Fire and Rescue Services attending in some capacity, building on established arrangements. Mutual aid was also required by other responders. However, initiative and generosity need to be supplemented by co-ordination at a national level for an incident of this scale to ensure the most effective deployment of resources.

Recommendation 12 deals with the need for national-level arrangements to provide emergency equipment, since a major incident will rapidly exhaust local stocks. We acknowledge the work done to date by Communities and Local Government (CLG), like the positioning of high volume pumps. This links with Recommendations 23 and 24. Further work is required to assess the cost implications of a national scheme for hardware against the benefits of greater public assurance that emergency equipment is readily available throughout the country to respond quickly to events and without randomly depleting regional resources.

Recommendation 12 Communities and Local Government should complete and, where necessary, initiate an assessment of the need for national-level arrangements to provide, fund and maintain, emergency response equipment (such as high volume pumps, firefighting foam and specialist pollution containment equipment). The review could also consider criteria for allocation and use of this equipment across the UK.

35 It was clear from the many reports from Buncefield that insufficient guidance was available to primary responders on a number of critical early issues, such as how to assess the impact of the smoke plume on air quality. This is addressed at Recommendation 13. Decisions on whether to fight the fire or to allow it to burn out in a controlled fashion depend on the availability of such assessments and we urge the Environment Agency to complete the work in hand on the controlled burn strategy guidance (see paragraph 51).

Recommendation 13 The Civil Contingencies Secretariat should review guidance to responders on assessing the extent of the impact of an incident at a COMAH site to ensure appropriate scales of response and resources are provided, at local, regional or national levels.

Review of off-site emergency plans

36 Effective emergency response depends upon a clear and concise emergency and contingency plan, trained and experienced responders and a well-informed community. Recommendations 14–20 focus on improving the off-site emergency preparedness and response. This primarily requires local authorities to review the effectiveness of their emergency plan and responders to review their training arrangements.

37 The primary need is for better guidance for local authorities and early responders to make effective plans for dealing with major incidents such as large explosions. During the development of the off-site emergency plan for Buncefield, there seems to have been little practical support or guidance for the local authority to understand the safety reports for the site, or on whom to consult about important ‘knock-on’ effects of a major incident, such as the need for and consequences of closing schools and hospitals, threats to clean water and electricity supplies. Recommendation 14 calls for improved guidance to assist local authorities draw up effective off-site emergency plans. Recommendation 15 calls for measures to ensure arrangements are effective in practice. Both recommendations build on work already underway by the Civil Contingencies

Secretariat¹⁰ and the Emergency Planning Society.¹¹ We commend this work and encourage its completion without delay.

Recommendation 14 The Civil Contingencies Secretariat, working with the Competent Authority, should arrange for national guidance to local authorities to be prepared, addressing as a minimum the areas covered in Recommendation 15. Guidance should also address the competencies required for emergency planners, and be clear on the resources that may be demanded for an effective emergency planning function. The guidance should be a living document, ie periodically updated in the light of new knowledge of handling major emergencies.

Recommendation 15 Local authorities should review their off-site emergency response plans for COMAH sites in line with the revised guidance produced in response to Recommendations 13 and 14, and in the case of fuel storage sites, to take account of explosions and multi-tank fire scenarios. The aim is to ensure plans contain the key information from relevant COMAH safety reports (without compromising the safety reports' confidentiality), which should be provided by site operators following their reviews of arrangements under Recommendation 1. The review should include but not be limited to the following:

- ▼ input from trained and competent emergency planners following clear guidance;
- ▼ working in conjunction with Regional Resilience Forums, and their equivalents in Scotland and Wales, in preparing their off-site emergency plans to understand potential impacts on the Region.^(Ref 10) The Local Resilience Forum structure encourages multi-agency co-operation and information sharing within a county. The Regional Resilience Forum,¹² and their equivalents, should determine where further consultation is applicable and determine how this is done within and across regions;
- ▼ working in conjunction with neighbouring local authorities in developing their off-site emergency plans and involving these authorities in training and in emergency exercises;
- ▼ extending co-operation beyond the statutory consultation distance (CD) supplied by HSE to take into account the worst possible impact of a major incident, in effect re-calibrating the public information zone, which conventionally aligns with the CD;

¹⁰ The Civil Contingencies Secretariat has launched a programme of work to identify and disseminate good practice. This would be a viable route for disseminating good practice in preparing and responding to COMAH sites. For industry, the competent authorities must continue to collate and disseminate good practice nationally and internationally.

¹¹ The Civil Contingencies Secretariat and the Emergency Planning Society aim to establish a set of core competencies designed to further enhance the professionalism of the workforce in the civil protection sector. By the end of 2008 a set of core competencies for professional emergency planning practitioners working in government and in public, private and voluntary sector organisations will have been drawn up.

¹² The Regional Resilience Forums are established by each Government Office to discuss civil protection issues from the regional perspective and to create a stronger link between local and central government on resilience issues. Similar arrangements are made in the devolved administrations.

- ▼ considering with other primary responders the fitness for purpose of the plans for the different tiers of the command and control structure (gold/silver/bronze);
- ▼ taking account, with appropriate expert input, of the local environment to identify what would be at risk and to identify the potential consequences.

CCS and the Competent Authority, as the enforcing authority under COMAH, should ensure the reviews are carried out.

38 The public health impacts of Buncefield appear to have been minimal.^(Ref 11) In our initial report we welcomed the establishment of a Health Protection Agency (HPA)-led working group aiming to construct frameworks and agreed working practices for any future post-incident sampling. We continue to await the completion of this work. We understand the Environment Agency may assume lead responsibility for the co-ordination of air quality monitoring following a major incident as they currently do for surface and groundwater (the extent and longevity of ground water contamination continues to be monitored by the Environment Agency). It is sensible that both HPA and EA should be actively involved in the development of the off-site plans by local authorities.

Recommendation 16 HPA, HPS and NPHS (National Public Health Service) Wales, EA, SEPA and EHSNI (Environment and Heritage Service Northern Ireland) should provide local contact details to local authorities and Local Resilience Forums¹³ (LRFs) to facilitate emergency plan development. This will ensure local authorities have clear consultation routes for the public health and environment aspects of their off-site emergency plans.^(Ref 2: HRF Rec 5)

39 The voluntary services were invaluable in their assistance to the emergency responders. The WRVS (Women's Royal Voluntary Service) and Salvation Army provided catering and the British Red Cross supported the rest centre. Local retailers and suppliers of domestic goods are to be commended for their generosity in supporting the work of the voluntary services. The volunteer groups involved found that there is a need to raise the profile of the volunteer groups and what they can do to support an emergency response. Recommendation 17 highlights the need for emergency plans to incorporate arrangements to meet the welfare needs of responders, an area where the voluntary sector has an important contribution to make.

Recommendation 17 Local authorities should ensure their off-site emergency plans give due consideration to meeting the welfare needs of responders, including arrangements to provide food and drink and toilet and washing facilities, on all shifts. This will also need to include guidance on rest breaks and the provision of accommodation for responders from outside of the local area. Plans should make provision for the contribution of the volunteer community in attending major incidents in the welfare and other supporting roles.^{(Ref 8: FRS Rec 26) (Ref 5: HRF Rec 38)}

¹³ The principal mechanism for multi-agency co-operation between all Category 1 and 2 responders in a local police area is the Local Resilience Forum (LRF). The aim of LRF is to facilitate fulfilment of the statutory duties of the members. The LRF is not a statutory body, but it is a statutory process under the Civil Contingencies Act 2004.



Figure 7 WRVS providing assistance to emergency service personnel during the response to the Buncefield explosions

40 Many, perhaps most, local authorities will need to revise their off-site emergency plans for COMAH sites in the light of our recommended review. Recommendation 18 calls on local authorities to take the necessary measures to bring their revised plans into effect. In taking evidence from responders in the aftermath of Buncefield, and considering the situation in other parts of Britain it was very clear to us that regular contact between responders greatly enhances the efficacy of the immediate response. Recommendation 19 calls on local authorities to test their (revised) arrangements in a practical way.

Recommendation 18 In reviewing their off-site emergency arrangements for COMAH sites, revised in accordance with our recommendations, local authorities should identify the facilities, resources and actions that are critical to successfully respond to an emergency and should provide contingencies for Buncefield-type sites. Local authorities should review and where necessary revise emergency arrangements to ensure that relevant staff are trained and competent and that there are enough trained staff and resources to perform the actions required by the emergency plan at all times.

Recommendation 19 Local authorities should ensure their revised off-site emergency arrangements for COMAH sites are tested within 12 months of production. Exercise scenarios based on real incidents should be compiled by CCS and the Competent Authority and available for multi-agency exercise development:

- ▼ All Category 1 responders should ensure their staff are trained within six months of production to deliver the emergency response.^(Ref 5: HRF Recs 7, 14 and 16)

- ▼ Local authorities should arrange for councillors and elected members to have awareness training regarding their role in planning for, responding to and recovering from emergencies to effectively represent their communities.¹⁴

41 During the early stages of Buncefield, there was some disappointment with the lack of availability of up-to-the-minute information on local radio and TV. Early advice to residents who were not evacuated was to 'go in, stay in, tune in', but it was not very clear where people should 'tune in' to, and it was also unclear to us what information was relayed to the local media by those in strategic control of the response as part of the communications function. Recommendation 20 therefore calls for an assessment of compliance with current national standards. To assist in the emergency response phase, the operator and Local Resilience Forums should seek an agreement with local media to deliver key messages during an emergency, for example, along the lines of the BBC Radio *Connecting in a Crisis* (CIC) initiative,¹⁵ where such arrangements are not already fully in place. These arrangements should be tested periodically.

42 There are no legal powers to force people to evacuate from their homes unless there is an act of terrorism.¹⁶ Providing information to explain to the community that the decision to evacuate is not taken lightly and that it is always taken to protect life may assist in gaining support for evacuation. Communications to the community should include what they have to do and where they should go, how they can keep informed and how they will be notified when it is safe to return. Local authorities, working with the police, should consider how to secure both council and privately owned properties that may be vulnerable because of smashed windows and provide the necessary information to occupiers.

Recommendation 20 Local Resilience Forums and devolved equivalents should assess and advise operators, local authorities and the Competent Authority on the effectiveness of communications with residents, local businesses, dutyholders and the wider community in the event of a major incident. The assessment should use an agreed standard in line with CCA2004 guidance *Communicating with the public*^(Ref 9) and include arrangements with local media to avoid conflicting advice being received, and to ensure key messages are transmitted.

¹⁴ Training is available at the Emergency Planning College, Easingwold www.epcollege.gov.uk/EMSEM.

¹⁵ 'Connecting in a Crisis' is a BBC initiative to help ensure that the public has the information it needs and demands during a civil emergency. It sets out to encourage emergency planners to work more closely with broadcasters in the preparation of strategies for communicating essential information. See www.bbc.co.uk/connectinginacrisis.

¹⁶ Generally speaking, the police do not have specific statutory powers to enforce a request or order to leave an area. The main exception to this is in relation to acts of terrorism where there are statutory powers to cordon off areas and it is an offence to fail to comply with an order to leave a cordoned area immediately. Evacuation may also be enforced under the Public Health Act 1984 if it is necessitated by infection or disease.^(Ref 12)

Responding to a Major Incident

43 Those who responded to the Buncefield incident raised three main issues in their reports and discussions with us. These were obtaining air quality information, obtaining health advice and firefighting arrangements. Recommendations 21 and 22 deal with air quality information and public health advice. Recommendations 23 to 25 deal with firefighting arrangements and endorse the recommendations made by the Hertfordshire Fire and Rescue Service fire response report.^(Ref 8) Recommendation 26 deals with communications between government and incident controllers during the emergency response.

44 The vast plume of smoke generated by the fire at Buncefield created several problems for the responders. The first issue was how to find out what was in the plume and if or where it was going to ground.^(Ref 13) The Environment Agency has identified and costed different service levels for air quality monitoring and modelling support, ranging from a 24/7 response capability to best endeavours support. The Environment Agency's proposal, including service levels, has been discussed by two Cabinet Office groups: the Interdepartmental Group on Specialist Scientific Advice; and the Official Committee on Domestic and International Terrorism (Prepare).

Figure 8 Firefighters tackle a blazing tank at Buncefield. The size of the Fire and Rescue Service response was unprecedented in modern times in the UK



45 These Cabinet Office groups endorsed the proposal and recognised the need for a 24/7 response capability. Recommendation 21 is about bringing into effect robust arrangements for air quality monitoring for the future. We commend the initiative to develop a more coherent approach to air monitoring and plume modelling during major incidents. In England, Defra has not made a decision yet on whether funding will be provided in line with the proposal from the Environment Agency. We would hope that a favourable decision is reached quickly and that Defra, as the lead department for air quality issues, ensures the new arrangements are implemented without delay.

46 The second issue was whether the plume was harmful to human health. This was a difficult question for the health advisory team¹⁷ to answer at the Strategic Co-ordinating Group (SCG) because of a lack of information to hand, and inadequate provisions at the time for dealing with this issue. The HPA have recognised the need to improve the provision of health advice to the SCG. There are two significantly different health roles required at the SCG – the co-ordination of health service resources (hospital beds, primary care etc) and the provision of specialist public health advice. The co-ordination of health service resources is the responsibility of the Primary Care Trust (PCT) and Strategic Health Authority (SHA). Most of the technical public health expertise is in the HPA. Different arrangements will be in place in devolved areas and these need to be taken into consideration in developing the health response arrangements.

47 The Department of Health and the Cabinet Office issued guidance^(Ref 14) in April 2007 outlining the replacement of the Health Advisory Team with the Scientific and Technical Advice Cell (STAC). It also summarises the roles and responsibilities of those organisations providing scientific and technical advice to the SCG. In Wales, the existing HAT arrangements currently remain. Discussions are ongoing with the National Public Health Service on taking forward similar arrangements to STAC in Wales.

48 The Environment Agency, Health Protection Agency, Met Office, Health and Safety Laboratory and Food Standards Agency have proposed that a multi-agency air quality advisory group is established in the emergency phase of a major air pollution incident to co-ordinate the provision of air quality data and advice to the STAC. This group would be chaired by the Environment Agency.



Figure 9 The smoke plume viewed above Hemel Hempstead

¹⁷ The responsibility for public health advice is shared between the PCT Director of Public Health (DPH) (statutorily responsible for the health of the local population) and the HPA (statutorily responsible for protecting the health of the community).

Recommendation 21 The CCS should conclude their review of arrangements for obtaining and using air quality data in an emergency. This revision of arrangements should be delivered no later than 2008. The review should include:¹⁸

- ▼ agreement on clear notification procedures;
- ▼ agreement on roles and responsibilities for collecting air quality data;
- ▼ arrangements to disseminate the above to all responders and include them in emergency plans;
- ▼ agreement on performance standards for quality and delivery;^(Ref 5: HRF Recs 5 and 15)
- ▼ consideration for the provision of local meteorological stations in the vicinity of COMAH sites, which can provide local wind direction and speed.

Defra should ensure that financial or resource restraints do not hinder the delivery of a robust air monitoring capability.

49 Recommendation 22 is about improving the provision of public health advice during the immediate emergency phase. Relevant toxicological information on combustion and pyrolysis products of substances stored on site should be incorporated into emergency plans together with the advice which would be needed on the basis of this. This would need to consider all credible major hazard incidents (Recommendation 1). We believe this information should be readily available as public health advice for each top-tier COMAH site by the HPA, HPS, NPHS Wales and equivalents based on the worst-case emergency scenario. This could be referred to during the initial emergency response until actual data from the incident are available.

50 A critical and immediate question for the incident response controllers was the public health matter of whether or not to fight the Buncefield fires. The Strategic Co-ordinating Group is only able to take informed decisions regarding protection of public health with knowledge of the harmful nature of the plume, and where it might ground. At Buncefield this information was not available to SCG and so, faced with the sheer magnitude of the plume, it was almost inevitable that the fire would be fought. The firefighting resulted in a limited escape of contaminated firewater from the site. The consequences of this are still under investigation. The disposal of the fire water that was contained and stored in the sewage treatment works storm water storage tanks has posed significant technical difficulties, not all of which are yet solved.

¹⁸ Defra has proposed that the Environment Agency take on the co-ordinating role for air quality in a major incident, excluding radiological and nuclear incidents or those involving chemical warfare agents. The project to draw up and implement the co-ordination arrangements includes Defra, Welsh Assembly Government, Health Protection Agency, Met Office, Food Standards Agency, Government Decontamination Service, local authorities and Fire Services. SEPA and EHS (Environment and Heritage Service Northern Ireland) are due to be consulted and included.



51 Since Buncefield, the Environment Agency has revised the Pollution Prevention Guidance (PPG28)^(Ref 15) on controlled burn to help site operators, firefighters and others decide when a controlled burn strategy could be used, ideally as part of an agreed pollution response plan following an environmental risk assessment. A controlled burn strategy, where the application of firefighting water or foam is restricted or prohibited, may be used for some incidents when the environmental impact of contaminated firewater run-off to surface and/or ground waters outweighs the impact on public health or has public health benefits. We commend this work as making a significant contribution to remedy one of the larger difficulties – that of assessing the impact on public health – facing the emergency responders at Buncefield.

Figure 10 Emergency services from all over the UK assisted in the operations at Buncefield

Recommendation 22 The Civil Contingencies Secretariat and Department of Health should clarify the different roles for providing health advice at Strategic Co-ordinating Group (Gold Command and Control Centre) to local responders. Local agreements should be in place in advance to allow health agencies to decide quickly who will do what in any incident so that the SCG chair receives the support they need. Different arrangements will exist in devolved areas and planning should take account of these.^(Ref 5: HRF Rec 23) Information relevant to public health arising from the incident at the major hazard site in question should be available at the outset to enable health responders to give accurate, useful advice when first needed.

52 As we said in our initial report, the emergency services, particularly the fire and police services, responded impressively and on a massive scale that was almost certainly unprecedented in modern times. Inevitably, there are lessons to be learned from such an exceptional event. We have noted, in paragraph 34, that the response to Buncefield involved the emergency responders on a national scale. There is a role for government in the allocation of extreme emergency equipment as we make clear in Recommendation 12. However, operators of high-hazard sites must also play their part in making the national inventory more effective and efficient. Recommendation 23 calls on industry to give leadership to establishing mutual aid

arrangements for tackling major fires anywhere in Britain. A number of the lessons related to the availability of equipment and the interchangeability of components such as couplings, which proved to be a problem during the response to Buncefield.

Recommendation 23 The operators of industrial sites where there are risks of large explosions and/or large complicated fires should put in place, in consultation with fire and rescue services at national level, a national industry–fire service mutual aid arrangement. The aim should be to enable industry equipment, together with operators of it as appropriate, to be available for fighting major industrial fires.^{(Ref 8: FRS Recs 2 and 25) (Ref 16: p 5)} Industry should call on the relevant trade associations and working group 6 of the Buncefield Standards Task Group to assist it, with support from CCS. The COMAH Competent Authority should see that this is done.

53 Through the *New Dimension* programme,¹⁹ Communities and Local Government (CLG) undertakes to provide the fire and rescue authorities (FRAs) with the equipment and consumables needed to respond to the types of incident covered by the S9 Emergencies Order.²⁰ We understand the roll-out of the provisioning programme is almost complete. Recommendation 24 calls for a review of the national inventory which will include hitherto unplanned-for emergencies. This would align with the statutory obligation on FRAs to assess likely risks and determine how best these can be met. The recommendation also asks that couplings be interchangeable – which could mean carrying stocks of adaptors or providing other suitable means of achieving this effect. Communities and Local Government have advised us they believe a suitable approach would be for FRAs to arrange call-off contracts with suppliers through Firebuy²¹ for individual Fire and Rescue Services (FRS) to draw upon when needed.

Recommendation 24 Fire and rescue authorities and their equivalents in Wales, Scotland and Northern Ireland should review the availability of materials and equipment nationally and determine if they are sufficient to respond to and manage major incidents.²² (Ref 8: FRS chapter 7, and Ref 10) Critical interface components, such as foam equipment couplings used by the FRS, should be capable of use both by the FRS and with any industry the authority may call upon. The administrations of Scotland and Wales should be involved in such a review as responsibility for the FRS is devolved. Communities and Local Government and equivalent administrations should see that this is done.^(Ref 8: FRS Rec 16)

¹⁹ CLG includes the *New Dimension* programme, which supplied equipment and procedures to enhance the capability of the Fire and Rescue Service to respond to a range of incidents. The Welsh Assembly Government and Scottish Executive have responsibility for the *New Dimension* programme in Wales and Scotland to support the devolved fire and rescue authorities. The Northern Ireland Fire and Rescue Service (NIFRS) have also implemented the *New Dimension* programme.

²⁰ Section 9 of the Fire and Rescue Services Act 2004 (FRS Act) came into effect in October 2004. It enables the Secretary of State, by Order following consultation, to place functions on fire and rescue authorities concerning specified emergencies. These exclude fires and road traffic accidents.

²¹ Firebuy (www.firebuy.gov.uk) is the national procurement arm of the Fire and Rescue Service for major items such as vehicles, clothing and equipment.

²² This is being taken forward by the Fire Service Practitioners Forum ‘Buncefield Task and Finish Group’.

54 Hertfordshire Fire and Rescue Service have produced a definitive report on lessons learned from fighting the Buncefield fires. Communities and Local Government ministers and their counterparts in the equivalent administrations should ensure that the FRS recommendations that are widely applicable are brought into effect without undue delay.

Recommendation 25 The recommendations in the Hertfordshire Fire and Rescue Service report^(Ref 8) into the lessons learned from the Buncefield fires that are widely applicable, should be put into effect where it is practical to do so as soon as possible. Communities and Local Government ministers, in co-operation with the Civil Contingencies Secretariat and equivalent administrations, should see that this is done.

55 During the response to the Buncefield incident, SCG received requests for information about the emergency and its response from several parts of government. These requests appeared uncoordinated, placing unnecessary demands on SCG and potentially leading to distraction of key strategic players and misinterpretation of what information was needed. For national emergencies, the arrangement is for all communications to and from central government to be routed via an identified lead government department and a nominated liaison officer. For the Buncefield incident, a liaison officer was deployed from the Government Office for the East of England Regional Resilience Team.²³ Recommendation 26 addresses the need to ensure that this key function is resourced properly to manage communications effectively between central government and the Gold Commander. In a major incident, the lead government minister and their counterparts in the equivalent administrations referred to in Recommendation 10 should ensure that effective lines of communications are in place and established procedures are being followed.

Recommendation 26 The Civil Contingencies Secretariat should review the procedures and arrangements²⁴ in government offices in the English regions for deploying liaison staff to ensure effective communications between central government and Gold Command (Strategic Control Group) in a major emergency. The review should ensure that communications are managed in a way which minimises the demands on Gold Command and maximises efficiency. It should also ensure that the necessary level of human and technical resources can be sustained over a significant period if required by the demands of the response and recovery phases. The review should be conducted with the equivalent administrations to ensure equivalent improvements in communication arrangements for incidents in devolved areas.

²³ The regional resilience team is a small group of civil servants within a regional government office dealing with civil protection issues under the leadership of a regional resilience director. Similar arrangements will exist in the devolved administrations.

²⁴ GO East and HPA have recognised the need to deliver incident management training and to increase the number of liaison officers and assistants as part of their reviews. Cabinet Office has identified workstreams to review the central government arrangement for responding to an emergency and for the provision and management of information in support of the central response. This will address issues that arose between Gold Command and central government.



Figure 11 Maylands Business Estate, one of the largest in south-east England, located next to the Buncefield site. After this photo was taken there was further commercial development on the cleared ground at centre right

Recovering from a major incident

56 In this section ‘recovery’ means the process of returning to full social normality following a major incident. COMAH emergency plans deal with only a small part of this process, namely restoration and clean-up of the environment, not wider social and economic issues. These are covered to some extent by more general government guidance.^(Ref 17) The recovery phase may be more difficult and protracted than the immediate response phase and it is essential that planning for recovery starts at once, while the emergency response is still underway. Paragraph 79 of our initial report identified the need to consider the interests of local residents and businesses in emergency planning, particularly in ensuring a smooth transition from response to recovery.

57 Recommendation 10 on ministerial roles recognises that there may well be a transfer of lead ministerial responsibility at this stage. CLG ministers have played a key role in overseeing the recovery from Buncefield and we assume would normally play this role in the event of future incidents in England (or their devolved administration counterparts in Scotland and Wales). We welcome this clear focus and Recommendation 27 indicates that it would be helpful for government to clarify that this is the intention. We believe in most situations it would fall to CLG to take on this role. An important benefit of having such a fixed arrangement is the preparedness of the relevant minister for exercising the role. We ask that this ‘default’ position be confirmed by government. This arrangement has the additional benefit that, in the event of an agreement in a particular circumstance that another minister should take responsibility for the recovery from a specific event, a clear and public transfer of responsibility would be required.

Recommendation 27 The Cabinet Office should confirm formally, to avoid any doubt, where lead ministerial responsibility lies for the recovery phase following a major incident until the affected community has regained social normality. We believe responsibility should lie, in most foreseeable situations, with Communities and Local Government (or its successors, or in the case of Scotland and Wales, its devolved administration counterparts) supported as necessary by other central departments. In the event it is agreed that another minister should assume this role in a specific situation, the transfer of responsibility should be made clear. Emergency arrangements should take full account of the need to ensure recovery starts as soon as possible, including a smooth handover of lead ministerial responsibility where appropriate.

58 Recommendation 28 provides for a clear transition at the local planning level. Recovery groups should convene quickly and include organisations not involved in the emergency response, such as the regional development agency (RDA). No time should be lost in factoring recovery issues into the deliberations and decisions attaching to the emergency response to major incidents such as Buncefield. This was put to us very strongly by responders, including those attending the Strategic Co-ordinating Group (also known as ‘Gold’) and local authorities, notwithstanding the immense task they will have dealing with the immediate situation.

Recommendation 28 Local authorities should ensure that recovery plans dovetail with off-site emergency response plans and the Regional Economic Strategy²⁵ (and devolved equivalents) to ensure that all relevant organisations are involved at an appropriately early stage.

²⁵ The RDA would play a key role in driving economic development in the region, especially if a major incident had an economic impact across a number of local authority areas or across the whole region.

59 Recovery from a major event on the scale of the Buncefield explosion is going to require substantial investment that will be beyond the existing financial capabilities of the local RDA. Therefore, Recommendation 29 calls for additional financial support to stimulate recovery in the aftermath of an extreme event.

60 Paragraph 79 of our initial report also welcomed CLG's initiative in setting up a task force to investigate options for government support to businesses and local economies following a disaster. We understand there have been some changes in these plans and it has become clearer to us that the issue of financial aid and special status to communities stricken by major incidents such as Buncefield was added to an already fairly heavy workload of the National Recovery Working Group (NRWG)²⁶ (see paragraph 16 and Annex 5 for more information). We are aware of the core work of the working group and believe that its detailed programme of work, when delivered, will make a valuable contribution to the effectiveness of the many organisations involved in post-incident recovery. However, it is also clear that the matter of financial aid and special status to assist the redevelopment of stricken communities should be detached from the working group's programme, and be dealt with as a separate and urgent matter by the Secretary of State for Communities and Local Government. Recommendation 29 therefore repeats our view that this work is very important and should be progressed swiftly.

61 While numerous forms of support have been provided to those affected by the Buncefield incident, better integrated arrangements (possibly based on special area status) would reduce administrative complexity and provide greater certainty to those in need. There is an appearance that critical decisions affecting the recovery of the business and residential communities around Buncefield are somewhat on hold pending a number of outcomes (eg in terms of changes to planning advice) that are beyond the control of local authorities and businesses. The doubts for the future of the area among those who might stay, move in, or develop a business precisely characterise what needs to be in place in the unlikely event of another major incident.

62 We make no specific definition of 'special status'. However, we are calling for suitable and early financial provision and sufficient relaxation of planning and zoning constraints to ensure as rapid recovery of the area as can be reasonably expected. What we mean by 'social normality' should have regard to the social and economic status of the community before the major incident, and also take account of changes to its status that could be anticipated during the recovery period, as if the incident had not occurred. Therefore, we anticipate the application of practical status indicators such as relative movement of house prices and unemployment trends compared to regional norms. It would also be essential to determine at the outset the minimum initial period that special treatment should last.

63 The subject of financial aid provided by government is bound to be complicated in the context of a disaster such as Buncefield. Matters such as insured losses, liability, and compensation are not obvious risks for underwriting with public money. So we stress we are talking about recovery: kick-starting the recovery of a stricken community that would otherwise deteriorate and impose other and perhaps greater costs on the social economy. We believe the financial equity and fairness issues, while difficult, are capable of being resolved. Taken

²⁶ By autumn 2007, the NRWG is expected to deliver a suite of guidance and a set of recommendations that will need to be taken forward by the relevant lead government departments. See Annex 5.

altogether there are a number of challenges to be overcome and balances to be struck in considering additional financial provision and special status. These would appear to be matters for local government, regional assemblies, regional development agencies, chambers of commerce and equivalent administrations to take forward with CLG and other government departments without delay. In calling for the lead minister to control special funding we do not envisage replacing or marginalising the role of the RDA's and their equivalents in this regard. Clearly the local regional administrations are best placed to administer funds and to monitor the recovery and to determine when the recovery is achieved.

Recommendation 29 Communities and Local Government should review options for government support to communities affected by a disaster and produce practical recommendations without delay. The review should consider the merits and mechanisms for providing immediate, short-term financial assistance to affected communities, for instance through establishing special status, and how long the period of special treatment should last. The lead minister for recovery that we ask to be confirmed in Recommendation 27 should have responsibility for controlling special funding provided for recovery. Suitable indicators of social and economic well-being should be adopted to assist in the monitoring of the recovery. The equivalent administrations should be involved in the review to ensure that appropriate financial support arrangements are put in place in their areas.

64 Paragraph 61 draws attention to the special difficulties being faced by those in the area around Buncefield. Recommendation 30 calls on government to consider the Buncefield area as an urgent special case for central support to its recovery while the recommendations in this report are brought into effect. We feel it is vitally important that the recovery of the Buncefield region should not be put on hold while these recommendations are being considered and implemented. Our recommendations should not only support communities should a major incident occur in their vicinity in the future; practical additional support should be applied without delay in the area around Buncefield.

Recommendation 30 Central government should give urgent consideration to support to assist in the recovery of the area around Buncefield, including to both help restore business confidence and attract new workers and new employment. The aim would be to apply to the Buncefield area the principles of our recommendations right away. The Secretary of State for Communities and Local Government should see this consideration takes place.

65 Recommendation 22 refers to the need for clarity of responsibility for public health advice during an emergency response. In fact, some health concerns persisted well after the Buncefield fires were extinguished and the site made safe, particularly in relation to firefighting foam and the likely ground penetrations. Recommendation 31 therefore identifies the need for national arrangements to co-ordinate monitoring of the health impact work after the immediate response phase has ended.

Recommendation 31 The Health Protection Agency and equivalent health bodies (HPS, NPHS and DHSSPS (Department of Health, Social Services and Public Safety, Northern Ireland)) should agree a framework for continued co-ordination of health impact assessment and response after the acute incident response phase stands down.

Recovery of the environment

66 The COMAH regime joins HSE with the Environment Agency and the Scottish Environment Protection Agency because of the potential for major accidents to the environment (MATTE)^(Ref 18) arising out of an incident at a COMAH site. A MATTE arising from Buncefield was notified to the EU in July 2006. Determining the extent of damage to the environment, and dealing with it, is an essential part of the recovery phase. In terms of public health, we have called upon HPA and others to begin the assessment of potential damage to public health from the first moments of an incident (see paragraphs 43 to 49 and Recommendations 21 and 22). We welcome the work done by HPA and other relevant bodies to improve the provision of advice to primary responders, and for the setting up of monitoring arrangements specifically targeted at the type of emergency being dealt with.

67 As in the field of public health, we believe that more can be done at the beginning of an incident with potential to cause a MATTE to assess the possible nature and extent of the threat to the environment. Legal obligations rest with the relevant dutyholder under the COMAH Regulations to identify all major accident scenarios and assess the consequences for safety and the environment (Recommendation 1). Local authorities perform a similar exercise to produce an off-site emergency plan (Recommendation 15). We have not found evidence generally of adequate guidance to Environment Agency staff for making an assessment of dangerous inventories stored on site or brought to site during an emergency and for quantifying, as far as possible, the loss to the environment and likely penetrations. We are confident this was done to an extent at Buncefield but we believe the lesson to be learned is that even more can be done by relevant parties to plan and prepare for worst-case scenarios and for the Competent Authority to ensure this is the case.

68 We also believe that at the onset of an incident, better co-ordination is required between operator, COMAH regulator, the emergency services and local authorities to understand the types and quantities of harmful products escaping from site. These will include both the process materials normally in use and storage on site, substances brought in to deal with the emergency response, and the implications of the contaminated mixtures that might result. We do not underestimate the technical difficulties in achieving this but believe the benefits, to the design of the follow-up monitoring programme and in helping ensure the relevant priorities are in place, outweigh the difficulties.

69 We believe that at the onset of an incident, measures should be in place to co-ordinate the implementation of emergency plans with an assessment of the risks to the environment. This will assist provisions for giving accurate and important advice to primary responders, and for the setting up of monitoring arrangements specifically targeted at the type of emergency being dealt with. We therefore welcome the Environment Agency initiative to conduct a review of relevant procedures and guidance relating to the best means to assess the damage potential of worst-case emergencies, also taking into account harmful products that may be brought to the site. Recommendation 32 asks for this work to be completed quickly, including the production of suitable guidance for primary responders and planners. It would be helpful to co-ordinate this work with the relevant part of Recommendation 22, and bring it into the ambit of the STAC, as described in paragraph 47.

Recommendation 32 The Environment Agency (in consultation with SEPA and the Northern Ireland Environment and Heritage Service) should complete, as quickly as possible, its review of methodologies for assessing the potential harm to the environment arising out of credible major incidents at COMAH sites, and from the emergency response scenarios attaching to them. The objective is to improve information provided to aid planners and emergency responders. The work should align with the arrangements introduced for the Scientific and Technical Advice Cell (STAC).



Strategic recovery

70 High-hazard industrial sites are often national assets of strategic economic importance. Recovery from a major incident at such sites may well therefore extend to restoring the flow of products that they supply. The Buncefield incident had a major impact on fuel supplies to Heathrow. Work continues to put fuel supply to the airport onto a sustainable and resilient footing for the longer term.

71 Partly prompted by the Buncefield incident, paragraph 4.42 of the recent Energy White Paper^(Ref 19) states that ‘The Government has also established with industry an Aviation Fuel Task Group (AFTG). It will analyse future jet fuel demand at Heathrow and other UK airports up to 2030 and what fuel supply infrastructure may be needed to meet demand. We will also look at the infrastructure needed for other oil products.’

72 We understand that one workstream of the AFTG is to review the Government Pipeline and Storage System (GPSS). The GPSS infrastructure continues to be used to help boost supplies to Heathrow as a consequence of the Buncefield incident. We welcome this initiative, which on the face of it, makes sensible use of an important national asset.

Figure 12 After the fires were out: Buncefield from Boundary Way, December 2006

Annex 1

Terms of reference and progress

This annex sets out the eight terms of reference for the Investigation and explains the progress that is being made towards accomplishing each of them.

1 To ensure the thorough investigation of the incident, the factors leading up to it, its impact both on and off site, and to establish its causation including root causes

The Board has published three progress reports from the Investigation Manager. This was followed by the Board's initial report on 13 July 2006, which summarised the three preceding reports and set out the Board's four main areas of concern. These have revealed the main facts of the incident, but have not speculated on why control of the fuel was lost. The explosion mechanism, ie the means by which unexpectedly high overpressures were generated, is subject to significant further investigation. Wider expert consultation has been undertaken on whether and what further research may be required and a report of this work will be published shortly.

The criminal investigation continues to make progress in pursuing all reasonable lines of inquiry into the facts and causes of the incident to enable the Competent Authority (HSE and the Environment Agency) to take a view on legal proceedings. When a decision has been taken by the CA, it will be made public.

2 To identify and transmit without delay to dutyholders and other appropriate recipients any information requiring immediate action to further safety and/or environmental protection in relation to storage and distribution of hydrocarbon fuels

The Competent Authority issued a Safety Alert to around 1100 COMAH dutyholders on 21 February 2006. Special attention was paid to 108 fuel depot owners storing COMAH quantities of fuel in Great Britain, seeking a review of arrangements for detecting and dealing with conditions affecting containment of fuel. Most dutyholders responded to the alert by the Easter deadline. Meanwhile, the Competent Authority visited all 108 depots to follow up the alert. An interim report was published on 13 June 2006 and is available at www.hse.gov.uk/comah/alert.htm.

The Environment Agency issued further advice to its inspectors to investigate secondary (bundling) and tertiary (drains and barriers) containment at depots in England and Wales in response to the Second progress report. The Environment Agency continues to monitor the effects of Buncefield on the surrounding environment and to issue updates on its website, www.environmentagency.gov.uk. The initiative is being handled separately for Scotland by the Scottish Environment Protection Agency, with joint inspections undertaken with HSE covering primary, secondary and tertiary containment, and management systems. A report by the Competent Authority on the outcome of its work was published on 29 March 2007. It is available on the websites of the members of the Competent Authority.

On 16 June 2006 investigators served two Improvement Notices on the manufacturers of the high level alarm switch installed on Tank 912, having identified a potential problem at other sites related to the setting of the switch for normal operations following testing. This was followed up by a Safety Alert from HSE on 4 July 2006 alerting operators relying on such switches of the potential problem.

The Chairman of the Buncefield Board wrote to the Chief Executive of the Health Protection Agency on 3 July 2006 enquiring into progress with informing regional resilience groups of early lessons learned from Buncefield, focusing on public health issues in the immediate aftermath of a major airborne incident, following up with a meeting in December 2006. HPA has assisted the Board with the recommendations contained within this report.

3 To examine the Health and Safety Executive's and the Environment Agency's role in regulating the activities on this site under the COMAH Regulations, considering relevant policy guidance and intervention activity

Work is progressing steadily on both parts of the review, concerning respectively HSE's and the Environment Agency's prior regulatory activities at Buncefield. The full findings of the review will be incorporated into the Board's final report (see term of reference 8). Immediate important lessons from the examination of the Competent Authority's prior role have been incorporated as appropriate into the lessons learned programme under term of reference 5. We expect to publish a report into the review of the policies and procedures of the Competent Authority later in the year, perhaps incorporating it into a further interim report under term of reference 8.

4 To work closely with all relevant stakeholders, both to keep them informed of progress with the Investigation and to contribute relevant expertise to other inquiries that may be established

The ongoing impact on residents and businesses of the Buncefield incident has been reported in the three progress reports and in the initial report in which, in Part 2, the Board set out its main areas of concern. The Board has maintained an active interest in releasing as much new information as possible to the community and its elected representatives to assist in understanding the events of 11 December 2005, and to maintain public confidence that progress is being made with the Investigation. As has been reported previously, residents and businesses continue to show remarkable resilience in the difficult aftermath to the Buncefield incident. Dacorum Borough Council in particular, but also St Albans and Hertfordshire Councils, have performed extremely effectively in very difficult circumstances, and have supported the Board in its engagement with residents and businesses, as has Mike Penning MP. Local residents and the business forums in the Hemel Hempstead area have provided input to this report, and more generally. We are very grateful for all this support.

The Board has also kept key government stakeholders informed of the Investigation's progress, and has maintained its interest in developments that have taken place since Buncefield to help manage the aftermath and support a return to normality for residents and businesses. We make special reference in this report to the difficulties for recovery of the area faced by the local authorities, residents and businesses.

The Board has engaged with all the public sector agencies involved in the emergency response to Buncefield and has met with a number of the key agencies, particularly the Category 1 (Gold) responders. The Board has outlined its conclusions and recommendations within the contents of this report, and many are based on the excellent reviews made by many of the agencies that responded to the incident.

5 To make recommendations for future action to ensure the effective management and regulation of major accident risk at COMAH sites. This should include consideration of off-site as well as on-site risks and consider prevention of incidents, preparations for response to incidents, and mitigation of their effects

Staff seconded from HSE, the Environment Agency and the Health Protection Agency are assisting the Investigation Manager and the Board to make sensible, practical and affordable recommendations for improvements in the light of the Buncefield incident. Key workstreams are in environmental protection; land use planning; emergency preparedness, response and recovery; fire and explosion mechanisms; control and instrumentation; human and organisational factors; health; and regulatory impact.

This report, making recommendations on the emergency preparedness, response to and recovery from incidents, is the second report under this term of reference. HSE has convened an industry-chaired task group (the Buncefield Standards Task Group) that includes the Environment Agency and the Scottish Environment Protection Agency and other primary responders, to consider emergency preparedness and response issues in parallel with the Board's work. This initiative has been welcomed by the Board in this report.

The work in producing the recommendations contained within this report has been supported by an immense amount of work undertaken by other agencies such as Hertfordshire Resilience, Hertfordshire Fire and Rescue Service, and the Health Protection Agency. With these recommendations, the Board has joined together the many strands of this subject, including issues concerning support to communities and businesses in the aftermath of an extreme incident.

The Board is close to recommending suitable arrangements for further research and modelling of explosion mechanisms in flammable vapour clouds.

HSE has completed its initial work on changes to land use planning advice and has issued a public consultation document seeking views by 22 May 2007. The Board has set out its own views to the consultation document and this may be viewed on our website. HSE has also concluded a public consultation exercise on behalf of a Cabinet Office led team on applying new knowledge of risks to society in the planning system (a subject often referred to as societal risk). The Board's response to the consultation document will be available on our website. The Health Protection Agency is consulting key agencies to improve public health advice and support during significant pollution events.

6 To produce an initial report for the Health and Safety Commission and the Environment Agency as soon as the main facts have been established. Subject to legal considerations, this report will be made public

This element is discharged by the publication of the Board's initial report on 13 July 2006.

7 To ensure that the relevant notifications are made to the European Commission

A report from the Environment Agency and HSE was made to the European Commission on 10 March 2006. Subsequently, the Environment Agency declared Buncefield a major accident to the environment (MATTE), and the Competent Authority has recently reported this to the European Commission.

8 To make the final report public

The timing for the publication of the final report remains uncertain and is of course linked to progress on the main terms of reference and to any decision on any criminal proceedings that might be considered. The possibilities include a further interim report in autumn 2007; decisions must necessarily depend on the timing of developments and consideration of the public interest.

Annex 2

Members of the independent Board

The Rt Hon Lord Newton of Braintree has been a life peer since 1997 after spending 23 years as a Conservative Member of Parliament for Braintree, Essex. From 1982 to 1988 he held ministerial positions at the Department of Health and Social Security. In 1988 he joined the Cabinet as Chancellor of the Duchy of Lancaster and Minister at the DTI. He then held the post of Secretary of State for Social Security from 1989 to 1992 when he was appointed Leader of the House of Commons, which he held until 1997. In 2002 he chaired the Committee that reviewed the operation of the Anti-terrorism, Crime and Security Act 2001.

Professor Dougal Drysdale is one of the leading international authorities in fire safety engineering. He was the Chairman of the International Association of Fire Safety Science until September 2005 and is currently the editor of the leading scientific journal in the field, *Fire Safety Journal*. His wide range of research interests includes the ignition characteristics of combustible materials, flame spread and various aspects of fire dynamics. He is a Fellow of the Royal Society of Edinburgh and a Fellow of both the Institution of Fire Engineers and the Society of Fire Protection Engineers.

Dr Peter Baxter is a Consultant Physician in occupational and environmental medicine at Cambridge University and Addenbrooke's Hospital, Cambridge. In the past, he has advised the government on the impacts on public health relating to air quality standards, major chemical incidents, natural disasters and climate change.

Taf Powell is Director of HSE's Offshore Division. He graduated in Geology and Chemistry from Nottingham University. His oil field career has been split between working in the UK and abroad in offshore exploration and development and regulation of the sector in licensing, well operations, policy and safety regulation. In 1991 he joined HSE's Offshore Division from BP and started work to develop the new offshore regulatory framework, one of Lord Cullen's recommendations following his inquiry into the Piper Alpha disaster. As HSE's Operations Manager, based in Aberdeen, he then led inspection teams and well engineering specialists responsible for enforcing the new regulations until 2000 when he took up his current role.

Dr Paul Leinster is Director of Operations at the Environment Agency. Up until March 2004 he was the Director of Environmental Protection, having joined the Agency in 1998. Before this he was the Director of Environmental Services with SmithKline Beecham. Previous employers also include BP International, Schering Agrochemicals and the consultancy firm Thomson-MTS where he was Managing Director. Paul has a degree in Chemistry, a PhD in Environmental Engineering from Imperial College and an MBA from the Cranfield School of Management. He has worked in the health and safety and environmental field for 30 years.

David Ashton is Director of HSE's Field Operations North West and Headquarters Division. He joined HSE in 1977 as an inspector in the west of Scotland where he dealt with a wide range of manufacturing and service industries, including construction, engineering and the health services. In 1986 he joined Field Operations HQ to deal with machinery safety. He then held the post of Principal Inspector of manufacturing in Preston for two years, before being appointed as a management systems auditor to examine offshore safety cases in the newly formed Offshore Division. In 1993 he became Head of HSE's Accident Prevention Advisory Unit, looking at the management of health and safety in organisations. Between 1998 and 2003 David was HSE's Director of Personnel, before being appointed to his current position.

Annex 3

Devolved and equivalent administrations

Information in this section is taken from the UK Resilience website to describe the emergency preparedness and planning arrangements in the devolved administrations (and equivalents), where they differ from UK government and local arrangements in England.

www.ukresilience.info/preparedness/devolvedadministrations.aspx

Scotland

The Civil Contingencies Act 2004 (CCA) applies to Scotland. The powers set out in Part 1 of the Act reside with Scottish ministers in line with the devolution settlement. It is supported by regulations made by the Scottish Parliament.

Scotland's principal guidance on the CCA, regulations and good practice is *Preparing Scotland*, a living document regularly updated to accommodate developments, changes in risk and their impact, and driving the development of emergency planning. Current activity to enhance *Preparing Scotland* will meet many of the objectives of the Buncefield recommendations while improving resilience, preparation and response to a wider range of risks. Since its inception, *Preparing Scotland* has recognised that the CCA regime can support activity required by COMAH and other regulations.

The Scottish government directorates are designated as leads on relevant issues in line with the 'lead department' principle at the UK level. In non-devolved areas, the Scottish government works closely with the UK government to ensure that Scottish needs are catered for.

Overall responsibility for civil protection policy in Scotland sits with the Civil Contingencies Unit (CCU) within the Scottish Government Police and Community Safety Directorate. The Scottish government chairs the Scottish Emergencies Co-ordinating Committee (SECC), which ensures that steps are taken to respond to the changing risk environment and determines the national strategy for the development of civil protection.

Scottish Executive Justice Department Civil Emergencies website:

www.scotland.gov.uk/Topics/Justice/emergencies/guidance

The Scottish Resilience Development Service has been established with a remit to address lessons identified in response to emergencies and exercises. It does so through exercising, training and by developing the competency of practitioners.

Where the Health Protection Agency (HPA) and the Environment Agency (EA) have been mentioned, the Scottish equivalents are Health Protection Scotland (HPS) and the Scottish Environment Protection Agency (SEPA).

Wales

The arrangements set out in Part 1 of the Act apply in Wales. However, there are some differences in the requirements that the Regulations place on Category 1 and 2 responders in Wales because of the unique administrative arrangements in Wales. As in England, the principal mechanism for co-operation between Category 1 and 2 responders under the Act will be the Local Resilience Forums (LRFs). The Welsh Resilience Forum (WRF) provides a national forum for multi-agency strategic advice on civil protection and emergency planning. The forum is a non-statutory advisory body.

The Welsh Assembly Government (WAG) or Wales Office, depending on the subject matter, is represented on the key committees and forums within the UK government relating to civil protection. They work closely with UK government departments to ensure that UK civil protection policy and planning is tailored to Welsh needs. A dedicated team in WAG supports multi-agency co-operation in Wales and engagement with the UK government on issues relating to civil protection and emergency preparedness.

Wales Resilience website:

<http://new.wales.gov.uk/resilience/regional-local-resilience1/?lang=en>

Where HPA and EA have been mentioned, the Welsh equivalents are the National Public Health Service Wales (NPHS) and Environment Agency Wales.

Northern Ireland

Civil contingencies in Northern Ireland are largely a devolved matter with responsibilities lying with Northern Ireland government departments. The Northern Ireland Office (NIO) in the UK government is, however, responsible for, among other things, policing, criminal justice and security in Northern Ireland.

The duties of the Act apply only to a limited number of organisations that deliver functions that are not transferred. These organisations are: the Police Service of Northern Ireland (PSNI); the Maritime and Coastguard Agency (MCA); and telecommunications operators. Because these organisations do not represent the full spectrum of response agencies in Northern Ireland, the Regulations treat these organisations in a slightly different way. In practice, it is anticipated that the PSNI, MCA and telecommunications operators in Northern Ireland will undertake their duties under the Act, but will relate to the other public service bodies listed in the Regulations in line with the arrangements in the Northern Ireland Civil Contingencies Framework and by participating in Northern Ireland co-operation, co-ordination and crisis management machinery.

The Central Emergency Planning Unit (CEPU) in the Office of the First Minister and Deputy First Minister (OFMDFM) promotes and co-ordinates civil protection arrangements in Northern Ireland. The Northern Ireland Assembly would normally have oversight of civil contingencies arrangements for transferred functions. The 'lead government department' principle applies to Northern Ireland departments as at the UK level.

The Central Emergency Management Group (CEMG) is a pan-Northern Ireland multi-agency forum for the development, discussion and agreement of civil protection policy. It is broadly analogous to the Regional Resilience Forums in England and Wales. Co-ordination at local and sub-regional levels may be facilitated by a range of organisations, with police district commanders and district council chief executives taking key roles in co-ordination. Northern Ireland has its own unique constitutional and organisational structures. Unlike in Great Britain many services are delivered on a Northern Ireland-wide (regional) basis, either by government departments or by their agencies and non-departmental public bodies.

Northern Ireland Central Emergency Planning Unit website:

<http://cepu.nics.gov.uk/>

Where HPA and EA have been mentioned, the Northern Ireland equivalents are the Department of Health, Social Services and Public Safety (DHSPS) and the Environment and Heritage Service, Northern Ireland (EHS).

Annex 4

Other major incidents causing extensive off-site damage

Three recent incidents are briefly described that show a relationship with Buncefield in that all of them caused extensive damage to the surrounding area. Two of them resulted in multiple fatalities. References are provided should further information be required.

Enschede, Netherlands

A fire broke out within the SE Fireworks depot in the eastern Dutch city of Enschede on 13 May 2000. The fire caused a massive explosion, killing 22 people and injuring over 900. Around 1500 homes were damaged or destroyed, and 1250 people were left homeless. The cost of the damage was estimated to be more than half a billion euros.

Emergency services from all around the area, including Germany, assisted at the scene. However, concern was raised that the preparedness for such a disaster was insufficient. In particular, Enschede fire brigade had insufficient information about the site, or the products stored by the company. This lack of information resulted in tactical errors that contributed to the deaths of four firemen, as well as other members of the public.

The cause of the fire has never been officially determined. The Oosting Committee, charged with investigating the incident, noted that not only had the company stored more fireworks at the depot than they had permits for, but also that most of these fireworks were wrongly classified as presenting no significant hazard (1.4G) or fire hazard (1.3G) rather than as a mass explosion hazard (1.1G). The explosives storage permits allowed only 1.3G fireworks and the lower hazard, 1.4G fireworks. The Committee's report also describes several storage issues which may have contributed to the origin and/or escalation of the fire.

However, the Committee was also critical of the role played by local and national government. The municipal administration was criticised for insufficiently inspecting the company and for not taking action against the company for a detected violation of the environmental permit in force. It was also criticised over planning issues and new development monitoring issues.

The national government was blamed for failing to act on recommendations from an investigation following the 1991 explosion of a fireworks factory in Culemborg, which showed problems with the classification of fireworks.

Sources

- ▼ Report from the Oosting Committee
- ▼ Henk Voogd *Disaster Prevention in Urban Environments*
- ▼ *Wikipedia* 'Enschede fireworks disaster'

Toulouse, France

At 10:15 am on 21 September 2001 a huge explosion occurred at the AZF (Azote de France) fertiliser factory, located about 3 km (2 miles) outside the city of Toulouse in France. The explosion shattered shop and car windows and tore doors from their hinges in the city centre. Over 500 houses became uninhabitable. At least 29 people were killed and thousands were injured.

Various hypotheses have been proposed but the exact cause of the explosion remains unknown. What is known is that at the time of the explosion, some 200–300 tons of ammonium nitrate was stored in the warehouse. This material had been classed as unsaleable; it included off-spec product and it was contaminated with oil from handling equipment, bitumen from the original floor in the building, iron oxide and sulphur. Such conditions will have increased its susceptibility to explosive initiation.

A secondary blast at a nearby explosives factory was also reported, which was believed to have been caused by sparks created by the explosion at AZF.

Sources

- ▼ www.unep.fr 'Ammonium Nitrate Explosion in Toulouse – France' 21 September 2001
- ▼ Frédéric Borrás *Bombs in the Heart of Cities*
- ▼ *HIInt Dossier* 'AZF Ammonium Nitrate Explosion' 18 May 2005

Danvers, Massachusetts

A massive chemical explosion occurred at a factory in Danvers, Massachusetts in the early morning of 22 November 2006. The factory, which produced solvent-based commercial printing inks, was destroyed and more than 100 homes and businesses up to one mile away were damaged, some beyond repair. As of early May 2007, over 50 families were still unable to return to their homes. No one was killed in the incident, but ten members of the local community were injured.

Investigators from the US Chemical Safety Board (CSB) believe that the explosion was caused by 'the inadvertent overheating of solvents left stirring overnight in an unsealed mixing tank, releasing flammable vapor which accumulated and ignited'.

Minor concerns were expressed regarding the environmental impact of the incident. It was noted that the water runoff from the water used by firefighters had left a purple sheen on the river. Tests carried out by the US Environmental Protection Agency following the incident showed low levels of the solvent toluene. This was not seen to be a significant risk, as the chemical evaporates quickly, and the water was not a local drinking water supply. Danvers' Fire Chief also stated that there was no risk of toxic fumes getting into the air.

Sources

- ▼ US Chemical Safety Board (CSB) news release 'In Preliminary Findings, CSB Investigations Say 2006 Danvers, Massachusetts, Explosion Caused by Solvent Vapor Accumulation...' 9 May 2007
- ▼ *Wikinews* 'Chemical plant fire decimates Danvers, Massachusetts neighbourhood' 22 November 2006
- ▼ *Boston.com* 'Explosion heard over 20 miles away destroys homes in Danvers' 22 November 2006

Annex 5

National Recovery Working Group terms of reference

Background to the Working Group

Following a number of recent incidents, it has become apparent that local responders would appreciate more comprehensive guidance to support them in dealing with the recovery stage of emergencies. This was most recently raised as an issue following the Buncefield fire, which led Ruth Kelly, Secretary of State for Communities and Local Government, to agree to investigate options for government support to businesses and local economies in the period following an exceptional disaster.

TIDO (Prepare), the Official Committee on Domestic and International Terrorism (Preparedness), at their meeting on 6 November 2006 therefore agreed that a National Recovery Working Group should be established to identify the gaps in information and support and to produce a single point of reference for recovery guidance for local responders.

Objectives of the Group

- 1 To investigate the recovery options for mitigating the short, medium and longer-term economic, social (including health) and environmental impacts of emergencies on communities.
- 2 To provide a single point of reference for recovery guidance to local responders.¹
- 3 To identify gaps in recovery support and guidance, and propose options for further work to fill these gaps to be fed into the relevant Capability Workstreams or other government programmes (this includes making proposals for what further support and funding options are required for businesses and the local economy).

Deliverables

Objective 1

- ▼ Case studies from recent incidents and exercises (national and international) on what recovery issues were faced and how they were handled, with good practice examples.

Objective 2

- ▼ Web-based advice (possibly on UK Resilience) on how and where local responders (particularly local authorities) can obtain assistance or advice on recovery issues. This will include a list of roles and responsibilities of each government department and other organisations, a list of recovery contacts, and a glossary of terms. Any differences that exist in guidance for devolved

¹ While local authorities normally take the lead on recovery issues, the guidance will be aimed at all agencies involved in the recovery process.

administration areas will be clearly flagged. Arrangements will also be put in place for the long-term management and updating arrangements for these website pages.

- ▼ To map out and link to existing government and other sources of guidance and support.
- ▼ Feed into the revision of *Emergency Response and Recovery* guidance.
- ▼ Work with the Emergency Planning College in review of the Community Recovery course.

Objective 3

- ▼ Recommendations to address gaps, including those in economic and local business support, to be taken forward by the relevant lead government departments.

All of the above will be consistent with the Civil Contingencies Act framework and its supporting documentation *Emergency Preparedness and Emergency Response and Recovery*.

Membership

Core membership

Recovery is by nature a cross-cutting subject and relates to a wider area of responsibilities and capabilities than is represented by the Capabilities Programme. As a result, a wide range of government departments will need to be represented on the Group. These departments will include:

- ▼ Communities and Local Government (CLG)
- ▼ Department for Culture, Media and Sport (DCMS)
- ▼ Department for the Environment, Farming and Rural Affairs (DEFRA)
- ▼ Department of Trade and Industry (DTI)
- ▼ Department for Transport (DfT)
- ▼ Her Majesty's Treasury (HMT)
- ▼ Department for Education and Skills (DfES)
- ▼ Department for Constitutional Affairs (DCA)
- ▼ Department of Health (DH)
- ▼ Home Office (HO)
- ▼ Cabinet Office (CO)
- ▼ Ministry of Defence (MOD)
- ▼ Government Decontamination Service (GDS)
- ▼ Government Offices (GOs)
- ▼ Welsh Assembly Government (WAG)
- ▼ Scottish Executive
- ▼ Northern Ireland
- ▼ Foreign and Commonwealth Office
- ▼ DfID [to be invited if they wish to attend]
- ▼ Health Protection Agency
- ▼ Environment Agency
- ▼ Department for Work and Pensions

Many of these departments have links with a series of government agencies. It is expected that these departments will represent those agencies at the meetings and provide communication links as necessary.

In addition, the Group will require representation from a wide range of other organisations. These will include:

- ▼ Local Government Association (LGA)
- ▼ Association of Chief Police Officers (ACPO) (representing all UK forces)
- ▼ Chief Fire Officers' Association (CFOA) (representing all UK services)
- ▼ Ambulance Service Association (ASA) (representing all UK services)
- ▼ Regional Development Agencies (RDAs)
- ▼ Confederation of British Industry (CBI)
- ▼ Association of British Insurers (ABI)
- ▼ Health and Safety Executive (HSE)
- ▼ Food Standards Agency (FSA)
- ▼ Coroners' Society for England and Wales
- ▼ Convention of Scottish Local Authorities (COSLA)
- ▼ Welsh Local Government Association (WLGA)

Wider stakeholders

The Group will also require input from wider stakeholders, including those organisations who have been involved in the recovery stages of recent incidents. In keeping the numbers on the Group manageable, it will not be possible for all these organisations to be personally represented. However, the Group will ensure that their views are captured through use, for example, of electronic stakeholder surveys and other consultation exercises, building on existing networks (eg Local and Regional Resilience Forums) where possible.

Chair and Secretariat

GONW Head of Regional Resilience (Kathy Settle) will chair the group. Contact details are: Kathy.settle@gonw.gsi.gov.uk or Tel 0161 952 4146 (office) or 07771 978920 (mobile).

Rhiannon Harries, Regional Resilience Division, Communities and Local Government, will provide secretariat support. Contact details are: Rhiannon.harries@communities.gsi.gov.uk or Tel 0207 944 8575 (office).

Scope

The guidance will be made as comprehensive as possible, commensurate with the time-limited nature of the Working Group. In the longer term, the website could be used to disseminate further guidance and case studies as they occur. The separate 'Grouping of Topics' paper lists some of the issues that have been raised by recent emergencies which will be considered for inclusion in the guidance, although this should not be viewed as comprehensive and will be amended and added to as the Project progresses.

Should the Group identify areas for further work, either in relation to providing or clarifying guidance, or filling gaps in support, then it will make recommendations on how these should be taken forward.

Timescale

The Group will be time-limited and will aim to complete its tasks within nine months of the first meeting.

Accountability and reporting processes

The Group is accountable to TIDO (Prepare) and will submit the deliverables outlined above to that body for sign-off. The documents will also be submitted to DOP (IT) (PSR)² for their acknowledgement prior to publication. In addition, the Group will provide regular progress reports (quarterly) to the Capabilities Programme Board via the Civil Contingencies Secretariat (CCS).

Definitions

Emergency

An event or situation that threatens serious damage to human welfare in a place in the UK or the environment of a place in the UK, or war or terrorism that threatens serious damage to the security of the UK. To constitute an emergency an event or situation must additionally require the implementation of special arrangements by one or more Category 1 responder. (*Emergency Response and Recovery*)

Recovery

The process of rebuilding, restoring and rehabilitating the community following an emergency. (*Emergency Response and Recovery*)

Response

Response encompasses the actions taken to deal with the immediate effects of an emergency. In many scenarios it is likely to be relatively short and to last for a matter of hours or days – rapid implementation of arrangements for collaboration, co-ordination and communication are, therefore, vital. Response encompasses the effort to deal not only with the direct effects of the emergency itself (eg fighting fires, rescuing individuals) but also the indirect effects (eg disruption, media interest). (*Emergency Response and Recovery*)

² The Ministerial Committee of Defence and Overseas Policy (Sub-committee on International Terrorism) (Ministerial Group on Protective Security and Resilience).

References

- 1 *Initial Report to the Health and Safety Commission and the Environment Agency of the investigation into the explosions and fires at the Buncefield oil storage and transfer depot, Hemel Hempstead, on 11 December 2005* Buncefield Major Incident Investigation Board 2006 www.buncefieldinvestigation.gov.uk
- 2 *Recommendations on the design and operation of fuel storage sites* Buncefield Major Incident Investigation Board March 2007 www.buncefieldinvestigation.gov.uk
- 3 *The Buncefield Investigation: First progress report* Buncefield Major Incident Investigation Board 2006 www.buncefieldinvestigation.gov.uk
- 4 *The Buncefield Investigation: Third progress report* Buncefield Major Incident Investigation Board 2006 www.buncefieldinvestigation.gov.uk
- 5 *Buncefield Multi-agency Debrief Report and Recommendations* Hertfordshire Resilience Forum March 2007
- 6 *Performance indicators for the assessment of emergency preparedness in major accident hazards* CRR345 HSE Books 2001 ISBN 978 0 7176 2038 8
- 7 *Emergency planning for major accidents: Control of Major Accident Hazards Regulations 1999 (COMAH)* HSG191 HSE Books 1999 ISBN 978 0 7176 1695 4
- 8 *Buncefield: Hertfordshire Fire and Rescue Service's review of the fire response* Hertfordshire Fire & Rescue Service 2006 ISBN 978 0 11 703716 8
- 9 *Civil Contingencies Act 2004: Part 1 Emergency Preparedness, Chapter 7: Communicating with the public* Cabinet Office 2004
- 10 *The Lead Government Department and its Role: Guidance and Best Practice* Civil Contingencies Secretariat 2004
- 11 *The public health impact of the Buncefield oil depot fire* HPA 2006
- 12 *Evacuation and Shelter Guidance. Non-statutory guidance to complement Emergency Preparedness and Emergency Response and Recover* HM Government Crown Copyright 2006
- 13 *Dispersion modelling studies of the Buncefield Oil Depot Incident* Hadley Centre technical note 69 Met Office 2006
- 14 *Scientific and technical advice in the Strategic Co-ordination Centre, Guidance to local responders* Department of Health/Cabinet Office 2007
- 15 *Pollution Prevention Guidelines* Environment Agency www.environment-agency.gov.uk/ppg (work in progress)
- 16 Niall Ramsden report, issues identified for further consideration post-Buncefield (excluding those specifically addressed in 'review of Buncefield TOR 5 lessons learnt – phase 1 issue mapping'), P748 Other Issues, October 2006 not printed
- 17 *Emergency Response and Recovery, Non-statutory guidance to complement Emergency Preparedness* HM Government Crown Copyright 2005

18 DETR *Guidance on the interpretation of major accidents to the environment for the purposes of the COMAH Regulations* The Stationary Office 1999

19 *Meeting the Energy Challenge, A White Paper on Energy* May 2007
Department of Trade and Industry 2007

Web references

The Civil Contingencies Act:
www.ukresilience.info/preparedness/ccact.aspx

The Civil Contingencies Act and COMAH Regulations:
www.ukresilience.info/preparedness/emergencyplanning/index.shtm
www.ukresilience.info/publications/epo_competency_framework_bulletin.pdf
www.ukresilience.info/preparedness/training/index.shtm

Introduction to the New Dimension programme:
www.communities.gov.uk/index.asp?id=1123766

New Dimension Water rescue and safety, and high volume pumping:
www.communities.gov.uk/index.asp?id=1123770

Bellwin:
www.communities.gov.uk/pub/68/FinancialManagementofLocalDisastersUseoftheBellwinSchemeSept2004PDF230Kb_id1137068.pdf

Other related reports

Arthur D Little *Review of emergency planning at major hazard sites: Final report to the Fire Brigades Union* 2007

A central Government Perspective Cabinet Office [2006] not printed

Issues and lessons for the future arising from the explosion and fire at Buncefield Oil Storage Depot – restricted Government Office for the East of England (GO East)

Centrex Police Operation Test, Structured debrief report Buncefield Oil Depot Fire, Debrief of Gold, Silver & Bronze commanders not printed

Prof Jonathan Crego *Buncefield Fire a Celebration of success: A 10,000 Volt conversation*

Ian Churchill *Northgate Information Solutions Business Continuity*
www.hertsdirect.org

Tim Hutchings *The Buncefield Incident from a business perspective* Chamber of Commerce www.hertsdirect.org

Report of Mass Casualty Workshop Bedfordshire & Hertfordshire Ambulance and Paramedic Service [2006] (Restricted) not printed

Buncefield Oil Distribution Depot Incident: Board Briefing Report Bedfordshire & Hertfordshire Ambulance and Paramedic Service [2006] not printed

Buncefield fuel storage depot explosion, December 2005: Lessons learnt
Environment Agency Response to Civil Contingencies Secretariat [2006] not printed

Summary of key resilience workstreams arising from issues identified following the fire at the Buncefield fuel depot Cabinet Office 2005

SQW Buncefield social impact assessment: Final report January 2007 Major Hazard Action Plans for HOSL, HOSL no 13 Ref. Code CR1 10 not printed

A guide to the Control of Major Accident Hazards Regulations 1999 (as amended). Guidance on Regulations L111 HSE Books 2006 ISBN 978 0 7176 6175 6

Preparing safety reports: Control of Major Accident Hazards Regulations 1999 (COMAH) HSG190 HSE Books 1999 ISBN 978 0 7176 1687 9

Emergency Planning for major accidents: Control of Major Accident Hazards Regulations 1999 (COMAH) HSG191 HSE Books 1999 ISBN 978 0 7176 1695 9

The planning (Control of Major Accident Hazards) Regulations 1999 SI 1999/981 The Stationary Office 1999 ISBN 978 0 11 082367 6

The Control of Major Accident Hazards (COMAH) Regulations 1999 Buncefield Complex Inter-agency Off-site Emergency Plan Issue 1 HESMIC October 2005 not printed

Hertfordshire Constabulary Headquarters Operational Planning Unit Operation Derrick Buncefield Oil Terminal D1-11 Green Lane, Hemel Hempstead, HP2 & HE December 2005 not printed

On-site emergency response inspection guidance: Draft version 3 HID Chemical Industries Forum www.hse.gov.uk

The Seveso directive and hazards of major accidents decree The Netherlands Ministry of Housing, Spatial Planning and the Environment 2006 www.vrom.nl/international

Lessons learnt from explosion of an unconfined cloud of vapour coming from a tank storing drain water mixed with hydrocarbons (Italy) 1999 Feedback seminar – IMPEL/ICPE inspectors. Reims, June 12-13 2001

Changes in risk prevention and control New legislative tools in France 30 July 2003

Direction De La Prevention Des Pollutions Et Des Risques 10th CCA meeting in Cagliari, October 15-17 2003

P Fewtrell and I L Hirst 'A Review of High-Cost chemical/petrochemical accidents since Flixborough 1974' Loss Prevention Bulletin no 140 IchemE 1998

Occupational health surveillance following deployment of the Buncefield oil depot fire, Hemel Hempstead, Hertfordshire 11 December 2005 on behalf of the Buncefield Fire Occupational Health Working Group revised February 2007

Glossary

Bronze Command The working name for the operational command level during a Major Incident

Buncefield Standards Task Group The joint Competent Authority/industry standards working group set up to review safety and environmental protection standards at fuel storage sites following the Buncefield incident. The Task Group published its initial recommendations on 12 October 2006

Civil Contingencies Act (CCA) The Civil Contingencies Act was set up in order to deliver a single framework for civil protection in the United Kingdom. The act is divided into two parts. The first sets out the roles and responsibilities for those involved in emergency preparation and response at a local level, whilst the second updates the 1920 Emergency Powers Act, taking into account the developments over the years, as well as potential risk factors faced in the 21st century

Civil Contingencies Secretariat (CCS) The Civil Contingencies Secretariat is housed within the Cabinet Office, and works alongside other Government departments, the devolved administrations and key stakeholders to assist with emergency preparation, response and recovery in the UK

COMAH See Control of Major Accident Hazards Regulations 1999

COMAH Regulations The Control of Major Accident Hazards Regulations 1999 (COMAH)

COMAH site A site to which the Control of Major Accident Hazards Regulations 1999 apply

Competent Authority The Control of Major Accident Hazards Regulations (COMAH) are enforced by a joint Competent Authority comprising the Health and Safety Executive (HSE and the Environment Agency in England and Wales, and HSE and the Scottish Environment Protection Agency in Scotland

Control of Major Accident Hazards Regulations 1999 The main aim of these Regulations is to prevent and mitigate the effects of those major accidents involving dangerous substances, such as chlorine, liquefied petroleum gas, and explosives which can cause serious damage/harm to people and/or the environment. The Regulations treat risks to the environment as seriously as those to people. They apply where threshold quantities of dangerous substances identified in the Regulations are kept or used

controlled burn A strategy used to reduce the risk of the run-off of contaminated firewater, by limiting or prohibiting the application of fire fighting water or foam

Environment Agency The Environment Agency is the lead regulator in England and Wales with responsibility for protecting and enhancing the environment. It was set up by the Environment Act 1995 and is a non-departmental public body, largely sponsored by the Department for Environment, Food and Rural Affairs and the National Assembly for Wales

firewater Water stored for use during, and used during, firefighting operations

foam In the context of this report, a foam used during operations to extinguish hydrocarbon fires

Gold Command The working name for the strategic command centre during a Major Incident – also known as the Strategic Co-ordinating Group (SCG)

groundwater All water below the water-table, as opposed to ‘ground waters’, which include groundwater but also sub-surface water above the water-table. The term ‘ground water’, where used in the previous progress reports, should normally have read ‘groundwater’

hazard Anything with the potential to cause harm

Health and Safety Commission The Health and Safety Commission is a statutory body, established under the Health and Safety at Work etc Act 1974, responsible for health and safety regulation in Great Britain

Health and Safety Executive The Health and Safety Executive is a statutory body, established under the Health and Safety at Work etc Act 1974. It is an enforcing authority working in support of the HSC. Local authorities are also enforcing authorities under the Health and Safety at Work etc Act 1974

HSC See Health and Safety Commission

HSE See Health and Safety Executive

hydrocarbon An organic chemical compound of hydrogen and carbon. There are a wide variety of hydrocarbons such as crude oil (basically a complex mixture of hydrocarbons), methane, propane, butane, etc. They are often used as fuels

Local Resilience Forum The Local Resilience Forum (LRF) is the principal mechanism for multi-agency co-operation between Category 1 responders. The LRF is not a statutory body, but it is a statutory process under the Civil Contingencies Act 2004

on- and off-site emergency plans Operators of top-tier COMAH sites must prepare adequate emergency plans to deal with the on-site consequences of possible major accidents and to assist with off-site mitigation. Local authorities for areas containing top-tier COMAH sites must prepare adequate emergency plans to deal with the off-site consequences of possible major accidents, based on information supplied by site operators

primary containment The tanks, pipes and vessels that normally hold liquids, and the devices fitted to them to allow them to be safely operated

public information zone (PIZ) An area around a COMAH site, in which site operators are obliged to inform, without request, those who live and/or work within the zone with information on safety measures at the establishment and on the requisite behaviour in the event of a major accident at the establishment. This is in accordance with regulation 14 of COMAH

pyrolysis The decomposition or transformation of a compound caused by heat

Regional Resilience Forum The Regional Resilience Forums are established by each Government Office to discuss civil protection issues from the regional perspective and to create a stronger link between local and central government on resilience issues. Similar arrangements are made in the devolved administrations

Regional Resilience Team The Regional Resilience Team is a small group of civil servants within a regional government office dealing with civil protection issues under the leadership of a regional resilience director. Similar arrangements will exist in the devolved administrations

responder Under the Civil Contingencies Act 2004, EA is a Category 1 responder, and HSE is a Category 2 responder. These categories define the roles played by each body in response to a major incident

risk The likelihood that a hazard will cause a specified harm to someone or something

run-off Uncontained liquid, either deposited on-site as rain, or in the context of the Buncefield incident, fuel and/or firewater not contained as part of the operation to control the incident

safety reports The COMAH Regulations require operators of top-tier sites to submit written safety reports to the Competent Authority

SCG See Strategic Co-ordinating Group

Silver Command The working name for the tactical command centre during a Major Incident

Strategic Co-ordinating Group Representation of all agencies deployed to resolve the Buncefield incident was established through a meeting process known as the Strategic Co-ordinating Group, also known as Gold Command

tank farm A facility where hazardous substances, very often petroleum products, are stored in tanks

tier The COMAH Regulations apply where threshold quantities of dangerous substances identified in the Regulations are kept or used. There are two thresholds, known as 'lower-tier' and 'top-tier'

top-tier See tier

Further information

Buncefield Major Incident Investigation
Marlowe Room, Rose Court 2 Southwark Bridge London SE1 9HS
Tel: 020 7717 6909
Fax: 020 7717 6082
E-mail: buncefield.inforequest@hse.gsi.gov.uk
Web: www.buncefieldinvestigation.gov.uk

Community/business support

Dacorum Business Contact Centre
Tel: 01442 867 805
Business Link Helpline Tel: 01727 813 813

Hertfordshire Chamber of Commerce
Tel: 01727 813 680

Dacorum Community Trust Mayor's Fund
To apply, call the freephone helpline on 0800 131 3351. Lines are open 9.30 am to 4.30 pm, Monday to Friday

Dacorum Borough Council
Tel: 01442 228 000
Web: www.dacorum.gov.uk

Hemel Hempstead Citizens Advice Bureau
19 Hillfield Road, Hemel Hempstead HP2 4AA
Tel: 01442 213368

Local authorities and emergency services

Dacorum Borough Council
Tel: 01442 228 000
Web: www.dacorum.gov.uk

St Albans District Council
Tel: 01727 866 100
Web: www.stalbans.gov.uk

Hertfordshire County Council
Tel: 01483 737 555
Web: www.hertsdirect.org

Hertfordshire Fire and Rescue Service
Web: www.hertsdirect.org/yrccouncil/hcc/fire/buncefield

Hertfordshire Constabulary
Web: www.herts.police.uk/news/buncefield/main.htm

Hertfordshire Chamber of Commerce
Tel: 01727 813 680
Web: www.hertschamber.com

Government links

Cabinet Office
Web: www.cabinetoffice.gov.uk

Department for Communities and Local Government
Fire and Resilience Directorate
Web: www.communities.gov.uk

Government Office for the East of England
Web: www.goeast.gov.uk

Environment Agency
Web: www.environmentagency.gov.uk

Department of Trade and Industry
Oil and Gas Directorate
Web: www.og.dti.gov.uk

Health and Safety Executive
Hazardous Installations Directorate
Web: www.hse.gov.uk/hid

Control of Major Accident Hazards
Web: www.hse.gov.uk/comah

Department for the Environment, Food and Rural Affairs
Web: www.defra.gov.uk

Health Protection Agency
Web: www.hpa.org.uk

Food Standards Agency
Web: www.food.gov.uk

Drinking Water Inspectorate
Web: www.dwi.gov.uk

Scottish Environment Protection Agency
Web: www.sepa.ork.uk

UK Resilience
Web: www.ukresilience.info

Scottish Executive Justice Department – Civil Emergencies
Web: www.scotland.gov.uk/Topics/Justice/emergencies/guidance

Wales – Local Resilience
Web: <http://new.wales.gov.uk/resilience/regional-local-resilience1/?lang=en>

Northern Ireland Central Emergency Planning Unit
Web: <http://cepu.nics.gov.uk>

Buncefields Standards Task Group (BSTG) –
superseded by: Petrochemical Process Standards Leadership Group (PPSLG)
Contact: colette.fitzpatrick@hse.gsi.gov.uk

National Recovery Working Group
Contact: Rhiannon.harries@communities.gsi.gov.uk

Industry links

United Kingdom Petroleum Industry Association (UKPIA)
Tel: 020 7240 0289
Web: www.ukpia.com

Chemical Industries Association
Tel: 020 7834 3399
Web: www.cia.org.uk

Three Valleys Water
Tel: 0845 782 3333
Web: www.3valleys.co.uk

United Kingdom Onshore Pipeline Operators' Association (UKOPA)
Tel: 01773 852003
Web: www.ukopa.co.uk

Tank Storage Association
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- ▼ *The Buncefield Investigation: Third progress report* 9 May 2006
- ▼ *The Buncefield Investigation: Initial report* 13 July 2006
- ▼ *Recommendations on the design and operation of fuel storage sites* 29 March 2007

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Defra:

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<http://www.defra.gov.uk/environment/airquality/publications/buncefield/buncefield-report.pdf>

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Buncefield:

Hertfordshire Fire and Rescue Service's review of the fire response

Hertfordshire Fire and Rescue Service November 2006 ISBN 978 0 11 703716 8

Angus Fire, Buncefield Oil Terminal Incident December 2005: Review of part played by Angus Fire and lessons learned
www.angusfire.co.uk

Other related reports/information

Report by SQW, Economic Developments Consultants *The Buncefield Oil Depot Incident: Economic and Business Confidence Impact Study* East of England Development Agency June 2006 www.eeda.org.uk

Quick Look Report – Buncefield Fire Swiss Fire Service 11 December 2005

Buncefield social impact report Dacorum Borough Council January 2007
www.dacorum.gov.uk/default.aspx?page=4191

Contract research reports for HSE

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Committee on mutagenicity of chemicals in food, consumer products and the environment (COM)

Committee on carcinogenicity of chemicals in food, consumer products and the environment (COC)

Committee on toxicity of chemicals in food, consumer products and the environment (COT)

www.advisorybodies.doh.gov.uk/coc/

Explosion Mechanism Advisory Group report

Buncefield Major Incident Investigation Board



Explosion Mechanism Advisory Group report

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Summary

The Buncefield Major Incident Investigation Board (MIIB) has been overseeing a comprehensive investigation of the incident and has published a number of reports on its findings. One important aspect of the incident was that a severe explosion took place, which would not have been anticipated in any major hazard assessment of the oil storage depot before the incident.

The Board invited a team of explosion experts from academia and industry to form a working group to advise on the work that would be required to explain the severity of the Buncefield explosion.

The Advisory Group identified a number of possible explosion scenarios but within the time available could not fully test them against the considerable amount of information available. Nevertheless, the Group has concluded that there is a strong likelihood that the cause of the severe explosion at Buncefield can be explained, although this will require further, more detailed work. However, it is the opinion of the Group that a comprehensive explanation is unlikely to be found without the conduct of further experimental and theoretical research.

It is recommended that a joint industry project be initiated with the task of completing the assessment started by the Advisory Group and, on the basis of its findings, defining the requirements of the research to be carried out in a second phase of the project.

Guidance to industry and the Health and Safety Executive (HSE) should be a primary deliverable of the project.

Introduction

1 The Buncefield Major Incident Investigation Board (MIIB) has been overseeing a comprehensive investigation of the incident and has published a number of progress reports¹⁻³ and an initial report⁴ on its findings.

2 The progress reports identify that the incident occurred following a spillage of unleaded petrol from one of the storage tanks. However, one important aspect of the incident was that a severe explosion took place, which would not have been anticipated in any major hazard assessment of the oil storage depot before the incident.

3 In its initial report, the MIIB stated that:

‘Further work is needed to research the actual mechanism for generating the unexpectedly high explosion over-pressures seen at Buncefield. This is a matter of keen international interest, and participation from a broad range of experts, as well as the industry, is essential to ensure the transparency and credibility of any research programme. The Board will consider further recommendations about the nature and scope of such work.’

The MIIB therefore invited explosion experts from academia and industry to form a working group to advise on the work that would be required to explain the severity of the Buncefield explosion. The first meeting of this Advisory Group was held in December 2006. The Group then had three subsequent meetings to review evidence and agree a report to the MIIB.

4 In its report *Recommendations on the design and operation of fuel storage sites*⁵ the MIIB stated:

‘We have asked the panel to advise us whether research is justified and if so the scope of such research, likely methods of funding it, and its governance arrangements, to ensure a satisfactory outcome. We have asked the panel to present its findings to us shortly after Easter and we shall make our recommendations known soon afterwards.’

5 This report is the response to this request and provides a summary of the technical issues examined by the Advisory Group along with its conclusions and recommendations.

Scope of review

Review process

6 The Advisory Group has carried out a preliminary assessment of the forensic evidence obtained following the incident and of the results of experiments carried out by the Health and Safety Laboratory (HSL). The objective of this assessment was two-fold:

- ▼ to determine whether a sequence of events could be identified that would explain why such severe explosion pressures were generated; and
- ▼ if this was not possible, to recommend to the Board what further actions would be required to explain the explosion severity.

7 In conducting the assessment, the Group made reference to previous fundamental laboratory-scale and large-scale experimental work. Although there was a preference to seek an explanation based on known mechanisms, the Group did not close itself to other potential means of generating the explosion. A summary of the technical issues considered by the Advisory Group is provided in Appendix 1.

Explosion mechanisms

8 An explosion can be produced when a gas cloud is ignited within a confined volume such as a building. As the flame propagates through the gas cloud it produces hot combustion products. The confinement prevents expansion of these combustion products and as a consequence, the pressure increases. In general, this continues until the confining structure fails, in some cases catastrophically.

9 This mechanism does not explain the type of explosion that occurred at Buncefield as the majority of the cloud was not confined. It is recognised that two ‘confined explosions’ did occur, but these events alone could not explain the severity of the overall explosion.

10 There are two known mechanisms for generating an explosion in a relatively unconfined vapour cloud. One is a deflagration, where the flame accelerates to high speed, which requires a mechanism for generating the flame acceleration. It has been shown in large-scale experiments that this can be provided by turbulence generated as the explosion propagates through pipework congestion typical of process plant.

11 In the case of Buncefield, this pipework congestion was not present to any significant degree and not at all in some areas where high pressures were produced. Trees and undergrowth were, however, present along both sides of Buncefield Lane. It is possible that these acted as a means of accelerating the flame in a manner similar to congested pipework regions on process sites.

12 The second mechanism is a detonation, which if sustained, can be much more damaging. It may arise from the coalescence of a strong shock wave and a fast-moving chemically reacting front. Together, this can undergo a transition to propagation faster than the speed of sound and produce over-pressures at the front in excess of 10 bar. It can also arise from the high temperatures and pressure generated by a shock wave in a confined, high flame speed deflagration or directly from strongly focused shock waves in a very reactive mixture. One possibility considered was the initiation of a detonation as a result of an explosion venting from either of two confined explosions. However, at Buncefield there was no clear evidence of even localised detonations.

Conclusions

13 The Group attempted to explain the explosion event at Buncefield using deflagration, detonation or a combination of both. It also examined other possible means of flame acceleration. However, it was not possible to identify a single scenario that could explain all aspects. In this the Group was limited by:

- ▼ uncertainty regarding the composition of the vapour cloud;
- ▼ apparent ambiguities in some of the forensic evidence;
- ▼ uncertainty regarding the explosion severity required to cause the level of damage observed, particularly to cars and buildings;
- ▼ the time available, as the possible scenarios could not be properly tested against the considerable amount of information available; and
- ▼ the difficulty of distinguishing between unburned gas flow ahead of the flame and burned gas flow, in the other direction, away from it.

14 Nevertheless, the Group concluded that there is a strong likelihood that the cause of the severe explosion at Buncefield can be explained. However, this will require further, more detailed work. It is the opinion of the Group that this should in the first instance involve the continuation of the assessment already started, fully testing a range of scenarios against the forensic evidence and the current scientific understanding of explosion mechanisms.

15 It is also the opinion of the Group that a full explanation is unlikely to be achieved without the conduct of further research.

Recommendations

16 It is recommended that a joint industry project be initiated that will, in its first phase, have the objectives of completing the assessment started by the Group and, on the basis of this, of defining the requirements for further research. This research – experimental and theoretical – would then be completed in a second phase of the project. Guidance to industry and HSE should be a primary deliverable of the work.

17 A proposal for the joint industry project has been prepared by the Group and is detailed in Appendix 2. The cost of the first phase of the project is estimated at not more than £200 000. The second phase of the work cannot be priced at this stage.

18 Governance of the project should be through a steering committee comprising stakeholders from industry and HSE, as regulator. The first phase of work would be conducted primarily by a technical committee, one member of which would act as project manager.

19 The Group recommends that this project should be initiated as soon as possible, with the first phase to be completed in early 2008. The additional experimental and theoretical work should then be completed within the following 18–24 months. To facilitate the first phase of the project being completed to schedule, it is suggested that there should be a maximum of ten sponsors. Broader support may be required for the second phase of the work.

Appendix 1

Technical considerations: Report of the Advisory Group on the explosion mechanism

1 To progress research into the mechanism that may have generated the high explosion over-pressures the Board wishes to receive recommendations concerning the nature and scope of that research with a view to ensuring the credibility of any research programme.

2 Paragraphs 5–8 of this appendix outline how over-pressures might be attained in combustion, while specific explosion scenarios are discussed in subsequent sections. This examination revealed several limitations in the current understanding of the relevant phenomena and the requested recommendations appear in paragraphs 37–38.

3 In the course of its work, the Group examined various scenarios for the initiation of two explosions that are suggested by CCTV records (see paragraphs 9–13) and for the subsequent flame propagation. Only one of the explosions was of seismic magnitude. In addition to information from CCTV records, the Group was aided in its studies by details of damage to buildings, tanks, cars, trees and shrubbery, all supplied by HSL. Examples of the damage are given in a series of photographs in Appendix 3. HSL also supplied the results of tests on cars exposed to explosive over-pressures. From the details of the damage sustained, the approximate over-pressures causing the damage were estimated. The Group was presented with these estimates which enabled isobars to be constructed showing over-pressures on a map of the site (see paragraph 39 and Figure 1). However, it should be noted that there is significant uncertainty regarding the magnitude of the over-pressures at the sources of the explosion that were considered and throughout the car park area.

4 HSL also presented results of computational fluid dynamics (CFD) computations concerning the way the vapour from the spilled fuel dispersed across the site. These proved to be difficult computations because, contrary to the situation in most CFD studies, the vapour flows and wind velocities were very small. Nevertheless, a combination of CCTV and computational evidence gave an indication of the changing depth of the fuel–air cloud. The variation of fuel–air concentration in the cloud was unknown but it would probably range from excess fuel at the ground to excess air at the top, with the most reactive mixture somewhere between. Where preliminary analysis has been carried out, worst-case stoichiometric conditions were assumed.

Over-pressures in combustion

5 The Group was able to estimate over-pressures generated by a variety of mechanisms. Some further details are given in paragraph 39. These included over-pressures across a flame, those arising from the degree of confinement and also the dynamic pressures arising from the gas flow ahead of the flame. High rates of change of heat release rate can generate strong acoustic waves and the associated pressure amplitudes were estimated, as well as the shock wave intensities at which pressure pulses and reaction fronts would coalesce in damaging detonations. These estimates of over-pressures were made for a variety of scenarios of explosive flame propagation and were compared with those derived from the observed damage. The comparisons gave guidance on the nature of flame propagation and the most probable scenarios are reported here.

6 An important feedback mechanism occurs when a turbulent flame propagates across obstacles. This causes turbulence in the flow of unburned mixture ahead of the flame. This turbulence increases the turbulent burning velocity, which in turn generates more turbulence ahead of the flame. This feedback results in flame acceleration and the eventual attainment of a maximum turbulent burning velocity (and maximum flame speed). Over-pressures also increase with flame speed. The maximum burning velocity is normally attained when any further increase in turbulence would reduce the burning velocity as a result of flame quenching. For the Buncefield event, maximum burning velocities and flame speeds (the vector sum of burning and gas velocities) were estimated theoretically and from the somewhat limited experimental data available on burning velocities and Markstein numbers.

7 High turbulent burning velocities can create a strong shock wave ahead of the flame, with associated elevations of pressures and temperatures. These elevations might reduce the auto-ignition delay time sufficiently to cause auto-ignition and detonation. Computations suggested that the maximum turbulent flame speed for near-stoichiometric butane–air in a confined duct was about 1200 m/s. This could generate a shock wave ahead of the flame with a pressure of 11.7 bar and a temperature of 825 K, sufficient to induce auto-ignition and consequent detonation. A similar mixture of pentane–air was unlikely to auto-ignite.

8 Shock wave interactions with the flame front can also induce higher flame speeds, in excess of the ambient speed of sound, and their intersections can create ‘hot spots’, both mechanisms aiding transition from deflagration to detonation.

Ignition

9 Though there is some uncertainty regarding ignition, the Board’s reports indicate that the emergency generator cabin, on the south side of the Northgate building and the emergency pump house, close to the north side of Bund A, both contained potential ignition sources. These locations are given in Appendix 3, Figure 3. Both buildings show evidence of having been subjected to an internal confined explosion.

10 CCTV evidence indicates that two explosions occurred with a time interval of one or two seconds between them, with the second being the severe explosion event. These explosions could have been separate explosions within the two buildings; however, other explanations are likely, as described in the following sections.

11 The Group considered that there was evidence to support the view that the first ignition occurred at a source in the emergency generator cabin, on the south side of the Northgate building, after a sufficiently flammable mixture had built up there. This conclusion was reached on the basis of both the forensic evidence and the belief that the emergency pump house was probably located within a fuel-rich part of the vapour cloud. An explosion in the emergency generator cabin and its aftermath are considered in paragraphs 14–25. Another scenario in which the first ignition occurred in the vicinity of the emergency pump house is examined in paragraphs 26–31.

12 The potential for a link between the two ignition sources was discussed by the Group. For example, an explosion in the emergency pump house could have had an effect on the local power supply that then resulted in electrical switching in the emergency generator cabin. However, at this stage any conclusion would be speculative at best.

13 The Group was aware that other ignition sources were possible, for example, one of the empty tanks suffered an internal explosion. Within the time available, it was not possible to consider alternative ignition sources in any detail. This should form part of any further work.

Explosion in the emergency generator cabin and its aftermath

14 Ignition was followed by a ‘bang-box’ explosion inside the generator cabin. This generated a high over-pressure, together with a fast-moving flame in an external cloud. Previous large-scale experiments suggested over-pressures of no less than 200 mbar and flame speeds in the region of 150 m/s. These studies also showed that when the external cloud contained obstacles, the over-pressure could be substantially higher. In the present case, fragments of the brickwork from the walls around the emergency generator cabin would have been propelled across the Northgate car park. It is possible that this could explain the observed abrasion of the trees and lamp posts on the side facing the generator building at the south end of the car park, but it is unlikely to explain such evidence at the north end of the car park. The Porsche car just outside the displaced doors of the cabin was severely damaged.

15 Blast from this explosion could be responsible for some of the car damage in the area south of the Northgate car park. The Group considered potential sequences of events following the explosion in the emergency generator cabin. These scenarios are described below.

Deflagration within the trees and shrubs

16 Large-scale experimental evidence indicates that, unless a transition to detonation occurs, a high-speed flame venting into an unobstructed area will rapidly decelerate. Thus the flame would propagate with diminishing speed across the south of the Northgate car park and enter the tree line along Buncefield Lane.

17 Consideration was also given to a jet flame initiating turbulent combustion in the boundary layer of a mixture of fuel and air. Computations showed that once the momentum of the initiating jet had declined, so also had the flame speed in the boundary layer, as observed in large-scale experiments.

18 Once the flame entered the trees and shrubs, it would accelerate rapidly up the tree line, reaching high speeds at the northern end. Damage to the trees and undergrowth was extensive and became progressively worse as Three Cherry Trees Lane was approached and continued eastwards along Cherry Tree Lane. Because of the feedback mechanism, which causes the flame to accelerate as it propagates, this tends to confirm that the flame was moving in a northerly direction. The trees and shrubbery would have acted as obstacles to the gas flow ahead of the flame, induced by the expansion of combusting hot gases, generating turbulence in the flow. The flame would also fold around the larger obstacles, such as tree trunks, developing a much larger surface area. The combination of the large flame area and a high turbulent burning velocity over that area would have resulted in a greatly increased rate of combustion. This would have caused the flame to accelerate to its maximum flame speed, possibly in the region of 400 m/s, creating a high over-pressure at the flame front and an additional over-pressure due to the semi-confined nature of the explosion. It is estimated that the magnitude of the total maximum over-pressure would be no less than about 1000 mbar. This pressure magnitude in the area of the trees is not inconsistent with some estimations of over-pressures.

19 In this scenario, the damage to the trees also suggests that the flame accelerated in a southerly direction down Buncefield Lane from the point of entry, but in this direction it travelled less far before reaching the edge of the flammable cloud. Therefore it did not accelerate to the same extent in this direction and would not have produced such high over-pressures here.

20 An important anomaly was a number of severely damaged cars in the south-east corner of the car park, at a point where the flame would enter the tree line. The flame speed would have been low at this point and associated over-pressures would be less than those estimated from the car damage. The pattern of damage between the Northgate Building and Fuji Building would also need some explanation, as this appears to change relatively suddenly, which does not appear to be consistent with a gradually decaying pressure wave.

21 In this scenario, the first explosion would be an explosion in the emergency generator cabin and the second more severe explosion would occur in the trees and shrubs towards the north end of Buncefield Lane and continuing east some distance along Three Cherry Trees Lane, where the vegetated verges were wider. The explosion in the emergency pump house would occur once the flame reached this area but would not have been observed on the CCTV.

Direct initiation of a detonation

22 An alternative scenario is that the explosion venting from the emergency generator cabin underwent a transition to detonation, possibly as a result of pressure and flame interaction with the Porsche car parked just outside the east end of the cabin. There was general agreement within the group that localised detonations might occur; however, a consensus could not be reached on the likelihood of these being sustained over the length of the car parks.

23 This scenario can explain the relatively even level of damage across the full car park area. It also offers a potential explanation for the apparent sudden change in the level of damage at points close to the edge of the cloud. Given the limited height of the cloud, pressure decay might be expected to be rapid.

24 However, the level of damage to the Northgate and Fuji buildings does not appear to be consistent with the very high over-pressures associated with a detonation front, even given the very short duration of this pressure pulse. There is insufficient information available to determine conclusively whether the severe damage caused to some of the cars is consistent with a detonation front or not. Because of the severe fire damage east of Buncefield Lane and in the vicinity of Bund A there was only limited data on over-pressures in this region.

25 The Group gave some consideration to the possibility of a combination of this scenario and the previous one. This is either a detonation in a limited section of the cloud to the south end of the car parks before the deflagration occurring in the trees and shrubs or a detonation occurring after flame propagation to the north end of the trees and shrubs. No clear evidence could be found to support either occurrence, but equally they could not be definitively excluded.

Explosion in the vicinity of the emergency pump house and its aftermath

26 Although there is no clear evidence that the first ignition occurred inside the emergency pump house, it is possible that incensive sparks were generated there after the activation of the site emergency system, and that these created the first ignition and explosion. The fuel–air mixture extended to a depth of more than 4 m from the area of the emergency pump house, at the apex between Three Cherry Trees Lane and Buncefield Lane, and extended down to the southern limit of Bund A. This large amount of fuel created the potential for a large explosion, although the gas dispersion analysis suggests that it was likely to be a fuel-rich mixture.

27 As with the description given in the previous section, where ignition was considered within the emergency generator cabin, ignition in the emergency pump house could have resulted in either:

- ▼ flame propagating towards the tree lines at both the north end of Buncefield Lane and along Three Cherry Trees Lane to the north of the site; or
- ▼ direct initiation of a detonation.

28 The possibility of direct initiation of a detonation was considered unlikely due to the expected fuel-rich concentration of the cloud in the vicinity of the emergency pump house and the pattern of damage. This possibility was therefore not considered further by the Group.

29 The first case would result in flame acceleration in a southerly direction in the tree line along Buncefield Lane. This is, in effect, the reverse of the process described in paragraphs 16–21 and equal magnitude pressures are possible in each case. This scenario has the benefit of providing a possible explanation of the high level of damage to cars parked at the south-east corner of the car park.

30 It is worth noting that in the third progress report³ on the incident, abrasion on the south side of posts and trees was taken to indicate a flame propagating north from the south end of the car park. The abrasions were taken to be as a result of a fast flame propagating towards the posts and trees. It was recognised by the Group that these abrasions could also have been caused by solid particles entrained by the high velocity of the burned gas, moving in the opposite direction to the propagating flame. The burned gas would tend to have significantly higher velocities than the unburned gas which would both enhance entrainment and intensify abrasion damage. Therefore the abrasions could also be indicative of a flame moving south from the north end of the car park/tree line. A difficulty with the scenario of a southerly spread of flame along the Buncefield Lane line of trees is the contrary evidence in paragraphs 16–21.

31 Alternatively, the explosion within the pump house may have been initiated on the arrival of a deflagration that had propagated from the emergency generator cabin. This second internal explosion would have occurred about one second after the first, the time for a deflagration to propagate between the two centres at a speed of 400 m/s. A detonation would take about a quarter of this time.

Alternative means of pressure generation

32 Because of the high concentration of fuel in the vicinity of the emergency pump house, there was the possibility of the creation of an intense fireball which would enhance mixing with air. Overall, the burning would probably be of a rich mixture, which, together with the large size of the fireball, would enhance the development of Darrieus-Landau flame instabilities that significantly increase flame front wrinkling. This would produce a large rate of change in the heat release rate, which could produce strong acoustic waves. These, through the baroclinic instability, would further wrinkle the flame, providing a feedback mechanism to enhance still further the rate of change of heat release rate and the generation of even stronger acoustic waves. These instabilities could create pressure oscillation amplitudes of 1000 mbar, which would contribute to increased over-pressures in the car parks.

33 In this case, the tree trunk damage in the Northgate car park might be indicative of a strongly induced flow into the base of a rising fireball. In this regard, the absence of soot on the tree trunk is noteworthy.

34 Another possibility was that this was followed by a second ignition at the emergency generator cabin. This would lead to the northward flame propagation along the line of trees on Buncefield Lane. In the absence of flame propagation towards the emergency generator cabin from the north, this scenario depends upon the statistical coincidence of a random spark in the generator building occurring one or two seconds after the first ignition. With the complex combined geometries of topography and flames, circumstances might arise in which flames could approach each other from different directions. This could lead to rapid burning of the trapped gas and the generation of strong acoustic waves that could further enhance burning. Sufficiently strong shock waves in a high pressure and temperature environment could induce detonation.

35 However, given the unusual nature of the Buncefield explosion, the Group could not reach a view on the likelihood of either of these occurring.

Conclusion

36 The Group found that it was not possible to describe definitely the nature of the severe second explosion. Given the time constraints, it was not possible to review fully what was a considerable amount of evidence and there is therefore still work to do in this area. Continuation with this assessment would help to define the necessary further work to determine the cause of the severe explosion in the Buncefield incident.

Recommendation for future research

37 In the course of the investigations certain areas emerged for necessary further research. Some of this research is of a more fundamental nature and some of it involves large-scale tests. The major areas identified to date for such work are:

- ▼ car damage as an indicator of explosion over-pressures;
- ▼ structural damage caused to buildings (similar to the Northgate and Fuji buildings) by high magnitude, short-duration shock wave;
- ▼ more data on burning velocities and Markstein numbers of key explosive mixtures at higher temperatures and pressures;
- ▼ more data on ignition delay times of key explosive mixtures at lower temperatures and pressures and on deflagration to detonation transition;
- ▼ the nature of premixed turbulent combustion in boundary layers;
- ▼ experimental and theoretical study of ‘bang-box’ ignition of external vapour clouds containing higher hydrocarbons;
- ▼ single and two-phase vapour cloud explosions in hydrocarbon–air mixtures;
- ▼ experimental and theoretical modelling of flame acceleration by finely spaced obstacles (to represent undergrowth) and tree-type obstacles;
- ▼ CFD simulation of vapour cloud formation, appropriate to low and no-wind conditions;
- ▼ study of flow of burned gas behind the flame, as well as of unburned gas ahead of the flame and their effects in abrasive damage.

38 Further research should be justified and prioritised to deliver a fuller descriptive and scientific understanding of the explosion scenario of 11 December 2005. This must be based on a more detailed assessment of the forensic evidence. The main primary deliverable from further work is revision of safety guidelines, based on an improved awareness of the complexities of the explosion and the accompanying fire hazards, that can be applied by industry.

Annex to Appendix 1: Estimations of over-pressures

39 Estimates of the dynamic over-pressures provided by HSL fall into five different categories, listed below. Such pressures can be quite high, but are difficult to assess because they require knowledge of the gas velocity, drag coefficient and the duration of the impulse.

- ▼ Estimates from **damage to building structures**.
 - These cover damage to windows, panelling, brickwork, doors, roofs, walls, internal floors, and bending and buckling of steel frames, and ripped-off panelling. They suggest over-pressures of no more than 200 mbar.
- ▼ Estimates of over-pressures at sources of ignition and '**bang-boxes**'. These are not quantified with much certainty, but are likely to be significantly in excess of 200 mbar.
- ▼ Estimates from **car damage** initially ranged up to 1000 mbar. However, more recent work by HSL suggested over-pressures in excess of 2000 mbar.
 - Some uncertainty is associated with the initial tests, as the procedures were unable to record the pressure at which the damage occurred. Instead, damage was correlated with the maximum over-pressure attained in the test. In general, the damage correlates better with the pressure difference between the inside and outside of the cars than with the higher final pressure in the test chamber.
 - Maximum values of the differences between external and internal pressures in the tests were about 200 mbar. This is also the approximate value that might be anticipated theoretically for the onset of buckling damage, due to an externally applied pressure. This matter is important because the damage to vehicles was almost exclusively 'crush damage', arising from a near equal over-pressure on all sides.
 - An important exception to this interpretation is the over-pressure estimate for the severe damage to the car in one of the tests, from a near-instantaneous pulse. The over-pressure in this experiment was quoted by HSL to be 'at least' 2000 mbar. This damage is almost, but not quite, as severe as that suffered by cars in the Fuji building car park. It is worthwhile to differentiate between cars that predominantly suffered from a relatively low level of 'crush damage' (which were outside the apparent region of the origin of pressure generation) and those that suffered more extensive damage (which tended to be within this region). The damage to the cars in the latter region was considerably higher, with some being extensively crushed and others having some of their panels partially torn off the body of the car.
 - It is also noteworthy that many of the tyres on cars in the high pressure region had their tyres deflated. This may have been due to the seal being broken by a high external pressure. Given the typical inflation pressure of car tyres, this might suggest an over-pressure in the explosion in excess of 2000 mbar.
- ▼ Estimates from damage to **trees, lamp posts and telegraph poles** along Buncefield Lane suggest over-pressures of 1000 mbar.
- ▼ Buckling forces on a **tank roof**, such as at Tank 12, were analysed. These show that collapse can occur with an external over-pressure of 100 mbar.
 - An attempt has been made to summarise over-pressures on the map in Figure 1, with overlaid isobars of 1000, 300, 150 and 40 mbar. Regions with pressures above 1000 mbar are shown shaded.

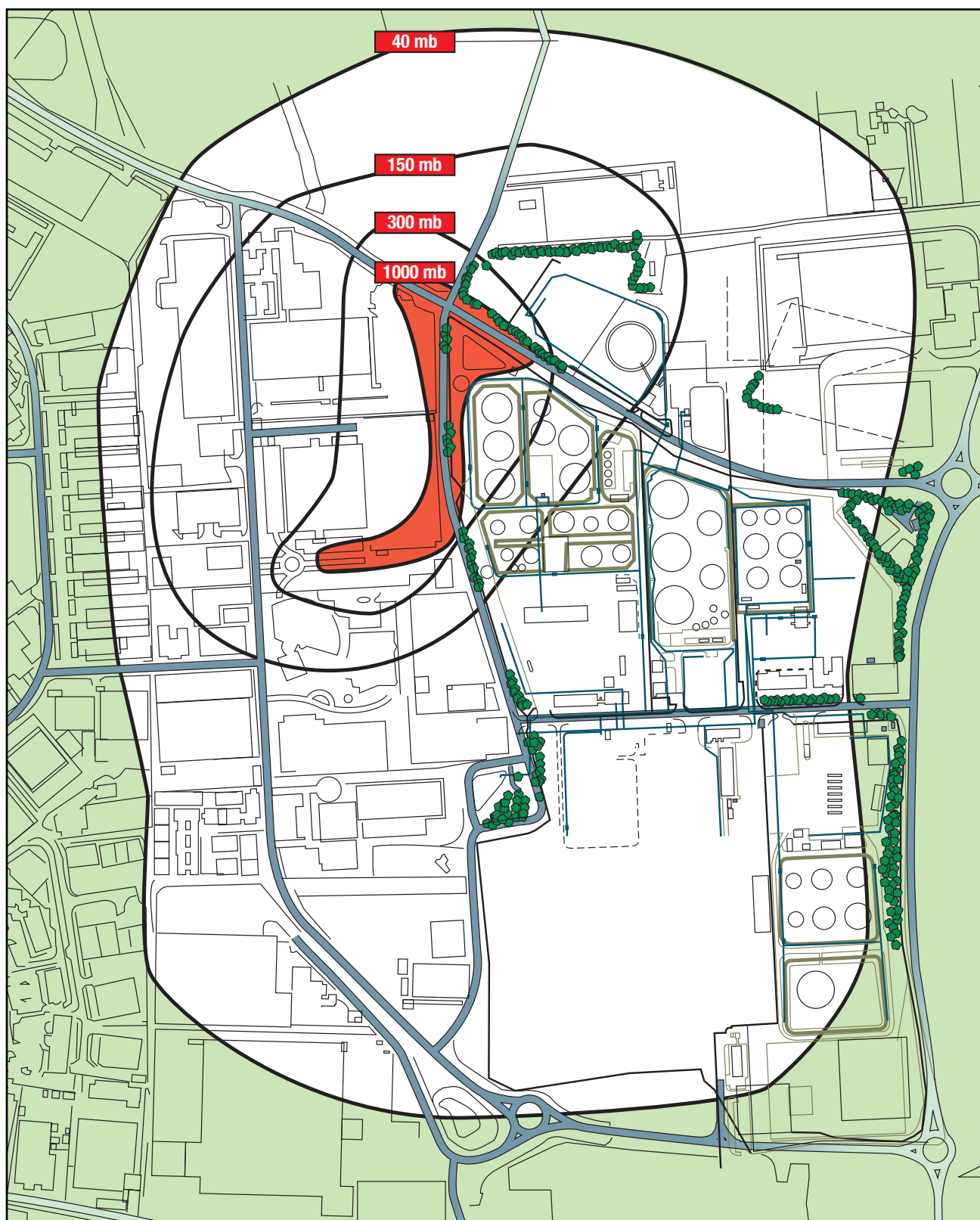


Figure 1 Map of the area around the Buncefield site showing approximate over-pressure isobars. These are based on the distribution of damage caused to buildings (including the pump house and the emergency generator cabin), tanks and vehicles as recorded by the primary investigation team. Inevitably, there are large error bars, particularly associated with the 1000 mb contour. It was noted that the damage to vehicles across the car park was remarkably uniform, but there is no information available on over-pressures that are required to cause such damage. The red shading corresponds to an area in which there were convenient markers that provided strong forensic evidence that the over-pressure was greater than 1000 mb. This does not preclude the possibility that such over-pressures were achieved beyond this area.

Appendix 2

Scope of further work to determine the explosion mechanism in the Buncefield incident

1 At around 06.00 on Sunday 11 December 2005, a number of explosions occurred at Buncefield Oil Storage Depot, Hemel Hempstead, Hertfordshire. At least one of these initial explosions generated significant and damaging blast pressures. The subsequent fires engulfed over 20 large fuel storage tanks across a high proportion of the site. There were no fatalities, but 43 people were injured and significant damage occurred to both commercial and residential properties in the vicinity as well as to the local environment.

2 The MIIB has been conducting a comprehensive investigation of the incident and has published a number of progress reports on its findings.¹⁻³ These reports identify that the incident occurred following a spillage of unleaded petrol from one of the storage tanks. The Board went on to publish its own initial report⁴ based on the findings in the three earlier reports. The initial report also sets out the Board's four main areas of concern arising out of the incident.

3 One important aspect of the incident was that a severe explosion took place, which would not have been envisaged in any major hazard assessment of the oil storage depot before the incident. Paragraph 35 of the first progress report¹ states:

‘Work is continuing to find out the exact nature and composition of the flammable mixture and to determine the precise mechanism which led to such a violent explosion. This includes establishing the nature and composition of the fuel from which the mixture was formed. Priority is being given to this work so that HSE’s advice to local planning authorities about developments adjacent to Buncefield and other fuel storage sites can be reviewed and, if necessary, amended.’

4 Initial work investigating the causes of the vapour cloud formation and the subsequent explosion has been carried out by HSL. However, in paragraph 77 of the initial report,⁴ the Board states that:

‘Further work is needed to research the actual mechanism for generating the unexpectedly high explosion over-pressures seen at Buncefield. This is a matter of keen international interest, and participation from a broad range of experts, as well as the industry, is essential to ensure the transparency and credibility of any research programme. The Board will consider further recommendations about the nature and scope of such work.’

5 This proposal for such work has been prepared in response to the goals identified by the Board in its reports.

Scope of work

6 The proposed programme has two phases although the actual number will depend on the outcome of each stage of the programme. The two phases are outlined in Table 1.

Table 1 Outline of programme

<i>Phase Title</i>	<i>Scope of work</i>
1 Initial assessment	Define what is known about the vapour dispersion and explosion at Buncefield, what can be explained by current understanding and what gaps in knowledge there are. If possible, interim guidance would be provided to industry and regulators on the basis of this analysis. Develop a full proposal for Phase 2.
2 Research to fill gaps	Conduct experimental and/or theoretical research to fill any gaps identified in Phase 1 and develop a generic solution to vapour cloud explosion modelling. This work would be directly related to the conditions pertaining to Buncefield and would aim to provide updated guidance to industry/regulators based on the conclusions of the research.

7 It is recommended that funding for the first phase of this project is sought from industry. At this stage, Phase 2 can be described only in broad terms and cannot be costed in a realistic manner. However, a budget price is provided in paragraph 30. This approach has the advantage that work can be initiated in the short term that will:

- ▼ provide a definitive record of the characteristics of the Buncefield incident relevant to the formation and dispersion of the vapour and to the explosion, including the distribution of damage to nearby items and structures;
- ▼ where possible, provide industry and the regulator with guidance for the operation of oil fuel storage sites based on this record of information and current knowledge of vapour cloud formation, dispersion and explosions;
- ▼ define the research that would be required in Phase 2 to confirm in further detail the explosion mechanism involved in the Buncefield incident and to provide improved guidance for both oil storage facilities and facilities storing other flammable liquids.

8 It is recognised that this proposal potentially involves a substantial research activity with the final guidance likely to take upwards of three years. Given the international relevance of the guidance to be provided from the investigations and the potential impact on industry, this approach is believed to be justified and consistent with the Board's intention as stated in paragraph 84 of the initial report:

‘The Board intends to address these issues in more detail, but not before seeing the preliminary conclusions of HSE's review. A measured approach is justified since the likelihood of a similar explosion remains low, and should be made lower still by a programme of actions designed to increase the reliability of primary containment. In our view, the importance of reaching conclusions that are considered, costed, and sustainable greatly outweighs any benefit that might be derived from coming to summary judgements.’

Phase 1 – Initial assessment

9 The initial assessment will have six main activities:

- ▼ review of apparently similar or relevant incidents;
- ▼ detailed review of data from the incident that are associated with the formation and dispersion of the vapour, the generation of the vapour cloud, and the subsequent ignition and explosion behaviour;
- ▼ assessment of potential scenarios for the explosion by comparison with observations from the incident;
- ▼ identification of gaps in information or understanding;
- ▼ formulation of interim guidance if possible;
- ▼ formulation of the Phase 2 research programme.

10 Further details of the activities are given in paragraphs 11–21.

Review of data

11 Information obtained from the investigations carried out by the MIIB, the Advisory Group and HSL will be collated and critically reviewed by a technical committee. The review will examine information related to:

- ▼ the discharge of unleaded gasoline from the tank and its evaporation;
- ▼ the development of the vapour cloud and its composition;
- ▼ the topography of the area in which the vapour cloud developed;
- ▼ potential ignition sources;
- ▼ the nature and extent of the damage caused by the explosion;
- ▼ the initial assessment and experimental work carried out by HSL;

and any other relevant information from other sources that is made available to the project. At the same time, the quality, reliability and value of the forensic evidence will be reviewed.

12 The objective of this activity is for the Technical Committee to have as detailed an understanding as possible of the conditions at the time of the explosion and of the forensic evidence left by the explosion (eg the pattern of damage to structures).

Assessment of scenarios

13 Given the current understanding of vapour cloud dispersion and explosions, potential scenarios will be identified that could lead to the generation of a severe explosion. This will include means of pressure generation that are not normally considered for this type of event. The scenarios will be tested against the understanding gained from the above review of data to determine if they could be consistent with the sequence of events and forensic evidence.

14 Two mechanisms for the generation of significant blast pressures that will be specifically included in this assessment are:

- ▼ a deflagration involving flame acceleration within a congested region. It is recognised at this stage that it is unlikely that on-site congestion, such as from pipework, would have been sufficient to provide significant flame acceleration, and the assessment will therefore focus on off-site features, including areas of vegetation and trees; and
- ▼ ignition within a confined volume resulting in the venting of a high velocity flame from the confined volume, which initiates a deflagration to detonation transition. Such a detonation might be able to propagate through at least part of the vapour cloud, generating high local pressures.

15 The possibility of pressure generation mechanisms not normally associated with this type of environment will also be considered. These include, for example, shock wave interaction with the flame front and pressures generated by a rapid change in phase, which could occur if any liquid droplets in the cloud were exposed to thermal radiation generated from combustion of part of the vapour cloud.

16 It is likely that this assessment will refer to previous experimental research and may involve modelling some aspects of the incident using existing dispersion and explosion models.

17 Based on the assessment of the scenarios, the panel will identify the gaps in understanding or information that need to be filled to explain the severity of the explosion in the Buncefield incident.

Interim guidance

18 On the basis of the assessment of the potential scenarios, it should be possible to prepare an interim review of guidance for operators of oil storage facilities, specifically in relation to the explosion issue. This guidance, which will also be of interest to regulators in the UK and overseas, will refer to the likely causes of the Buncefield explosion and highlight any actions operators or local planning authorities may need to take, including additional assessment or changes to facilities. It will also aim to provide important guidance for regulatory inspections.

Phase 2 proposal

19 The gaps in information or understanding identified during the assessment of potential scenarios will be used to prepare a proposal for Phase 2, if required.

20 Phase 2 would continue to address the Buncefield incident and therefore also be relevant to comparable facilities. The interim guidance provided in Phase 1 would be updated in the light of the results of the further research.

Deliverables

21 The deliverables from Phase 1 will be:

- ▼ report that provides:
 - a review of past incidents considered to be similar to Buncefield;
 - a record of information relevant to the formation and dispersion of vapour at Buncefield;
 - a record and critical review of the forensic evidence relevant to the explosion at the Buncefield site;

- identification of potential scenarios and mechanisms that could have led to the generation of a severe explosion at Buncefield;
 - determination of scenarios consistent with the forensic evidence;
 - a list of the gaps that need to be filled in our understanding and in the information needed to establish the cause of the severe explosion;
- ▼ interim guidance for operators of storage facilities, if possible; and
- ▼ a detailed proposal for Phase 2.

Phase 2 – Research to fill gaps

22 Phase 2 is likely to involve experimental research combined with modelling studies but it is possible that a need for more fundamental research will be identified. The experimental work is likely to involve both laboratory and large-scale experiments. Large-scale experiments would be necessary as the physics of explosions are scale dependent. Laboratory experiments can, however, provide fundamental data that underpin the understanding and modelling of the large-scale phenomena.

23 As stated above, Phase 2 would allow an update to the interim guidance issued following Phase 1. This would provide definitive recommendations on measures that could be justified to prevent a recurrence of the type of explosion that occurred at Buncefield.

Project delivery

Project management

23 The project will be overseen by a steering committee, which will comprise representatives of the stakeholders including: industry sponsors, the regulator, other potentially interested parties, industrial organisations and co-opted relevant specialists. The steering committee will be responsible for defining and monitoring the overarching aims of the project and ensuring its successful completion. It will review and provide comment on reports drafted by the technical committee and will provide authorisation for the publication of any reports.

24 Project management will be provided by a nominated project manager, who will co-ordinate the activities associated with the project and be responsible for providing a record of meetings and activities. It is recommended that for Phase 1, the project manager will be a member of the technical committee.

25 The main activities of the project will be carried out through the technical committee, which will comprise experts from industry, government and academia. The project structure is illustrated in Figure 2.

26 It will be the responsibility of the project manager to facilitate the technical discussions, and to compile the input from different members of the technical committee and form them into a single coherent and agreed report. It is suggested that this report should contain recommendations regarding the structure and management of Phase 2 of the project.

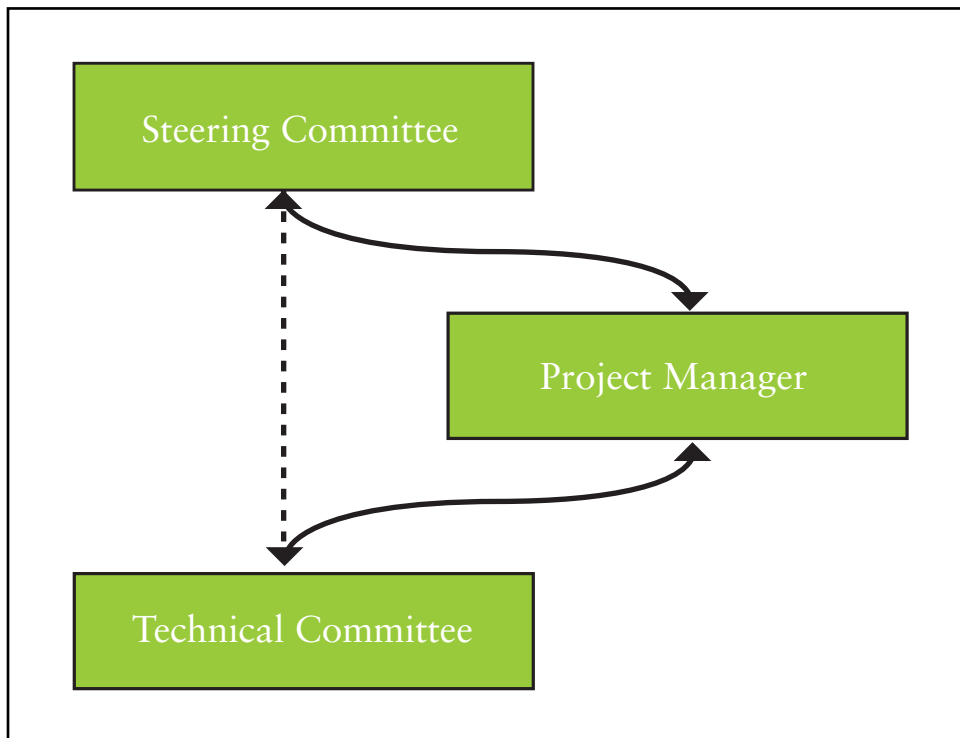


Figure 2 Project structure

Schedule

27 It is anticipated that the draft of the main Phase 1 report would be completed within a period of up to nine months and will include any industry guidance that can be provided at this stage.

28 The Phase 2 proposal will be produced within this period. The scope of work described in Phase 2 will be based on the gaps in our knowledge and understanding identified in Phase 1.

Commercial

Project cost

29 It is estimated that the price for conducting the Phase 1 study will be no more than £200 000. To ensure that Phase 1 can be initiated and completed without avoidable delay, it is suggested that the sponsor group should be limited to between five and ten members.

30 At this stage it is not possible to cost Phase 2, but as it is likely to involve large-scale experiments, it is anticipated that the budget for the programme of work will be in excess of £1 million. It may be appropriate to widen the sponsor group for this Phase to reduce the cost to individual members.

Terms and conditions

31 This proposal is subject to agreement on terms and conditions. Once interested parties have been identified, draft contractual terms and conditions will be distributed for comment.

Appendix 3

Map of the Buncefield depot and a selection of relevant photographs indicative of the damage

Figure 3 Pre-incident layout of Buncefield depot and immediate surroundings





Figure 4 Fuji building looking north-west from the boundary with the Hertfordshire Oil Storage Ltd (HOSL) site



Figure 5 North side of the Northgate building

Figure 6 Looking east from the edge of the HOSL West site into the British Pipeline Agency Ltd site (Tank 4 on the left of the picture). The white tanks in the background are on the HOSL East site



Figure 7 Looking east across the top of Tank 912. Tank 12 is in the background, across Cherry Tree Lane





Figure 8 Looking west into Northgate building car park, from the position of Tank 912 (HOSL West)



Figure 9 View into Tank 912

Figure 10 Looking south-west towards the Northgate building from Tank 915 (HOSL West)



Figure 11 View of the north side of the Northgate building, between the Northgate and Fuji buildings





Figure 12 View looking north towards the Northgate and Fuji buildings, with the Buncefield depot just off picture on the right. The emergency generator cabin is highlighted

Photograph courtesy of Hertfordshire Constabulary



Figure 13 Emergency pump house on the HOSL West site, from its north-east corner

Figure 14 HOSL West emergency pump house from the south-west side. The line of trees behind marks Cherry Tree Lane



Figure 15 Steel post in the west car park of the Northgate building. The post shows abrasion marks on its south face





Figure 16 View south along Buncefield Lane, showing sooting of lower parts of telegraph poles and trees



Figure 17 Abrasions to the base of a tree in the Northgate building west car park, viewed from the south

Figure 18 Damaged car
in RO building car park
(car facing south)



Figure 19 Cars on Three
Cherry Trees Lane (near
Catherine House)





Figure 20 Damaged cars at the south-west of the Northgate building car park; Boundary Way is in the background. The picture also shows blast damage to the north-west corner of the 3-Com building

Figure 21 Emergency generator cabin, close to the south-east corner of the Northgate building, viewed from the north east. The north-east segment of the damaged 3-Com building is shown to the left of the picture



Figure 22 Damaged car located at the south end of the Fuji building car park, adjacent to the hedge with the Northgate building car park



Appendix 4

Membership of the Advisory Group

- ▼ Professor Dougal Drysdale, University of Edinburgh (member, Major Incident Investigation Board)
- ▼ Professor Derek Bradley, University of Leeds
- ▼ Professor Geoffrey Chamberlain, Shell Global Solutions
- ▼ Dr Laurence Cusco, Health and Safety Laboratory
- ▼ Mike Johnson, Advantica
- ▼ Professor Hans Michels, Imperial College, London
- ▼ Professor Vincent Tam, BP Exploration

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- 1 *The Buncefield Investigation: Progress report* Buncefield Major Incident Investigation Board 21 February 2006
- 2 *The Buncefield Investigation: Second progress report* Buncefield Major Incident Investigation Board 11 April 2006
- 3 *The Buncefield Investigation: Third progress report* Buncefield Major Incident Investigation Board 9 May 2006
- 4 *Initial Report to the Health and Safety Commission and the Environment Agency of the investigation into the explosions and fires at the Buncefield oil storage and transfer depot, Hemel Hempstead, on 11 December 2005* Buncefield Major Incident Investigation Board 13 July 2006
- 5 *Recommendations on the design and operation of fuel storage sites* Buncefield Major Incident Investigation Board March 2007

Buncefield Major Incident Investigation Board reports are available at:
www.buncefieldinvestigation.gov.uk

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Recommendations on land use planning and the control of societal risk around major hazard sites

Recommendations on land use planning and the control of societal risk around major hazard sites

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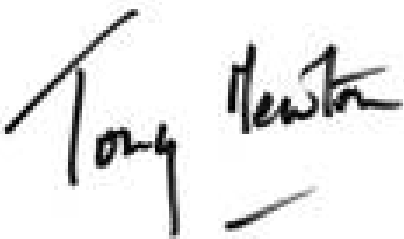
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Foreword

This is the fourth of the Board's reports to make recommendations for future action to ensure the effective management and regulation of major accident risk at COMAH sites. Without doubt the subject matter – land use planning and societal risk – has proved the most difficult and technically challenging that the Board has addressed. It is also the longest of the three reports because we have made a particular effort to help make our conclusions and recommendations intelligible beyond the narrow community of practitioners.

In our previous reports containing recommendations the direction of travel was always clear; the judgement call was about how far and how fast. With land use planning on the other hand we have been conscious that it is also about balancing several disparate interests – strategic, economic, social, safety and environmental. The understanding of the risks involved is an important step in reaching decisions and this has led us to address the very technical subject of risk assessment and try to shed some light on it. At the end of the day land use planning and societal risk necessarily entail political judgements. What we are proposing is a tool for flexible, transparent decision making which we believe will assist in achieving more consistent outcomes for the system for land use planning around major hazard sites in the future.

What has encouraged us in developing our ambitious stance is the conviction that there are important benefits to be secured. A more cohesive system, greater collaboration between interested parties and more refined risk assessment tools can enable industries to provide the products we need, while maintaining the levels of safety that everyone expects in a developed society and avoiding the unnecessary blighting of development opportunities. We also believe that wider understanding of the subject and the challenges it poses is crucial to gain acceptance for the decisions that emerge from the process. We trust our report, as well as recommending worthwhile improvements, serves to advance that better understanding.

A handwritten signature in black ink, appearing to read 'Tony Newton', with a short horizontal line underneath.

Lord Newton of Braintree
Chair of the Buncefield Major Incident Investigation Board

Executive summary

In this report we give our views on how the planning system around major hazard sites can be improved in the aftermath of the Buncefield explosions and fires of 11 December 2005.

We explain in the Introduction the approach that can be found in our previous reports for preventing major incidents such as occurred at Buncefield. Preventing major incidents depends upon the proper design and operation of major hazard installations. Limiting their impacts on people and the environment in an event relies on adequate emergency preparedness and response measures. We believe fundamentally that the land use planning system around major hazard sites needs to be more integrated with the Control of Major Accident Hazards Regulations 1999 (COMAH) regulatory system for major hazard sites in Britain than is currently the case. Thus, the principle of decisions being taken by the local planning authority and in line with broader development plans for the region is sound enough, but a weakness is the separation between the COMAH regulatory system and the system for developing advice to planning authorities. The roles of the COMAH Joint Competent Authority and the site operators in the planning system around major hazard sites therefore need to be remodelled. The national benefits of strategic sites like Buncefield should be more integrated with the needs of the local economy.

In Part 1 we focus on improving the way that all the stakeholders in the planning system for major hazard sites are organised. We develop the case for integrating the land use planning and the COMAH systems to achieve sensible consistency in the measures for safety and environmental protection around major hazard sites. In our view this can be achieved in part through greater technical involvement from the site operators. We also believe planning decisions should in future take account of the societal risks of fatal accidents from major incidents by incorporating the size and distribution of the population around the site using a technique known as quantified risk analysis (QRA). Our preferred system is one where the planning authority takes decisions that are informed by expert technical submissions on risks and control measures, including from the emergency responders, and we see the Competent Authority being responsible for the standards of technical submissions, and for the standards of the controls to be achieved by the planning decision process.

Thus Recommendation 1 calls for a wide-ranging review of the system for land use planning around major hazard sites to begin without delay. The review should include the system for granting hazardous substances consent and the incorporation of societal risk into land use planning decision making. We make it clear that we are calling for a new approach that is applicable to all major hazard sites since the issues involved are not confined to Buncefield-type sites alone.

In addition, we make several recommendations on the economic issues raised by Buncefield for the continued co-location of major hazard sites with large communities. Because we call for the COMAH and land use planning systems to be more integrated we believe that increased burdens on site operators will be minimised. The costs of risk reduction measures also need to be considered in relation to the commercial beneficiaries of the measures. We call as well for the revised planning system to be systematically and clearly explained to the general public.

Notwithstanding our call for a wide-ranging review to begin without delay, we have in Part 2 identified a number of primarily technical issues relating to the assessments that inform land use planning decisions around major hazard sites. These need to be



Figure 1 Caravan park next to Canvey Island depot, near the Thames Estuary, Southern England

addressed in parallel with the wide-ranging review if changes to the system are to be delivered within five years. We explain that the simplified, generic approach to risk assessment currently used around flammable storage sites needs to be replaced by a site-specific assessment of risks, using QRA methods, leading to a planning system that is more responsive to the levels of risk posed by each particular site. This is a necessary response to the improvements in risk controls. Specific examples are in moving away from expressing harm in terms of ‘dangerous dose or worse’ to a risk of fatality, in aligning the risk assessment in the COMAH safety report system with land use planning, and in setting priorities on the management of sites to ensure continuing integrity of the control measures incorporated in the planning decisions. We also address some of the anomalies attaching to the hazardous substances consents system, eg on dormant sites.

Moving to a QRA approach is also necessary for societal risk to be taken into account in a consistent way in Britain, ie to ensure that broadly similar levels of risk receive broadly similar responses in the planning system.

We call on the key stakeholders – some of whom have had little involvement to date – to demystify the concept of societal risk and to envisage a future system where they support the planning authority in coming to transparent decisions on what level of societal risk can be accepted in a planning application. This should be subject to guidance on tolerability limits developed by HSE and agreed nationally. We also call for the planning authorities to be suitably resourced to develop the expertise and procedures necessary for their role.

We commissioned a report from the engineering consultancy Det Norske Veritas to describe what a risk-based system incorporating societal risk might look like at a flammable storage site. The results of this work confirmed that a fully risk-based land use planning system around such sites is feasible, and is used elsewhere in Europe. We summarise the findings in Part 2 and in Annex 10.

We conclude our report by addressing retrospective applications of this method since it is inevitable there will be some places where the societal risk will be of concern due to developments which have already taken place. These locations will need to be managed through a specific and proportionate response.

Introduction

Background

1 This report sets out recommendations concerned with land use planning around high-hazard industrial facilities regulated under the Control of Major Accident Hazards Regulations 1999 (COMAH) and addresses the related concept of societal risk. The recommendations are made by the independent Investigation Board, chaired by Lord Newton of Braintree, set up to supervise the investigation into the explosions and fires at the Buncefield oil storage depot, Hemel Hempstead, Hertfordshire on 11 December 2005. The Health and Safety Commission¹ directed the investigation using its powers under section 14(2)(a) of the Health and Safety at Work etc Act 1974.

2 Item five of the investigation's terms of reference required us to 'make recommendations for future action to ensure the effective management and regulation of major incident risk at COMAH sites. This should include consideration of off-site as well as on-site risks and consider prevention of incidents, preparations for response to incidents and mitigation of their effects'.

3 Our Initial Report, published on 13 July 2006,^(ref 1) identified four principal work streams that would form the basis for our continuing work and developing recommendations. Those work streams are:

- ▼ design and operation;
- ▼ emergency preparedness for, and response to, incidents;
- ▼ advice to planning authorities; and
- ▼ examination of the Health and Safety Executive's (HSE's) and the Environment Agency's roles in regulating the activities on the Buncefield site.

4 This report concentrates on the third of these – the system for land use planning around major hazard sites in Britain.² It builds on the broad conclusions set out in paragraphs 80–86 of our Initial Report, but ranges more widely over the key components of the planning system around major hazard sites, not just HSE's contribution to it. The platform for this report has been two consultation exercises conducted in 2007 and our consideration given to the issues raised in responding. The first consultation document was *Proposals for revised policies for HSE advice on development control around large-scale petrol storage sites* CD211^(ref 2) published by HSE in February 2007. The second consultation document was *Proposals for revised policies to address societal risk around onshore non-nuclear major hazard installations* CD212,^(ref 3) published April 2007 by HSE on behalf of a government-wide task group co-ordinated by the Cabinet Office. Our responses to both these consultations can be found on the Buncefield website www.buncefieldinvestigation.co.uk. HSE's conclusions from CD211 were published on 4 December 2007 and from CD212 on 30 January 2008, both available on HSE's website www.hse.gov.uk.

¹ The Health and Safety Commission merged with the Health and Safety Executive on 1 April 2008. The roles and functions of the Commission have now transferred to the 'new' HSE.

² Our remit is to address the major hazards system regulated by the COMAH Competent Authority whose jurisdiction applies in England, Wales and Scotland and we use the term 'Britain' in this sense throughout the report. We hope that the Office of the First Minister and Deputy First Minister for Northern Ireland will nonetheless find our report useful.

The Board's approach

5 The impacts of the explosions and fires – physical, environmental, strategic and economic – were very extensive. As we said in paragraph 80 of our Initial Report, one of the starkest issues raised by the event is the location of sites with such major hazard potential alongside neighbouring residential and commercial development.

6 Major hazard sites are identified for regulatory purposes by the nature and quantities of the materials they handle, and are subject to the COMAH regime (see Annex 3). Many of these sites are essential for maintaining the supply of products which we rely on and take for granted. Buncefield was an important link in delivering fuel supplies for ground and air transport, especially for Heathrow airport. The strategic importance of major hazard sites must be balanced by high standards of safety and control.

7 The point we made in paragraph 63 of our Initial Report was that no harm can arise so long as there is no failure of primary containment of the fuel in its storage tanks. There needs to be a clear hierarchy underpinning the various safety, environmental and planning controls.³ The starting point for us is therefore the proper design, installation, operation and maintenance of the equipment intended to maintain primary containment, allied with a consistent approach to ensuring its integrity.

8 The potential for a major incident can only be reduced, not entirely eliminated, as there will always be some degree of residual risk in any industrial operation. The means of early detection of loss of fuel from a tank therefore needs to be integrated with appropriate secondary and tertiary containment measures⁴ to prevent the release from escalating into a serious incident. The Board published its conclusions and 25 recommendations on integrity management, incident prevention and control measures in its fifth report *Recommendations on the design and operation of fuel storage sites*^(ref 4) on 29 March 2007.

9 For top-tier sites, COMAH requires the preparation of both on-site and off-site emergency plans to minimise as far as possible the consequences of a major incident. The Board published its conclusions and 32 recommendations on emergency planning and preparedness in its sixth report *Recommendations on the emergency preparedness for, response to and recovery from incidents*^(ref 5) on 17 July 2007. The first of these recommendations is for operators to revise their emergency plans to take into account scenarios such as vapour cloud explosions and severe multi-tank fires that, before Buncefield, had not been considered credible by the sector or the Competent Authority. Subsequent recommendations deal with the necessary arrangements for managing on-site and off-site incidents.

³ Operators are required to control the major hazard risk preferably by its elimination, or by reducing it, or otherwise by protecting against it.

⁴ Secondary containment is enclosed areas around storage vessels (often called bunds) created usually by concrete or earth walls. Their purpose is to hold any escaping liquids and any water or chemicals used in firefighting. Tertiary containment includes things such as drains designed to limit the passage of chemicals off site and raised kerbs to prevent liquids that have breached the bunds from escaping into the general area around the site.

We also call for improved communications between the operators and the communities surrounding major hazard sites to ensure practical and realistic understanding of the risks and the arrangements for their control. These reports reflect a much wider perspective than hitherto towards the hazards that need to be considered in both design and operation of sites, as well as in emergency planning.

10 Further mitigation of the off-site consequences of a major incident is achieved by controlling the uses to which land in the immediate vicinity of major hazard sites can be put. In this context land use planning takes into consideration the extent of the danger posed beyond the boundaries of the site and the size and nature of any proposed development. It seeks to balance the need for making best use of the land available for development with the protection of those who will occupy or use these developments. It is this subject that this report addresses.

11 One response to the Buncefield incident, and the serious structural damage the explosion caused in the vicinity, was to call for a widened restriction to development around this and similar sites. Another response was to seek to limit the hazard potential of such sites in the light of proposed commercial and social developments around them. Such reactions are understandable but we believe the real need is to balance safety with strategic and economic considerations, and this is our general approach.

12 This balance has to meet rising expectations for provision of housing and employment on the one hand and on the other hand the rising expectation (especially after Buncefield) of being safe at home and at work. We consider that the land use planning system at major hazard sites has not kept pace with these changes in society and in Part 1 we call for a wide-ranging review. We also set out key areas meriting attention and, by way of introduction, an outline description of the constituents of the system. We go on in Part 2 to make more detailed recommendations where we believe it is necessary to provide clarity.

An overview of the land use planning system around major hazard sites

What we see

13 It was clear at the outset of our investigation that land use planning (taken as a whole, and not just HSE's role in it) was the most complex and sensitive issue to be addressed. The planning history of the Buncefield site and neighbouring developments (see Annex 4, reproduced from the Initial Report) tells its own story. The site opened some 40 years ago, before a specialised planning system around major hazard sites had developed. There were few houses and no commercial buildings in the immediate vicinity. Since then activities within the site have intensified, and as Annex 4 shows, both residential and commercial development has taken place outside. The purpose of the land use planning system is to control the uses to which land in the immediate vicinity of major hazard sites can be put and to be responsive to changes in risk presented by such sites. Prior to Buncefield the planning advice at flammable storage sites would not have covered the likelihood of a violent explosion. Equally, the risk control measures and the emergency response arrangements at such sites would not have been primarily directed at the possibility of a large flammable vapour cloud. This suggests that the system for giving planning advice around major hazard sites should be integrated with the regulatory system for controlling the risks of major hazards to humans and the environment created by the site itself, which has been the subject of our fifth and sixth reports.

Figure 2 Oil depot in Shore Street, Kirkwall. Note the proximity of houses, business premises and a public road



14 In considering the planning system around major hazard sites we have sought to address the following:

- ▼ Does the system balance safety and economic development appropriately?
- ▼ How well does it work?
- ▼ What might an exemplary system look like?
- ▼ Is such a system feasible and can it be justified in terms of cost?
- ▼ If so, what actions are required and by whom?

15 The fundamental principle of the land use planning system is that decision making is the responsibility of the local planning authority, usually the local authority. The planning authority reaches decisions on applications for development in the vicinity of major hazard sites having taken account of relevant social, economic and safety factors and generally determined in accordance with the development plan in that part of the country.⁵ The Competent Authority provides the advice about suitability on grounds of safety and environmental impact and its role is as adviser under the requirements of the Seveso II Directive,^(ref 6) not as decision maker. We believe the principle of decision making by the local planning authority supported by specialist advice is sound.

16 Beyond that, though, the system is showing its age after three decades of application. Economic activity has intensified and major hazard sites are usually of national strategic importance. Much of Britain is densely populated and non-nuclear major hazard industrial sites tend to be in areas of high population density where the demand for land to build houses, business premises and leisure facilities is intense. Building more houses is a high political priority, and such housing must be accompanied by employment opportunities and associated infrastructure.⁶ The planning bill currently under public consideration draws attention to the need to facilitate (speed up) strategic economic development. The national land use planning system around major hazard sites must balance the sometimes opposing pressures of local and national strategic economics and this clearly requires an understanding of the individual and societal risks created by the co-location of high-hazard sites and humans.

17 In our view the planning system around high-hazard sites has not adapted sufficiently in response to these pressures. We see a current system:

- ▼ that makes insufficient demands of site operators who create the major hazard risks;
- ▼ that does not consult site operators about potential developments in the immediate vicinity of their sites;
- ▼ where the processes and criteria used for land use planning and COMAH safety report assessment do not match;

⁵ Section 38(6) of the Planning and Compulsory Purchase Act 2004 requires decisions to be made in accordance with the development plan unless material considerations indicate otherwise.

⁶ For example, Dacorum Borough Council, the planning authority for the Buncefield site, has estimated that for the latest spatial plan for 12 000 new houses near to Buncefield to be viable, 18 000 new jobs will be needed.

- ▼ which has no means of taking account of the total population at risk in the immediate vicinity of the site;
- ▼ where HSE is not routinely consulted in the critical early stages of regional development planning, and when it is consulted is not always able to respond adequately;
- ▼ where the underpinning technical assessment processes need updating to bring into effect a significant body of HSE work relating to assessment methodologies;
- ▼ that takes little account of local site conditions in terms of actual inventories present, the standard of integrity management and the impact of the regulatory regime;
- ▼ that has a serious anomaly in not including gasoline pipelines; and
- ▼ that is poorly understood by the public and many of the stakeholders.

What we propose

18 We want to see a system that is more integrated and more consistent. We have structured our report into two main parts. Part 1 considers the organisation of the system and how it can be made more integrated. It identifies deficiencies in the current organisational process and points to where improvements can be achieved. However, it also recognises that the system runs across various parts of central and local government and that such improvements may not be easily achieved. We therefore recommend a wide-ranging review to deal with the limitations of the system in its present form, which we identify in this report, including those mentioned in paragraph 17.

19 Our preference is for a system where the site operator plays a much greater part in informing the planning authorities of the major hazards risks and their control measures; where key stakeholders such as the emergency responders have an input; and where the planning authority takes a clear and expert lead in the decision-making process.

20 We see the role of HSE as agreeing the methods by which the planning consultation zones are derived, including the practical information that needs to be considered by the planning authority, but no longer being responsible for the actual technical assessment. HSE should adopt the role of regulatory overseer to the new regime aligning with the Competent Authority's functions under the COMAH Regulations. It will be necessary to give public assurance that the site operators' input into the system is sensibly technical and objective, and we see HSE as providing the regulatory technical oversight in this regard.

21 We see a strong link between the revised planning requirements we are calling for and the requirements for preparing on-site and off-site emergency response plans, for which the COMAH Competent Authority is the enforcing authority. We see as inevitable the integration of the planning system around major hazard sites with the COMAH regime. This will deliver, for the first time, an integrated regime for the control of major hazard risks at industrial sites in Britain.

22 Part 2 of our report looks at the risk assessment process that provides the technical underpinning of the system and how it is applied in practice. Ultimately, risk assessment involves judgement but we also advocate the much wider use of a method known as quantified risk assessment if planning is to be more responsive

to the risks at major hazard sites. Quantified risk assessment (QRA) is not new and is already used in COMAH assessments and widely used offshore, particularly for comparing the risk impacts of different options. In the context of land use planning around major hazard sites it can be a tool for decision-making that enables the total local population at risk at specific sites to be taken into account, and can help deliver consistent planning advice across industry sectors. Taken as a whole, implementing all our recommendations (in Parts 1 and 2) will address the limitations we have identified in the current system.

What we consider to be the benefits

23 Why are we proposing organisational and technical changes to the current land use planning system at high-hazard sites? These changes will come at a price, so what do we consider are the main benefits of our proposals? Firstly, as we say in paragraph 18, our proposals address the deficiencies we have described. The resulting system should be better tailored to 21st century circumstances and deliver improved social and economic benefits.

24 In moving to a planning system based on assessing the risks on a site-by-site basis, what might success look like? We anticipate in the planning system a relationship between the major hazard site and its surrounding community and natural environment where:

- ▼ unnecessary blights on development opportunities are minimised;
- ▼ economic and/or social development⁷ of the area around a site can increase in response to improving the major hazard risk controls on the site;
- ▼ incorporating new knowledge and invention in building design and construction and other measures can reduce the vulnerability of the surrounding populations;
- ▼ account can be taken of the impact of risk reduction measures as the improved controls are applied;
- ▼ site operators can vary production throughputs, product inventories etc in response to suitable measures for increasing control of major hazard risks;
- ▼ site inspection and enforcement by the Competent Authority is targeted in the most appropriate way to give public assurance that the major hazard risks are continuing to be adequately controlled;
- ▼ degradation of the facilities, and other major changes on- and off-site are properly accounted for, as time goes by, in relation to their impact on the major hazard risk controls;⁸

⁷ This is analogous to the control of the design of the on-site buildings at major hazard installations. We envisage measures to adequately reduce major hazard risks to allow increased off-site development will be costly and address the economics of this in Part 1, paragraph 55 et seq.

⁸ The safety report is resubmitted on a five-year cycle and account needs to be taken of any changes that affect the major hazard risks.



Figure 3 View of the AZF chemical plant in the south-west suburbs of Toulouse, which exploded on 21 September 2001, killing 30 people

- ▼ the relationship of the hazard to the vulnerable population will be consistent and capable of comparison between sites, and therefore easier for the planning authority to explain its decision to local people why, for example, a new development will not be approved even though there are already buildings/homes in that area;
- ▼ highest risk aspects can be targeted, ie decisions can be taken as to where the greatest impact on the risk levels can be made to optimise off-site and on-site risks;
- ▼ technical considerations and assumptions underpinning COMAH regulation of industrial sites are the same as for planning purposes;
- ▼ of necessity site operators are consulted on impact of new developments to risk;
- ▼ societal risk is inextricably linked to the planning system around major hazard sites; and
- ▼ an integrated approach to regional/development/spatial plans can be taken by all stakeholders in the planning stages, rather than incrementally.

25 What are the potential drawbacks of our preferred system? One significant issue will be the period required for transition to a revised system, which will have significant implications for HSE, the industry, Communities and Local Government (CLG) and relevant ministers of the devolved administrations and planning authorities. In addition, a risk-based approach will not significantly reduce the consultation distances without the improvements to the control measures we have recommended in our fifth report on design and operation of fuel storage sites. Nonetheless, we are clear that the advantages in moving to a more integrated and consistent risk-based planning system around major hazard sites outweigh the disadvantages and therefore that the costs and effort involved in developing the system are justified. There will be technical imperfections in any revised arrangements, but no more so than the current system, and these should improve quickly as our other recommendations take effect and improved failure frequency data becomes available.

What needs to be done?

26 Much of what we say is not new but previous ideas for improvements have not always been taken forward. We judge the reasons include resource constraints and competing priorities within the relevant government departments.

27 We recognise that moving from the current system to one that is more integrated and responsive to risk will take time. It will require the commitment of local planning authorities and operators, and a greater involvement of the emergency responders, public representatives, and the regional agencies and business forums. As this field spans a number of policy areas and there does not appear to be a clear point of responsibility, we expect specific ministers in the relevant administrations to be given the lead.

28 Because any transition will take time, we want to see both the wide-ranging review of the organisation and the more detailed technical recommendations taken forward in parallel. We consider the review should begin without delay if we are to have a system fit for 21st century circumstances within a reasonable time frame.

29 The key objectives of economic development, planning policy and risk assessment must be balanced in the national interest. The Buncefield incident caused massive damage to homes and businesses and illustrated the devastating potential of major hazard sites. Equally, in the loss of half of Heathrow airport's fuel supply, it showed the strategic importance of such sites to the UK economy. Major hazard facilities such as refineries, fuel depots and chemical plants are generally of high strategic importance and tend to be cheek by jowl with large populations. Challenges to the restrictions placed on development in the vicinity of such sites are continuing to arise, as they have done in the past but perhaps with more frequency. There is no justification for settling for over-cautious restrictions as a long-term solution. But equally, in moving to a new planning regime that is responsive to risk, there will need to be public assurance that retrospective action will be taken where there are concerns for the societal risk around certain sites. Such retrospective action has been taken, eg in the Netherlands and France in response to the Enschede,⁹ and Toulouse¹⁰ disasters.

⁹ On 13 May 2000, the fireworks warehouse, operated by SE Fireworks exploded in Enschede, north-east Netherlands. 23 people were killed and nearly 1000 were injured.

¹⁰ On the 21 September 2001, Shed 221 storing ammonium nitrate on a plant operated by AZF exploded in Toulouse, SW France. 30 people were killed and nearly 9000 were injured.

30 We wish to make it clear that we are calling for a new approach that is applicable to all major hazard sites, as it is not sensible to artificially restrict changes to Buncefield-type sites only. We acknowledge that this is a sweeping stance to take and that progress towards this goal will need a serious and energetic cross-government effort, eg to get the different parties on board, some of whom will have had little or no past involvement in land use planning. The key players in the new system must also be able to incorporate economic factors into decision-making involving societal risk in development applications. Those principally involved – CLG and the devolved administrations, HSE, the planning authorities and COMAH dutyholders – will require some room to propose a programme for retrospective application that is practical and proportionate. Also, because there are national civil security issues attaching to many major hazard sites, Cabinet Office and the primary authorities for civil contingencies in the devolved administrations must become involved too. The priority now is to begin work on all fronts. Buncefield has served as a call for the difficulties to be confronted with a sense of urgency and priority.

Part 1

Improving the organisation of the land use planning system around major hazard sites

31 Site operators require planning permission from the planning authority and a Hazardous Substances Consent from the hazardous substances authority (HSA) (both are usually the local planning authority). HSE is a statutory consultee for both and either 'advises against' or 'does not advise against'. That advice has to be taken into consideration by the planning authority before making its decision. If approval is given, it may be with conditions. Enforcement under both controls is also the responsibility of the planning authority. This has led to difficulties in the past for planning authorities trying to enforce conditions recommended by HSE and in practice conditions are rarely attached to consents nowadays. However, the hazardous substances consent sets a maximum inventory of defined hazardous substances that can be held on site.

32 To expedite the issuing of hazardous substances consents to meet changes in regulatory requirements a system of deemed consents was agreed whereby operators could apply for streamlined consent for up to twice the average stored inventory on their site. This scheme was extended, we believe, at the introduction of COMAH as further sites came into jurisdiction. Since then, changes to other regulations, which provide definitions of generic categories of substance and qualifying threshold quantities which are in turn used by hazardous substances regulations, went through without deemed consent. However, the last consultation in 2005 on changes to the substances and quantities covered specifically by hazardous substances consent – prompted by changes to the Seveso II Directive – sought to rule out deemed consents. We understand that industry responses were not in favour of this and the changes proposed have yet to be implemented. The work by HSE to map the revised consultation distances around all the sites with deemed consents is not yet completed.



Figure 4 A view across the ex-Royal Naval Air Station and the oil storage tanks – Portland, Dorset, Southern England. The end of Chesil Beach can be seen on the left of the picture. Weymouth is across the bay joined by a road bridge, shown above the tank farm

33 Once hazardous substances consent has been granted, the HSA passes the papers to HSE who defines on a map the area within which planning authorities have to consult HSE for other planning applications (the 'consultation distance'). HSE also sets three zones within the consultation distance which are the basis for HSE's advice. Ultimately, HSE will either 'advise against' or 'not advise against' as it does for hazardous substances consent. (See Annex 4 for more information on this subject.)

34 Subsequently, when individual applications are submitted for off-site developments that are within the Consultation Distance, the planning authority has to make the decision having taken advice from HSE. Where the planning authority approves an application against HSE advice, and an opportunity has been provided for HSE to explain the nature of the risks to the planning authority, then HSE can invite the Secretary of State for CLG, and the relevant minister in Wales, to 'call in' the decision for review. In Scotland, a planning authority wishing to proceed against HSE's advice has to notify the planning application to the Scottish ministers who may call it in for their own decision.

A more integrated system

35 The first area we believe merits attention is the way in which major hazard risk assessment under the COMAH regime and the general planning system around major hazard sites operate together. Plainly, these two systems are essential components of the decision-making process but they are not consistent.

36 The first example of inconsistency derives from HSE having to conduct its technical assessments on information provided in applying for a consent. HSE has expressed concerns that the information is not always adequate for its purposes and the timeframe in which it is expected to formulate its advice too short. More fundamentally, HSE bases its risk/hazard assessment on the maximum consented quantity, which can significantly exceed the quantities actually stored. Also, where companies have generic consents to store substances, HSE bases the assessment on the most hazardous substance within that generic consent.

37 Both situations – maximum consented volumes and most hazardous substance – can produce larger zones and consultation distances than the actual circumstances may require. Companies are sometimes prepared to work with HSE and planning authorities to take steps to reduce the large consented inventories but this is not always the case and it is not legally required of the operator. Larger consented quantities are valuable to companies and there are difficulties for the planning authorities in reducing these because of compensation issues. Uncertainty also arises where consents exist but have not been used, or where operations have ceased and future intentions are not clear. This is because unless specific steps are taken to revoke or withdraw it, the consent remains with the land.

38 We understand these issues and others have been reviewed and options for change have been produced by HSE. The outcomes of the review were shared with the cross-government task group considering societal risk (see paragraph 4) but we are unsure whether any further action was intended.

39 Another inconsistency between the two regimes is what legally constitutes a change of use from the point of view of the planning system and what changes might be significant from a risk point of view. This is because the planning system defines a range of 'use classes', and change of use within a single class does not generally require new planning permission. Some developments involving change within a single planning use class would alter HSE's advice had it been part of the original application, for instance because it increases the number of people present or introduces people of different vulnerability to the risks presented by the site.

However, such changes will not often be considered by HSE because its advice is, generally speaking, only given for the use described in the original application, and not for others in the same planning use class.

Societal risk

40 Societal risk is an established concept for taking into account the total population at risk. A report in 1983^(ref 7) noted that people perceive ‘high consequence hazards’ as different from hazards which do not have the potential to injure many people at once. A number of multiple fatality industrial incidents over the last 40 years illustrate this point, and as with Flixborough¹¹ and Piper Alpha,¹² have led to improvements in standards of major hazard risk control and changes to the regulatory system. Even where the individual risk is low, societal risk can remain significant and be the main driver for risk reduction measures. Following the Buncefield incident, where fortunately there were no fatalities, there has been intense public reaction due to the extreme damage to the vicinity, the disruption to national fuel supplies, and the losses sustained by residents and businesses.

41 In our Initial Report (paragraph 86) we noted the incremental development around Buncefield and observed that cumulative risk should receive more attention given that the system for generating planning advice currently focuses on developments subject to planning approval as they arise. Incremental development around Buncefield is described in Annex 4, which depicts all building development by type from the mid-1960s to 2005.

42 Our Initial Report acknowledged the cross-government work on this issue being co-ordinated by the Cabinet Office which began before the Buncefield incident. That work informed a consultation exercise (CD212) which addressed societal risk and raised questions about how it could be applied in practice. We welcomed this first public consultation on societal risk.

43 Our response to CD212 (available on the Buncefield Investigation website) made clear that we viewed land use planning and societal risk as inextricably linked. We concluded that societal risk should be integrated into the land use planning system around major hazard sites so that it registers and responds to the cumulative effects of serial planning decisions. We also supported the idea that HSE should be consulted by planning authorities during the preparation of development plans so that information about societal risk could be considered at this stage. This does happen to some extent at the moment but HSE’s input to development planning is inconsistent and needs placing on a more formal basis. The important contribution HSE should make in planning around major hazard sites should also be emphasised in the planning statements issued as guidance for planning authorities by CLG and the devolved administrations.

44 The summary of findings from CD212 (published by HSE on 30 January 2008) shows that a large majority of respondents were in favour of taking account of societal risk in both the assessment and provision of on-site control measures and the decision-making process for land development around sites. Furthermore, most

¹¹ In 1974 an explosion at the Nypro caprolactam plant at Flixborough killed 28 workers and led to the establishment of the Advisory Committee on Major Hazards (ACMH). See Annex 6.

¹² In 1988 a series of explosions that followed an initial release of gas from a compressor module on the Piper Alpha North Sea platform east of Aberdeen killed 167 workers and two rescuers.

respondents agreed that societal risk should be considered when drawing up local development plans as well as when considering individual planning applications.

45 Finally, we observed that treatment of societal risk in CD212 was very general and qualitative and that more detailed work is needed to resolve technical issues and achieve effective, workable policies and procedures. In short, we call for societal risk, whatever the current deficiencies in its estimation and application, to be integrated into the land use planning system around major hazard sites. Ministers agreed, following the consultation on CD212, that HSE should include societal risk in its land use planning advice. HSE has indicated that the next stage of the exercise is to focus on more detailed consultation with the planning authorities to establish detailed procedures. We welcome this general commitment from government and ask that the means of implementing it is pursued without delay.

Roles, contributions and collaboration

46 The third area meriting attention is to look at the roles of the main players in the system and how they interrelate. In paragraph 15 we stated our support for the fundamental principle of the land use planning system, namely local decision making. That said, there is a lack of clarity in some of the roles in practice and the contributions from the main players are not optimal. The work of the Advisory Committee on Major Hazards (ACMH – see Annex 6) was groundbreaking in its time, but we consider that their principles should now be revisited. We have argued earlier that the pressures on the system have intensified severely since the ACMH era and this justifies a wide-ranging review of roles and contributions.

Contribution of site operators

47 Site operators have limited involvement in the off-site planning process once they have once received their hazardous substances consent from the HSA. Little is demanded of them as far as the land use planning system around major hazard sites is concerned, despite their unique knowledge of the site risks and their responsibility under COMAH for systematically assessing their operations for major hazard potential, including those that could have off-site consequences. For ‘top-tier’ COMAH sites this assessment process is formalised in requiring a safety report to be submitted to the Competent Authority.

48 In our previous reports we have called on operators to improve their risk controls and enhance their emergency preparedness and support to off-site emergency response planning. It is therefore entirely consistent for operators to also conduct the main risk assessment process for land use planning and thereby contribute more effectively to the information on which the planning authority will make its planning decisions. In return they will be informed and consulted about relevant developments on a more formal basis than at present.

Role of HSE

49 Currently it is HSE that designates the consultation distance based on the information it receives from the planning authority arising from the operator’s application for a hazardous substances consent. Following what we have said above, the call should be made on site operators to undertake the necessary technical assessments from which the risk zone contours would be derived. It would be more consistent and effective for HSE to set the standards for technical contributions by COMAH operators to the planning system around major hazard sites, and to check that the operators do so adequately. We understand that in the Netherlands there is a prescribed methodology which site operators are required to follow in conducting assessments for land use planning purposes (see Annex 7).

50 Such an approach in Britain would ease the demand on HSE's technical resources and bring alignment with the COMAH regime, placing the responsibility for the risk assessments on the operator who creates the major hazard risk in the first place. HSE should then become the national custodian of risk assessment methodologies and standards. In that role it should systematically gather and analyse information about major incidents nationally and internationally. HSE should also have a systematic approach to reviewing assessment methods, gathering such information as it needs to inform this process. For site-specific situations HSE's role should be to check assessments conducted by the site operator against the standard methodology, but we believe its role should not be to conduct the assessments itself.

51 With respect to planning authorities HSE's role is formally to act as adviser but the reality must look different to many planning authorities. Nominally, they reach decisions on planning applications having considered all relevant factors, of which advice from HSE is but one. However, as local democratic representatives, it is difficult for them to go against negative safety advice. Furthermore, HSE has the option where its advice is not taken to invite the Secretary of State to 'call in' the application. Historically this option has been rarely exercised; but there are no published criteria HSE uses for so doing, and in consequence HSE may sometimes be perceived as offering advice while having available a further sanction if that advice is not followed. HSE also becomes involved in negotiations with developers, planning authorities and communities where planning advice is problematic, although it is unclear to us how this actually aligns with HSE's responsibilities. In any case this conveys a strong impression that in reality, HSE is in overall control of the planning decision.

Role of planning authorities

52 The planning authorities take decisions on planning applications having taken into account the interests of the local community (both business and residential), the interests of the developer and relevant safety and environmental considerations. This includes advice from HSE regarding developments within the consultation distance of a major hazard site. Of recent years this advice has been available in the vast majority of cases through a software tool developed by HSE. This is known as PADHI (Planning Advice for Developments near Hazardous Installations).

53 HSE advice, though, only takes account of the potential to cause human harm because its remit is limited to occupational health and safety. No account is taken of damage to property and disruption to personal lives and economic activity, but we believe it should and that the Buncefield event amply demonstrates why. If a wider view of 'harm' is taken, then the planning authority will need to seek advice from other organisations in addition to HSE.

54 The above briefly illustrates the complexity of the decisions planning authorities can be faced with. There is guidance to planning authorities in the various administrations¹³ on how to balance the various considerations in reaching their decisions, but not sufficient guidance on how to balance safety considerations in relation to other issues around major hazard sites – there needs to be greater clarity and transparency over how decisions are reached. Decisions that will increase the population around major hazard sites should be clearly explained to all those

¹³ In Scotland, Circular 5/1993 describes HSE's advisory role regarding health and safety grounds for refusal or imposing conditions. General guidance on determining planning applications, including whether a consideration is material and the weight to be given to it, is in Scottish Planning Policy 1 – the Planning System. In Wales, Annex A of National Assembly for Wales Circular 20/01 provides guidance on the role of HSE in relation to planning applications.

affected. More resources may be required to assist planning authorities to interpret specialist advice and to fully understand the wider impacts of their decisions and we return to this point in Part 2.

A more collaborative approach

55 The difficulties sketched out above suggest that more interaction and iteration should be designed into the planning process. The Dutch operate a system that brings together the main interested parties in an attempt to reach mutually satisfactory conclusions (see Annex 7) and the French are developing a similar system. In our response to CD212 we supported as eminently sensible the idea mooted of operators, developers and planning authorities getting together to consider the implications of an intended development before difficult issues related to societal risk arose. We believe this more collaborative approach merits closer examination, not just confined to societal risk issues.

56 For problematic applications the planning authority could bring together the developer, the site operator, representatives of the local residential and business communities, relevant regulatory bodies and the various organisations represented on the Regional Resilience Forum, and other relevant stakeholders, eg insurers. The planning authority, while retaining the responsibility for the final decision, could then act more in the role of processing the expert advice it receives before coming to a decision. This would go a long way to securing greater transparency in the planning decision making around major hazard sites. HSE for its part can suggest practical strategies to reduce risk and offer advice on ideas being considered. It may be that modest changes and concessions by some of the parties present will enable the development to proceed. With this collaborative approach to reaching decisions, the consultation distance and the zones within it need not act as such a rigid determinant of HSE advice, provided the safety implications of an intended solution are recognised and accepted by all parties. In this way HSE can remain in a genuinely advisory role and the question of call-in should not arise.

57 This chimes with a wider point made in our sixth report^(ref 5) (in paragraphs 26–27 and Recommendations 8 and 9 under the heading ‘Warning and informing the public’) which reinforces the need to maintain continuing communication between the site operator and the residents and businesses in the vicinity of major hazard sites. By its very nature, such communication requires joint working with the local authority and integration with the plans of Category 1 responders.¹⁴ The essence is to establish an ongoing relationship between site operators, those who in the worst circumstances could be affected by their operations and those bodies with key responsibilities for emergency planning and response. Were such arrangements in place, then the collaborative approach to land use planning decision making we are suggesting should be a relatively straightforward extension to it.

¹⁴ Category 1 responders are organisations at the core of the response to most emergencies (eg emergency services, local authorities, NHS bodies and the Environment Agency/Scottish Environment Protection Agency). Category 1 responders are subject to the full civil protection duties under the Civil Contingencies Act 2004. Category 2 responders are other organisations that are likely to be involved in emergencies such as HSE, utilities and transport companies.



Conclusion

58 We conclude that land use planning policy and practice has developed in a piecemeal fashion and this part of the report has illustrated our view in three areas. Our concern is that the current system has not kept pace with the intensification of pressures on it and does not fully serve the local and national interests in striking the best balance between safety for local communities and maintaining economic activity. Our observations are not intended as criticism of any of the individual organisations involved; the issue is the cohesiveness of the system as a whole.

59 We are therefore calling for a wide-ranging review of the planning system around major hazard sites. We believe that many people already acknowledge the deficiencies we have identified (and more) and that ideas for improvements have been proposed but not yet taken forward. We want to see a review conducted with urgency independent of other recommendations in this report. The review should at a minimum make recommendations that deliver a more integrated system that incorporates societal risk, and better balances and harnesses the contributions of the main parts of the system.

Figure 5 Flames are seen behind a house next to the Buncefield oil depot on 12 December 2005 in Hemel Hempstead, England

60 In preparing our responses to CD211 and CD212 and in developing this report, we reached a number of detailed conclusions that we set out below. We expect the review we call for to include the following:

- ▼ site operators¹⁵ – those that create the major hazard risks and manage the control measures – should play a new and significant part in the land use planning process;
- ▼ societal risk should be considered in land use planning applications;
- ▼ the land use planning system around major hazard sites should not just consider direct physical harm to people but should have regard to the wider consequences and incorporate other harms to communities, including those arising from the potential impact to property, livelihoods, amenities and the environment;
- ▼ HSE should be consulted by planning authorities during the preparation of development plans and provide relevant advice so that information about societal risk can be considered at this stage;
- ▼ planning legislation and land use classes should be reviewed and amended as necessary to ensure that proposed developments of significance to the risk assessments within the consultation distance of COMAH sites always become subject to the revised system – including changes of use to, or significant changes in population numbers at, existing buildings;
- ▼ improvements should be made to the standard of hazardous substances consent papers received from planning authorities and the short times specified within which HSE is expected to respond to these;
- ▼ HSE should systematically gather and analyse information about major incidents nationally and internationally. It should also systematically review risk assessments methods for use in the land use planning system around major hazard sites, gathering such information as it needs to inform this process.

Recommendation 1 We recommend a cross-government and wide-ranging review of the land use planning system around non-nuclear major hazard sites in Britain. The review should include:

- ▼ the system for hazardous substances consents;
- ▼ the system for determining planning applications around major hazards sites;
- ▼ the relationship between planning applications around major hazard sites and development plans and planning;
- ▼ the scope of hazardous installations to which the land use planning system should be applied; and
- ▼ the integration of societal risk into the planning system around major hazard sites.

¹⁵ Site operators would normally be dutyholders under the COMAH Regulations and therefore be responsible at the outset for identifying the major hazard scenarios, calculating the likelihood and degrees of harm arising from them, and for establishing the preventive or mitigatory measures to reduce risks on the site as low as reasonably practicable.

The aim of the review should be to revise the planning system around major hazard sites in Britain to produce a more consistent and transparent system across the non-nuclear, onshore major hazards sector. The system should be responsive to levels of risk presented at each site. It should ascribe responsibilities to dutyholders and the relevant authorities, including in the devolved administrations, in a proportionate and targeted manner. A minister should be responsible in each administration for seeing the review is carried out.¹⁶

The review should be commenced without undue delay in order to implement its conclusions within a reasonable timeframe. Wherever feasible, work on revising the elements of the system should be undertaken simultaneously rather than sequentially.

Recommendation 2 The review should take account of our approach to improving the control of major hazard risks at major hazard sites.

Our approach integrates:

- ▼ integrity levels of the major hazard sites in relation to containment of dangerous substances and process safety;
- ▼ mitigation against the effects of a major incident on off-site populations and installations;
- ▼ preparedness for emergency response to limit the escalation of potential major incidents;
- ▼ land use planning; and
- ▼ the regulatory system for inspection and enforcement under COMAH and other relevant law.

Economic considerations

61 Further support for a collaborative approach comes from the economic standpoint because of the interdependency between containment measures, emergency preparedness and controlling the uses to which land in the immediate vicinity of major hazard sites can be put. This means that the risk of loss of containment, the level of which is defined by on-site measures, needs to be considered in tandem with land use planning and societal risk, as both affect the overall level of risk posed by a major hazard site. If land use planning and loss of containment risks are considered separately then it is possible that land use planning restrictions could be too stringent, constraining economic development and the building of homes or amenities beyond what is necessary to achieve an acceptable level of risk.

62 So, as we remarked in our response to CD211, the economic case for land use planning should capture all the variables in the crucial measures of the costs and benefits of restricted development, including costs to the industry and wider society. There are many potential economic models of how to represent such an integrated system. Recommendation 3 calls for a comprehensive assessment of the economic costs and benefits inherent to the planning system around major hazard sites.

¹⁶ In Recommendation 10 of our sixth report we call for a minister to be responsible, *inter alia*, for seeing that lessons learned from major incidents – and therefore our recommendations – are carried out.

63 Another way of looking at this is to consider who creates the risk around major hazard sites. Clearly, at new sites this is the site operator. At existing sites those who decide to develop the surrounding land could be deemed responsible for at least increasing the societal risk of those exposed to the major hazard. Also HSE's analysis of replies to CD212 states that most respondents favoured the person or organisation causing the increase in risk to pay for any additional measures.

Recommendation 3 We recommend that the economic case for a revised land use planning system around major hazard sites arising from the wide-ranging review should consider the full range of the costs and benefits of restricted development, including costs to the relevant industry sectors, local businesses and regional economies, and the use of land for housing and public amenity.¹⁷ This should be undertaken as part of the wide-ranging review called for in Recommendation 1.

64 We have noted some early thinking around use of market-based mechanisms identified in HSE's economics working paper.^(ref 8) Such mechanisms would involve risk trading or compensation for risk, providing funds for risk reduction measures, and allowing developments of economic or social importance to go ahead, while ensuring that effective risk management takes place to offset any increase in risk.

65 One difficulty with such market-based mechanisms is the incremental nature of containment costs. If they are large, a 'free rider' problem can arise, whereby no developments go ahead until one developer pays for the next level of containment measures. At this point other developers may develop land capitalising on the containment expenditure of another. Were developers to form an alliance, covering containment costs jointly, then this problem would become less significant. However, one consequence may still be that land is not developed within the most beneficial timescale.

66 Another source of difficulty arises from site operators knowing more about the risks of containment failure than the surrounding community. To address this, the Competent Authority could make available information on the levels of risk posed by each site to developments located within the consultation distance. Doing so would facilitate the use of market-based mechanisms and support the collaborative approach to planning decision-making we are advocating. Such an approach to risk information would also allow more informed understanding of why certain planning decisions are taken – eg to not allow further development in an already populated neighbourhood next to a site. This will be of interest to insurers, to potential developers, to business risk managers and to public representatives having an interest in societal risk within their communities, although there may be difficulties where security issues preclude the release of certain information.

67 Recommendation 4 acknowledges that, notwithstanding such difficulties, these ideas should be considered further so that an economic appraisal can be conducted for a system that incorporates both societal risk and the probability of containment failure as part of the wide-ranging review of the land use planning system around major hazard sites we are advocating.

¹⁷ See the Board's response to the regulatory impact assessment accompanying CD211, available on the Buncefield website www.buncefieldinvestigation.co.uk.

Recommendation 4 We recommend that the use of market-based mechanisms identified in HSE's recently published economics working paper,^(ref 8) are considered further to assess their potential application within the revised land use planning system around major hazard sites. We would expect HSE to co-ordinate this work with the wider economics community having an interest in the planning system.

Public understanding

68 We believe that there is insufficient public understanding of the planning system in general, even among key stakeholders, though the diligent can quarry such information from the web. Lack of basic understanding is compounded by the lack of clarity in roles of those involved. It is important to make the system more comprehensible if it is to command respect. The planning bill that is under current scrutiny presents an opportunity to develop greater public understanding of the planning system, although it is intended to apply only in England and Wales with just some minor consequential changes in Scotland. The review we are recommending provides a further excellent opportunity to advance public understanding in the planning system around major hazard sites, by using web-based materials and other media to explain the revised system in an accessible way to lay readers.

69 While we believe that HSE is an obvious candidate for developing a guide to planning around major hazard sites, having produced a considerable body of excellent public guidance, the Department for Business, Enterprise and Regulatory Reform (BERR) and the devolved administrations have significant and differing interests and should play a strong part in producing the guidance we call for in Recommendation 5.

Recommendation 5 We recommend that the workings of the revised land use planning system around major hazard sites are described in guidance in a form accessible to the general public. The guidance should have ownership of all the key government stakeholders, including the devolved administrations.



Figure 6 Aerial picture of oil storage tanks at West Thurrock, east of London. Note the London orbital motorway (M25) on the left of the picture and occupied commercial buildings towards the top. The tidal flats of the River Thames are at the bottom (north) of this picture

Part 2

Risk assessment and other technical issues

70 In this part we argue in favour of adopting a consistent approach for the land use planning system around major hazard sites in Britain which is responsive to the risks derived from specific sites. It examines risk assessment, the key subject which provides the technical underpinning for the system, and some related technical issues. Risk assessment in this context is the computational tool for determining the balance between the control of risk to people, the environment and property, and the development of land for social and economic benefit. This important contribution has come principally from HSE through its expertise in risk assessment and its provision of advice to the planning authority based on that expertise.

71 Attention was first drawn to the disaster potential of major chemical installations in 1967. This led in time to a requirement on the planning authority to consult the health and safety regulator on proposals to develop land in the vicinity of major hazard installations. This procedure was given particular impetus by the Flixborough disaster in 1974. Fuller background appears in Annex 6.

72 HSE's contribution, based on assessment calculations, is to set the consultation distance round major hazard sites within which the planning authorities are required to ask for HSE's advice on any intended developments and to divide the area within this into three zones. The technical basis on which this is done was documented in 1989 in the risk criteria document.^(ref 9) Although only published as a discussion document, this has since been used by HSE as the basis for its policy in various settings, including at planning appeals. There have been subsequent refinements, but the main features remain essentially unchanged.

73 As pointed out in paragraph 3 of Annex 5, risks generated on site can only be reduced but they cannot be eliminated, and there will be some degree of residual risk off site. HSE's assessments for land use planning purposes assume that all necessary steps have been taken by the operator to comply with relevant environmental, safety and health regulations and the measures described in the COMAH safety report. The risk assessments for land use planning are the residual risks under these circumstances.

Risk analysis techniques for establishing land use planning zones

74 All such techniques need to consider three aspects in making an assessment. The first is to identify events – fires, explosions and toxic releases – that could have major hazard potential. Next the consequences of each event need to be estimated in terms of human harm. Finally frequencies need to be assigned to such events using published sources of failure rates, for instance, and presented as the chance per year of such an event occurring. Generally speaking, the more severe the event the less its likelihood but the greater its consequences in terms of human harm.

75 From this it can be seen that risk assessment requires difficult judgements based on formulating assumptions, estimating probabilities of infrequent events and incorporating the uncertainty surrounding these. Underestimating the likelihood of major events may lead to unacceptable levels of risk to those in the vicinity of a major hazard site, while overestimating it may lead to unnecessary blighting of otherwise economically viable land. Risk assessments have to be conducted to a high standard to be credible to planning authorities and we therefore say more about the current techniques and judgements involved before introducing our conclusions and recommendations.

Simplified risk approach

76 In the years following the Flixborough incident HSE adopted a hazard-based approach for setting zone boundaries: a site-specific risk-based approach was not generally feasible at that time. This approach is nevertheless risk based, albeit in a simplified and semi-qualitative form. For clarity, we will use the term ‘simplified risk assessment’. The aim of this approach is to achieve a separation between developments and the site which provides a very high degree of protection against the more likely smaller events, while also giving very worthwhile (sometimes almost total) protection against unlikely but foreseeable larger scale events. This approach was endorsed by the Advisory Committee on Major Hazards at the time, and became one of its fundamental principles for controlling major industrial risks in built-up areas.

77 To apply the approach in practice involves the identification and selection of a single major event – fire or explosion. Its effectiveness depends to a considerable degree on the identification of the most appropriate worst-case event that dominates the risk scenario. Then a separation distance is determined based on a ‘dangerous dose’, a term defined by HSE (see Annex 8) which spans fire, explosive and toxic events. The risk assessed in this way is that of an individual at a particular place being exposed to a dangerous dose or worse.

Quantified risk approach

78 Planning enquiries have, over the years, concluded that HSE’s advice should take specific account of the likelihood of death or injury to the public. HSE has responded by developing techniques to quantify the risks associated with hazardous installations, based on a range of foreseeable failure scenarios. The method is widely used for toxic releases, such as the unintentional loss of containment of chlorine gas being stored on a chemical plant. The risk to an individual in a specific location is the summation of the risks arising from these different scenarios. This process is known as quantified risk analysis (QRA) and we refer to it as the QRA approach. The 1989 risk criteria document sets out HSE policy, and the reasons for criteria adopted in this approach, and the Cullen Report^(ref 10) in 1990 on the Piper Alpha disaster strongly advocated the use of QRA for operational safety and risk reduction purposes (see Annex 6). As a result numerous techniques have been developed for applying QRA to major hazard risk control.

Estimation of consequences

79 HSE, in doing both simplified and quantified risk assessments for land use planning purposes, uses ‘dangerous dose or worse’ as its measure of consequence in terms of human harm (see Annex 8). Most other organisations and countries use a measure based on the risk of fatality and as does HSE it in its tolerability of risk guidance.^(ref 11) The use of ‘dangerous dose or worse’ has implications which we will return to in paragraphs 97–99 in terms of being able to compare risks and therefore achieve broadly similar advice in response to broadly similar risks.

Comparison of the two approaches

80 In 1998 HSE initiated a fundamental review of its involvement in land use planning (Annex 9). A subsequent project to implement the findings of the fundamental review examined HSE’s use of simplified and quantified risk analysis. The resulting report identified key advantages and disadvantages of each approach and some of these are summarised below. It made a range of recommendations to improve the consistency of simplified risk analysis, where this is adopted, but also urged HSE to continue to perform research into QRA methods so that some of the reasons for having to resort to the simplified approach could be resolved.

81 In summary, simplified risk analysis is usually appropriate where:

- ▼ there is insufficient information for QRA or some of the available information contains a high degree of uncertainty;
- ▼ the surrounding population density and demand on land use are low; or
- ▼ it would generate similar results (in terms of the sizes of land use planning zones and the advice given) to those from QRA, as might be presumed where there is a single risk source. After Buncefield, this would be unlikely at COMAH top-tier sites.

82 There are also objective criticisms to the simplified risk approach, a number of them put in the 1989 risk criteria document,^(ref 9) such as:

- ▼ vagueness in terminology, for example ‘a very high degree of protection’, ‘worthwhile (sometimes almost total) protection’, ‘unlikely but foreseeable’;
- ▼ the resulting protection can be excessively restrictive in terms of land use;
- ▼ some arbitrariness and lack of transparency in selection of the worst-case event, and through this, potential inconsistency in treatment between installations; and
- ▼ the difficulty of comparing the degree of protection achieved with that for other everyday risks.

83 A further review following the 1998 fundamental review noted that if a site has both hazards that are analysed by the simplified risk approach and hazards that are analysed by QRA it is very difficult to add the two together to get an overall risk from the site.

84 The advantage of QRA, coupled with use of appropriate risk criteria, is that it deals with the objections to the simplified approach set out in the two previous paragraphs. However, use of QRA is not without its own difficulties. For example, assigning frequencies to rare events, such as major equipment failures, can introduce a high degree of uncertainty. Also the resources required for performing full QRA will be greater than for the simplified approach (though the time and costs are much less than they once were).

Evolution of analysis techniques

85 A large number of major hazard sites in the UK have been subject to simplified risk analysis. The majority of these sites, about 650, store or handle flammable materials such as liquefied petroleum gas and petrol.

86 Because the QRA approach is to be preferred wherever the standard of data and the computational effort justifies it, the first transition to a QRA approach occurred with toxic substances in the early 1980s, following criticism of the simplified risk approach at a public inquiry. QRAs for flammable substances, though, are more complex because of the range of events (flash fire, jet fire, pool fire, vapour cloud explosion) that have to be considered and allocating frequencies to these events is subject to significant uncertainty. HSE has devoted considerable effort to developing QRA techniques for flammable substances but its adoption has not yet been achieved on a routine basis.

87 However, there are examples where the transition has been made for flammable substances. For many years the land use planning zones for natural gas pipelines were set as simple multiples of a pre-calculated distance. We understand that these zones were criticised by the sector and HSE committed to moving to a more transparent risk basis. Methodologies were developed to make the zones round all these pipelines fully risk based and these have now been used for land use planning decision making on the natural gas network for some five years.

Consistency and potential improvements

88 Amid all the technical complexity we believe it important to have a clear guiding principle to pursue. The necessary principle is that assessments conducted for individual sites should compare the risks presented in a consistent way and thereby result in broadly similar advice being given in response to broadly similar risks.

89 There are a number of current shortcomings to the present system which cover the assessment techniques and the inputs to these calculations, and influences or circumstances which might vary from one site to another. The consequence in each case can be that the actual risk presented by a specific site is not properly assessed, thereby potentially leading to inconsistency. The ones that have come to our attention are:

- ▼ the continuing use of simplified risk assessment for most flammable materials rather than QRA;
- ▼ the use of ‘dangerous dose’ for consequence estimation rather than the risk of fatality;
- ▼ no account taken of the total population at risk within the vicinity.
- ▼ little account taken of standards on site and the quality of integrity management, nor credit given for risk reduction measures;
- ▼ little account taken of the impact of the regulatory regime;
- ▼ assessments based on consented quantities and the ‘worst in class’ substance in a generic category, and not on the actual inventories; and
- ▼ drawing a distinction between those already at risk in the proximity of a site and new developments.

90 We recognise that there must be confidence that the risk reduction measures and quality of site management have some permanence. Permissions for developments, once granted, cannot be withdrawn as a result of a decay in standards on site. However, there are ways of tackling this which we consider below. We also recognise that pursuit of the consistency principle has practical and resource implications which we address later.

A preferred way forward in reaching planning decisions

91 In a number of places in this report we have identified weaknesses in the current system when applied to modern-day situations. We have also identified improvements that are quite self-evidently needed. In Recommendation 1 we call for these to be addressed in a review. We also have become convinced, over the two and a half years of our work, that an integrated system for control of major hazard risks is needed to bridge the gaps and remove the inconsistencies that have developed over the years in the various parts of the system for controlling major hazard risks in the UK, eg between land use planning and COMAH regulation. We address this aspect in our second recommendation. Below we address our preferences for the future planning system around major hazard sites.



Figure 7 Polmont, west of Edinburgh, Scotland: skiers descend Polmont artificial ski slope run by Falkirk District Council against a backdrop of the Grangemouth oil refinery

92 We call for the recommendations below to be dealt with in conjunction with the wide review and to encourage those responsible to immediately start work on the things that can be tackled right away. Our recommendations below are based on what we have learned of the planning system, and are informed by the recommendations in our fifth^(ref 4) sixth^(ref 5) and seventh^(ref 12) reports, and also the ongoing investigation into deep root causes, and into the regulation of Buncefield by the Competent Authority. To test our thinking we commissioned an expert report on what a system would look like that was consistently applied in the major hazards sector (and based on actual conditions), and integrated within an overall system for control of the industrial major hazard risks. We also wanted to learn whether such a system would be feasible, and whether it is in operation anywhere else.

93 The work encouraged us that the recommendations we call for below are feasible and beneficial. We outline the aims and conclusions of the work in paragraphs 121–126 (‘Application to major hazard sites’). A more detailed summary of the report is at Annex 10.

94 The conclusion from earlier in this part of our report is that quantified risk assessment should be employed and we call for this in Recommendation 6. There are numerous applications of QRA and we provide an example of an approach at a Buncefield-like site in Annex 10. Given the range of QRA available, we do not envisage any major hazard sites where the data are insufficient or too uncertain, or the required effort and resource are not justified to apply a quantified risk-based approach to land use planning. The key impacts of its introduction will be to achieve consistency of approach across all major hazard sites in Britain, and to align with the COMAH regulatory system. The transition to QRA for toxic substances occurred some time ago and we acknowledge that HSE has devoted considerable effort to developing QRA techniques for flammable substances. Its adoption, though, has not yet been achieved on a routine basis.

95 Buncefield has created an opportunity for HSE to commit to this transition without encountering undue resistance from other stakeholders. Where there are significant uncertainties in important data, then research should be commissioned to resolve them and sharing of incident frequency data should be commenced without delay. We address this in Recommendation 7. We would expect the industry, in the light of Buncefield, to share frequency data without the need to change legislation. We understand there will be an EU Directive requiring sharing of incident frequency data, which in principle we welcome.

96 We also believe that the resource premium for undertaking site-specific QRA as against simplified risk analysis is not as significant as it once was. With commitment in principle now and the early commissioning of the necessary research, the sector should be in a position within five years to make the transition in practice to use of QRA for flammable substances.

Recommendation 6 We recommend HSE adopts a policy for the consistent application of formal risk assessment of land use planning applications around major hazard sites that is responsive to levels of risk at particular sites.

Recommendation 7 Priority should be given to improving source terms and frequency data relevant to QRA at major hazard sites. This should include:

- ▼ improvements in defining major hazard scenarios at flammable storage sites called for in Recommendation 1 of our sixth report;^(ref 5)
- ▼ improving recording and sharing of incident data and improvements to investigation of root causes of incidents and near misses called for in Recommendations 23–25 of our fifth report;^(ref 4) and
- ▼ integrating the outcomes of the explosion mechanism project group set up in response to our seventh report.^(ref 12)

We call on the COMAH operators and the Process Safety Leadership Group¹⁸ to take the lead in delivering these outcomes, and the Competent Authority to give technical support.

Estimating consequences of an event

97 Paragraph 79 explains that for land use planning purposes HSE uses ‘dangerous dose or worse’ as its measure of consequence in terms of human harm. This arose out of the 1989 report on risk criteria.^(ref 9) We understand that HSE is probably unique in this respect and that most other organisations and countries use a measure based on the risk of fatality. However, we acknowledge that HSE’s introduction of the dangerous dose or worse concept was entirely sensible in its time (see Annex 8). The use of dangerous dose or worse has become a barrier to comparing the risks presented by different sites, regardless of whether simplified risk analysis is used or QRA. One reason for this is that at flammable storage sites the ‘or worse’ portion is of greater consequence than at a toxic site. In other words the risk of a fatality at a flammables storage site is more likely than other kinds of harm, and therefore the dangerous dose concept prevents comparisons of individual risk between sites handling different hazardous substances. In contrast, the use of risk of fatality allows more ready comparison of risks, provided a consistent methodology is used, making it in our view the best approach for risk determination in the future.

¹⁸ The Process Safety Leadership Group was established in August 2007, replacing the Buncefield Standards Task Group.

98 In addition, the results of simplified and quantitative risk-based analyses cannot be added because the level of risk associated with the simplified risk-based zones is not known and the risks from different types of hazard at the same site cannot be combined. Thus at large establishments, such as oil refineries, current HSE practice is to perform simplified risk analysis for some parts of the establishment, and QRA for others. In principle, applying QRA to different parts of a site and using risk of fatality as the harm criterion allows combination of the risks to give a total risk in the vicinity of the site. It also allows comparison against other risks of everyday life.

99 Finally, criteria for assessing societal risk are based on the concept of the risk of fatality to varying numbers of people. For instance, the HSE criterion in R2P2^(ref 13) considers the chance of an event causing 50 or more fatalities. In Part 1 we have recommended that societal risk is integrated into the land use planning system around major hazard sites. Plainly, this cannot happen while the land use planning system still uses dangerous dose as its harm criterion.

Recommendation 8 We recommend that HSE universally adopts individual risk of fatality as the criterion for expressing the consequence of events, in preference to the risk of receiving a dangerous dose or worse.

Reliability of engineered systems

100 A key motivator in pursuing these land use planning issues derives from our overall approach, as explained in the Introduction. If across-the-board improvements are achieved in primary containment, then credit should accrue for this. In the very first recommendation of our report for the design and operation of fuel storage sites,^(ref 4) we call on the sector and the Competent Authority to agree a consistent method of determining the safety system performance in terms of the probability of failure. We see this as the starting point for assessing, in broad terms, the risk category for a particular site for the purposes of planning advice. It follows that the pursuit of better and best practices produces an economic benefit beyond that of increased reliability of on-site operations.

101 There will be relatively few entirely new large-scale sites built in the UK and therefore the means of achieving risk reduction and the extent of the reduction reasonably achievable will continue to vary from site to site. However, what the planning system requires is that the major hazard risks from sites are determined in a consistent way, assuming all reasonably practicable measures have been taken to reduce the risks. Guidance already exists on how to account for reliability of engineered systems and human actions. This presents the site operator with options on how to achieve the desired degree of reliability, taking into account any nearby sensitive populations or resources and the nature and intensity of operations at the site.

Recommendation 9 We recommend that the risk assessment methodology and criteria for land use planning purposes align with those for risk assessment under the COMAH regime. The methodology should take account of the reliability of the engineered systems designed to achieve improved standards of primary containment, as called for in Recommendation 1 of our fifth report. The methodology should also incorporate a realistic major incident scenario in the light of Buncefield (explosions, multi-tank fires) as called for in Recommendation 1 of our report making recommendations for emergency preparedness etc.^(ref 5) Account should also be taken of the vulnerability of the surrounding population and any mitigatory measures that apply to people or buildings and other physical assets.

The Competent Authority should see that these revisions are carried out to a satisfactory standard and that appropriate guidance is issued to ensure the necessary improvements to risk assessments are delivered in practice.

Roles of the site operator and the Competent Authority

102 The arrangements for maintaining the site at the required level of safety and environmental integrity must be robust to give ongoing assurance of the basis of the planning consent. It is the primary duty of the site operator, as the risk creator, to be the risk controller. The level of maintenance, testing and inspection, and upgrading required will depend on many factors, not least the age of the plant. HSE has reported^(ref 14) a lowering of the integrity of the major hazard risk controls on ageing facilities offshore. While we have not sought specific evidence, there is strong anecdotal evidence that a similar situation exists to some degree onshore.¹⁹ Plant operated beyond its design date may self-evidently be more prone to failure or less reliable than more modern systems. Engineering standards will change particularly in response to an incident such as Buncefield. On individual sites, changes to process or to management systems (eg by corporate mergers or large-scale contractorisation) can infringe the safety integrity levels required. We have already made recommendations relating to maintenance, testing and inspection in our design and operations report;^(ref 4) Recommendation 10 partly repeats Recommendation 2 of that report to indicate the importance of alignment between our series of reports and their recommendations. At some major hazard facilities there may be a number of operated sites²⁰ where the management of some aspects of major hazard risk controls must be suitably shared between the operators.

Recommendation 10 Operators of major hazard sites should, as a priority, review and amend as necessary their management systems for maintenance of equipment and systems to ensure their continuing integrity in operation. Where there are a number of operators at a facility (as there were at Buncefield) the review should be integrated between site operators to the appropriate extent. The Competent Authority should see that this is done.

103 Regulation should provide adequate public assurance that initially the safety integrity levels for key safety equipment on the site have been properly assessed and the site designed and provisioned accordingly. We see the COMAH safety report as the vehicle for this. The inspection, investigation and enforcement regime should include adequate verification of the arrangements for maintaining the safety integrity levels commensurate with the risks to vulnerable populations and to the environment.

Recommendation 11 We recommend that the regulatory regime for major hazard sites should ensure proper assessment of safety integrity levels (SILs) through the development of appropriate standards and guidance for determining SILs. Application of the methodology should be clearly demonstrated in the COMAH safety report submitted to the Competent Authority for each applicable site. Existing safety reports will need to be reviewed to ensure this methodology is applied.

¹⁹ Leading from the top – avoiding major incidents conference organised by HSE on 29 April 2008. Over 200 industry leaders came together to share learning from incidents such as those at Texas City, Buncefield and the Thorp plant in Sellafield. Discussions served as a reminder to senior managers that the rates of conventional safety accidents and injuries in the past few years could not, in itself, be taken as positive assurance of an overall improvement in process safety across the major hazard industries.

²⁰ These are so-called ‘domino sites’. The COMAH Regulations provide for integrating the management of risks whereby one site can have an adverse impact on another. There were three major operators on the Buncefield site.

104 Taken together, Recommendations 10 and 11 align with our view that site operators should take a much more significant role in the revised system with the Competent Authority setting the standards and checking that the system is being operated effectively as we set out in paragraphs 47–51. These issues are being pursued by the Competent Authority as part of its response to our fifth report.^(ref 4) We of course welcome this.

Consented quantities

105 As we have previously observed, the land use planning system around major hazard sites illustrates clearly the tension that can exist between strategic economic considerations prevailing at major hazard sites, and local economies. As reported in paragraph 36, HSE, as a matter of sensible technical policy, bases its planning advice on the maximum consented quantity, which can considerably exceed the quantities actually stored. Also where the consent is for a generic category of hazardous substances, the assessment is based on the most hazardous substance within that category even if that substance is not actually present. Both these situations can produce larger zones and consultation distances than circumstances require.

106 It would be relatively straightforward to conduct the risk assessments for any site based on the maximum hazardous capacity of the site under realistic operating conditions, both in terms of quantities and substances present. To avoid unwarranted restrictions on site owners, the inventory used in assessments could take into account consented plans for increasing the quantities on site, but not beyond the land capacity or the process capacity of the site (and not of course beyond the hazardous substance consented inventory).

Figure 8 Oil storage tanks at Falmouth docks, Cornwall, in south-west England. Note the occupied buildings adjacent to the storage tanks, and the estuary which leads into the English Channel



107 However, for reasons that we explain above, it is unusual to attach conditions to major hazardous substances consents (see paragraph 31) and consultation zones continue to exist where an operator in possession of major hazardous substances consent has ceased to operate, unless steps are taken by the minister responsible to revoke the consent.²¹ We readily appreciate that retaining consent, or maintaining a far greater consent inventory than the site can actually handle, is in the commercial interest of the consentee. We do however challenge whether in every case it is in the overall public interest to restrict off-site development as a result of dormant consents or large spare capacities. At the same time we fully understand that HSE has no basis in the present circumstances for using anything other than maximum/most hazardous quantities in its assessment work.

108 The revised approach to planning around major hazard sites that we call for will apply risk assessment on a site-specific basis, and calls on the site operators to take on a much more significant role. It is therefore time to deal with this issue of consented quantities in a sensible and pragmatic way. To strike a balance between the genuine national interest in the strategic potential of major hazard sites and the regional or local economies we call on CLG, the devolved administrations, BERR and HSE to consider making changes to the management of major hazard substances consents. We ask, in Recommendation 12, for the necessary steps to be taken to limit or remove consents where the circumstances merit. We also call for a negotiated approach to the nature and quantities of hazardous substances that are to be taken into account in the revised system for planning consent around hazardous installations.

Recommendation 12 We recommend that CLG and the relevant ministers in the devolved administrations, HSE and BERR consider reforms to the major hazardous substances consent system, with the aims of:

- ▼ streamlining and simplifying the withdrawal of consents on sites that are ‘dormant’; and
- ▼ allowing the size and nature of the hazardous inventories to be varied to enable realistic risk assessment for off-site planning purposes, including for revised development plans.

Existing and new developments

109 HSE is frequently asked to comment on proposals to develop or redevelop land where there may already be other land users who are closer to the major hazard site and where there is incompatibility with HSE’s criteria. The policy is to ‘accept’ existing arrangements which are a legacy of our industrial heritage but not to increase those risks further. Therefore we have a system that for understandable reasons produces situations where businesses and residents are located within the inner zones of consultation and yet new developments that would bring welcome improvements to the prosperity or social amenity of the region are prevented.

110 It can be hard to communicate the message that HSE does not have a means for objecting to risks which already exist but has to rely on on-site safety measures

²¹ This is illustrated at Hemel Hempstead where the consents are legitimately retained by the former operators of the Hertfordshire Oil Storage Limited and British Pipeline Agency Limited parts of the former Buncefield site. It is not known whether these sites will be reinstated.

and evacuation plans, yet can ‘advise against’ new development. HSE can be depicted on the one hand as being too cautious and restrictive in its advice on new development applications, and on the other hand of condoning unacceptable risk to the occupants of existing developments. Within the current system HSE will often struggle to secure acceptance for the advice it provides, notwithstanding the advice may be entirely inevitable.

111 We consider this situation would benefit from the joined-up approach to reaching land use planning decisions which we suggest in paragraphs 55–57 where the planning authority is supported in its decision-making role by key representatives for the regional interest, and if necessary for the national strategic interest. Technical information relating to the risks posed by the site would be provided by the COMAH operator under guidance developed by the Competent Authority, and aligned with the roles of regulator and operator under the COMAH Regulations. The planning authority will need to have the relevant expert advice available to it, and have sufficient expertise itself to process the information.

Recommendation 13 In moving to a fully risk-based system, and as part of the review called for in Recommendation 1, there should be a wider perspective given to the management of new planning applications where off-site development already exists. Consideration should include:

- ▼ the parties who should come together to give relevant and necessary advice and expert support to the planning authority;
- ▼ the size and nature of the existing population exposed to the risks on site;
- ▼ the safety integrity levels and environmental protection measures on the site relevant to the nature and intensity of operations;
- ▼ the mitigatory measures (ie means of reducing the consequences of a major incident) achievable for off-site buildings;
- ▼ the emergency preparedness and response arrangements;
- ▼ the needs of the regional economy as formally determined by the relevant authorities, and expressed in regional policies such as the Regional Spatial Strategy and Regional Economic Strategy;
- ▼ the strategic economic/national interest issues if relevant; and
- ▼ the further reductions that may be achieved in residual risk arising from the major hazard site.

CLG, the Welsh Assembly Government, the Scottish Government and HSE should give consideration to this issue and produce the necessary guidance to see the revised approach is implemented effectively.

Technical issues relating to societal risk

112 In addition the discussion of societal risk in Part 1, which focused on systemic issues, there are some important technical issues to resolve. HSE’s summary of findings from consultation through CD212 lists a number of these. The most pressing issue at present is to achieve common agreement on how societal risk is measured and what the relevant criteria are.

113 Societal risk is a difficult concept to apply and further work is needed on how it can be used for ranking sites and prioritising mitigation measures. The relation between the likelihood of a serious incident, its severity and the consequences in terms of fatalities depends critically on the configuration of the population around the site, and it will increase with each new development around the site. The calculation of societal risk is usually expressed in the form of a graph showing the probability of events with greater than a certain number of casualties (F/N curves²² – see Annexes 5 and 10), but it can also be more clearly displayed in the form of area-specific risk. HSE's publication R2P2^(ref 13) proposed a societal risk criterion (a 1 in 5000 chance per annum of an event causing 50 fatalities). HSE has since proposed a more complex formulation and gone on to develop a ranking technique based on it, though there is not yet general agreement over how it can be applied to all hazardous sites. Clearly further research work is needed but we believe a rudimentary method of estimating societal risk agreed now between parties is more important than academic perfection. Refinement can come later. We understand that HSE intends to take this work forward as part of an agreement between ministers following the CD212 consultation. We believe that in going forward with the revisions to the planning system around major hazard sites, the boundaries of acceptability of societal risk need to come to public debate and a public consensus needs to be developed.

114 Another difficulty is that there is no clear basis in law for taking into account society's aversion to multiple fatality events (known as scale aversion) when conducting a numerical risk assessment or enforcing risk reduction measures, but HSE's policy is to reflect societal risk when making judgements about whether measures are grossly disproportionate in relation to what is reasonably practicable. While such aversion is not measurable in a literal sense, the debate about whether, and to what extent, scale aversion should be introduced has run for some time. Guidelines are needed on what weighting to give to more severe incidents to allow practical application of societal risk. HSE advises that this issue is being pursued as part of its ongoing work on societal risk, and we encourage HSE to conclude this work as soon as practicable.

Recommendation 14 We recommend that HSE should bring together key stakeholders and experts in the planning system (planning authorities, developers, operators, regulators, risk assessment specialists) with a view to reaching agreement as early as possible on:

- ▼ the way societal risk is measured and assessed;
- ▼ the data sources required for assessment purposes;
- ▼ the acceptability criteria for societal risk values around particular sites; and
- ▼ a suitable weighting factor for more serious, less frequent events (scale aversion).

²² FN curves are a means of plotting, normally on a logarithmic scale, the frequency (F) of a fatal incident against the numbers of people (N) who may be killed in such an incident.

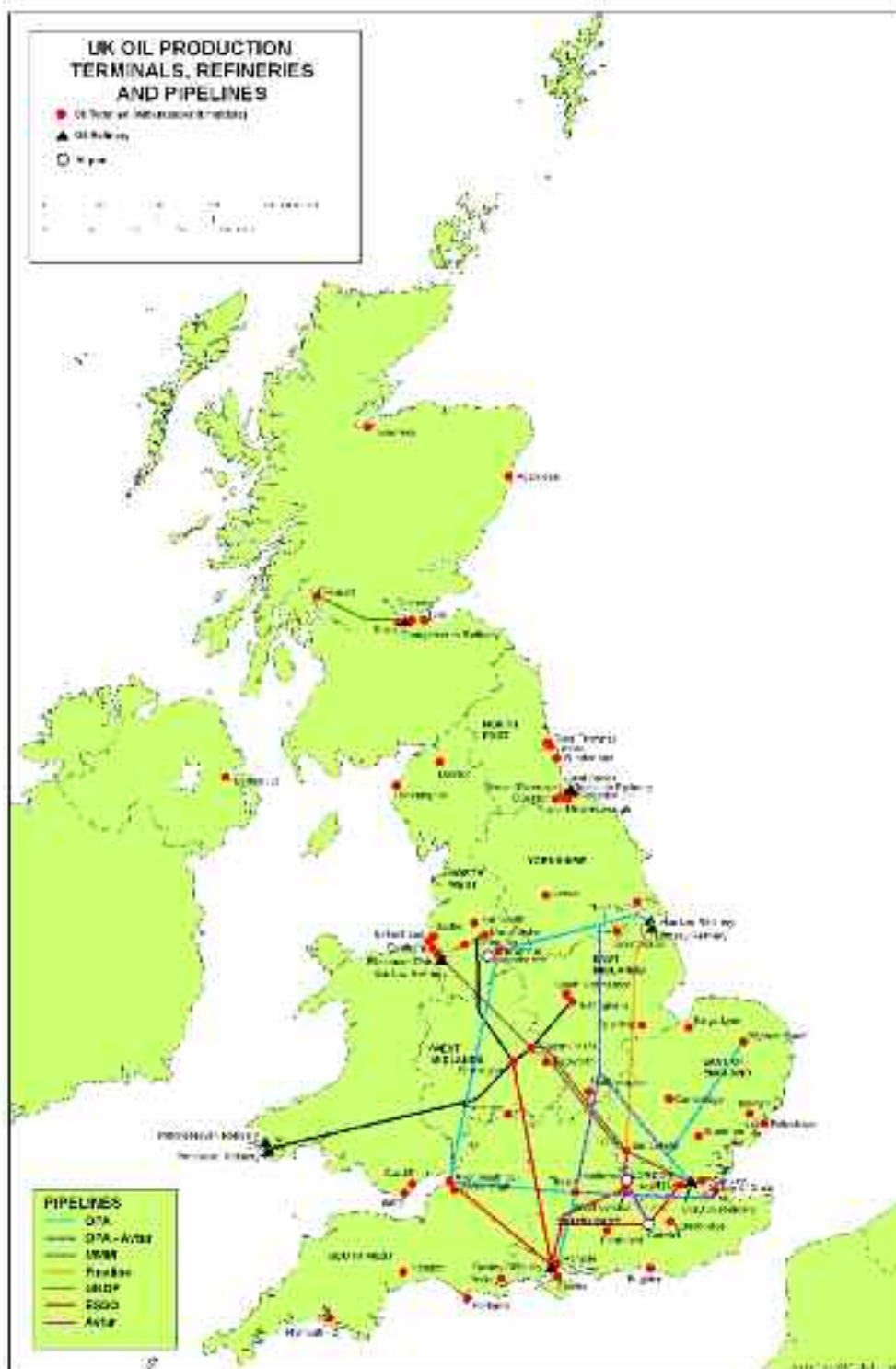


Figure 9 Privately operated refineries, pipelines and terminals in Britain. Note that some of the terminals are currently not operating (eg Buncefield)

Applying land use planning controls to gasoline pipelines

115 While there is no suggestion that the large gasoline pipelines which supplied the Buncefield site directly contributed to the major incident, there is an anomaly relating to regulation of such pipelines which we consider now needs rectifying. Under the Pipelines Safety Regulations 1996 (PSR) gasoline pipelines are subject to the same general duties as all other pipelines, covering design, construction and installation, operation, maintenance and decommissioning. However, they are excluded from the additional duties for pipelines conveying fluids with a major accident hazard potential. Consequentially, there are no requirements to produce an emergency plan for gasoline pipelines nor to set land use planning zones around them.

116 We understand that when PSR was enacted, HSE intended gasoline pipelines to be subject to the additional requirements but this has not happened. Subsequent research commissioned by HSE showed that although the levels of risk were low, the potential consequences of an accident were very serious and confirmed that gasoline pipelines should be treated as presenting a major accident hazard potential.

117 We conclude that PSR should be amended so that gasoline pipelines are subject to land use planning and emergency planning controls, ie the sorts of controls around other major hazard installations should apply in relation to development near pipelines. Recommendation 15 addresses this aspect. We understand that HSE is now taking this work forward and we welcome this initiative and encourage its completion.

Recommendation 15 HSE should take necessary steps to amend the Pipeline Safety Regulations with the aim of extending land use and emergency planning controls (and other suitable regulatory protections if necessary) to major pipelines carrying gasoline (petrol).

Figure 10 A large smoke clouds hangs over the north-eastern city of Enschede. A fireworks warehouse near the city centre exploded on 13 May 2000, killing 23 people.

Public understanding

118 The basis on which HSE advises planning authorities was published in 1989 in a discussion document entitled *Risk criteria for land use planning in the vicinity of major industrial hazards*.^(ref 9) There has since been a fundamental review in 1998 and consideration given to how to implement the conclusions of that review (see Annex 9). It was not until 2007 and the issue of CD211 that HSE first set out its policy objectives and principles on land use planning.



119 For those ultimately affected, namely site operators and local communities, the basis on which land use planning decisions are reached can be difficult to understand. We therefore call on those responsible for revising the system in line with our recommendations to produce suitable technical guidance on how decisions should be reached by the planning community. Notwithstanding the technicalities that will inevitably have to be managed in determining planning applications, the technical guidance should be comprehensible to a lay audience.

Recommendation 16 We recommend that HSE should review, update and publish documentation on the process for handling land use planning risk assessments around major hazard sites by local authorities, and the main contributors to the decision-making process. The resulting publication should be capable of being understood by a lay audience.

Local planning authority resources

120 In moving to the revised system called for in this report the local planning authority will be required to take a much more transparent lead in the planning application decision-making process. Support from emergency responders and other key stakeholders is envisaged as being made available, and much more input from the site operator is also called for. The Competent Authority is also asked to provide expert guidance on the operation of the system and to see that it functions properly. Nonetheless we foresee that for many if not all planning authorities there will need to be a significant increase in resources and expertise available for it to manage the planning process effectively and consistently. In Recommendation 17 we ask for due consideration to be given to this vital aspect.

Recommendation 17 Local planning authorities and the administrations responsible for them should ensure the necessary expertise and other resources are available to implement the revised planning system around major hazard sites, as well as management systems to ensure maintenance of competencies, monitoring, audit and review of the planning systems in their authority.

Application to major hazard sites

121 We commissioned work to demonstrate what a feasible risk-based system might look like. An important aim of this commission was to present a model system to the lay reader who until now has had to manage with rather abstract descriptions. We also wanted to have some tangible indicators of the advantages and disadvantages of a QRA-based system that could be consistently applied to all major hazard sites compared to the status quo where a simplified risk approach is applied at flammable storage sites. The work included some preliminary risk analysis based on a part of the Buncefield site ('the model site'), primarily to gain a better understanding of the issues associated with the quantification of the risk posed by such a site. The scope of work is described in Annex 10, together with the detailed results. We asked to see a methodology that would enable a QRA to be carried out which would give predictions for both individual and societal risk, identifying the major uncertainties in the analysis.

122 Aware that other countries subject to the Seveso Directive, such as the Netherlands and Belgium, adopt a quantified approach to determine the risks from flammable storage sites we also asked for the methodology used for risk assessment and development control in the Netherlands to be applied to the model site. We also asked for a review of the predictions in order to consider whether a

methodology based on risk rather than a mixture of risk and hazard could potentially be used in the UK for future land use policy around all major hazard sites.

123 The key success criteria are whether the model system is responsive to changes in risk on and off site, whether it can incorporate societal risk in addition to risk-based land use planning zones (as are currently produced by the simplified risk approach), and whether the system would be affordable. The outcome of the work appears to meet the criteria and strengthens our call for work to begin without delay to develop a consistent risk-based system for use throughout the major hazard sector in Britain.

124 The work demonstrates that it is possible to carry out a QRA of a large petroleum storage facility and generate individual and societal risk predictions reasonably quickly and without significant expense despite the uncertainties. The current system for land use planning in Britain is based either upon the simplified risk approach or QRA. This hybrid approach has a number of disadvantages as we have pointed out. It would be possible to extend the QRA approach to all types of major hazard site and thereby develop a land use planning system which is consistently based on risk. A move to a universal QRA approach would be less straightforward than the simplified risk assessment approach but it would remove many of the undesirable features of the current system. It would also make the system consistent across Britain. Such systems, where the QRA methodology is defined by the regulator and the analysis is carried out by the site operator, are currently operated in the Netherlands and Belgium.

Figure 11 Smoke rises above Enschede. This picture was taken at 90° from the viewpoint in Figure 10. Both pictures illustrate the density of residential buildings around the fireworks warehouse

125 To consider societal risk, the population within the vicinity of the site that is exposed to the individual risk of fatality has to be considered. We are drawn to the approach in the Netherlands and Belgium where regional public authorities and



emergency services, operators and others consider new developments subject to some absolute guidelines set by the national regulator. Risk contours are developed by the site operators using actual site conditions processed in accordance with a methodology set by the national regulator. Off-site conditions and types of vulnerable populations are incorporated into the data provided for decision making.

126 The overall societal risk from a single installation can be broken down to show the main contributors to societal risk both in terms of the source of risk and the receptor of risk (the people and/or buildings that could be affected by the various hazard scenarios). Annex 10 shows the main societal risk contributors derived from the various hazard sources. The breakdown of the data in terms of receptors shows which measures to reduce the effect on the target feature would be most effective. There is obvious scope to calculate the most effective means, with due regard to cost, to reduce societal risk. Societal risks can also be added together, so the overall societal risk from all the major hazards within a local authority area could be determined and the local planning authority would be able to see the effect on the societal risk over a period of time due to changes in both the hazardous sites and even small changes in the population in the vicinity of these sites. This would enable better spatial planning than is possible on information available within the current system.

Implementation and priorities

127 In paragraph 88 we set out consistency of assessment of risk as our guiding principle. To achieve it we have identified a number of relevant issues and made recommendations. Overall it moves in the direction of a more individualised approach to sites to identify the risks they present in a way that is more closely related to actual circumstances.

128 We say above that we expect work to begin on revising the land use planning system without delay and in parallel with the wide review called for in Recommendation 1. We do recognise and commend the work done so far by HSE in responding to the land use planning issues raised at Buncefield though more needs to be done. We also recognise that the frequency data for vapour cloud formation and ignition and over-pressure propagation in open flammable clouds are uncertain. For the present, until the explosion mechanism work yields results, the uncertainties can be managed in the same way that they are currently managed, eg by using statistical outliers, sensitivity analyses and conservative assumptions in the event frequency data. Sensitivity analysis uses a range of failure event frequency data to test the assumptions behind the ones used in the risk calculations.

129 The explosion mechanism of the hazard of open flammable cloud explosions is only one new aspect to be incorporated in future revisions of the scenarios that feed the risk assessments. Revisions to all the scenarios that feed risk assessments need to be undertaken. In addition the new consultation distances applied by HSE to flammable storage sites are only applied to new developments. The impact of the Buncefield incident on the risks at and around existing sites needs to be viewed afresh. In the covering note to CD212^(ref 3) HSE suggested there are already some sites to which HSE could give priority treatment as the current system is overhauled and agreed methodologies for new risk assessment approaches developed. The Competent Authority will need to agree with COMAH operators and planning authorities a programme of reviews of the sites of greatest concern, with clear timescales against which progress can be measured and reported.

130 Account should also be taken of the impact of the measures that we call on in our reports to the risks of a major incident as we believe the risks will reduce significantly as the improved controls are applied.

131 We also expect the ALARP²³(risks ‘as low as reasonably practicable’) risk threshold to change as a result of what we learn from Buncefield. In other words, measures that would perhaps have been deemed unreasonable in terms of the cost of achieving a risk reduction may come into the scope of the ALARP condition in the light of a revision to the worst-case scenarios after Buncefield, accounting for open flammable cloud explosions and multi-tank fires. This needs to be considered for the major hazards sector as a whole. It is not uncommon for operators with duties under safety and environmental legislation to see the risk threshold under the ALARP principle as a ceiling, the point at which they may safely stop seeking further improvements. In fact the ALARP threshold is the floor on which dutyholders need to stand, the starting point for best practice that is rightly expected by the public and those who might be affected by the major hazard risks created by the site.

Recommendation 18 The Competent Authority should agree a priority programme with site operators and planning authorities for assessing societal risk at sites of identified concern using the risk assessment methodologies developed in line with our recommendations. Account should also be taken whether the ALARP threshold has been raised due to considering previously unaccounted hazard scenarios.

132 Input to planning around major hazard sites under the system that we favour will be wider than from HSE alone. Quite apart from the critical new role for planning authorities and operators, guidance needs to be developed on how to use the criteria relating to risk contours, and societal risk indicative criteria when an acceptable approach and methodology for using societal risk have been devised. The Competent Authority will need to set the standard for what to do and for the criteria, while leaving the decisions to those affected. This is not a case of the regulator standing back from difficult situations. The Competent Authority will determine what needs to be provided – and by whom – to operate the system. The Competent Authority will also check that the system is operating as intended.

133 The Competent Authority will also have to decide how it will react, within its statutory role, to societal risk anomalies that come to light in the application of the revised system and there may well be lessons in how the French, Belgians and Dutch have adapted their systems to compensate for unacceptable societal and environmental risk at existing installations in the light of applying new knowledge or invention.

134 What are the potential downsides of our preferred system? A risk-based approach is unlikely to significantly reduce the planning contours without the improvements to the control measures we call for being carried out in practice. For example, under the method adopted for the analysis that produced a model of a risk-based planning system (see Annex 10) it was shown that the Northgate Building was a significant contributor to societal risk at Buncefield. Modelling the Northgate building so as to be further away from the site showed how the societal risk could be lowered. In reality, under a risk-based system, it might be practicable to reduce societal risk by improving the risk control measures (on- or off-site, or both).

²³ The ALARP principle is further explained in Annex 5 (in the section ‘QRA applications of relevance to land use planning around major hazard sites’).



135 A key disadvantage will be in the period of transition to a revised system which will have significant implications for central and regional government and industry. To illustrate the difficult questions to be faced, eg on retrospection and interim application (with, as yet, incomplete tools), one need only look at Recommendation 3, which calls for a broad economic case ‘including costs to the industry and wider society’ to be factored in. These will take some time and intellectual effort to determine, and the obvious question will be ‘what do we do in the meantime, or do we wait?’ On the subject of retrospection (which we have referred to, eg in paragraphs 29–30 and 126) we wish to make it clear that we are not calling for the bulldozing of swathes of perimeter developments or decommissioning of major hazard sites. We are looking for the Competent Authority, COMAH operators and planning authorities to agree what are the priorities for action when factoring in societal risk, and to make targeted and proportionate responses and maintain public confidence.

136 Recommendation 13, which calls for reforms to the management of the decision-making process, illustrates the same issue. Some two and a half years after Buncefield progress now lies in confronting the difficulties and not being deterred by them. While we have addressed the questions of the scope of application, the pace of progress and what to do during an interim phase of several years, we will greatly value the commitment now of CLG and relevant ministers of the devolved administrations, and HSE in particular to press ahead on a number of fronts in the interests of balancing the necessary pace of progress with technical and resourcing factors.

Figure 12 A view of the smoke plume at the height of the Buncefield fire as seen by police maintaining the cordon in the Leverstock Green area of Hemel Hempstead. Leverstock Green is one of the nearest residential areas to the Buncefield depot and many people were evacuated

Annex 1

Terms of reference

This annex sets out the eight terms of reference for the Investigation and explains the progress that is being made towards accomplishment of each of them.

1 To ensure the thorough investigation of the incident, the factors leading up to it, its impact both on and off site, and to establish its causation including root causes

The Board has published three progress reports from the Investigation Manager between February and June 2006. These were followed by the Board's initial report on 13 July 2006, which summarised the investigation to date and set out the Board's main areas of concern. The reports have revealed the main facts of the incident, but have not speculated on why control of the fuel was lost.

The explosion mechanism, ie the means by which unexpectedly high over-pressures were generated, is subject to significant further investigation. An advisory group was appointed to make recommendations to the Board on whether and what further work could be undertaken in this regard – see term of reference 5.

The criminal investigation is pursuing all reasonable lines of inquiry into the facts and causes of the incident to enable the Competent Authority (HSE and the Environment Agency) to take a view on legal proceedings.

2 To identify and transmit without delay to dutyholders and other appropriate recipients any information requiring immediate action to further safety and/or environmental protection in relation to storage and distribution of hydrocarbon fuels

The Competent Authority issued a Safety Alert to around 1100 COMAH dutyholders on 21 February 2006. Special attention was paid to 108 fuel depot owners storing COMAH quantities of fuel in Great Britain, seeking a review of arrangements for detecting and dealing with conditions affecting containment of fuel. Most dutyholders responded to the alert by the Easter deadline. Meanwhile, the Competent Authority visited all 108 depots to follow up the alert. An interim report was published on 13 June 2006 and is available at www.hse.gov.uk/comah/alert.htm.

The Environment Agency issued further advice to its inspectors to investigate secondary (bundling) and tertiary (drains and barriers) containment at depots in England and Wales in response to the second progress report.

The Environment Agency continues to monitor the effects of Buncefield on the surrounding environment. Any changes picked up during monitoring will be reported on its website, www.environmentagency.gov.uk. The initiative is being handled separately for Scotland by the Scottish Environment Protection Agency, with joint inspections undertaken with HSE covering primary, secondary and tertiary containment, and management systems.

On 16 June 2006 investigators served two Improvement Notices on the manufacturers of the high level alarm switch installed on Tank 912, having identified a potential problem at other sites related to the setting of the switch for normal operations following testing. This was followed up by a Safety Alert from HSE on 4 July 2006 alerting operators relying on such switches of the potential problem.

The Chairman of the Buncefield Board wrote to the Chief Executive of the Health Protection Agency on 3 July 2006 enquiring into progress with informing regional resilience groups of early lessons learned from Buncefield, focusing on public health issues in the immediate aftermath of a major airborne incident, following up with a meeting December 2006.

The Buncefield Investigation Manager wrote to HSE on 30 August 2007 with observations on the reliability of servo level gauging systems. HSE subsequently held discussions with the Process Safety Leadership Group on this subject and provided an update report to MIIB on 31 October 2007.

3 To examine the Health and Safety Executive's and the Environment Agency's role in regulating the activities on this site under the COMAH Regulations, considering relevant policy guidance and intervention activity

Work is progressing steadily on both parts of the review, concerning respectively HSE's and the Environment Agency's prior regulatory activities at Buncefield. The full findings of the review will be incorporated into the Board's final report (see term of reference 8). Immediate important lessons from the examination of the Competent Authority's prior role have been incorporated as appropriate into the lessons learned programme under term of reference 5.

4 To work closely with all relevant stakeholders, both to keep them informed of progress with the Investigation and to contribute relevant expertise to other inquiries that may be established

The ongoing impact on residents and businesses of the Buncefield incident has been reported in the three progress reports and in the initial report in which, in Part 2, the Board set out its main areas of concern. The Board has maintained an active interest in releasing as much new information as possible to the community and its representatives, such as the local MP Mike Penning, to assist in understanding the events of 11 December 2005, and to maintain public confidence that progress is being made with the Investigation.

As has been reported previously, residents and businesses continue to show remarkable resilience in the difficult aftermath to the Buncefield incident. Dacorum Borough Council in particular, but also St Albans and Hertfordshire Councils, have performed extremely effectively in very difficult circumstances, and have supported the Board in its engagement with residents and businesses, as has Mike Penning MP.

The Board has also kept key Government stakeholders informed of the Investigation's progress, and has maintained its interest in developments that have taken place since Buncefield to help manage the aftermath and support a return to normality for residents and businesses.

The Board has engaged with all the public sector agencies involved in the emergency response to Buncefield and has met with a number of the key agencies, particularly the Category 1 (Gold) responders. This is not an issue in which the Board has primary responsibility, but has outlined its conclusions and recommendations within the contents of its sixth report *Recommendations on the emergency preparedness for, response to and recovery from incidents*.

The MIIB continues to meet from time to time with residents, businesses, agencies, government departments and public representatives to inform them of progress.

5 To make recommendations for future action to ensure the effective management and regulation of major accident risk at COMAH sites. This should include consideration of off-site as well as on-site risks and consider prevention of incidents, preparations for response to incidents, and mitigation of their effects

The Board's fifth report (March 2007), made recommendations for the design and operation of Buncefield-type sites. HSE convened an industry-chaired task group (the Buncefield Standards Task Group) which included the Environment Agency and the Scottish Environment Protection Agency, to also consider design and operation issues in parallel with the Board's work. This initiative was welcomed by the Board in its report.

The Board's sixth report (July 2007) made recommendations for the emergency preparedness for, response to and recovery from incidents. The work in producing the recommendations contained within the report was supported by an immense amount of work undertaken by other agencies such as Hertfordshire Resilience, Hertfordshire Fire and Rescue Service, and the Health Protection Agency. With these recommendations, the Board joined together the many strands of this subject, including issues concerning support to communities and businesses in the aftermath of an extreme incident.

An expert group was appointed in 2006 to give advice to the Board on possible explosion mechanisms of relevance to Buncefield. A report by the advisory group was published in August 2007 as the Board's seventh report. It recommended further investigations leading to a decision on whether full-scale research is required. The further investigations are currently ongoing.

HSE completed its initial work on changes to land use planning advice and issued a revised policy for large petrol storage sites in December 2007. The outcomes of consultation on societal risk around onshore non-nuclear major hazard installations was published in January 2008. The Board set out its own views to both consultation documents (see www.buncefieldinvestigation.gov.uk).

This report, the Board's eighth, sets out the Board's considered position for securing improvements to the system for land use planning around major hazard sites.

6 To produce an initial report for the Health and Safety Commission and the Environment Agency as soon as the main facts have been established. Subject to legal considerations, this report will be made public

The Board's initial report was published on 13 July 2006.

7 To ensure that the relevant notifications are made to the European Commission

A report from the Environment Agency and HSE was made to the European Commission on 10 March 2006. Subsequently, the Environment Agency declared Buncefield a major accident to the environment (MATTE), and the Competent Authority reported this to the European Commission in July 2006.

8 To make the final report public

The timing for the publication of the final report remains uncertain and is linked to progress on the main terms of reference and to any decision on any criminal proceedings that might be considered.

Annex 2

Members of the independent Board

The Rt Hon Lord Newton of Braintree has been a life peer since 1997 after spending 23 years as a Conservative Member of Parliament for Braintree, Essex. From 1982 to 1988 he held ministerial positions at the Department of Health and Social Security. In 1988 he joined the Cabinet as Chancellor of the Duchy of Lancaster and Minister at the Department for Trade and Industry. He then held the post of Secretary of State for Social Security from 1989 to 1992 when he was appointed Leader of the House of Commons, which he held until 1997. In 2002 he chaired the Committee that reviewed the operation of the Anti-terrorism, Crime and Security Act 2001.

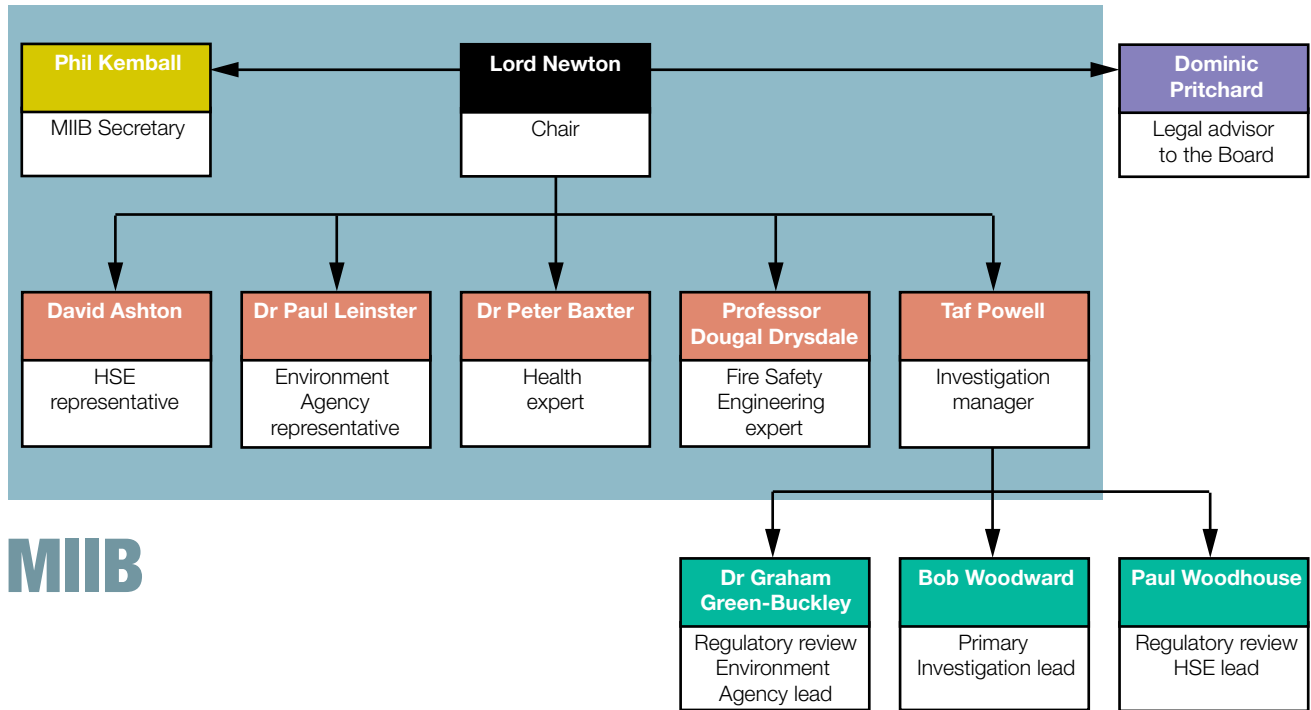
Professor Dougal Drysdale is one of the leading international authorities in fire safety engineering. He was the Chairman of the International Association of Fire Safety Science until September 2005 and is currently the editor of the leading scientific journal in the field, *Fire Safety Journal*. His wide range of research interests includes the ignition characteristics of combustible materials, flame spread and various aspects of fire dynamics. He is a Fellow of the Royal Society of Edinburgh and a Fellow of both the Institution of Fire Engineers and the Society of Fire Protection Engineers.

Dr Peter Baxter is a Consultant Physician in occupational and environmental medicine at Cambridge University and Addenbrooke's Hospital, Cambridge. In the past, he has advised the government on the impacts on public health relating to air quality standards, major chemical incidents, natural disasters and climate change.

Taf Powell is Director of HSE's Offshore Division. He graduated in Geology and Chemistry from Nottingham University. His oil field career has been split between working in the UK and abroad in offshore exploration and development and regulation of the sector in licensing, well operations, policy and safety regulation. In 1991 he joined HSE's Offshore Division from BP and started work to develop the new offshore regulatory framework, one of Lord Cullen's recommendations following his inquiry into the Piper Alpha disaster. As HSE's Operations Manager, based in Aberdeen, he then led inspection teams and well engineering specialists responsible for enforcing the new regulations until 2000 when he took up his current role.

Dr Paul Leinster is Director of Operations at the Environment Agency. Up until March 2004 he was the Director of Environmental Protection, having joined the Agency in 1998. Before this he was the Director of Environmental Services with SmithKline Beecham. Previous employers also include BP International, Schering Agrochemicals and the consultancy firm Thomson-MTS where he was Managing Director. Paul has a degree in Chemistry, a PhD in Environmental Engineering from Imperial College and an MBA from the Cranfield School of Management. He has worked in the health and safety and environmental field for 30 years.

David Ashton is Director of HSE's Field Operations North West and Headquarters Division. He joined HSE in 1977 as an inspector in the west of Scotland where he dealt with a wide range of manufacturing and service industries, including construction, engineering and the health services. In 1986 he joined Field Operations HQ to deal with machinery safety. He then held the post of Principal Inspector of manufacturing in Preston for two years, before being



appointed as a management systems auditor to examine offshore safety cases in the newly formed Offshore Division. In 1993 he became Head of HSE's Accident Prevention Advisory Unit, looking at the management of health and safety in organisations. Between 1998 and 2003 David was HSE's Director of Personnel, before being appointed to his current position.

Annex 3

The COMAH regulatory regime

Part 1: Regulatory framework for high-hazard sites

[reproduced from Initial Report Annex 8]

1 The regulatory framework for sites such as Buncefield, which present potential major accident hazards, comprises requirements imposed on the site operators under both health and safety and environmental legislation, complemented by the requirements of planning law. In particular, the Control of Major Accident Hazards Regulations 1999 (COMAH) apply.

Health and safety law

2 Operators in the process industries are subject to the requirements of the Health and Safety at Work etc Act 1974 (the HSW Act) and the Management of Health and Safety at Work Regulations 1999 which require, respectively, safety policies and risk assessments covering the whole range of health and safety risks.

Control of Major Accident Hazards Regulations 1999 (COMAH)

3 COMAH's main aim is to prevent and mitigate the effects of those major accidents involving dangerous substances, such as chlorine, liquefied petroleum gas and explosives which can cause serious damage/harm to people and/or the environment. The COMAH Regulations treat risks to the environment as seriously as those to people. They apply where threshold quantities of dangerous substances identified in the Regulations are kept or used. There are two thresholds, known as 'lower-tier' and 'top-tier'. The requirements of COMAH are fully explained in *A guide to the Control of Major Accident Hazards Regulations 1999 (COMAH). Guidance on Regulations L111.*^(ref 15)

4 The COMAH Regulations are enforced by a joint Competent Authority comprising HSE and the Environment Agency in England and Wales, and HSE and the Scottish Environment Protection Agency (SEPA) in Scotland. Operators will generally receive a single response from the Competent Authority on all matters to do with COMAH. The Competent Authority operates to a Memorandum of Understanding, which sets out arrangements for joint working.

5 The COMAH Regulations require operators of top-tier sites to submit written safety reports to the Competent Authority with the purpose, among others, of demonstrating that major accident hazards have been identified and that the necessary measures have been taken both to prevent such accidents and to limit any consequences. Operators of top-tier sites must also prepare adequate emergency plans to deal with the on-site consequences of possible major accidents, and to assist with off-site mitigation. Local authorities for areas containing top-tier sites must prepare adequate emergency plans to deal with the off-site consequences of possible major accidents, based on information supplied by site operators.

6 The COMAH Regulations place duties on the Competent Authority to have in place a system of inspections for establishments subject to the Regulations, and to prohibit the operation of an establishment if there is evidence that measures taken for prevention and mitigation of major accidents are seriously deficient. The Competent Authority also has to examine safety reports and inform operators about the conclusions of its examinations within a reasonable time period.

7 The inspection plan for a particular establishment is drawn up by inspectors from the Competent Authority based on previous interventions at the site and on information gained from the assessment of the safety report. The inspection programme requires input from a range of inspectors with specialist knowledge and identifies and prioritises issues. The focus of the programme is to ensure that the key risk control measures for preventing and mitigating major hazards are maintained.

8 The adequacy of this process and its application at Buncefield by HSE and Environment Agency inspectors is subject to a review under term of reference 3.

Environmental legislation

9 Some of the establishments regulated under the COMAH Regulations are also regulated by the Environment Agency and SEPA (the Agencies) under the Pollution Prevention and Control Act 1999 (PPC).

10 While the purpose of the COMAH Regulations (the prevention of major accidents) differs from that of PPC, the means to achieve them are almost identical. They require industry to have good management systems to control risk. PPC includes a specific duty to prevent and mitigate accidents to the environment which is complementary to the main COMAH duty. The Agencies manage this overlap between their different regimes following the principle that accident prevention work on COMAH sites is generally more significant because of the greater risks.

Supporting guidance and standards

11 The legal requirements are supported by a large body of guidance and standards that set out recognised good practice in the control of major accident hazards. This includes national and international standards, industry guidance and guidance published by the Competent Authority. Examples of the latter are *Reducing error and influencing behaviour* HSG48,^(ref 16) *Successful health and safety management* HSG65 (Second edition)^(ref 17) and *Containment of Bulk Hazardous Liquids at COMAH Establishments – Containment policy Supporting Guidance for Secondary and Tertiary Containment*.^(ref 18)

Land use planning

12 The land use planning aspects of the Seveso II Directive are given effect in the UK by the Planning (Hazardous Substances) Regulations 1992, as amended in 1999. Under these Regulations the presence of hazardous chemicals above specified thresholds requires consent from the hazardous substances authority, usually the local planning authority. HSE is a statutory consultee on such occasions. The role of HSE is to consider the hazards and risks which would be presented by the hazardous substances to people in the vicinity, and on the basis of this advise the hazardous substances authority whether or not consent should be granted. HSE will also supply a consultation distance around the site. Any future developments in these zones require HSE to be consulted.

13 The aim of health and safety advice relating to land use planning is to mitigate the effects of a major accident on the population in the vicinity of hazardous installations, by following a consistent and systematic approach in providing advice on applications for planning permission around such sites.

14 Historically, HSE has based its land use planning advice on the presumption that site operators are in full compliance with the HSW Act. Section 2 of the Act places a duty on an employer to ensure, so far as is reasonably practicable, the health and safety of his employees. There is a corresponding duty in section 3 to ensure, so far as is reasonably practicable, that others (including the public) are not

exposed to risks to their health and safety. These duties are goal-setting and operators are expected to determine the most appropriate means to comply with them, without the need for detailed approval from HSE.

15 Under the General Development Procedure Order 1995, both HSE and the Environment Agency are statutory consultees for:

- ▼ the development of a new major accident hazard site; or
- ▼ developments on an existing site which could have significant repercussions on major accident hazards; or
- ▼ other developments in the vicinity of existing establishments, where the siting or development is such as to increase the risk or consequences of a major accident.

Part 2: Planning regulatory regime in Britain

Background

16 Regulation of major hazard sites under the Control of Major Accident Hazards Regulations (COMAH) and other health and safety law is complemented by the requirements of planning law.

17 Under the Planning (Hazardous Substances) Act 1990 and associated Regulations, the presence on, over or under land of a hazardous substance in excess of a specified amount (controlled quantity) requires consent from the hazardous substances authority, usually the local planning authority (LPA). The Act empowers the Secretary of State (for Communities and Local Government) to specify the hazardous substances and their controlled quantities. Flammable materials such as petroleum spirits and aviation fuels require consent in quantities above 5000 tonnes. The amounts present at Buncefield would significantly exceed this level.

18 HSE establishes a ‘consultation distance’, made up of three zones (to become four zones as a result of changes recently introduced by HSE for new planning applications), around hazardous sites based on the substances consent granted. LPAs are required to consult HSE (and others, including the Environment Agency or the Scottish Environment Agency (SEPA)) before future development takes place within consultation zones so that HSE can advise on appropriateness of a proposed development and minimise off-site risk to members of the public. LPA consultation is required by the Town and Country Planning (General Development Procedure) Order 1995 (as amended). Advice on planning applications is considered on a case-by-case basis.

19 The decision on whether the proposed development should go ahead is a matter for the LPA, not HSE. Where the LPA proposes to go against HSE’s advice that permission should be refused, it is required to give HSE an opportunity to ask the relevant minister in England or Wales to call-in the application. Called-in applications are very rare. In Scotland a decision to go against is automatically advised to ministers who may decide to review the application.

20 Land use planning around major hazard installations in Britain has its origins in the reports^(refs 19–21) of the Advisory Committee on Major Hazards (ACMH) which was set up following the explosion at Flixborough, the third report in particular. ACMH recognised the importance of providing planning authorities

with a source of safety advice prior to the establishment of new major hazard installations and, subsequently, on further development in the vicinity. Five years after the final ACMH report, HSE produced a separate document setting out its approach to land use planning.^(ref 9) Various reports had been produced about HSE's approach to giving land use planning advice as a result of an internal 'Fundamental Review of Land Use Planning'; however, the 1989 document remains the key published document covering the policy on giving land use planning advice.

Legal basis for HSE's involvement in land use planning around major hazard sites

21 Over the years, the legal basis for giving the advice has been set out in acts, regulations and departmental guidance. These include:

- ▼ the Notification of Installations Handling Hazardous Substances Regulations 1982;
- ▼ the Planning (Hazardous Substances) Act 1990;
- ▼ the Planning (Hazardous Substances) Regulations 1992;
- ▼ the Town and Country Planning (General Development Procedure) Order 1995;
- ▼ the Planning (Control of Major-Accident Hazards) Regulations 1999;
- ▼ *Planning Control for Hazardous Substances* DETR Circular 04/2000; and
- ▼ *Hazardous Substances Consent – A Guide for Industry* DETR Sept 2000.

22 The current position is that the establishment of a new hazardous installation requires Hazardous Substance Consent (HS Consent). HS Consent is a planning matter and the responsibility of planning authorities, most usually local authorities at district level or unitary authorities.

23 The planning legislation relating directly to hazardous substances prescribes the controls on hazardous substances, their quantity and location, and the physical state in which they are kept and used. However, planning controls on subsequent development near to COMAH sites is general in nature and focused on other aspects of controlling development. It can prove difficult to control those aspects of development which might be significant when located near to COMAH sites.

Procedure for formulating planning advice

24 HSE must be consulted about HS Consent for new sites in accordance with the Town and Country Planning (General Development Procedure) Order 1995 (the 1995 Order). Once a hazardous installation is established, HSE must be consulted about development proposals nearby, also in accordance with the 1995 Order.

25 At the time of the Buncefield incident the procedure for giving advice relied on the definition of three zones around the hazardous installation (conventionally named inner, middle and outer). The zones are derived from a risk assessment process applied to the installation as specified in the HS Consent. The risk assessment may lead to risk-based zones where the likelihood (frequency) of a particular level of harm is predicted from a representative set of hazardous events and zones are set according to different likelihoods. This system is usually referred

to as quantitative risk assessment (QRA). In other cases the risk assessment may lead to zones based on three hazard ranges (that is, to different levels of harm) predicted from one or more hazardous events from the representative set considered. This system implements a philosophy that was described by ACMH as the ‘protection concept’.

26 In either case, these zones are usually shown on a map of the area around the installation, which is produced by HSE and supplied to the planning authority (a three-zone map). All proposed developments that require consultation with HSE are allocated to one of four sensitivity levels, with 4 being the most sensitive and 1 the least sensitive. A ‘go/no go’ decision matrix is used to determine the advice according to the development sensitivity and the zone in which it is located.²⁴

27 Following a consultation exercise in 2007, HSE published its plans to extend the outer consultation distance at large-scale petrol storage sites in Britain to 400 m. In addition, a new inner development proximity zone of 150 m radius is to be incorporated within which HSE’s planning advice will be more restrictive. The revised interim policy will apply only to new planning applications and is intended to be introduced in the summer of 2008.

Annex 4

Planning history of Buncefield site and neighbouring developments

[Reproduced from Annex 3 of Initial Report]

1 Planning permission was granted in 1966 to Shell Mex and BP Limited, Regent Oil Co Limited, Mobil Oil Co Limited, and Petrofina (GB) Limited to develop 91 acres of land at Buncefield for the construction of a storage and distribution depot for petroleum products. St Albans Rural District Council initially refused the application on the grounds that it was an inappropriate development in the Green Belt and would have a detrimental effect on the amenity of the locality. On appeal, the Minister of Housing and Local Government granted permission subject to a number of conditions relating to design of the site, tree planting and restrictions on the size of office premises.

2 At the time that the terminal was built in 1968, the site was well screened by hedges and trees, but there were about nine dwellings on the periphery of the site to the north whose amenities were affected by the site, and a farm to the south. One of the nine dwellings to the north was converted in 2000 to create five separate properties. Since 1968 there has been general encroachment and development of adjacent land. This can be seen on the map in Figure 13. The majority of this building development took place during the period from the mid-1960s to the early 1980s, comprising the construction or redevelopment of residential properties and a number of schools and industrial premises to the west of the site, all of which fell within a 3 km radius as shown on the map. Between 1990 and 2006, a few additional industrial premises were built around the site.

3 Dacorum Borough Council is the principal planning authority for the site, but a small section to the north of Cherry Tree Lane falls to St Albans District Council.

4 The local planning authority decides whether developments can go ahead. But arrangements have existed since 1972 for local planning authorities to obtain consultee advice from HSE and its predecessors about the safety implications for developments from risks associated with major hazards. Between 1991 and 2005, 28 applications were passed to HSE for advice relating to a variety of commercial or residential developments around the Buncefield site. HSE advised against four of these proposals and advised that seven others could be allowed subject to certain conditions. As far as is known, the local authority followed HSE's advice in these cases.

5 In addition to these specific developments on which HSE was a statutory consultee, HSE is from time to time consulted on other matters. For example, HSE was consulted on four local structure plan revisions.

6 The complex began operations in 1968 after a pipeline was constructed to link two Shell refineries at Stanlow at Ellesmere Port in Cheshire and Shell Haven on the Thames Estuary at Stanford-le-Hope in Thurrock. The depot operated originally under licence given under the Petroleum (Consolidation) Acts 1928 and 1936. The Planning (Hazardous Substances) Act 1990 and subsequent statutory provisions, the Planning (Hazardous Substances) Regulations 1992 (PHS Regulations) and later the Planning (Control of Major Accident Hazards) Regulations 1999 introduced new procedures for consent to be sought from the hazardous substances authority to store hazardous substances.

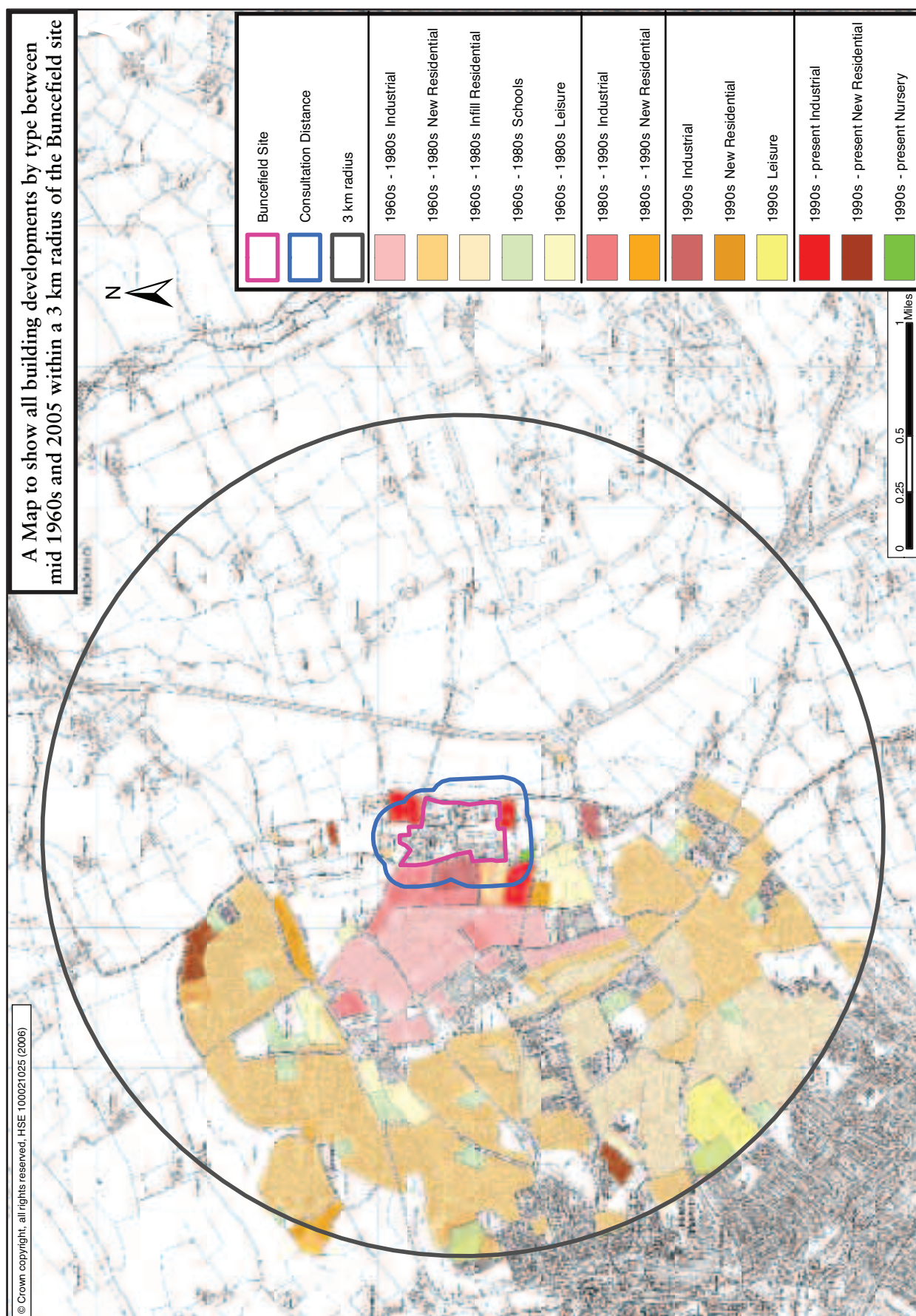


Figure 13 Developments within 3 km of the Buncefield site between 1966 and 2005

7 The consent identifies the hazardous substances and their location on site and defines certain conditions of use such as maximum size, temperature and pressure of storage vessels. Figure 16 contains some details of consents obtained for the Buncefield depot. The consents for Shell UK Oil Limited have been included in this table as they have not been revoked, although Shell no longer operates from this site.

HSE's role in land use planning

8 HSE's specific role in land use planning is twofold:

- ▼ Under the PHS Regulations, the presence of hazardous chemicals above specified threshold quantities requires consent from the local hazardous substances authority, which is usually also the local planning authority. HSE is a statutory consultee on all hazardous substances consent applications. Its role is to consider the hazards and risks which would be presented by the hazardous substance(s) to people in the vicinity, and on the basis of this to advise the hazardous substances authority whether or not consent should be granted. In advising on consent, HSE may specify conditions that should be imposed by the hazardous substances authority, over and above compliance with statutory health and safety requirements, to limit risks to the public (eg limiting which substances can be stored on site, or requiring tanker delivery rather than on-site storage). Hazardous substances authorities should notify HSE of the outcome of all applications for consent, and where consent has been granted should supply copies of the site plans and conditions.
- ▼ HSE uses the information contained in consent applications to establish a consultation distance around the installation. This usually comprises three zones or risk contour areas. The consultation distance is based on the maximum quantity of hazardous substance(s) that the site is entitled to have under its consent. HSE notifies the local planning authorities of all consultation distances in their areas. The General Development Procedure Order 1995 requires the local planning authority to consult HSE about certain proposed developments (essentially those that would result in an increase in population) within any consultation distance. HSE advises the local planning authority on the nature and severity of the risks presented by the installation to people in the surrounding area so that those risks are given due weight by the local planning authority when making its decision. Taking account of the risks, HSE will advise against the proposed development or simply note that it does not advise against it.

9 HSE's approach to land use planning is set out in more detail in Annex 2 of the first Progress Report.^(ref 22) Some of this process is now being devolved to certain local planning authorities.

10 The consultation distance represents the furthest distance at which HSE wishes to be consulted about developments near hazardous installations/major accident hazard pipelines. This does not mean that there is no risk beyond the consultation distance, just that the predicted risks are sufficiently low that they need not be part of a planning decision.

11 Within the consultation distance, HSE undertakes an assessment of the hazards and risks from the installation and produces a map with three contours representing defined levels of harm or risk which any individual at that contour would be subject to, based on information relating to the hazardous substances consent. The harm or risk to an individual is greater the closer to the installation.

The contours form three zones, with the outer contour defining the consultation distance around major hazard sites. The local authority consults HSE on relevant proposed developments within this consultation distance

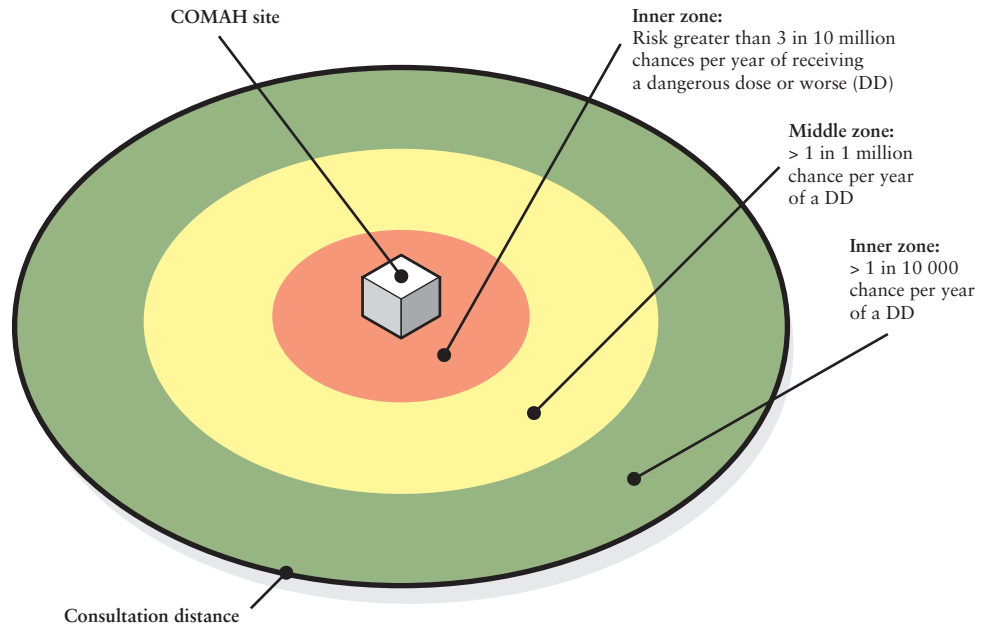


Figure 14 Consultation distance and zones

12 When a planning application is received, HSE or the local planning authority first identifies in which of the three zones the proposed development is located. Secondly, the proposed development is classified into one of four ‘sensitivity levels’. The main factors that determine these levels are the number of people at the development, their sensitivity (vulnerable populations such as children, old people) and the intensity of the development. With these two factors known, a simple decision matrix is used to give a clear ‘Advise Against’ or ‘Do not Advise Against’ response to the local planning authority, as shown in Figure 15:

Level of sensitivity	Development in inner zone	Development in middle zone	Development in outer zone
1	DAA	DAA	DAA
2	AA	DAA	DAA
3	AA	AA	DAA
4	AA	AA	AA
Sensitivity level 1	<i>Example</i>	Factories	
Sensitivity level 2	<i>Example</i>	Houses	
Sensitivity level 3	<i>Example</i>	Vulnerable members of society eg primary schools, old people’s homes	
Sensitivity level 4	<i>Example</i>	Football ground/large hospital	
DAA means Do not Advise Against the development			
AA means Advise Against the development			

Figure 15 Land use planning ‘sensitivity levels’ and decision matrix

13 More comprehensive guidance on the allocation of sensitivity levels is given on the Planning Advice for Developments near Hazardous Installations website (www.hse.gov.uk/landuseplanning/padhi.pdf).

History of the consultation distance around the Buncefield site

14 HSE has had arrangements with local planning authorities for consultation around developments in the vicinity of major hazards since the early 1970s, although it was not until the implementation of the Notification of Installations Handling Hazardous Substances Regulations 1982 (NIHHS Regulations) in 1983 that HSE first received notification from Shell Mex and BP of the terminal as a major hazard. A generic non-site-specific consultation distance of 250 m from the boundary of the site was set for consultation purposes and the relevant local planning authority was notified. At that time it was customary to issue a generic consultation distance without performing a site-specific assessment. This consultation distance was based upon the assumption that the main hazard was from thermal radiation following a major fire within the bund.

15 In 1992 the site expanded and Mobil and Shell sent another notification and application for consent to store certain amounts of flammable material. The existing consultation distance was maintained at a generic 250 m from the site boundary. There are no records of the technical assessments that were performed when the local planning authority sought advice on developments within the vicinity of the site, but early assessments were based then, as now, upon a pool fire following loss of containment of a substantial quantity of flammable liquid. However, for tanks that were banded there was a continuing assumption that any subsequent fire would be within the confines of the bund.

16 In 1996 a site-specific reassessment was performed based upon consented amounts of flammable material, and the consultation distance was reduced from 250 m to 190 m. The original 250 m was set in the early days of HSE giving land use planning advice, to ensure that all developments that might be advised against would be subject to consultation. By 1996, technical policy and methodology had been reviewed. In addition, three-zone maps were now being produced so that development control advice could be given more quickly and efficiently. The new policy assumed that the bund would not be able to contain the full contents of a tank following a sudden, catastrophic failure. It was assumed that the bund would be overtopped and the resulting pool fire would extend beyond the confines of the bund.

17 In July 2001 another consultation distance was calculated due to an extensive reassessment of the hazards from the site following the submission of a batch of new consent applications from the oil companies. The regulations requiring consent to store flammable substances were changed in 1999 to include additional flammable materials. The consultation distance was reduced from 190 m to 185 m. This was unchanged following a further consent application on 8 July 2005 from BP. The presence of the additional material did not alter the main basis of the calculation which assumed the worst-case event was the catastrophic failure of the largest tank containing gasoline. The consultation distance was reduced slightly owing to a slight change to the inputs in the model used to perform the calculations. See Figure 17 for a representative plan of the site showing the consultation distance since July 2001.

Some details of hazardous substances consents issued for the Buncefield oil storage and transfer depot

Operator	Hazardous Substances Consent applications
Texaco Limited	19 September 1983:* 10 571 tonnes motor spirit
Mobil Oil Co Limited	8 November 1983:* 17 650 tonnes petrol
Hertfordshire Oil Storage Limited	30 November 1992: 34 020 tonnes motor spirit 18 October 1999: 15 314 tonnes kerosene
BP Oil UK Limited	18 November 1992: 17 650 tonnes gasoline in name of Mobil Oil Co Limited 26 October 1999: 15 080 tonnes automotive petrol and other petroleum spirits 21 October 2003: 15 200 tonnes automotive petrol and 10 522 tonnes petroleum products classified as dangerous for the environment (most likely to be gasoline or diesel) 3 May 2005: 26 900 tonnes automotive petrol and 10 522 tonnes petroleum products classified as dangerous for the environment (most likely to be gasoline or diesel)
British Pipeline Agency Limited	26 October 1999: 70 000 tonnes automotive petrol and other petroleum spirits
Shell UK Oil Limited	19 September 1983:* 37 397 tonnes HFLs Class 4 and 42 561 tonnes kerosene and white oils 30 November 1992: 34 013 tonnes petroleum spirit and 39 000 tonnes diesel, gas oil and kerosene 1999: 33 000 tonnes motor spirit and 17 000 tonnes kerosene

Figure 16 Hazardous substances consents issued

** Note: The first applications for 'consent' were in 1992, before then different arrangements were in place, ie these were notifications under NIHHS and consent was not required.*



Figure 17 Plan representing the hazardous substances consents and consultation area around the Buncefield depot since July 2001 (for illustration only)

Annex 5

Hazard and risk and the application of QRA and ‘dangerous dose or worse’ to land use planning around major hazard sites

1 The study of risk uses a number of terms with specific meanings which can vary to a degree from common usage. This annex provides a simple explanation of their meanings in this context. The current definitive text on the subject is HSE’s *Risk criteria for land use planning in the vicinity of major industrial hazards* 1989.^(ref 9)

Hazard and risk

2 The word **hazard** means a situation with the potential to cause harm (injury or death) but does not imply whether the likelihood of the harm being realised is high or small. The adverse consequences to people arising from the loss of containment from a tank of pressurised toxic gas or a large tank of flammable liquid are examples. In contrast **risk** means the frequency or likelihood (probability) of a harmful event such as injury or death from a major hazard incident.

Residual risk

3 The COMAH Regulations require the site operator to take all measures necessary to prevent major accidents and limit their consequences to persons and the environment. These measures can reduce the risk of an event occurring with off-site consequences but cannot entirely eliminate it. The irreducible minimum level of risk, having taken all necessary control measures, is known as residual risk. Land use planning decisions need to take residual risk into account. The intention is to control significant developments near to major hazard sites to avoid undesirable increases in the numbers of people exposed to the residual risk from the site.

Individual risk

4 This risk relates to the likelihood that a particular person might be harmed. Such a person may be a named individual with known habits, or a typical inhabitant of a house or a typical user of a leisure facility at a specified location. To provide general application, typical cases are the ones of interest, though this needs to be done with some care because of the wide variations in people’s habits and vulnerability to harm.

5 Individual risk is expressed as the probability of a typical user of the development under consideration (eg a house, block of flats, factory, office, care home or sports facility) being harmed in the course of a year from the major hazard site.

Societal risk

6 Societal risk is a measure of the likelihood of a large-scale incident involving mass casualties, which depends upon integrating the risk of a major incident occurring with the number of people living or working in the vicinity of the site who could be exposed and suffer death or major injuries. The derivation of the

societal risk estimates requires, in addition to data on the integrity of the plant for deriving individual risk, an up to date knowledge of the size and distribution of the working and residential population around the site under review. Quantitative risk assessment is required to derive estimates of societal risk.

7 Societal risk is expressed as the relationship between frequency and the number of people sustaining a specified level of harm in a given population due to the realisation of specified hazards.

8 Societal concern is an expression of the public aversion to large-scale incidents. For example a rail accident with multiple fatalities will command huge public attention and calls for preventive action whereas most fatal car accidents attract little notice even though they are responsible for more deaths each year than rail travel. The Flixborough and the Piper Alpha disasters (between them resulting in 195 deaths) resulted in global interest – both incidents resulted in a loss of public confidence in the regulatory system and in the industrial sectors.

9 Societal risk can be subdivided in a number of ways. For example:

- ▼ national societal risk: the risk to the nation as a whole due to a particular type of activity, eg nuclear power generation or production of dangerous pathogens;
- ▼ local societal risk: the risk to a localised population from a particular type of activity, eg the risk of harm to the population of Canvey Island from the various petrochemical installations in the area; and
- ▼ case societal risk: the risk at a particular location or from a particular activity, eg people using a retail development in the vicinity of a hazardous installation.

10 In the context of land use planning at a major hazard site, societal risk is the likelihood of a disaster involving the off-site population in the vicinity of the site. For example an investigation was carried out into a proposal for additional petrochemical installations in the Canvey/Thurrock area (see Figures 1 and 6 in the main report) where there were existing sites of major accident potential. Each additional installation would have generated a ‘case societal risk’ but the overriding concern was with the cumulative risk to the local population from all the installations, existing and proposed, in that area, ie the extent of the ‘local societal risk’.

11 The concept of societal risk is more difficult to express in terms of numbers than individual risk. There will be a range of events that can be postulated. These will be of different magnitudes, with different probabilities of occurrence, and different degrees of harm arising from them. Generally speaking in the UK, the more severe the event the less its likelihood but the greater its potential consequences in terms of human harm and environmental impact. Therefore societal risk is often expressed as a line on a graph which plots the relationship between the likelihood of an event and its estimated consequences in terms of the number of fatalities. Such lines, or curves, are called FN curves. The shape of this curve depends on how the population is distributed around the site, and is therefore very site specific. Obviously, the distribution of the population around a site changes as new developments take place, whereas the individual risk will not change if hazardous operations and their control measures on the site do not change. Therefore the societal risk around a site can change when the individual risk does not.

12 Measures of societal risk have been developed based on integrating the area under the FN curve. However, this simple ‘risk integral’ does not allow for distinguishing between one accident causing 100 fatalities and 100 accidents each

causing one fatality over the same time period. Therefore weighted risk integrals have been developed to account for society's aversion to multiple fatality events. FN criterion lines have also been drawn as standards for comparison. The calculated risk integral for a specific situation is then capable of comparison against the same integral calculated for a criterion FN curve.

QRA applications of relevance to land use planning around major hazard sites

13 The full scope quantified risk assessment (QRA) and the production and interpretation of FN curves²⁵ is the accepted best means for studying societal risk, but it is relatively costly, time-consuming and requires a high level of technical capability. Screening can be undertaken to determine at which sites the full scope technique is required because of increased concerns for societal risk, or where a more approximate (and therefore quicker and cheaper) means may be appropriate.

14 The fundamental principle of management of health and safety at work is the ALARP²⁶ principle. To demonstrate risks are ALARP site operators have to undertake a risk assessment, the depth of analysis of which should be proportionate to the major hazard risks taking account of the nature of the site operations and the size of the exposed off-site population. Where the risks relate to major hazards and the potential for killing or harming a number of people or creating a major accident to the environment, some form of QRA will be required. Even where the protection concept is currently used at flammable storage sites, QRA is deployed to determine the most significant individual risks arising from a site against which to assign consultation distances for land use planning purposes.

15 To integrate societal risk into land use planning around major hazard facilities, site-specific QRA will be needed. The key principles that illustrate the requirement for QRA are as follows:

Setting priorities and comparing risk values when adopting best practice or state-of-the-art technology at COMAH sites

See *A guide to the Control of Major Hazards Regulations 1999 (as amended). Guidance on Regulations*^(ref 15)

16 This is of particular relevance at fuel storage sites following the Buncefield incident to ensure the highest integrity of containment measures to prevent the escape of fuel from storage tanks. A single model QRA would be applicable to a range of similar sites. Given the relatively uncomplicated nature of such sites compared to say a large refinery or a nuclear energy installation, the suitable methodology would be relatively straightforward.

Estimating the percentage contribution to individual and societal risk of single large buildings and proposed developments around the site, showing how the method is capable of measuring the impact on societal risk of incremental development

See Annex 10 to this report

²⁵ FN curves: see paragraph 113 and its footnote in the main report, and Annex 10 in general.

²⁶ ALARP = as low as reasonably practicable. Risks are deemed ALARP where there is gross disproportion between the costs to the dutyholder of doing more, against the benefit gained (in terms of risk reduction) in doing it.

17 Prior to the Buncefield incident, the design event chosen for deriving the consultation distances using the protection-based system was a tank failure and pool fire, but post-Buncefield the unintentional release of fuel and the formation of a vapour cloud that can flow off site may lead to either a flash fire or a large explosion and both scenarios need to be included in risk assessment. What the QRA incorporating the three hazard types (pool fire, flash fire and vapour cloud explosion) would look like is shown in the example we commissioned in Annex 10. Individual risks of fatality at specific locations can be calculated along with the percentage of the individual risk due to tank events, as compared to overfill events and failure of feed pipelines.

Setting the interim consultation distance based on best practice in design and operations of an installation until the causes of the explosion at Buncefield are better understood

See *Recommendations on the design and operation of fuel storage sites*^(ref 4) and HSE press release *HSE publishes land use planning consultation outcome* EO46.07 4 December 2007

18 HSE's interim solution to land use planning around fuel storage depots was to extend the consultation distances to the area of damage observed in the Buncefield explosion, with the proviso that it should remain in force until research provides more information on the mechanism of the vapour cloud explosion which took place at Buncefield. A precautionary approach can be justified when the level of uncertainty is high, but can be very restrictive on future economic development around sites, particularly, for example, where the means of preventing the initiating event (such as a petrol tank overfill) can be improved.

Providing a structured, objective and quantified approach to meeting ALARP can contribute to understanding the hazards and the measures needed to control them

See *A guide to the Control of Major Hazards Regulations 1999 (as amended)*. *Guidance on Regulations* and *The Public Inquiry into the Piper Alpha Disaster*^(ref 10)

19 Good practice applies 'defence in depth' by adopting accepted engineering principles, along with good operating and maintenance practices. Meeting these measures or going beyond them in seeking to further reduce individual and societal risk under the ALARP criterion can be demonstrated using QRA.

Annex 6

Development of risk criteria for use in land use planning

1 As early as 1967 Her Majesty's Factory Inspectorate (HMFI), one of the forerunner regulators to HSE, first drew attention to the disaster potential of major chemical installations. In time this led to the then Department of Environment issuing a circular (DOE 1/72) requiring planning authorities to consult HMFI on proposals to develop land in the vicinity of major hazard installations.

Flixborough

2 In 1974 a large amount of vapour escaped from one of the plants at the Flixborough chemical works, leading to a large unconfined vapour cloud explosion which killed 28 workers and caused considerable devastation on site. It also raised concerns about off-site consequences, though no members of the public were killed.

3 In response, the newly established Health and Safety Commission (HSC) set up the Advisory Committee on Major Hazards (ACMH). Its remit was to make recommendations for improving the understanding of accidents arising from major hazard sites, preventing such accidents occurring and mitigating their consequences where they did happen. In its three reports in 1976, 1979 and 1982,^(refs 19–21) ACMH made a number of statements which were seminal in influencing HSE's approach to land use planning. For example it endorsed the consultation arrangements provided for under circular DOE 1/72 as being essential for preventing incompatible land uses. HSE, it said, had both the information and expertise needed to formulate advice on the safety implications of major hazard installations.

Canvey Island studies – 1978 and 1981 reports^(ref 23)

4 Arising from a public inquiry to consider revoking planning permission, HSE was asked to carry out a study of the risks to people living in and around Canvey Island from the existing oil refinery in the area and a proposed additional one. The reports identified both the individual and societal risks to the public arising from ten major hazard installations. Following substantial public and Parliamentary debate, a societal risk value of 500 deaths at a frequency of 1 in 5000 years was accepted at that time as just tolerable and that the somewhat higher risk prior to safety improvements was not.

Piper Alpha Inquiry 1988–1990^(ref 10)

5 The explosion and fire on the Piper Alpha oil production platform in the North Sea in 1988 caused the deaths of 165 platform workers and two rescuers. It led to a major inquiry conducted by Lord Cullen. This provided confirmation that the major events predicted by risk analyses were indeed realistic and that QRA could be a useful tool in trying to reduce the risks. The inquiry report in 1990 recommended a much more modern system of safety regulation for the offshore industry and this led to new regulations which explicitly required the use of QRA.

Study of major hazard aspects of transport of dangerous substances and ports 1991^(ref 24)

6 This study by HSC's Advisory Committee on Dangerous Substances (ACDS), which took five years, examined those substances and transport aspects, including ports, most likely to give rise to significant risks. Societal risk criteria were used as one test of the tolerability of risk at some of the fixed sites (ports, parking areas, marshalling yards). The study endorsed the above Canvey post-improvement criteria, developed an approach for their use in decision making, and reported that not only did this reflect UK and worldwide experience of events involving major installations, but also society's decreasing willingness to tolerate increasing numbers of fatalities. However, it was noted that a community which derived significant economic benefit from the hazardous activity may well be more tolerant.

HSE publication *Reducing risks, protecting people* (R2P2), 1999 and 2001^(ref 13)

7 In response to the Sizewell B inquiry, HSE published in 1988 (with an update in 1992) reports on the *Tolerability of risk from nuclear power stations*.^(ref 11) These not only formulated and published guidelines on the tolerable levels of individual and societal risk to workers and the public, but outlined how they might be applied to inform regulatory judgements.

8 *Reducing risks, protecting people* articulated how statutory bodies responsible for administration of the Health and Safety at Work etc Act 1974 approached decisions about the management of risk. Following public consultation, R2P2 set down the criterion it had adopted for addressing societal concerns where there is a risk of multiple fatalities occurring from a single event at a major hazard installation. The criterion was that the risk of an accident causing the death of 50 people or more in a single event should be regarded as intolerable if the frequency is estimated to be more than 1 in 5000 years. This value was derived for a single installation using the levels of risk that society was prepared to tolerate at the multi-site industrial complex at Canvey Island and taking account of technological improvements since the Canvey study.

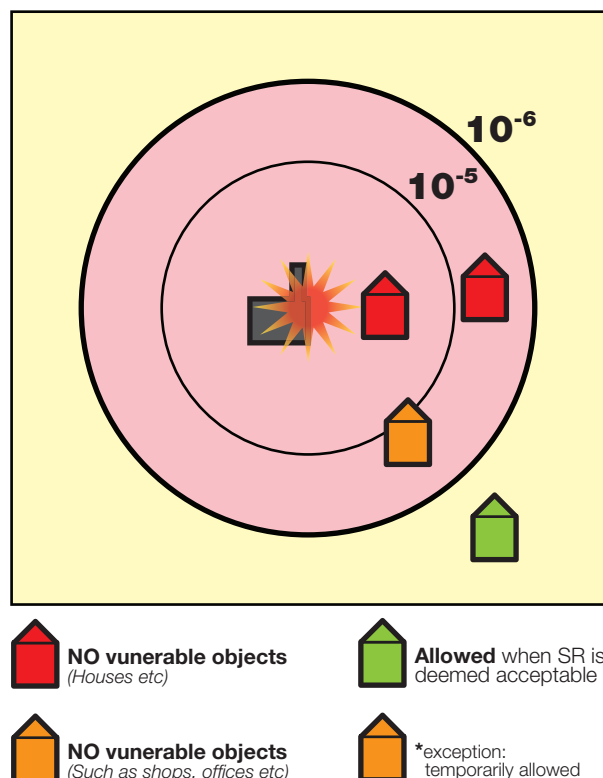
Annex 7

The Dutch land use planning system

Summary of Dutch approach

- 1 The Dutch currently get site operating companies to prepare a QRA showing individual risk (location-specific risk) and societal risk. The inputs, such as failure frequencies, are set down in a common reference book. Some of these failure frequencies are reached by agreement between the various authorities.
- 2 Because of disagreement among experts, the Dutch have recently insisted that everyone uses the same computational methodology, which includes built-in methodologies such as dispersion codes. The Det Norske Veritas (DNV) code 'SAFETI' is used (called SAFETI-NL).
- 3 Once contours and FN curves are produced, they are compared against criteria. For individual risk, strict limits are applied to developments within the 10^{-5} and 10^{-6} contours. These are mandatory with time limits for implementation established by a decree operational from 1 November 2004. The decree imposes limit values for the location-based individual risk for vulnerable objects (red icons) and target values for 'less vulnerable' objects (orange icons). Vulnerable objects are residential properties and equivalent premises, such as schools and hospitals, less vulnerable objects are, for example, small offices and working places, playing fields etc. Compliance with the limit value of 10^{-5} per annum for the location-based risk must be reached within three years from the decree being operational and compliance with the limit value of 10^{-6} per annum for the location-based risk must be reached by 1 January 2010 for all vulnerable objects in the vicinity of establishments subject to the decree.

Figure 18 Risk criteria for new situations



4 From 2005 any 'vulnerable objects' – (red icon: houses, schools etc) will not be allowed within the 10^{-5} zone, then from 2010 none will be allowed within the 10^{-6} zone. The limit values are not so strict for 'less vulnerable objects' such as offices. They are targets but may be temporarily allowed. The orange icon represents these as targets, but may also be temporarily allowed.

5 For societal risk there is a criterion line, which had a slope of -2 and was a strict limit reflecting a large aversion to major accidents. The policy was that no part of the FN curve could cross it, but this caused problems so the limit was changed to an orientation line. Various parties (local authorities, public, fire brigades etc) now have to get together to agree development plans. The limit is there to inform any discussion; if it is exceeded then the reasons have to be recorded and justified.

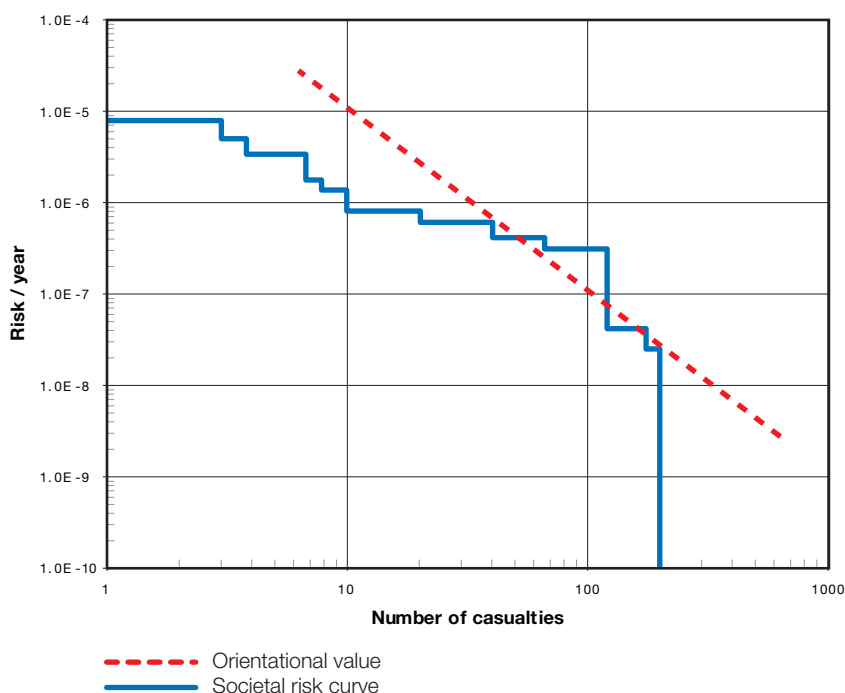


Figure 19 Societal risk plot (FN curve format) for determining maximum allowable population at risk from a major hazard incident on the site (see paragraph 113 in the main report and Annex 10 for further information on FN curves)

6 To help the various parties understand the implications of any change in societal risk, new methodologies have been developed which show the changes to societal risk on a colour coded map.

7 The concept of societal risk and associated criteria were found to be difficult to understand for many people and difficult to implement by the authorities. This was because societal risk is not a single figure that can be displayed as a contour on a map. At the request of the Dutch Government, consultants have developed a concept for an area-specific approach to societal risk. This approach considers the risks not from the perspective of the source causing the risk, but from those who are at risk. This area-specific approach shows societal risk displayed by coloured areas on maps. Orange indicates an area where societal risk is already high so development is limited, green means there is some room for more urban development and so on.

8 For further information, see *Area Specific Societal risk, societal risk on the map*,^(ref 25) a paper by TNO (the Netherlands Organisation for Applied Scientific Research), which gives an account of the 'traffic light' approach with examples of colour-coded maps.

Annex 8

Harm criteria used in risk assessment

1 One of the key elements in conducting a risk assessment is setting the criterion for the harm that an event can cause. The seriousness of different potential events that can arise from major hazards can only be compared if there is a consistent criterion for the harm level, which is applicable across different types of hazard, especially 'toxics' and 'flammables'. This annex explains the two main harm criteria used.

Risk of fatality

2 This criterion relates to the probability of an individual receiving fatal injury. It is widely used and allows relatively consistent comparison of risks within and between sites, nationally and internationally. It does not accommodate serious injury, nonetheless many everyday risks are expressed in these terms. For instance, the road safety reports, and accident prevention initiatives, are based on annual fatality statistics. However, this criterion still needs to be used with care since there are different definitions, depending on whether the level of hazardous material presents, for example, a 1% or 50% risk of fatality.

Dangerous dose

2 HSE uses dangerous dose as its main harm criterion. This dose is defined as the level of toxic gas, or heat, or explosion over-pressure which gives all the following effects:²⁷

- ▼ severe distress to almost everyone;
- ▼ a substantial fraction requiring medical attention;
- ▼ some people seriously injured, requiring prolonged treatment; and
- ▼ death in highly susceptible individuals.

3 The risk assessed in this way is the probability over the following year of an individual at a particular location being exposed to a dangerous dose or worse, depending upon the distance from source of the exposure.

4 Originally HSE advised on the basis of a concept of 'protection' of those exposed to a hazard so that the separation distance between development and hazard provided a high degree of protection against the more likely smaller events, while giving worthwhile protection against unlikely but foreseeable larger scale events. To apply the concept in practice required the identification of the worst events (of fire, explosion or toxic release) and then determination of a separation distance based on exposure to a defined level of harm, namely the dangerous dose.

²⁷ Note that damage to buildings is not taken into account except where such damage may cause harm to people. This approach does not account for damage to the environment.

5 Later HSE changed to advising LPAs on the basis of risk for some types of hazard. In these cases the risk was the probability per year of an individual at a particular location being exposed to a dangerous dose or worse. Based upon information supplied by the LPA, HSE produces a three-zone map, the outer boundaries of which represent either defined levels of risk or specified consequences from the identified event. This is further illustrated in Annex 4.

6 The choice of the dangerous dose criterion is to accommodate risks of serious injury as well as death and because there are technical difficulties in calculating risks of death from a hazard to which individual members of a population may have widely differing vulnerabilities. However, contained within the concept of 'dangerous dose or worse' is a range of outcomes with some types of event being more biased towards causing fatalities. Thus two different events assessed as having similar consequences in terms of dangerous dose may in fact cause very different results in terms of the number of fatalities. In practice, the use of dangerous dose makes it difficult to compare risks within sites between different types of hazard (toxics and flammables), and between sites.

7 The following is an extract from risk criteria document 1989,^(ref 9) explaining the provenance of the concept of dangerous dose or worse at that time. This extract puts into context the value of adopting dangerous dose or worse, although many of the considerations favouring this approach have been overcome.

Dangerous dose or worse

'48 It has often been assumed that risk criteria for major hazards should relate to the likelihood of death. This seems straightforward and easy to compare with risks from other hazards in life. However there are two important problems with a criterion based on the risk of death in the present context:

- (a) society is concerned about risks of serious injury or other damage as well as death;*
- (b) there are technical difficulties in calculating the risks of death from a hazard to which individual members of a population may have widely differing vulnerabilities.*

49 The second point may be appreciated by considering an example, such as the toxic gas chlorine. If a cross-section of the population were exposed to a dangerous cloud of chlorine, some people would be more seriously affected than others, and a proportion might die. Those who died could have had some pre-existing condition or weakness which made them more vulnerable, but there might also have been people who had simply been exposed to high-concentration pockets of gas in the cloud. It is not possible to identify in advance who these people would be, nor is it possible to predict a particular person's susceptibility to chlorine. Thus it is not possible to say with certainty what is the probability of a particular person being killed by a particular exposure to chlorine. This implies that it is not possible to calculate an individual risk of death for a particular person. However, there are techniques (eg probit transformations) which permit the calculation of proportions of populations affected by a given level of harm; these are also subject to uncertainties.

50 It is of course possible to take "average" or "typical" susceptibility and average concentration, and to use these to produce "average" individual risks. This "average" might conceal a very wide range of risks to particular people, and it is not clear whether it has any real meaning.

51 *One approach to this sort of problem is to consider the case of the particular individual who is most at risk. This would give an indication of the maximum likely level of individual risk in situations where there is a variation about the average. The approach is questionable for the present purpose as there may be no obvious limit to susceptibility; people with severe breathing problems may be extremely sensitive. Thus it is not possible to draw the line and define the “worst case” individual.*

52 *It is possible to avoid some of these problems by using an injury criterion other than death. For example, it is possible to define a dose of toxic gas, or heat, or explosion overpressure which gives all the following effects: severe distress to almost everyone; a substantial fraction requires medical attention; some people are seriously injured, requiring prolonged treatment; any highly susceptible people might be killed. This might be described as a ‘dangerous’ dose, as it has the potential to cause death but it will not necessarily do so. Then the risk assessed is that an individual at a particular place will be exposed to such a dangerous dose or worse. The results of such an assessment may be described as:*

“The risk that a typical user of the development will be exposed to a dangerous dose or worse of toxic gas, heat or explosion overpressure”.

Annex 9

HSE's fundamental review of its role in land use planning

1 In 1998 HSE initiated a fundamental review which scrutinised its role in, and approach to land use planning. The review was wide ranging and covered issues such as:

- ▼ the criteria and methodology used for setting planning zones and for 'calling in' planning applications;
- ▼ codification so that HSE can provide transparent and accurate advice without detailed individual assessment of planning applications;
- ▼ devolving the codified advice so that local planning authorities (LPAs) can deal with the vast majority of planning applications themselves and developing a communication strategy to ensure buy-in to this devolution;
- ▼ reconsidering what to assess under the Consents legislation; and
- ▼ positioning HSE to influence any European developments.

2 The fundamental review reported back with a range of recommendations in 2001, and was followed up in 2002 by initiation of an implementation project. The Project Initiation Document identifies the following recommendations as within scope:

- ▼ the criteria and methodology used for setting planning zones and for 'calling in' planning applications should be reviewed and, if necessary, revised and then published;
- ▼ HSE's advice to LPAs on chemical major hazards and pipelines should be further codified so that transparent and accurate advice can be given without detailed individual assessment of planning applications;
- ▼ the codified generic advice should be devolved to LPAs so that they can deal with the vast majority of planning applications which are in the vicinity of chemical major hazards and pipelines.

3 Additionally, it was considered that the project:

- ▼ should consider the respective roles of COMAH and legislation relating to land use planning in ensuring that risks (both societal and individual) to members of the public are appropriately controlled and if necessary, develop policy and guidance;
- ▼ should reopen the debate on what to assess under the Consents legislation;
- ▼ should contribute to the work of European Commission Technical Group 5, re-established following the Toulouse ammonium nitrate explosion, so that HSE can be in a position to influence any European developments;
- ▼ should develop and implement a communication and engagement strategy to ensure optimum buy in by LPAs and other key stakeholders to the devolution proposals.

4 One product of this is devolution of a decision-making tool to LPAs – Planning Advice for Developments near Hazardous Installations (PADHI), which uses individual risk as the criterion. During 2006 and 2007, HSE gave all planning authorities in England, Scotland and Wales online access to PADHI+, which comprises a consultation zone library for all hazardous installations and pipelines together with a PADHI+ advice generator. The computer code in PADHI+ generates a decision to not advise against (DAA) or advise against (AA) based on HSE’s experience of giving advice to LPAs. The decision matrix based on the ‘sensitivity level’ of the development is shown in paragraph 12 of Annex 4.

5 Another consequence of the implementation project was for HSE to commission two independent reviews, both of which reported in 2004. These were:

- ▼ review of HSE’s risk analysis and protection-based analysis approaches for land use planning; and
- ▼ HSE land use planning models and methodologies review.

6 However, during the implementation of PADHI+, HSE began work with a cross-government task force exploring future policy on societal risk. The feasibility of delivering all the recommendations of the fundamental review was reconsidered in terms of interaction with societal risk policy. As a result a number of the recommendations of the fundamental review have yet to be implemented.

See www.hse.gov.uk/landuseplanning for more information.

Annex 10

Summary of work commissioned of DNV by MIIB to develop an illustrative risk based approach to land use planning around flammable storage sites

Introduction from the Buncefield Board (MIIB)

1 Det Norske Veritas (DNV) was commissioned to provide an independent illustration of what a risk-based model for land use planning at flammable storage sites might look like. We present a summarised version of their report below.

2 The work carried out by DNV shows how risks from a large petroleum facility can be estimated in the form of individual and societal risk and illustrates the advantages of adopting QRA in a new land use planning system in Britain. It demonstrates clear advantages in land use planning over the protection concept in use at the time of the Buncefield incident, but the events included here of vapour cloud formation, flash fire and explosion were not recognised hazards before the incident.

3 The assumptions and methodologies used in this report were the decision of DNV and have not been approved by the Buncefield Board or its advisors, nor subjected to external peer review. The frequency data used in computing the frequency curves in Figures 20–24 are based on internationally available data. The relevant sources of data for those figures are Lastfire, and Purple Book, and references are provided as footnotes to the text.

Summary report

Background to the report

4 At the time of the Buncefield incident neither the regulator nor the industry considered a large flammable cloud explosion to be a reasonably foreseeable event that needed to be taken into account in the design and operation of flammable storage sites, and in the emergency preparations and response planning at such sites. Since Buncefield the reliance on a protection-based approach to land use planning around flammable storage sites has been questioned. The Buncefield Major Incident Investigation Board (MIIB) that was appointed by Government to oversee the incident investigation has responded to two consultation documents issued by the Health and Safety Executive on land use planning (CD211) and on societal risk (CD212).

5 In its response to CD211 MIIB indicated that (a) advice on land use planning should be based more on a consideration of risk, (b) more attention should be paid to the population at risk and (c) it considered that land use planning should be responsive to the levels of risk presented by each particular site. In its response to CD212 it gave a view that land use planning and societal risk are inextricably linked. The MIIB commissioned Det Norske Veritas (DNV) to carry out an independent preliminary risk analysis using the Buncefield site as it was prior to the explosion to illustrate the QRA method and its uses by incorporating the now-recognised full range of hazards fuel storage sites may present.

Scope of and approach to the report

6 The scope of work defined by MIIB was as follows:

- ▼ provide an independent view on what a risk-based approach to land use planning in the vicinity of large petroleum storage facilities might involve and show how this might

be achieved in practical terms. This would include consideration of risk-based options in place elsewhere, particularly in Europe, including their perceived limitations. It would take into account HSE published material, and previous reports of MIIB and the hierarchy of control of major hazard risks;

- ▼ establish the nature of data that need to be determined or assigned in order to produce a risk-based model, and their source;
- ▼ show whether such a model can incorporate inherent risk reduction measures as called for in MIIB reports;
- ▼ show to what extent such a model could be used to determine societal risk and therefore provide an input into any decision making process.

7 DNV's approach to this work was as follows:

- ▼ develop a methodology that could be applied to a site similar to the Buncefield site that would enable a quantified risk analysis (QRA) to be carried out which would give predictions for both individual and societal risk, identifying the major uncertainties in the analysis;
- ▼ apply the methodology used for risk assessment/development control in the Netherlands to the same site;
- ▼ review the predictions and consider whether a methodology based on risk rather than a mixture of risk and hazard could be used in the UK for future land use policy around major hazard site.

Methodology and assumptions

8 The methodology used followed the classical approach to process QRA. Generally DNV considered the assumptions made to be reasonable, neither overly conservative nor optimistic so that the analysis gives a realistic estimate of the risk, although it is recognised that the error band will be quite wide, and this would need to be taken into consideration should the predictions be used for decision making. The system that was analysed comprised the west part of the Buncefield site, including the tanks in the vicinity of Tank 912 which was the source of leakage, the bunds, the feed pipelines and the export pipelines.

9 The hazard types analysed were:

- ▼ pool fires;
- ▼ flash fires;
- ▼ vapour cloud explosions.

10 Extrapolation from conventional dispersion codes was used to determine cloud sizes in low wind speed conditions to replicate the vapour/aerosol cloud that was produced at Buncefield (as the task was beyond the scope of CFD²⁸ was beyond the scope). Pool fires were modelled using a solid flame technique. Vapour cloud

²⁸ Computational fluid dynamics (CFD) is a method that enables the study of the dynamics of things that flow. CFD is the numerical approximation to the solution of mathematical models of fluid flow and heat transfer. Computational fluid dynamics is one of the tools (in addition to experimental and theoretical methods) available to solve fluid-dynamic problems.

explosion modelling was based on the observed effects of the Buncefield explosion (RR511),^(ref 26) by deriving decay curves from an assumed cylindrical cloud. A number of decay curves were used to represent the range of effects seen at Buncefield and larger and smaller clouds than ignited at Buncefield. The curves were derived for use in the Multi Energy framework, assuming a maximum overpressure of 350 mbar. Flash fires were represented by the same cloud that was used for the explosion predictions. The effect of the hazards on people in different building types was based on available vulnerabilities.

11 Frequency analysis used generic data from both HSE and Purple Book^(ref 27) sources. The overfill frequencies were derived from data provided either by MIIB (termed MOC data) or by the Lastfire Group²⁹ (again via MIIB). Ignition probabilities were assigned based on an assumption that delayed ignition increases with cloud size and cloud duration. Explosion probabilities were also assigned and assumed increasing probability with cloud size.

12 A number of different analyses were carried out with the following assumptions:

- ▼ the overfill frequency was as per the MOC data, with tank failure data as per HSE;
- ▼ the overfill frequency was as per the Lastfire Group data, with tank failure data as per HSE;
- ▼ the overfill frequency was as per the Lastfire Group data, with tank failure data as per the Purple Book;
- ▼ the overfill frequency was as per the Lastfire Group data, with tank failure data as per the Purple Book with mitigation measures to ensure that the release duration did not exceed 600 seconds.

13 In the DNV analysis Northgate was the main contributor to societal risk in the area. A small sensitivity analysis was carried out to examine the effects on the overall or area societal risk³⁰ at Buncefield of moving the Northgate building 100 m and 200 m further away from the installation.

14 The predictions were given in terms of:

- ▼ hazard frequency and individual risk contour plots;
- ▼ individual risk at specified locations;
- ▼ societal risk.

15 The method of analysis used in the Netherlands for land use planning was also applied to the same site.

²⁹ Lastfire (Large Atmospheric Storage Tank Fires) is a consortium of international oil companies engaging in projects reviewing the risks associated with fires in storage tanks and developing suitable industry practise to mitigate the risks
www.resprotint.co.uk/lastfire.htm.

³⁰ Otherwise known as local societal risk – see Annex 5 for an explanations of national, local, and case area risk.

Results

16 The preliminary analyses using methods adopted for this project show where most of the potential risk lies and where control measures need to be focused:

- ▼ only the overfill events, the failure of the feed pipelines and the tank failures gave cloud formation rates that were sufficient to give a vapour cloud above the assumed threshold explosion volume (ie the other scenarios gave only flash fires and pool fires);
- ▼ the contribution to the offsite risk from explosions following the failure of the feed pipelines was insignificant compared with the overfill and tank events;
- ▼ the pool fires do not give levels that are considered to give fatal injuries at any of the buildings.

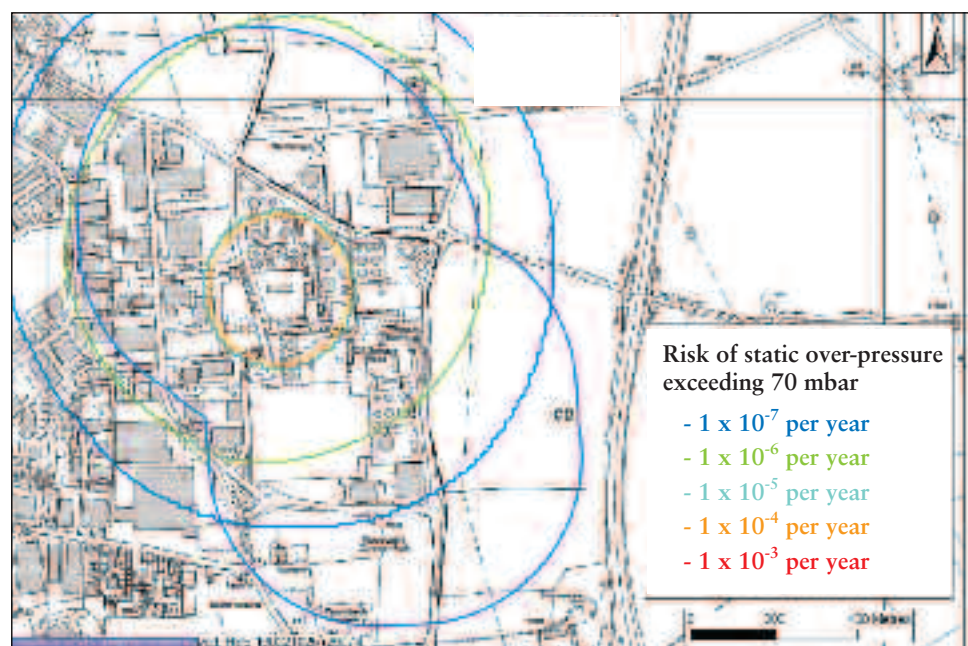
17 The explosions included in the analysis have the potential to cause significant knock on or 'domino' effects (failure of adjacent tanks and subsequent ignition of released liquids, as occurred during the incident). The effects of these secondary events were not included in the risks presented.

18 Examples of the outputs are shown below. The blue line marked CD on the plots is the consultation distance assigned by HSE for the Buncefield site following the implementation of Option 4 (CD211). The other contours show plots of the frequency of the overpressure generated should an explosion occur. The contours join up those points where the frequencies are the same.

19 Figure 20 shows the plots of where the frequency of an over-pressure exceeds the dangerous dose (in this case 70 mbar). The dangerous dose here represents that dose which would cause a few per cent deaths in a vulnerable population. Figure 21 shows similar plots, but where the frequency of an overpressure exceeds 140 mbar. This is the dangerous dose HSE uses for a normal population.

20 The frequencies are 1 chance in 10 million per year (1×10^{-7} /year) for the outer contours (dark blue), 1 chance in a million per year (1×10^{-6} /year) for the next one further in (green), 1 in 100 000 (pale blue), 1 in 10 000 (orange) and 1 chance in 1000 per year (red).

Figure 20 Frequency of over-pressure exceeding 70 mbar (HSE dangerous dose for vulnerable population)



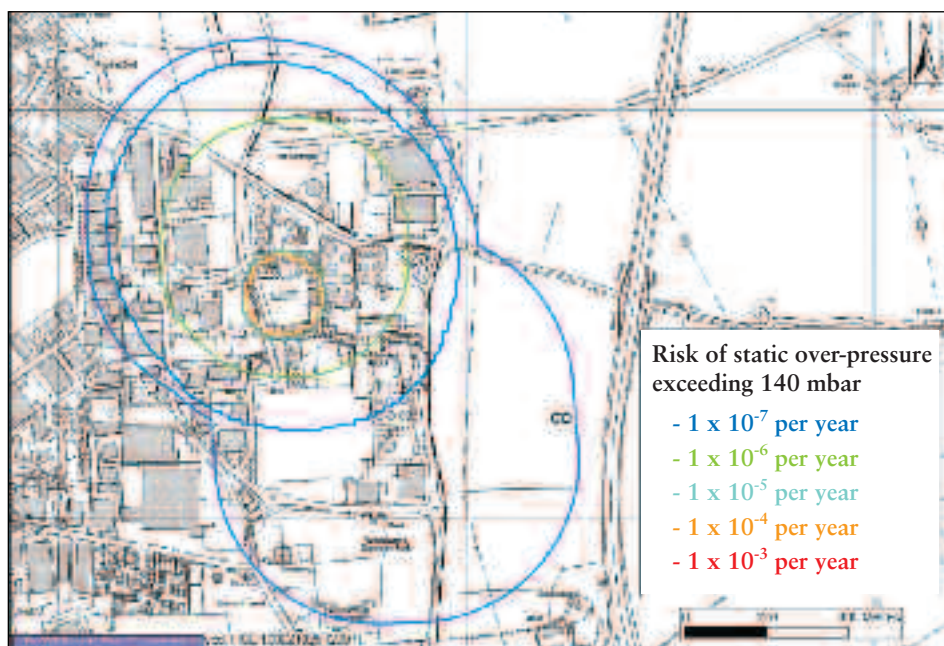


Figure 21 Frequency of over-pressure exceeding 140 mbar (HSE dangerous dose for a normal population)

21 These frequency plots could be used to delineate zones for land use planning purposes using the 1 in 100 000, 1 in a million and 1 in 10 million risk of dangerous dose or worse contours for a normal population. It can be seen that using the assumptions used in the calculations in this report this would lead to a smaller consultation distance. It might therefore be possible to utilise some of these frequency plots for land use planning purposes bearing in mind that these contours are for explosions only, but it would be advantageous and less confusing to use risk of death from all events rather than just the risk of over-pressure.

22 The contours in Figure 22 show risk of fatality gives rise to a 1 chance in 10 million per year of death that is comparable with the existing consultation distance. These are location specific risk contours. They are for people in typical brick buildings occupied for 365 days per year being affected by the process hazards on the site. They show the risks to people in the vicinity of the installation from the various hazardous events that might occur from loss of containment of the petrol. It is easier to compare the risks in these terms with other risks such as



Figure 22 Individual risk of fatality

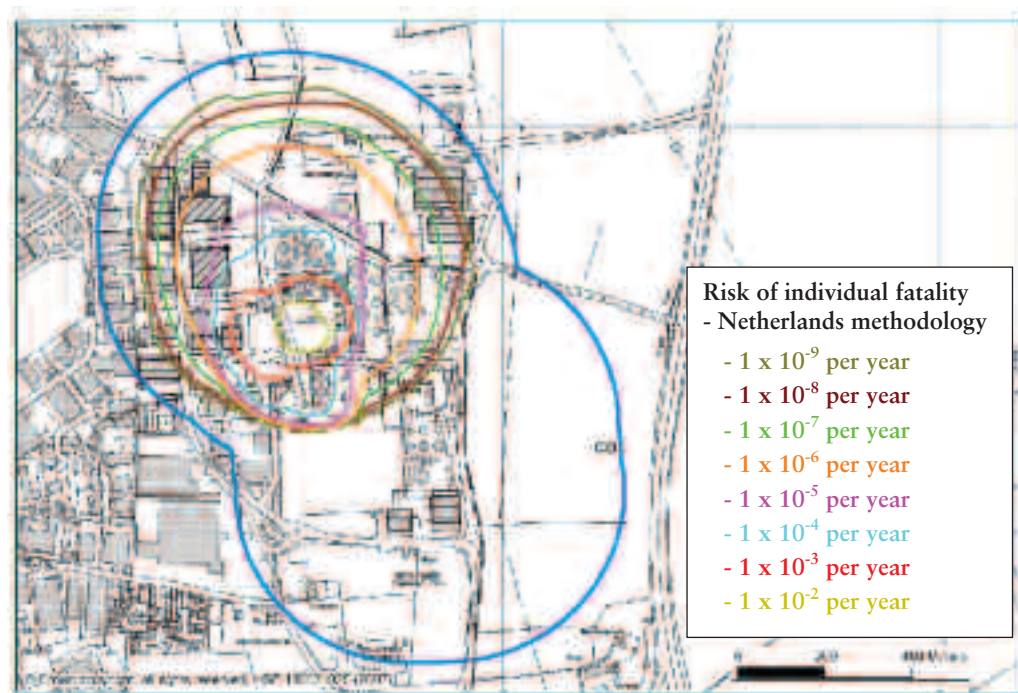


Figure 23 Individual risk of fatality (Netherlands methodology)

being struck by lightning since most other risks are similarly expressed as risks of death. They are also more readily comparable (with care) with HSE risk criteria as set down in R2P2.^(ref 13) For example the tolerable risk to a member of the public from a work activity should be no worse than 1 in 10 000 per year (1×10^{-4}) represented by the orange contour.

23 In Figure 23 it can be seen that the risk contours generated using the Netherlands methodology are even smaller than those above and are well within the existing HSE defined consultation distance.

Societal risk (FN format)

24 FN curves are obtained by plotting the frequencies at which multiple fatality events might kill N or more people. The technique provides a useful means of comparing the impact profiles of man made accidents.

25 In Figure 24 the red line indicates the frequency of killing N or more people arising from overfilling events; the green line from tank failures, and the black line the societal risk from both events, adding the risks together. The plot is relatively flat showing a relative small change in frequency of event until you get to the really large accidents involving over 200 people. After this the frequency reduces rapidly until the limit of possible people killed is reached. The FN plot usefully shows that the overall societal risk can be broken down to show the various contributors to the overall FN risk curve. This can be used to target where you put your risk reduction measures

Conclusions from the study

26 The QRA demonstrated that the risks associated with a large petroleum storage facility can be determined, despite the uncertainties and different assumptions representing different site conditions or different levels of safety give different risk predictions. The analyses show the effects of changing assumptions regarding:

- ▼ the frequency of overfilling a tank (which might be achieved by a more reliable overfill protection system);

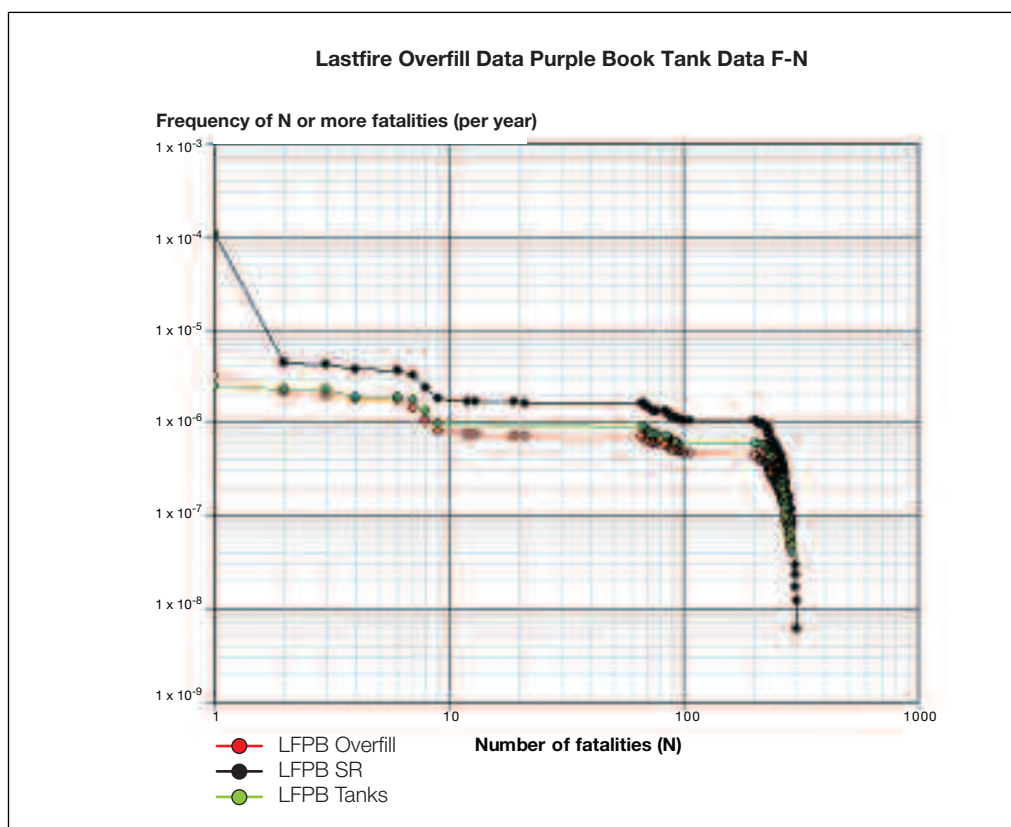


Figure 24 Societal risk arising from major hazards on the model site

- ▼ the reduction in the duration of the overfill (which might be achieved by gas detection and remotely or automatically operated valves); and
- ▼ the mitigation due to different building design as well as the effect of different base frequency data.

27 Other QRAs of this type of facility would likely follow the same approach, but, there is considerable scope for differences in the details in different QRA's, particularly the assumptions for frequencies and the analysis of consequences, and hence there would be differences in the numerical risk values predicted. Some of the more significant uncertainties in the analysis were:

28 The different properties of gasoline, including seasonal variations:

- ▼ the rate of formation of a vapour/aerosol cloud given a release of gasoline from piping or tank at different heights and with different potential mechanisms for the formation of both vapour and liquid droplets which remain airborne;
- ▼ the dispersion of the vapour/droplet cloud, particularly in low wind speed conditions;
- ▼ the size of the steady state cloud in different weather conditions;
- ▼ the magnitude of overpressure given ignition of the cloud both within and outside the cloud;
- ▼ the frequency of releases from piping and tanks;
- ▼ the probability and timing of ignition;
- ▼ the probability of an explosion given ignition for different weather conditions and sizes of cloud.

29 With further investigation the values used for some of the assumptions could become more robust (eg overfill frequency, tank failure frequency), but some will require considerably more time and analysis (eg likelihood of over-pressure generation) and for consequence information possibly even experiments (eg gasoline dispersion in low wind speed conditions, magnitude of an explosion and what conditions would/would not cause over-pressure). Work on the explosion mechanism that occurred at Buncefield has started, but detailed information for design purposes may take some time to produce. Data could be improved by the introduction of a formal system for collection, reporting and sharing of data across the onshore process sector. Such a system has been recommended by MIIB.³¹ The system could be similar to the data sharing system developed for the offshore sector after the Piper Alpha accident. The COMAH Competent Authority could, either by regulation or agreement with the sector,³² introduce a similar system for the onshore process sector, and if this was as successful as the offshore system, would produce a good quality database within a few years. If data already in the possession of companies (as provided to the Lastfire Group) were to be made available, this would put the frequency values on a far sounder footing and thereby improve the robustness of process QRAs.

30 The QRA estimates both the individual risk and societal risk of fatality that are needed for decision making. This type of analysis is currently used as a basis for onsite decisions (but with the inclusion of more scenarios) and its use could be extended to off-site land use planning decisions. Its use for such purposes would require some changes to be made to the current UK system. Possible changes are discussed below.

31 The current system of land use planning used in the UK derives essentially from a consultative document issued in 1989.^(ref 9) HSE uses a combination of hazard (the protection concept) and the risk of a 'dangerous dose or more'³³ to define land use planning zones. In short the protection concept quantifies the consequences for a single scenario and determines the distance to a dangerous dose from that single scenario, whereas the risk-based approach quantifies both the consequences and the frequencies of a number of different scenarios and cumulates them. The use of dangerous dose is different from most QRAs (which use fatality), is different from the risk measure used in most other European countries for land use planning purposes, is different from the values assigned by HSE to the tolerability of risk framework and is different from data used to compare risk predictions with everyday risks. There would therefore be many advantages if the HSE changed to a land use planning system based on the risk of fatality.

32 Land use planning zone boundaries determined over the last few years would normally be based on the information in the hazardous substances consent (HS Consent). Although this information is specific in terms of the size of the largest vessel, it may not be specific in terms of the material (because of generic material classes). Consequently HSE bases its assessment on what could be stored

³¹ See Recommendations 23, 24 and 25 in *Recommendations on the design and operation of fuel storage sites*.^(ref 4)

³² Offshore hydrocarbon release reporting is voluntary, but universally supported by industry.

³³ A dangerous dose of a toxic gas will give a range of effects because of different susceptibilities of different people, but will give all of the following – severe distress to almost everyone, with a substantial fraction requiring medical attention, serious injury with a requirement for prolonged treatment for some people and highly susceptible people might be killed.

under the terms of the HS Consent rather than what is actually stored on the site, so the risk at a zone boundary is based on a hypothetical risk. In determining the boundary HSE generally uses a material with properties at the most severe end of a class. There is very limited account taken in these assessments of measures that are in place at the site to mitigate the risks. The zone boundaries are therefore larger than if they took into account the actual material and the control and mitigation measures. Further, the current system does not lend itself to the cumulation of risks from different hazard types nor to the extension to societal risk.

33 The Netherlands and Belgium use both individual and societal risk (of fatality) as inputs and determinants for land use planning. The two approaches have some advantages and some disadvantages, such as:

- ▼ the methodology is set in the Netherlands so that two sites with the same design would pose the same individual risk. This may not be the case in Belgium;
- ▼ it is understood that the methodology in the Netherlands is fixed for a period of five years, and after this time changes can be made to update the methodology. This could impact on the location of the land use planning zones. In Belgium the methodology is more flexible and so changes to methodology and experience (such as the Buncefield incident) can take place more quickly. Again, however, these can impact on existing land use planning zones;
- ▼ the use of individual risk of fatality allows the effects of different types of hazards to be combined and also extended in a consistent way to societal risk.

34 As in the UK, the methodology for the analysis and the use of the risk predictions for land use planning are determined by the regulator. The actual analysis, however, is carried out by the operator of the site. A similar system if applied to the UK as control would still rest with the regulator, but the time and cost to carry out the analysis would fall on the occupier, and given that most occupiers of major hazard sites have carried out some QRA, the additional cost would be relatively small. Although QRAs were expensive when the methodology was being developed (some 30 years ago) since then there have been significant advances in the computer programs which aid the analysis, so that the cost of QRAs is now much less. Much of the cost of a QRA is associated with the time for the definition of input data and assumptions rather than the analysis itself and most sites will already have these input data.

35 As far as the cost of doing QRA is concerned, HSE has already invested considerable resources into the development of state of the art consequence models over the last 25 years and in 2004 there were approximately 80 models and over 20 methodologies in the HSE land use planning portfolio. HSE also has much data on most of the frequencies required for an analysis. Major companies have also developed QRA methods, using either commercially available or in-house developed consequence models, and either generic or company specific frequency data and use these for decision making. The development of a standard methodology, incorporating the experience that HSE has acquired in the determination of risk at major hazard installations, should therefore be reasonably straightforward. The methodology would, however, need to include sufficient detail so that all the information required by a planning authority to decide on the appropriateness of a new hazardous installation or development in the vicinity of an existing installation was made available. This would mean that the risk predictions would be based on the actual operations at an installation (eg as detailed in the COMAH safety report for top-tier sites) including the prevention measures, the extent and reliability of the control measures, and mitigation, eg through building design, and take account of emergency response. It would be expressed not only in terms of individual risk but also in terms of societal risk of fatality.

36 The issue of CD212 and feedback from the consultation indicated the level of interest in societal risk and the difference in both knowledge and expectations of stakeholders compared with that prevalent at the time the land use planning risk criteria document^(ref 9) was issued in 1989. The feedback indicated:

- ▼ there was considerable support for using societal risk to aid decisions regarding both on site control measures and land use planning;
- ▼ it was considered important that the assessment of the site operations and the land use planning process could give acceptable levels of safety to people in the vicinity.

37 For most QRAs where the individual risk of fatality is determined, the extension to societal risk requires relatively minor effort. Methodologies typically in current use are straightforward to implement and transparent. Given the availability of aerial photographs and the existing knowledge about the external population (by the number of people who could be affected by the activities at a site and the distribution of information to those within a specified distance of an installation), the data required should be readily available and be sufficiently detailed to be a suitable input for long-term land use planning decisions and individual applications. The extension from individual risk to societal risk would therefore have benefits for improving site safety as well as providing more information for land use planning. Decisions about the safety of people in on-site buildings do not necessarily need to be based on a QRA, but the extent, severity and likelihood of harm do need to be considered and this would be, in most cases, be quantitative (as there is a numerical criterion for new buildings, an ALARP demonstration is required for existing buildings and HSE guidance contains a quantified methodology). Hence the use of risk for decisions for off-site development will bring land use planning in line with on-site decisions for safety of people in buildings.

38 The overall societal risk from a single installation can be broken down to show the main contributors both in terms of the source of risk and the receptor of risk. The PLL ('potential loss of life' – a single number that represents societal risk) can indicate the percentage reduction in risk that can be achieved, and, with a cost of life input, it can be determined whether risk reduction either at source or by mitigation is likely to be reasonably practicable. Societal risks can also be added, so the overall societal risk from all the major hazards within a local authority area could be determined for the LPA who would be able to see the effect on the societal risk over a period of time due to changes in both the hazardous installation and the population in the vicinity of the installation (for this to be effective the analysis would need to be 'live' and societal risk calculations would need regular updates in line with changes on the major hazard installation and in the population in the vicinity, probably as part of COMAH updates). This would enable better long-term spatial planning than is possible on currently available information.

39 A move in Britain to an approach that was totally based on risk (individual and societal risk of fatality) would retain some of the advantages inherent to the current system for land use planning around major hazard sites. It would at the same time remove many of the undesirable features of the current system discussed above, enable land use planning around major hazard sites to be more soundly and consistently based, and would be a close representation of the risks from an installation. In the development of such a system the main challenges would be technical with a consensus needed on the appropriate methodology, and in the management of the changes to some land use planning zones as well as the costs. It could not be expected that the predicted risk levels at an installation in Britain

would correspond with the predicted risk levels at the same facility in a different EU country (even though they may be the same), which would be the ideal situation, but a change to a common and defined system based on risk of fatality would mean that the risk measures are consistent. Further, it would enable a consistent methodology to be used for both on-site and off-site decisions, and could be devised to incorporate the best features of the current systems that have been developed for use in other EU countries (eg the Netherlands and Belgium) or by major companies and so would be a robust basis for decision making. A move to an approach based on the risk of fatality would also bring UK land use planning in line with advice on airports, the advice in R2P2 and remove much of the current confusion and inconsistencies.

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Glossary

ALARP acronym for the legal term ‘as low as is reasonably practicable’. It requires the weighing up of the level of risk against the costs in the widest sense of averting that risk. Only where the dutyholder can show that the costs of averting the risk are grossly disproportionate to the benefits from further reducing the risk can it be said that the risk has been reduced ALARP.

COMAH the Control of Major Accident Hazards Regulations 1999 Regulations (COMAH).

COMAH sites sites to which the COMAH Regulations apply.

Competent Authority the COMAH Regulations are enforced by a joint Competent Authority comprising HSE and the Environment Agency in England and Wales, and HSE and the Scottish Environment Protection Agency (SEPA) in Scotland. The Competent Authority operates to a Memorandum of Understanding which sets out arrangements for joint working.

consultation distance the distance round major hazard sites set by HSE within which local planning authorities are required to consult HSE on all new planning applications.

containment barriers which, in the event of a spill, can prevent spilled materials from reaching the environment.

Control of Major Accident Hazards Regulations 1999 the main aim of these Regulations is to prevent and mitigate the effects of those major accidents involving dangerous substances, such as chlorine, liquefied petroleum gas, and explosives which can cause serious damage/harm to people and/or the environment. The Regulations treat risks to the environment as seriously as those to people. They apply where threshold quantities of dangerous substances identified in the Regulations are kept or used. See also Seveso II.

dangerous dose a dose large enough to lead to: severe distress to all; a substantial number requiring medical attention; some requiring hospital treatment; and some (about 1%) fatalities.

dutyholder in the context of this report, any person or organisation holding a legal duty – in particular those placed by the Health and Safety at Work etc Act 1974, the Management of Health and Safety at Work Regulations 1999, and the COMAH Regulations 1999.

Environment Agency the Environment Agency is the lead regulator in England and Wales with responsibility for protecting and enhancing the environment. It was set up by the Environment Act 1995 and is a non-departmental public body, largely sponsored by the Department for Environment, Food and Rural Affairs and the National Assembly for Wales.

hazard anything with the potential to cause harm.

Health and Safety Commission the Health and Safety Commission was a statutory body, established under the Health and Safety at Work etc Act 1974, responsible for health and safety regulation in Great Britain. It merged with the Health and Safety Executive on 1 April 2008. The roles and functions of the Commission have now transferred to the ‘new’ HSE.

Health and Safety Executive the Health and Safety Executive was a statutory body, established under the Health and Safety at Work etc Act 1974, and an enforcing authority working in support of the HSC. It has now merged with the Health and Safety Commission, taking over its roles and functions. Local authorities are also enforcing authorities under the Health and Safety at Work etc Act 1974.

HSC see Health and Safety Commission.

HSE see Health and Safety Executive.

Northgate a business located alongside the north-western perimeter of Buncefield whose premises was affected by the Buncefield incident.

on-site and off-site emergency plans operators of top-tier COMAH sites must prepare adequate emergency plans to deal with the on-site consequences of possible major accidents and to assist with off-site mitigation. Local authorities for areas containing top-tier COMAH sites must prepare adequate emergency plans to deal with the off-site consequences of possible major accidents, based on information supplied by site operators

over-pressure for a pressure pulse (or blast wave), the pressure developed above atmospheric pressure is called the over-pressure.

Planning Advice for Developments near Hazardous Installations (PADHI) software tool developed by HSE which in the vast majority of cases allows local planning authorities to obtain HSE's advice on an intended development within the consultation distance of a major hazard site.

pool fire a fire over a pool of fuel and/or water or other liquids.

primary containment the tanks, pipes and vessels that normally hold liquids, and the devices fitted to them to allow them to be safely operated.

quantified risk analysis/assessment (QRA) a systematic analytical technique for quantifying the risks associated with hazardous installations, based on assessing a range of foreseeable failure scenarios. The risk to an individual at a specific location is the summation of the risks arising from the different scenarios.

Regional Resilience Forum The Regional Resilience Forums are established by each Government Office to discuss civil protection issues from the regional perspective and to create a stronger link between local and central government on resilience issues. Similar arrangements are made in the devolved administrations.

responder under the Civil Contingencies Act 2004, the Environment Agency is a Category 1 responder, and HSE is a Category 2 responder. These categories define the roles played by each body in response to a major incident.

risk the likelihood that a hazard will cause a specified harm to someone or something.

safety integrity level (SIL) a safety integrity level (SIL) is a measure of safety system performance, in terms of the probability of failure on demand. There are four discreet integrity levels, SIL 1–4. The higher the SIL level, the higher the associated safety level and the lower the probability that a system will fail to perform properly.

safety reports the COMAH Regulations require operators of top-tier sites to submit written safety reports to the Competent Authority.

secondary containment Enclosed areas around storage vessels (often called bunds), created usually by concrete or earth walls. Their purpose is to hold any escaping liquids and any water or chemicals used in firefighting.

Seveso II In 1976, a major accident occurred in Seveso, Italy, where the accidental production and release of a dioxin as an unwanted by-product from a runaway chemical reaction led to widespread contamination. A number of such incidents, and the recognition of the differing standards of controls over industrial activities within the European Community, led the European Commission to propose a Directive on the control of major industrial accident hazards. The Directive on the Major Accident Hazards of Certain Industrial Activities (82/501/EEC) was adopted on 24 June 1982, and is generally known as the Seveso Directive. Following a complete review of the Directive by the European Commission a new one, now known as Seveso II, came into force on 3 February 1997 and was implemented in Great Britain on 1 April 1999 by the Control of Major Accident Hazards Regulations 1999, except for land use planning requirements, which were implemented by changes to planning legislation.

tertiary containment the site surface and associated drainage, boundary walls, roads, containment kerbs and any features such as road humps that can provide some retention of liquids. Proper design of drainage systems will limit loss of product out of the site and prevent lost product permeating into the ground with the potential risk that it can migrate to groundwater, or contaminate surface waters and land.

tier the COMAH Regulations apply where threshold quantities of dangerous substances identified in the Regulations are kept or used. There are two thresholds, known as 'lower-tier' and 'top tier'. Annex 1 gives a brief background to the origins of these Regulations.

top-tier see tier.

Further information

Useful links

Buncefield Major Incident Investigation

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Fax: 020 7717 6082

E-mail: buncefield.inforequest@hse.gsi.gov.uk

Web: www.buncefieldinvestigation.gov.uk

Community/business support

Dacorum Business Contact Centre

Tel: 01442 867 805

Business Link Helpline Tel: 01727 813 813

Hertfordshire Chamber of Commerce

Tel: 01727 813 680

Dacorum Borough Council

Tel: 01442 228 000

Web: www.dacorum.gov.uk

Dacorum Community Trust

Tel: 01442 231396

Web: www.dctrust.org.uk

Hemel Hempstead Citizens Advice Bureau

19 Hillfield Road, Hemel Hempstead HP2 4AA

Tel: 01442 213368

Local authorities and emergency services

Dacorum Borough Council

Tel: 01442 228 000

Web: www.dacorum.gov.uk

Dacorum Community Trust

Tel: 01442 231 396

Web: www.dctrust.org.uk

St Albans District Council

Tel: 01727 866 100

Web: www.stalbans.gov.uk

Hertfordshire County Council

Tel: 01483 737 555

Web: www.hertsdirect.org

Hertfordshire Fire and Rescue Service

Web: www.hertsdirect.org/yrccouncil/hcc/fire/buncefield

Hertfordshire Constabulary

Web: www.herts.police.uk/news/buncefield/main.htm

Hertfordshire Chamber of Commerce
Tel: 01727 813 680
Web: www.hertschamber.com

Government links

Cabinet Office
Web: www.cabinetoffice.gov.uk

Communities and Local Government
Fire and Resilience Directorate
Web: www.communities.gov.uk

Government Office for the East of England
Web: www.goeast.gov.uk

Environment Agency
Web: www.environment-agency.gov.uk

Department for Business, Enterprise and Regulatory Reform
Oil and Gas Directorate
Web: www.og.berr.gov.uk

Health and Safety Executive
Hazardous Installations Directorate
Web: www.hse.gov.uk/hid

Control of Major Accident Hazards
Web: www.hse.gov.uk/comah

Department for the Environment, Food and Rural Affairs
Web: www.defra.gov.uk

Health Protection Agency
Web: www.hpa.org.uk

Food Standards Agency
Web: www.food.gov.uk

Drinking Water Inspectorate
Web: www.dwi.gov.uk

Scottish Environment Protection Agency
Web: www.sepa.org.uk

UK Resilience
Web: www.ukresilience.info

Scottish Executive Justice Department – Civil Emergencies
Web: www.scotland.gov.uk/Topics/Justice/emergencies/guidance

Wales – Local Resilience
Web: <http://new.wales.gov.uk/resilience/regional-local-resilience1/?lang=en>

Northern Ireland Central Emergency Planning Unit
Web: <http://cepu.nics.gov.uk>

Process Safety Leadership Group (replaced the **Buncefield Standards Task Group**)

Contact: colette.fitzpatrick@hse.gsi.gov.uk

National Recovery Working Group

Contact: Rhiannon.harries@communities.gsi.gov.uk

Industry links

United Kingdom Petroleum Industry Association (UKPIA)

Tel: 020 7240 0289

Web: www.ukpia.com

Chemical Industries Association

Tel: 020 7834 3399

Web: www.cia.org.uk

Three Valleys Water

Tel: 0845 782 3333

Web: www.3valleys.co.uk

United Kingdom Onshore Pipeline Operators' Association (UKOPA) Tel: 01773 852003

Web: www.ukopa.co.uk

Tank Storage Association

Tel: 01244 335627

Web: www.tankstorage.org.uk

Investigation reports

Buncefield Major Incident Investigation:

- ▼ Progress Report published 21 February 2006
- ▼ Second Progress Report published 11 April 2006
- ▼ Third Progress Report published 9 May 2006
- ▼ Initial Report, published 13 July 2006
- ▼ Recommendations on the design and operation of fuel storage sites published 29 March 2007
- ▼ Recommendations on the emergency preparedness for, response to and recovery from incidents published 17 July 2007
- ▼ Explosion Mechanism Advisory Group report published 16 August 2007

Available from www.buncefieldinvestigation.gov.uk

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Main report: <http://www.defra.gov.uk/environment/airquality/publications/buncefield/buncefield-report.pdf>

Appendices: <http://www.defra.gov.uk/environment/airquality/publications/buncefield/buncefield-append.pdf>

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www.eeda.org.uk

Swiss Fire Service: *Quick Look Report – Buncefield Fire 11 December 2005*

Buncefield social impact report Dacorum Borough Council, January 2007
www.dacorum.gov.uk/default.aspx?page=4191

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WS Atkins Science and Technology: *Derivation of fatality probability functions for occupants of buildings subject to blast loads Phases 1, 2, & 3 147/1997 and Phase 4 151/1997*

Biomedical Sciences Chemical and Biological Defence Sector Defence Evaluation and Research Agency: *Review of blast injury data and models 192/1998*

Available from: www.hsebooks.com

Government Advisory Bodies

Committee on mutagenicity of chemicals in food, consumer products and the environment (COM)

Committee on carcinogenicity of chemicals in food, consumer products and the environment (COC)

Committee on toxicity of chemicals in food, consumer products and the environment (COT)

www.advisorybodies.doh.gov.uk/coc/

The Buncefield Incident

11 December 2005

The final report of the Major Incident Investigation Board

Volume 2

In the early morning of Sunday 11 December 2005, a series of explosions followed by a large fire destroyed large parts of the Buncefield Oil Storage and Transfer Depot and caused widespread damage to homes and businesses surrounding the site.

The then Health and Safety Commission (now Health and Safety Executive) appointed a Major Incident Investigation Board with an independent chair, Lord Newton of Braintree. This was a new departure in major incident investigation which allowed the Board to contact individuals and organisations who were affected or who had expert knowledge and experience, and to keep the public informed of progress with frequent reports.

This is the ninth and final report of the Buncefield Major Incident Investigation Board. It is made to the Boards of the Health and Safety Executive and the Environment Agency that together form the joint Competent Authority responsible for regulating the Buncefield site.

Volume 1 draws attention to some of the ways the Board has set about its business. It explains the significance of the Buncefield Depot and describes briefly how the explosions and fires happened and the damage they caused. It also summarises all the Board's recommendations to regulators, industry and government.

Volume 2 brings together all the Board's previous reports in a single publication for the public record and for future reference: three progress reports; an Initial Report; a report into the explosion mechanism; and reports giving recommendations on design and operation of fuel storage sites, emergency preparedness for, response to and recovery from incidents, and land use planning and the control of societal risk around major hazard sites.

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