MONTHLY INJURY SUMMARY

August, 1965

We had three accidents this month which resulted in disabling injuries. Our total year to date now stands at 15 as compared with 21 for a similar period last year. The frequency rate now stands at 3.16 versus 4.71 for 1964.

Two of the disabling injury accidents occurred at Long Beach; the first of which involved a polycharge operator. He was struck by a section of 2" pipe on the hip and lower back area.

The operator attempted to put a poly on recovery but found the recovery line plugged. The recovery line is a 2" line that rises 5 feet vertically from the center of poly into a 12 foot horizontal section. The end of poly recovery line is coupled to the main header line. The recovery operator and the charge operator removed the coupling and attempted unsuccessfully to back wash the line with water. The charge operator was standing on the poly cooling jacket cover and opened and closed the recovery valve rapidly to loosen the plug with poly pressure (120 psi). After several unsuccessful attempts, the helper started to chip the packed section by inserting a screwdriver into the end of the pipe. Suddenly, the plug broke loose and the discharge from the end of pipe caused it to twist around 180° and then ended up resting on the recovery valve handle, the edge of the poly and the floor.

The charge operator seeing the pipe twist, jumped to the floor from the poly (not more than 2 ft.) and he believes the pipe hit him in the back as his feet reached the floor. He left the building immediately. Later x-rays disclosed no broken bones. He lost 14 days as a result of this accident.

One of the most serious aspects of this accident was the venting of VCl into building during the time when the recovery valve was open for about five minutes before the foremen came by and closed the valve. (Corrective action to be taken forthcoming from Long Beach).

The other accident at Long Beach resulting in a disabling injury occurred to a mill operator who slipped on oil slick and twisted his knee.

The maintenance crew had pulled the screw from the Prodex extruder and pushed the screw out of the building. The crew members had forgotten to plug the cooling oil pipe hole of the screw, and therefore, oil had dripped onto the floor. About this time the maintenance men left the area as the coffee truck had arrived but neglected to wipe up the oil.

The mill operator was walking to the millroom area when he slipped and fell striking his knee on the cement floor. He reported the accident and continued to work. About midway through the shift, his knee started hurting and he was sent to the hospital for x-rays and then to the doctor's office. No fracture was shown but the doctor recommended rest for several days. He lost five days as a result of the accident.

An accident at Calvert City resulted in a disabling injury to a chemical engineer (in training). He caught his finger in a door and the tip of the finger was sheared off.

The engineer was entering the foremen's office after a routine check through the production building. The door through which he entered is a heavy conventional type with a door closer attached. As he opened the door, he noticed the janitor was cleaning the floor near the door. He hesitated a moment for the janitor and as he stood there, he placed his hand on the door jam in a restful position, not realizing that the door closer was holding the door open for a few seconds. As the door closed it caught his little finger of the right hand between the jam and the door, severing the end of his finger.

He reported at once to the plant nurse and then the company doctor and in turn to the hospital where the tip was sutured back on. Time lost as a result was 3 days.

Corrective steps taken at Calvert (by the Accident Investigation Committee)

1. Decided to install pullman type hinge protector due to the position of the door and amount of traffic.

An incident at Avon Lake General Chemical may have experience value for our plants. It concerns the use of Isopropyl Percarbonate (IPP).

The Sope operator in preparing for a charge removed a tray of IPP (10#) from the freezer. The procedure is then to weigh out an amount of the IPP as required by the recipe. This was done, the lid was replaced and the tray returned to the freezer. A plastic liner which had been over the IPP on the tray was inadvertently left out on top of the freezer. After the catalyst was put into the charge bottle and the cover was being tightened, the operator noticed smoke in the Sope room. The fire alarm was turned in and one fire extinguisher was used. There was no flame, injuries, damage to equipment, or loss of material other than the plastic liner. It was only a matter of minutes and the liner was gone. The decomposing of the plastic liner is believed to have been caused by small particles of IPP adhering to the liner and being allowed to warm up in the room.

Avon Lake General Chemical now removes all the liners and washed thoroughly before discarding. They have also contacted the manufacturers to have the liners eliminated (previous shipments did not have them.)

All supervisors have been contacted to instruct them about the hazards of IPP and the proper method of handling.

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