Pedricktown Dispersion Resin Plant
Vinyl Chloride Fugitive Emission Release
March 30, 2000

Summary and Cause of Incident: On Wednesday, March 29 around 10:00 a.m., an asbestos gasket ruptured on a recovery system line causing a fugitive Vinyl Chloride emission release of 3 pounds. No injuries resulted and there was no impact on the surrounding community. This incident has been classified as a New Jersey TCPA EHS ACCIDENT - EQUIPMENT FAILURE & HUMAN ERROR.

Board of Review: A Board of Review was held at 11 a.m. on Thursday, March 30 with the following attendees:

Darrell Robinette	-	Senior Operations Specialist
Dave Dufort	-	Process Engineer
	-	Poly Technician
Bill Russell	-	Lead Technician
Ron Betts	-	Raw Material Technician
Otis Sistrunk	-	Environmental Engineer

Corrective Actions:

1. Replace the asbestos gaskets on the line, 3 in total, with Flexitalic gaskets. – *Bill Russell, Completed* 3/29/00
2. Re-label the recovery line in 3 new locations. – Bill Russell, Completed 3/29/00
3. Discuss and drill this and other likely incidents at Shift Meetings. – Carl DeGrazio by 6/30/00
4. Perform internal audit to evaluate the labeling of process lines in the Poly building. – Bill Russell by 4/30/00
5. The performance of the Poly Technician will be reviewed along with the necessary actions to prevent reoccurrence. – Bill Russell / Darrell Robinette / Dave Dufort by 4/10/00

Narrative: Around 10:00 am on Wednesday, March 29, Ron Betts was walking by the tank farm area when he noticed foam emitting out of an unlabeled recovery line flange. He notified the Poly Technician, to rectify the situation isolated the nearby recovered Vinyl Chloride monomer tank and pump discharge, but, in confusion, opened a valve connecting the leaking recovery line to a 6" feed line which contained 3' of residual recovered Vinyl Chloride monomer (RVCM). The Lead Tech was notified around 10:02 via the Console Tech. The Lead Tech turned on the near-by water monitor to knock down the foam and vapor from the line to determine where the leak was. He then notified Waste Treatment that the water pumps would turn on, then proceeded to pull the building Gas Alarm. Waste Treatment was then notified to divert the area sumps and close the storm drains to divert the run off water. The Lead Tech then closed the valve on the inside of the building, isolating the recovery line to a 6' section, shut off the water monitors, and closed the valve connecting the recovery line to the RVCM pump.

Facts Surrounding the Incident:

1. The foam initially noticed emitting out of the flange was slurry which entered the line during a Premix transfer.
2. The Vinyl Chloride was introduced to the surroundings through the leak when the valve connecting the recovery line to the RVCM line was opened by the Poly Technician.
3. The recovery line is a low point in the system which is only used when recovering the South Premix Tekmars or the RVCM pump. The line was most likely filled with slurry from a Premix transfer.
4. The gasket most likely ruptured due to thermal expansion of the liquid trapped in the line from the increase in ambient temperatures from night to day time.

5. If the people involved in attempting to control the situation had taken time to evaluate the situation before reacting, the release would have been less severe and controlled with little to no intrusion.

Management Systems Investigation:

1. . has worked in the area as a Charge Technician since 1981.
2. He was re-certified in this position in October 1998.
3. Emergency response was immediate and effective.
4. Though the labeling on the lines was hard to see, it did not play a role in the incident.
5. Examination of the gasket revealed a 1/16" separation where the gasket ruptured.
6. Confusion was noted by some site personnel regarding gas alarm assembly points. A gas alarm drill had already been scheduled for April to reinforce assembly points.
7. Notifications were made to the proper state and federal agencies as a precaution. This incident was not a permit violation and the Fugitive Emissions will be reported per our facility wide permit requirements.
8. The NJDEP arrived on site shortly after the incident to review the incident at the Pedricktown plant. The gasket, location of the spill, and actions taken were reviewed. The NJDEP was satisfied by the actions taken at the site.

Conclusion:

The release occurred when opened the wrong valve (Human Error) to control a gasket failure (Equipment Failure) on the equipment recovery header. The maximum Vinyl Chloride readings detected by a local GC point was 3.92 ppm at source. The total Vinyl Chloride emitted was calculated to be 3 pounds.

Approvals

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Darrell Robinette - Senior Operations Specialist - BOR Chairman

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Dave Dufort - Process Engineer

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Poly Technician

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Bill Russell - Lead Technician

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Ron Betts - Raw Material Technician

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Otis Sistrunk - Environmental Engineer