



INTERNAL CORRESPONDENCE

CHEMICALS AND PLASTICS

P. O. BOX 471, TEXAS CITY, TEXAS 77590

TO (NAME) Mr. R. N. Wheeler
COMPANY
LOCATION SOUTH CHARLESTON PLANT

DATE February 13, 1976

RECEIVED

FEB 16 1976

COPY TO Mr. R. L. Frantz

SUBJECT

R N WHEELER JR.

Dear Nick:

Enclosed please find the temperature/pressure recording chart for D-16 when it went out of control on the midnight shift, February 12. No inhibitor was added because the pressure reached the point where the additive system would not function. The technique for addition will be revised so that it can be added under any pressure. However, addition of an inhibitor will not always stop a reaction dead in its tracks and to assume that emergency venting can be eliminated is being naive. The rupture disk did not blow in this case, the operator opened the valve by hand to relieve the excess pressure. As you know, severe foaming always occurs under fast pressure release in a suspension autoclave and a lot of resin slurry passes out through the vent. The enclosed pictures tell the story of the resin that was released in this particular case. Under no condition would we want to try to vent in a situation like this to a gas holder. The line would plug, fouling the whole system with polymer.

We do not know why this autoclave went out of control. There was no problem immediately before or after this batch. It may have been a mischarge caused by an instrument malfunction that cannot be reconstructed.

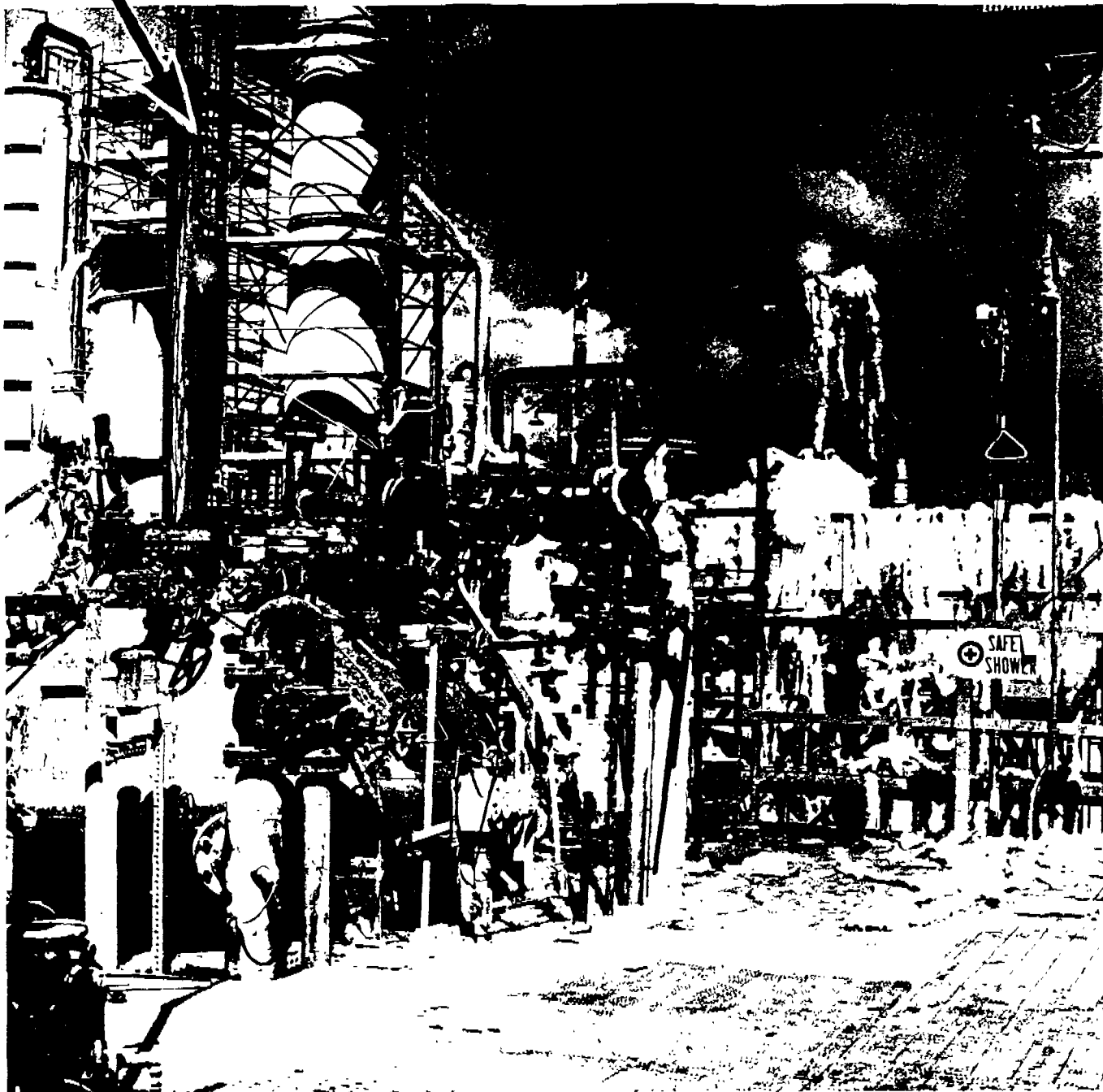
I think this is important evidence to present to the EPA to point out what can happen in this type operation and try to convince them that it is unrealistic to assume that emergency venting will not occur, that operators and hardware will make mistakes and to try not to be too punitive in their approach to this matter and invite a disaster.

M. E. Eisenhower

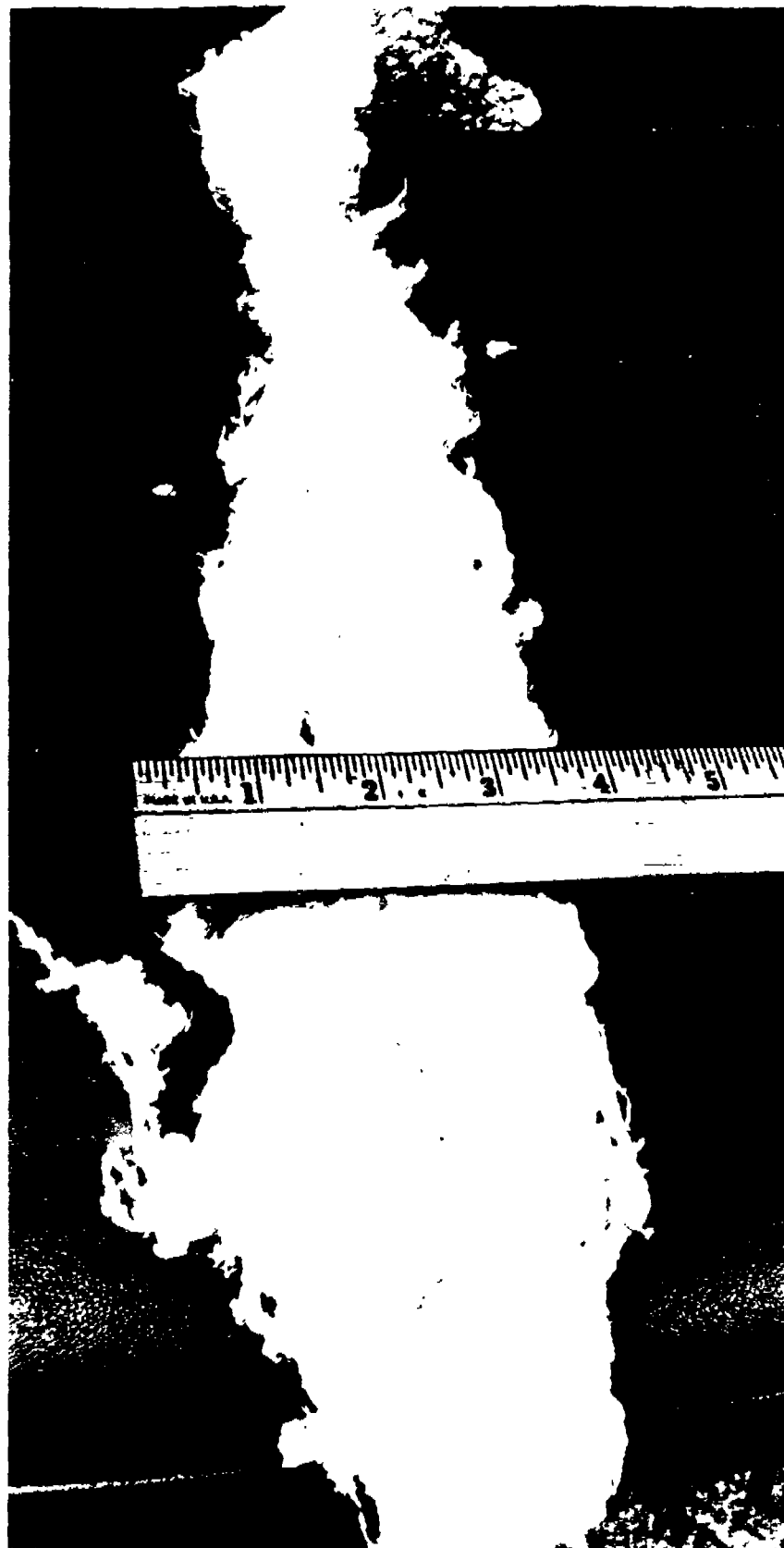
MEE/mjb
Enclosures

1101
039780

PL 700, D-16
HAND VENT



UIC
039761



100
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UCC
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