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MAY 25 '84

Conoco Chemicals Company
Conoco Inc.
P. O. Box 91, New Highway 25
Aberdeen, Mississippi 39730
(601) 369-8111

Route: 557

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File: Aberdeen~~xf~~ OSHA

May 9, 1984

A. de Jean King
OSHA Area Director
Federal Building, Suite 1445
100 West Capital Street
Jackson, MS 39201

Dear Mr. King:

On March 2, I spoke with you and others in your office to report an emergency release of vinyl chloride that occurred from a railcar in the Conoco Chemicals Aberdeen, Mississippi plant. A transcript of that call is attached. At your request, following is additional information relevant to the incident.

Incident Summary

At approximately 4:40 p.m. on Thursday, March 1, 1984, a release of VCM liquid occurred from railcar number UTLX 98233. At the time of the release, the car was positioned in the tank farm area of the plant at unloading spot #8. Due to a combination of events, the car rolled out of position, causing the unloading lines to be pulled from the railcar unloading valves. The release was discovered by plant employees at about the same time and emergency response actions were taken immediately. The railcar was secured at 5:05 p.m. There were no injuries and four possible employee overexposures. Medical surveillance was conducted on the appropriate employees within two hours of exposure.

Plant Incident Response

The release was discovered by plant employees who immediately notified yard and safety personnel, who in turn notified the process control room. The plant's emergency response program was immediately initiated. The vapor release alarm was sounded, a public address system announcement was made, and the tank farm's firewater deluge systems were started.

Five plant employees were directly involved in responding to the incident. Scott air packs were worn during the time of response. Several other employees were marginally involved in responding to the release and were potentially overexposed. Within two hours of the incident, appropriate personnel were given medical surveillance. Medical evaluation to date indicates no detectable effects in those tested.

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Investigation and Incident Cause

Subsequent investigation indicated the direct cause of this incident was the total failure of the air and hand brake systems on the railcar. Contributing factors to the incident included a very slight grade slope in the unloading area and failure of the metal chocks to resist movement of the car during unloading.

These factors, in combination, resulted in the car movement and the unloading lines being pulled loose from the unloading valves.

Actions To Be Taken

As a result of the investigation of the cause of this incident, the following actions are being taken to prevent similar occurrences.

1. An overall review of railcar braking systems has been done. Steps will be taken to assure that railcars can be secured in the unloading position by some functional braking system before unloading.
2. Different chocking systems are being reviewed. Although the chocks in use at the time were in accord with current industry practice, it is felt a better chock material or design may be desirable.
3. Level the grade slope of the No. 8 unloading station. Although the slope of the trackage at this station was very small, it was evidently enough to provide the potential energy necessary to allow the car to roll off spot, given this set of circumstances.

A. H. Sather

A. H. Sather
Safety Director

rah

attachment

cc: JF, CRM, PEM, DWH, RAF
T. Grumbles ✓
J. Doyles

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