ATTACHMENT III

PLAINTIFF'S EXHIBIT CEL-812

02.13.2

CELANESE QUALITY

Interoffice Memorandum

TO (Name and Location)
Mr. C. R. DeRose

FROM (Name and Location)
Jaime Garza

REFERENCE NO.
JG-034-86

Re: Notification To Regulatory Agencies Regarding The Asbestos Spill In The Filled Resins Area

On August 20, 1986, at about 10:00 A.M., the S.H.E. Department was notified that an asbestos spill had occurred in the Filled Resins Area. Upon investigation by Mr. G. Ille and I of the incident, the following information was obtained:

About 6:20 A.M. on August 20, 1986, a batch of asbestos was to be dumped from the asbestos dump chamber to the ribbon blender located on the 5th floor of the Filled Resins Area. The asbestos is gravity fed via pipe connected with quick disconnect victaulic couplings. Apparently, the pipe connection located just above the ribbon blender had been disconnected and the asbestos dumped at the dump chamber fell on top of the ribbon blender. Some of the asbestos fell from the ribbon blender onto the floor and between the ribbon blender and the grating opening, down to the lower floors. It was apparent that some of the asbestos spilled was accumulated on the I-beams located just below the ribbon blender and on some of the equipment located below the 5th floor. Clean-up of the spill was begun immediately after discovery of the spill. The initial information obtained was that only three bags of asbestos was dumped before the spill was discovered, however, it is now apparent that 8 bags of asbestos was actually dumped. Each asbestos bag contains 35 lbs. of asbestos. Approximately 10 feet from where the spill occurred on the 5th floor, there is a wall ventilation fan. The exhaust from the ventilation fan is located just above the MH-2 control room structure.

Clean-up efforts included a complete wash down of the area with water, after all asbestos that could be picked up by shoveling was done. Therefore, it is assumed that water fell from floor to floor down to the slab of the building. The water was then swept to the outside of the building where some of the water remained pooled until it evaporated. Further clean-up efforts were conducted later in the day, which Mr. G. Ille will document.

Asbestos is listed as a hazardous substance, which when spilled in excess of the reportable quantity, must be reported to the National Response Center (NRC). The reportable quantity for an asbestos release is 1.0 lb. Release is defined as any spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, or disposing into the environment.

Because of the uncertainty of how much asbestos was spilled into the environment, the S.H.E. department concluded that the NRC should be notified of the incident. This was based on the earlier information that only 3 bags of asbestos was spilled. If we assumed that only 1% of the asbestos spilled was lost to the environment, that quantity would place the spill above 1.0 lb and require notification. Knowing now that 8 bags of asbestos was spilled, the precautionary measure of notifying was justified. Additionally, the S.H.E. Department was initially told that the incident occurred at about 5:30 A.M. and was reported as such.

The National Response Center was notified of the incident on August 20, 1986 at 1:00 P.M. The information was supplied to Petty Officer R. Wallace. I told Officer Wallace of the incident as described above and added that we believed that most of the asbestos was cleaned up. However, not knowing for sure how much asbestos was actually lost to the environment, Celanese Engineering Resins, Inc. was reporting in an "overabundance of precaution". Officer Wallace asked several questions.

Name of individual making report: Jaime Garza
Name of Company: Celanese Engineering Resins, Inc.
Mailing and Street Address: P.O. Box 428, Bishop, Texas 78343
One mile south of Bishop, Texas on U.S. HWY 77 Business.
Date and Time of Occurrence: August 20, 1986
5:30 A.M.
Have Other Health Authorities in Texas Been Notified: No. I responded that I would do so after our conversation was completed.

Petty Officer R. Wallace had no other comments and our conversation was terminated.

At 1:15 P.M., Mr. W. T. Palmer, TACB Regional Supervisor was also notified of the incident. I essentially told him the same thing I told Petty Officer R. Wallace. Furthermore, I told Mr. Palmer that the NRC had already been notified. Mr. Palmer told me that he did not anticipate any problems in the way we handled the situation and that we did not need to go anywhere else with the information (I assume he meant that no further reporting to any other TACB offices was necessary).

At 1:20 P.M., the Nueces County Health Department was also notified of the incident. My intentions were to talk to Mr. A. L. Cock; however, he was not in the office at the time. I proceeded to pass on the information to his secretary, Ms. Carmen