Inter-organization Correspondence

B.F.Goodrich

TO	FIELD POINT OR AKRON DEPARTMENT & BLDG. NO.	DATE YOUR LETTER
H. Waltemate	Cleveland	
FROM	**FIELD POINT OR AKRON DEPARTMENT & BLDG. NO.**	**DATE THIS LETTER**
J. W. Gressler	Pedricktown	June 28, 1972

SUBJECT

1972 Type #10 Incident #9

INCIDENT OF EXPERIENCE VALUE - REPETITIVE #10 "FILL BUILDING OR AREA WITH EXPLOSIVE MIXTURE" - MASS RESIN - PEDRICKTOWN

On Wednesday, June 28, 1972, at 7:02 a.m. we experienced Repetitive Accident #10 in Mass Resin (Building 512). A small vinyl leak occurred at the hamer blind between Reactor 7100 and Reactor 8200.

The incident was reviewed by the following people:

W. A. Reed - Mass Resin Manager
W. T. Kloepfer - Computer Engineer
- Console Technician
n - Lead Technician
- Operating Technician
J. W. Gressler - Safety Engineer

Facts

Reactor 7100 (prepoly) was in reaction. Autoclave 8100 was in the process of being prepared to accept the charge from the prepoly. Autoclave 8200 was on recovery and was due to be transferred. At 6:35 a.m. T took 8200 off of recovery so that he could use the vacuum jets to pull a vacuum on 8100. was then ready to transfer 8200, however, he put 8200 to pre-transfer instead of transfer. He immediately realized what he had done and immediately put 8200 to hold. He then re-entered it to transfer.

At 7:02 a.m. got a message on the computer typewriter that the MSA gas analyzer had activated. He called the building via the Terryphone system. was on the screening and grinding side of the building and reported to the polymerization side. He saw the leak and notifie to put the prepoly to hold. In the meantime, Hewitt arrived and activated the master gas alarm, fog system, and emergency fans. The building was re-entered. It was determined that the leak had occurred thru an improperly tightened hamer blind between Reactor 7100 and Reactor 8200.

Good

A formerly undetected programming error permitted the prepoly to drop its charge to the wrong autoclave. None of the operating procedures had been violated. True, the hamer blind was incorrectly installed; however, there is no way to check the proper installation short of pressure testing the line.

The prepoly was taken out of hold and the remainder charged to the proper reactor without further incident.

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Corrective Action

1. The incident will be reviewed in all departmental meetings.
2. We will review the proper technique for tightening hamer blinds.
3. We have corrected the programming error to prevent a recurrence.

J. W. Gressler

JWG:rp

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

N. Waltemate
7-14-72