

Facts

1. The hose which blew off was 12 feet long and 5 inches in diameter. It was a stainless steel flexible hose with a maximum operating pressure of 30 PSIG. The hoses are equipped with 2 - 5" female Evertite adapters (Part "D" coupler).
2. The Evertite coupler is a quick disconnect type with two clamps on it. As stated earlier Ford had noticed that the clamps were not secure and was in the process of securing them when the hose blew off.
3. In addition to resin in the eyes he received a small laceration of the lower lip.
4. We have also determined that the safety glasses may have prevented a more serious injury to the eyes. We will submit , name for membership in the "Wise Owl Club".
5. Under section A5.14 of the USA Standard Z16.1-1967 this accident does not constitute a "Lost Time Injury." *The man was held for observation only and no treatment was given.*

Corrective Action

1. Chains and clips were installed on the Evertite couplings. This was done to prevent the clamps from working themselves loose.

All plants should check their Evertite couplings.

2. A plant wide survey is being conducted to determine if chains and clips are needed in other areas.
3. It will now be standard procedure for two employees to switch hoses in the silo area. *Not sure if this is necessary.*

4. This accident will be discussed in all departmental meetings.

2-11-72 W. W. Gressler
J. W. Gressler

JWG:rp

cc: O. F. Beckmeyer
J. L. Nelson - R. D. Scott
E. W. Harrington - P. H. Lawrence
G. Pow
W. E. Brodine
W. L. Cato
E. E. Mitchell - P. D. Terry
A. R. Webber
H. T. Evans
J. M. Smith
C. J. Nosal
J. Parlier

J. W. Goetsch - E. C. Martinelli -
J. Dunlap
W. A. Reed - M. F. Knapp
W. E. Horton - J. Fletcher
J. J. Kremenz

REDACTED

NGC 15697

B. F. Goodrich Chemical Company**Inter-Organization Correspondence**

To D. L. Dowell	From J. W. Gressler
Location Cleveland	Location Pedricktown
Department	Department
Subject NEAR MISS TO - REPETITIVE #11, CLOBBERED BY A MOVING OBJECT	
Date January 24, 1972	

On January 20, 1972 at approximately 11:45 a.m. _____, dryer technician was struck in the face by a transfer hose when it came uncoupled from a transfer line. He was admitted to Salem Memorial Hospital, Salem, New Jersey with abrasions of the right eye. He was released in the a.m. on January 22, 1972 and returned to work on his regular shift January 23, 1972.

At approximately 10:00 a.m. _____ reported to the silo area in Building 541 to change the transfer hose from resin Silo 3J to Silo 1J. The change was made without incident. In changing the hose only one end had to be switched, the end to the silo. The hose end attached to the line from the dryer building was not tampered with by _____

_____ returned to the silo area between 11:30 and 11:45 a.m. to check the slide valve to Silo 1J. He had returned to the silo area because the weight in the storage bin at the dryer building was not dropping off. He thought that possibly the slide valve was stuck and would not allow the resin to be transferred to Silo 1J. As he was getting ready to leave the silo area he heard the line from the dryer building vibrate. He looked at the transfer hose and noticed that the coupling locks were not secured. As he went to secure them the hose blew off striking him in the face. When the hose hit _____ it knocked his hard hat and safety glasses off.

He reported to the dispensary where Miss Jane Jackson, Plant Nurse, flushed his eyes with copious amounts of water. Pontocaine 1/2% was added to both eyes, to numb the eyes, so she could begin to clean the eyes. Miss Jackson removed large amounts of resin and irrigated the eyes. She then added 2% sodium fluorescein (a solution used for determining damage to the eyes). She noted that the right eye was holding the sodium fluorescein and decided that Dr. Charles Norton, Plant Physician, should see him. He was taken to Dr. Norton's office where he was examined. Dr. Norton found Ford's vision to be slightly impaired, it showed a reading of 20/25. Dr. Norton did notice that the cornea had been scratched, however, he did not know to what extent. He decided to refer _____ to Dr. Robert Cox, Ophthalmologist.

Dr. Cox examined _____ and decided to admit him to Salem Memorial Hospital for observation with what he thought might be a chemical burn of the right eye. (It was learned later that the accident had caused abrasions and not a chemical burn. _____ was released January 22, 1972 and returned to work on his regular shift January 23.

JAN 31 1972

NGC 15698

B.F. Goodrich Chemical Company

Inter-Organization Correspondence

1972, Type #10 Incident
2

To H. Waltemate Location Cleveland Department	From W. A. Riley Location Long Beach Department
Subject Poly No. 1 Vent Stack Separation on 1/23/72 (Repetitive Accident Type No. 10) "Fill Building Or Area With Explosive Mixture"	
Date January 27, 1972	

A preliminary report of the subject accident was telephoned to D. L. Dowell, in your absence, on 1/24/72. Following is a narrative report of the incident.

Description

At 6:10 am on 1/23/72, Poly No. 1 vented 38 minutes after charging 103 EP Charge No. 810. Simultaneous with the rupture of the two 3 inch 720F, 210 psi rated Frangible rupture discs, mounted in series within the vent stack approximately 10 feet apart, the vent stack separated from the 6 inch long spool piece attached to the poly vent nozzle. This separation released essentially the entire unreacted portion of the 10,000 lb. monomer load into the operating floor area of the polymerization building and necessitated plant evacuation for a period of 15 minutes. There resulted neither injury to personnel nor significant equipment damage.

The accompanying photographs show the point (A) at which the vent stack separated from the spool piece (B).

Investigation

Inquiry into the cause of the accident was conducted immediately following the release, again on Monday, 1/24/72, and at 8:00 am on Tuesday, 1/25/72, when a Board of Inquiry Meeting was held with polymerization personnel on duty at the time of the accident. These investigations revealed the following information:

1. Charge No. 810 was completed with the addition of monomer at 5:32 am. The charge data sheet and reaction temperature/cooling water temperature recording chart support the statement Charge Operator who charged the poly, that charging and initial reaction were normal until the time the specified reaction temperature of 136°F was reached.

The recording chart further shows full cooling water was called for in a normal manner when the reaction temperature was reached. However, the temperature continued to rise at a nearly undiminished rate until the poly vented at 160°F.

2. Charge Operator, reported Poly No. 1 agitator was not running when he returned to the polymerization building. He stated that he checked the motor circuit breaker and found it in the on position. The recording chart indicates, beyond reasonable doubt, that the agitator was running at least until the time the charge reached reaction temperature. No one recalls having heard or silenced the poly agitator alarm during the period Poly No. 1 was on heat-up.

REDACTED

NGC 15699

JAN 31 1972