**BFGoodrich** **INTER-ORGANIZATION CORRESPONDENCE**

| TO | FIELD POINT OR DEPT. & BLDG. NO. | DATE YOUR LETTER |
|---|---|---|
| MIKE BRECKENRIDGE | RESIN MANUFACTURING MANAGER | |
| **FROM** | **FIELD POINT OR DEPT. & BLDG. NO.** | **DATE THIS LETTER** |
| ISIAH PARKER | "A" SHIFT FOREMAN - RESIN | 07/13/92 |

SUBJECT

PLAQUEMINE PLANT
REPETITIVE INCIDENT - TYPE 15
MISCELLANEOUS - MONITORING EXPOSURE ABOVE 1 PPM

SUMMARY

On May 27, 1992, wore personnel monitoring badges to sample their exposure to VCM vapors during that day. both samples indicated levels above 1 PPM during the period worn, without the use of respiratory protection. Neither employee reported any unusual physical effects.

BOARD OF REVIEW

A Board of Review was conducted on June 24, 1992. The following people were present:

| | | | |
|---|---|---|---|
| C. Bayard | - Plant Manager | M. Thompson | - Environmental Spec |
| M. Breckenridge | - Mfg. Manager | H. Catoir | - Prod/Maint Coord. |
| T. J. Guillot | - Prod. Coordinator | D. Prejean | - Safety Ass't. |
| M. Comeaux | - Safety Foreman | | - Operator Tech |
| J. Richards | - Process Engineer | | Resin Foreman |

NARRATIVE

The day on which the employees were monitored was basically routine. Mr. as Resin Foreman, did not knowingly have an opportunity to wear respiratory protection. He made several trips through each reactor area and the VC Recovery Area. He did not notice any VC (Vinyl Chloride) leaks.

as Shift Floater, spent most of the day cleaning up in the finishing building (non-regulated area). However, approximately 3 hours of Mr time was spent in Train I area to clean the pit under 1D autoclave. was also involved in this task. Neither man noticed any high concentrations of VC vapors during that task. No respiratory protection was worn by during the day he wore the monitor.

FACTS SURROUNDING THE INCIDENT

1. The value of 1.79 PPM was the result of Mr. TWA (Time Weighted Average) sampling.

2. The value of 1.93 PPM was the result of TWA sampling.

REDACTED

3. M.. authorized the entry to clean the pit under the autoclave. The readings from the gastech meter indicated allowable limits, not requiring respiratory equipment.

4. The area reading from the chromatograph on the day of the incident was not unusually high.

MANAGEMENT SYSTEMS INVESTIGATION

1. Neither individual is knowledgeable as to where he may have come into a high concentration of VC to give a TWA above one. The pit cleaning task is the only incident that both employees worked on together during the day of the monitoring.

2. Mr. have been trained on vessel entry and have performed this task many times.

3. There was no safety rule violation.

CONCLUSIONS

The two probable sources of high concentration which could have caused the exposure are: fugitive emissions within the reaction area, and intermittent high concentrations in the resin being removed during the pit cleaning.

CORRECTIVE ACTION

| | | |
|---|---|---|
| 1. | Evaluate the use of Canister Respirators | M. Comeaux |
| 2. | All foremen will be members of VCM Exposure Reduction Task Force to review their exposures | T.J. Guillot |
| 3. | Increase emphasis on actions taken from area chromatograph monitoring | Resin Foreman |
| 4. | Wear air respirator while cleaning reactor pits | T. J. Guillot |

Isiah W. Parker

pc: Board of Review
Managers
All Foremen