

TO: H. J. Kletke

FROM: S. E. Hale

DATE: March 3, 1993

SUBJECT: REPETITIVE ACCIDENT TYPE 10A: TOXIC CHEMICAL RELEASE
REPORTABLE VCM SPIII - LOUISVILLE LPA

On 2/19/93 at 1:45 PM, a calculated 8.4 lbs. of VCM was released when the equipment recovery line failed under the VCM vapor recovery filters. A call was placed to 911. Prompt response by area personnel minimized the loss.

On 2/22/93 at 10:00 AM a Board of Review was held in the LPA Conference Room with the following in attendance:

H. Kletke	S. Hale
R. Mueller	S. Clark
A. Simpson	S. Deetsch
F. Schuler	F. Levy
S. Brown	

Corrective Action:

1. Remove and cap defective line. Complete 2/19/93
2. Review the incident with all area personnel. SEH Complete
3. Utilize all area personnel to identify and drive replacement of corroded equipment. SEH/STB Complete
4. P&ID line replacement status check. STB/SAD 3/31/93
5. Focus equipment replacement on liquid VCM service lines. Task Force
6. Establish Integrity Task Force. SEH Active.
7. Install a high pressure alarm on the equipment recover header. FFI Complete

Narrative:

On 2/19/93 at 1:45 PM, Carl Frank, Instrument Mechanic was working near the vapor recovery filters when he heard a "pop" followed by a hissing noise. He began to smell an odor. He quickly notified Mike Warfield, Production Supervisor.

Mike applied water to the leak using a hose, requested the equipment be placed on recovery and instructed to sound the fire alarm.

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A call was placed to 911 at 1:55 PM. After area monitoring assured a safe condition, the all clear was given.

Based upon area monitor readings and measured volumes, the release was calculated to be 8.4 lbs. of VCM.

Facts Surrounding the Incident:

1. The equipment recovery header was not in use at the time of the incident.
2. The failed line was 17 year old schedule 40 carbon steel.
3. Liquid VCM was present in the recovery header.

Management Systems Investigation:

1. The involved corrosion was inside out in nature.
2. The failure was chemical pitting on the bottom surface only.
3. The failure was not freeze related.
4. The source of the liquid VCM was a failed equipment recovery valve seat at FIL-SF VCM charge filter.
5. The valve was locked in the closed position.
6. The seat failure resulted from heat.

Conclusion:

The line failure was the result of extensive chemical pitting aggravated by undetected VCM liquid pressure.



S. E. Hale
General Foreman - LPA

SEH:lds

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