

MR. D. M. CONNOR

Firestone Plastics Company

DIVISION OF THE FIRESTONE TIRE & RUBBER COMPANY

HARVEY S. FIRESTONE, FOUNDER

GENERAL OFFICES
ONE PENNSYLVANIA PLAZA
PERRYVILLE PLANT
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May 18, 1979

State of Maryland
Department of Licensing & Regulation
Division of Labor and Industry
Occupational Safety and Health
203 East Baltimore Street
Baltimore, Maryland 21202

ATTENTION: Mr. Harvey A. Epstein, Commissioner

RE: VCM Discharge

Dear Mr. Epstein:

In compliance with the reporting requirements set forth in the OSHA VCM Standard 1910.1017, this is a report of an accidental release of vinyl chloride vapors into a work area. The majority of the information contained herein was given to Mr. Andrew A. Alcarese, of your office, during a phone conversation with Paul Eldreth, our plant safety engineer, on May 16, 1979.

The accidental release occurred at the Perryville, Maryland plant of the Firestone Plastics Company during the 4 p.m. to midnight shift on Sunday, May 13, 1979 when an operator failed to properly valve-off the steam jet prior to charging vinyl chloride to a reactor. With the steam jet valve open, an estimated 1,000 pounds of liquid vinyl chloride was accidentally transferred to the steam jet surge tank, causing a vinyl chloride vapor exposure at approximately 3600 PPM in the first floor work area of the suspension polymerization building.

All operating personnel not directly involved in securing the equipment were immediately evacuated from the area, two operators donned their protective respirators and remained in the area to properly valve-off the escaping vapors. Within ten to fifteen minutes the work area had been ventilated and the air concentration of vinyl chloride returned to normal levels of less than 1 PPM.

The two operators who were in the area of high exposure were requested to see the company physician for examination at the time of the exposure and again on May 15, 1979. Each refused claiming that they were not experiencing any ill or side effects. However, both have since indicated that they will undergo the medical examination upon returning to work from their scheduled days off.

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Since the release was not caused by a mechanical failure, but rather an operator error, the method to prevent a future accidental release of a similar or like nature will involve personnel training and procedural changes. First, all operating personnel involved in the batch charging procedure have been personally contacted by production supervision and reinstructed on the proper "check-out" procedure prior to batch charging. Secondly, a check-sheet requiring the operators initials and verification that all valves have been properly closed prior to reactor charging has been instituted.

In addition, we are currently modifying and relocating the steam jet from its existing position on the charge manifold to a more direct piping arrangement at the top of the reactor. This design change should eliminate the possibility of accidentally transferring liquid vinyl chloride to the surge tank, should the operator fail to properly close the steam jet valve.

It is felt that this design change, along with the corrective steps mentioned earlier, should adequately prevent a future accidental release of this nature from occurring.

Sincerely,

Peter J. Foley
PLANT MANAGER

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