Inter-organization Correspondence

B.F.Goodrich

TO	CITY, SUBURB OR AKRON DEPARTMENT & BLDG. NO.	DATE YOUR LETTER
H. Waltemate	Cleveland	
FROM J. W. Gressler	CITY, SUBURB OR AKRON DEPARTMENT & BLDG. NO. Pedricktown	May 11, 1972

NEAR MISS - CATALYST ADDED WHILE CLEANING REACTOR - PEDRICKTOWN

1972 Type #6 Incident #6

On Thursday, May 4, 1972, at approximately 6:00 p.m. Repetitive Accident #6 "Splashing Chemical Exposure" occurred in Mass Resin, Building 512. While reactor 8300 was being cleaned by a contract utility employee lauroyl peroxide and a small amount of Lupersol 223 were added to the reactor. No injuries resulted.

Facts

The incident was not reported until Monday, May 8, 1972, 4 days It was reported by the contract utility employee because he thought that a couple of technicians were treating the incident lightly. They were fortunate no injury resulted.

The vessel had been prepared properly and all precautions taken before entry was permitted. Two contract employees had entered the vessel to do the cleaning. The cleaning was about finished when one contract employee asked the other to exit and remove the equipment which was in the manway. The reason the equipment was removed is so the agitator could be rotated manually. The autoclave is horizontal with a helical agitator. The agitator must be rotated so the cleanings behind the agitator can be swept out. The contract employee that removed the equipment then left the area of the autoclave to perform other duties. He is a relatively new employee and had not been indoctrinated properly by the lead technician. He did not realize that he was to remain at the manway until his co-worker had finished.

First Unsafe Act

(1) each Unsafe Act

The operating technician noticed that the one contract employee had left the vessel and removed the equipment so the technician assumed that the cleaning job was complete. The technician proceeded to change the hamer blinds and prepare the autoclave for the next charge. At this point the autoclave had not been properly checked. He then added the lauroyl peroxide and started to add the Lupersol 223 when he heard the man inside yell. He immediately stopped and checked the autoclave. It should be noted that the operating technician violated the procedure on counts:

Third Unsafe Act — an accident waiting

Fourth Unsafe Act

(A) He did not check the area bulletin board to see if the vessel entry permit had been removed.

Fourth Unsafe Act

(E) The catalyst was added prematurely. It is not to be added until the catalyst addition light indicates the catalyst is to be added.

When advised of the incident W. A. Reed, Mass Resin Manager and J. W. Gressler conducted a meeting which was attended by all parties involved. The seriousness of the incident and the complications which could have resulted were discussed. Reed interviewed each individual in the department to try to pinpoint any additional problems. Reed has expressed his deep concern to each individual in the department and stressed, once again, that shortcuts will not be tolerated.

NGC 15734

REDACTED

MAY 15 1972

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Corrective Action

1. We will review, once again, the vessel entry procedure with all employees.
2. The incident will be discussed in all departmental meetings.
3. The autoclave entry procedure is being revised.
4. The technician who added the catalyst has been reprimanded for his negligence.
5. The lead technician has also been reprimanded for not reporting the incident promptly and failure to clearly instruct and communicate with people under his direction.

J. W. Gressler

JWG:rp

cc: D. L. Dowell - O. F. Beckmeyer
J. L. Nelson - R. D. Scott
E. E. Mitchell - P. D. Scott
E. W. Harrington - P. H. Lawrence
W. E. Brodine
G. Pow
R. A. Kelley - Akron
A. R. Webber
H. T. Evans
J. W. Goetsch
W. A. Reed
W. E. Horton
J. M. Smith
H. G. Miller
File

For an incident treated lightly by the technicians, management put it in proper perspective by handling it sternly.

W. Walton
5-19-72

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