

NATIONAL EMERGENCY COORDINATION COUNCIL

BACKGROUND GUIDE

Letter from the Executive Board

Greetings Delegates! It gives us immense pleasure to welcome you all to this simulation of the National Emergency Coordination Council (NECC) at 'La Martinere Model United Nations 2025'. We look forward to an enriching and rewarding experience.

The agenda for the session is: "Formulating and Executing a co ordinated response framework for the Bhopal pesticide plant gas leak incident, involving legal accountability, and indictment of officials within union carbide India limited, while simultaneously devising and implementing comprehensive strategies for economic damage control, restitution, and community rehabilitation."

And the Freeze date is: 3 December 1984.

This study guide is by no means the end of the research, we would very much appreciate it if the members are able to find new realms in the agenda and bring it forth to the committee. Such research combined with good argumentation and a solid representation of facts is what makes an excellent performance.

In the session, the executive board will encourage you to speak as much as possible, as fluency, diction, or oratory skills have very little importance as opposed to the content you deliver. So prime emphasis on research is recommended.

The Executive Board looks forward to an efficient & progressive committee as the issue is very sensitive. We, therefore, expect you all to play your roles with responsibility. Hopefully we, as members of the Executive Board, will also have a chance to gain insight from this committee.

All the best! Regards,

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Suggested Pattern For Researching

To start researching on the agenda of the committee, participating members should do the following:

- Research Your Portfolio/Position Thoroughly Understand the institutional role, powers, and limitations of your assigned portfolio. Since no single document will lay out exact stances, delegates must do the tedious yet rewarding task of digging into archival news clippings, government gazettes, commission reports, legal statutes, and scholarly articles to form a realistic position.
- Understand the Agenda in Context (3 December 1984 Freeze Date) Delve into the Bhopal Gas Tragedy and the related events that unfolded immediately before 3rd December 1984. Research industrial safety norms at the time, governmental preparedness, the socio-economic conditions in Bhopal, and the role of Union Carbide India Limited (UCIL). Use both the references provided in this guide and additional resources such as Parliamentary records, investigative journalism, academic analyses, and NGO publications.
- Break Down the Agenda into Sub-Topics When preparing for the committee, delegates should break the agenda into clear sub-topics and structure their research around the major dimensions of the Bhopal crisis. This includes, but is not limited to, examining issues of legal accountability and the indictment of responsible parties, analyzing government and institutional response failures, and understanding the challenges of emergency medical aid and humanitarian relief. Delegates may also explore strategies for economic damage control and compensation mechanisms, alongside plans for community rehabilitation and long-term rebuilding. Environmental cleanup and safety reforms form another crucial area of focus. For each of these dimensions, participants are expected to prepare concrete talking points, draft statements, and actionable directives that can be advanced in committee.

Suggested Pattern For Researching

- Collect Proof & Evidence; For every claim or allegation you intend to make in committee, attempt to back it with concrete evidence i.e. official reports, credible news articles, legal documents, or survivor accounts. Evidence-based arguments always carry more weight in debates and directive drafting.
- Anticipate Opposition & Contradictions; Don't just know your stance, research the likely perspectives of other portfolios. Identify their contradictions and prepare counterarguments, questions, or rebuttals to gain leverage in debate.
- Stay Updated and Flexible; Since this is a crisis committee, directives will evolve rapidly. Be ready to adapt your research into fast, practical solutions that can be implemented in the simulated scenario.
- Commit to Realism & Rigor; Delegates are expected to put in serious effort to ensure the debate reflects the gravity of the Bhopal disaster. This committee is not just about winning points but about simulating how India could have responded more effectively. Your research and preparation will directly shape the authenticity of the learning experience.

Committee Overview

ABOUT NATIONAL EMERGENCY COORDINATION COUNCIL (NECC)

The National Emergency Coordination Council (NECC) is a unique and dynamic committee format in Model United Nations (MUN) conferences. It combines elements of crisis management, collaboration, and strategic decision-making to create an engaging and fast-paced experience for delegates.

In the National Emergency Coordination Council (NECC), delegates step into the roles of key decision-makers and stakeholders positioned in the immediate aftermath of the Bhopal Gas Tragedy on 3 December 1984. The freeze date requires participants to act strictly within the knowledge, resources, and political realities of that moment, without the benefit of hindsight. Delegates must think creatively and respond swiftly as the crisis evolves, crafting strategies to contain the disaster, ensure accountability, and safeguard public welfare. The committee environment allows them to directly engage with one another through negotiations, alliances, and even rivalries, while forming coalitions or pursuing independent agendas. Every action, whether public or private, will influence how India manages one of the most catastrophic industrial disasters in its history.

The Executive Board Members provide situations/updates also known as Crisis Updates from time to time to the delegates directing the process and adding unexpected turns. Based on these updates, members of NECC need to be competent at conducting thorough research, have fast thinking, and be flexible enough to adjust to changing conditions as mentioned in the Updates provided. They should be ready to participate in vigorous discussion, compromise, and fast thinking in order to forward the goals of their characters and add to the committee's overall storyline.

NOTE: Necessary directive information with directive examples and format will be given to the delegates in the committee itself after the explanation and understanding of the procedure.

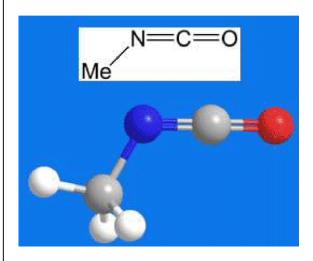
1969: Union Carbide builds factory in Bhopal, the state capital of Madhya Pradesh, India. Bhopal's pesticide plant was established in 1969 to manufacture and package Union Carbide's carbaryl insecticide for India's agricultural market, aligning with the broader Green Revolution—era push for agrochemicals.



1973: First methyl isocyanate (MIC) imported from the USA to Bhopal. UCIL began importing methyl isocyanate (MIC) from the United States to Bhopal in 1973 as part of the build-out of MIC-based carbaryl (Sevin) production, introducing an exceptionally hazardous and reactive intermediate into on-site handling streams. MIC exposure is associated with severe eye irritation, respiratory tract burning, breathlessness, and pulmonary edema, with the potential for lasting corneal and pulmonary damage in significant exposures.



1979: The Bhopal plant starts to manufacture its own MIC. An MIC production unit was added to the Bhopal site in 1979, shifting the operation from reliance on imported MIC to on-site generation through the methylamine–phosgene process used as an intermediate step toward carbaryl manufacture. This localization of MIC production increased inventories and handling of MIC within the plant, elevating process safety demands on storage, instrumentation, and emergency mitigation systems.



December 25, 1981: A leak of phosgene gas killed Union Carbide worker Ashraf Khan, and severely injured two others. A phosgene incident on 25 December 1981 killed UCIL worker Ashraf Khan and severely injured two others, marking the plant's first fatal toxic exposure and revealing gaps in maintenance and protective practices. Contemporary accounts describe the victim's phosgene inhalation during maintenance and death within 72 hours, underscoring the lethality of phosgene and foreshadowing recurrent toxic releases at the site.

January 9, 1982: 25 workers were hospitalized as a result of another leak at the plant. Another leak on 9 January 1982 led to hospitalization of roughly two dozen workers, reported variously as 24–25 persons, indicating persistent containment and protective equipment failures. The sequence of late-1981 and early-1982 events catalyzed worker grievances about safety and hazard allowances, further highlighting systemic deficiencies.



May 1982: Safety week and worker complaints. During a company-sponsored "safety week" meant to address grievances, repeated toxic leaks occurred, and workers directly raised concerns to visiting American management officials about hazards and operating conditions. Requests for hazardous-duty pay proportional to the risks of handling MIC and phosgene were rejected, reinforcing low morale and distrust amid ongoing leak events.

1982: Cost cutting and downsizing

Cost-cutting accelerated: staffing was reduced by 335 positions with reported \$1.25 million in savings, the MIC unit crew was cut from 12 to 6 and maintenance from 6 to 2, and training durations and supervisory coverage (including Night Shift MIC supervisor) were curtailed. Independent analyses describe broader underinvestment effects by 1984, including reduced operator strength, less frequent readings, and degraded safety systems and maintenance, contributing to an increasingly fragile safety envelope.

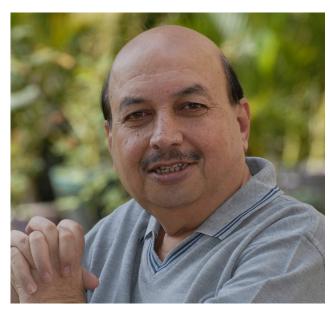
October 5, 1982: Community Hospitalizations

A further leak on 5 October 1982 involved MIC and other substances and required hospitalization of hundreds of nearby residents, demonstrating off-site impact potential beyond the plant perimeter. Worker unions distributed community warnings after the incident, flagging "lives of thousands ... in danger" and "safety measures deficient," reflecting public risk awareness rising months before the catastrophe.

1982-1984: Keswani's warnings

Local journalist Rajkumar Keswani published a series of investigative warnings—including "Wake up people of Bhopal, you are on the edge of a volcano!" and "Please Save this City"—detailing recurring leaks, worker fears, and alleged cover-ups. Subsequent articles such as "Bhopal Sitting on Top of a Volcano," "If You Do Not

Understand This You Will Be Wiped Out," and "Bhopal on the Brink of a Disaster" were explicit that a mass-casualty industrial event was foreseeable absent remedial action.



September 1984: Internal WV warning on MIC tanks

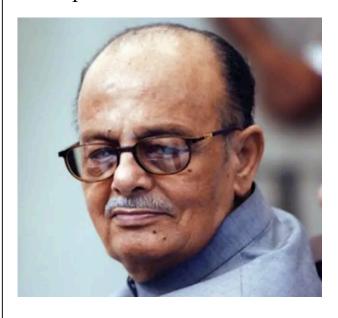
In September 1984, an internal UCC memo regarding the Institute, West Virginia MIC unit warned of a "runaway reaction that could cause a catastrophic failure of the storage tanks holding the poisonous [MIC] gas," a risk scenario later publicized by U.S. Congressman Henry Waxman. Evidence indicates this warning was not relayed to Bhopal, and within weeks Bhopal continued to store large MIC inventories with degraded mitigation systems, compounding vulnerability to the very runaway scenario the WV memo described.

Historical Background

POLITICAL BACKDROP

In 1984, Madhya Pradesh was governed by Chief Minister Arjun Singh of the Indian National Congress, overseeing state-level industrial regulation and emergency coordination.

Nationally, Prime Minister Indira Gandhi was assassinated on 31 October 1984, and Rajiv Gandhi was sworn in the same day amid widespread unrest and an accelerated national political transition.



Timeline—

31 Oct 1984: Indira Gandhi assassinated in New Delhi; Rajiv Gandhi assumes office as Prime Minister.

Nov 1984: Post-assassination violence and political churn affect national and state administrations' focus and preparedness.

Dec 1984 (pre–3 Dec): Electioneering under way ahead of late-December polling dates nationwide.

Historical Background

LEGAL POSITION IN INDIA

The Factories Act, 1948 governed worker health, safety, and welfare, but the specialized "hazardous processes" chapter (Sections 41A–41H) was inserted later (1987), meaning pre–December 1984 the statute contained general safety duties and state "dangerous operations" rule-making rather than a consolidated major-hazard regime.

The Water (Prevention and Control of Pollution) Act, 1974 created the Central and State Pollution Control Boards and prohibited polluting discharges, forming the primary national framework for industrial effluents before the Bhopal leak.

The Air (Prevention and Control of Pollution) Act, 1981 extended that framework to air emissions nationwide, empowering boards to regulate industrial air pollution prior to December 1984.

Pre–1984: Factories Act in force with general safety provisions and state rules under Section 87 for dangerous operations; no dedicated hazardous-process chapter existed yet.

1974–1984: Water Act in force establishing CPCB/SPCBs and regulatory powers over discharges.

1981–1984: Air Act in force providing national authority to prevent and control air pollution from industrial sources.

LEGAL POSITION GLOBALLY (STRICT LIABILITY PRINCIPLE)

The common-law rule in Rylands v Fletcher (1868) imposed strict liability for the escape of dangerous things arising from a non-natural use of land, a principle widely recognized across common-law jurisdictions by 1984. The House of Lords in Rylands v Fletcher (1868) established strict liability for the escape of a dangerous thing brought onto land for a "non-natural" use, making the keeper liable for resulting damage irrespective of negligence. The rule's classic elements are: a thing likely to do mischief if it escapes; brought and kept by the defendant; a non-natural use of land; and actual escape causing damage, with limited defenses historically recognized in English law. By the late 20th century, this principle had been widely recognized across common-law jurisdictions and provided a baseline paradigm for hazardous enterprise liability, even as jurisdictions diverged on scope and defenses and, in India, later evolved toward absolute liability after 1984.

Historical Background

THE U.S. STRICT LIABILITY (RESTATEMENT)

The Restatement (Second) of Torts adopts strict liability for "abnormally dangerous activities," articulating that one who carries on such an activity is subject to liability for resulting harm even if utmost care is exercised. Section 520 lists factors to identify an abnormally dangerous activity: high degree of risk, likelihood of great harm, inability to eliminate risk by reasonable care, uncommon usage, inappropriateness to place, and risk outweighing community value, thereby focusing analysis on unavoidable residual risk rather than fault. By 1984, these sections were deeply influential in U.S. tort doctrine and comparative discussions about ultra-hazardous operations, especially for chemicals and explosives, even though adoption and application varied among states.

Europe's Seveso I Directive (82/501/EEC)

Adopted on 24 June 1982 following the 1976 Seveso accident in Italy, the Seveso I Directive required operators handling listed dangerous substances to prevent major accidents and limit their consequences, marking an EU-level, risk-based regulatory approach to major hazards. Core obligations included notification to competent authorities, safety reporting, internal emergency planning (and coordination with external plans), land-use controls, and public information—prefiguring modern major-accident hazard regimes before Bhopal. Although Seveso I preceded Bhopal, the disaster reinforced the Directive's central premises that systematic safety management, emergency preparedness, and public warning are essential where large inventories of highly hazardous substances are present.

3rd December 1984

In the early hours of 3 December 1984 in Bhopal, a runaway reaction in a storage tank of methyl isocyanate (MIC) at Union Carbide India Limited (UCIL) led to a massive toxic release over the city. Within roughly an hour, tens of tones of MIC and reaction products vented as key safety systems were offline or overwhelmed and public warnings and coordinated response faltered.

PLANT CONDITIONS

By the evening of 2 December, critical protections were degraded: MIC refrigeration had been shut since June 1984, the flare tower was out of service for maintenance, and the vent gas scrubber was on standby and not designed for a large runaway event. Firewater sprays functioned but could not reach the top of the vent stack effectively, and reduced staffing and supervisory coverage due to prior cost-cutting left the operation less resilient to an emergency.

ONSET AND RELEASE

- Around 11:30 pm on 2 December, operators observed a small MIC leak and rising tank pressure in Tank E610, indicating an abnormal condition developing in storage.
- By about 12:40–12:50 am on 3 December, temperature and pressure spiked as an exothermic reaction accelerated, venting MIC vapor through relief devices to the scrubber and then to the stack.
- Between roughly 12:50 am and 2:00 am, an estimated 30–45 tons of MIC and reaction products escaped to the atmosphere, forming a dense, ground-hugging cloud that moved southeast across Bhopal.

WARNING AND ALARMS

The internal plant siren was triggered at 12:50 am, but the external public siren—decoupled from the plant siren since 1982—was only briefly sounded and then turned off, delaying community alerting at the critical early stage. The external siren was turned on again around 2:30 am, by which time the gas had already spread widely through nearby neighborhoods

3rd December 1984

OFFICIAL NOTIFICATIONS

The superintendent of police was informed around 1:00 am that residents in Chola and other areas were fleeing, yet repeated police calls to the plant between 1:25 and 2:10 am initially elicited assurances that "everything is OK" before staff acknowledged uncertainty. Army engineer units mobilized around 3:00 am to assist with evacuations and transport of the injured as municipal medical resources quickly became overwhelmed.

COMMUNITY IMPACT OVERNIGHT

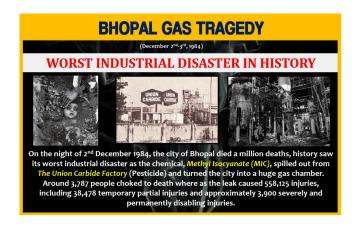
Residents awoke to burning eyes, choking, and breathlessness and many fled on foot, often inadvertently moving with or into the path of the heavier-than-air cloud as it hugged low-lying areas. Hospitals received conflicting information—first ammonia, then phosgene, then "MIC"—and clinicians lacked antidotes or protocols for MIC inhalation injury, compounding early morbidity and mortality. By morning, mass cremations and burials began as casualties surged, and authorities sealed the plant to outsiders

IMMEDIATE PLANT ACTIONS

Operators attempted ad hoc mitigation—transferring MIC and deploying available sprays—but instrumentation problems, inadequate capacity, and disabled systems prevented effective control of the release. Post-event examination found the tank shell intact despite internal temperatures exceeding safe limits, consistent with relief-valve venting rather than catastrophic rupture.

EARLY ACTIONS ON 3 DECEMBER

Before 8:00 am on 3 December, state authorities ordered the plant closed and detained local managers as criminal investigations commenced. The central government then asserted control over the site and data while corporate teams arriving that week faced restrictions, setting the stage for later disputes over causation and responsibility.



Focus Questions

- Given the scale and suddenness of the gas leak on 3 December 1984, what combination of emergency measures could be implemented immediately to minimize further casualties, prevent public panic, and restore order, considering the limitations of the state machinery at that time?
- In the case of any systemic lapses, what comprehensive reforms could political leaders, regulatory institutions, and local communities realistically implement to prevent future industrial disasters, and how can these measures balance public safety, industrial growth, and social trust?
- Considering the role, authority, and resources of the position you represent, what are the immediate and long-term priorities your portfolio would pursue in addressing this crisis, and how could your actions influence broader recovery, accountability, and public confidence?
- Who bears primary responsibility for the escalation and human toll of the disaster, Union Carbide India Limited officials, the parent company in the US, state regulators, or government authorities, and what legal, administrative, or ethical mechanisms could be employed to hold them accountable while ensuring that justice is timely, effective, and perceived as legitimate by the affected communities? ng that week faced restrictions, setting the stage for later disputes over causation and responsibility.

List of Valid Sources

- Government Reports
- PTI, PIB
- Government Websites
- Government-run News channels
- Standing Committee Reports/ Commission Reports
- RTI Proofs
- Parliamentary Standing Committee Reports
- Questions and Answers of the Parliament



THE TWELFTH SESSION