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HW--15237

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RECORD CENTER FILE

MAY 28 1956

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Richland, Washington November 29, 1949

TO: FILE

HAIFORD WORKS

Area Investigation

Mear Sorious Accident

Arca:

200 West

Time:

8:42 P. M.

Division: S Division

Persons Involved:

Operator and Technical Leanee

Injury or Damage:

Superficial Laceration to

Head of Operator.

Damage to bell jar.

Classification Cancelled (Change to

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Description of Conditions Involved:

Date of Occurrence: November 9. 1919

At approximately 8:42 P. H., November 9, 1949, an explosion involving Mickel Carbonyl occurred in Coating Hood No. 25, located in the 235 Building process area.

During the 8-4 shift, Mickel Carbonyl gas cylinders feeding the bell jar in Conting Hood No. 25 were changed by manipulating valves so that an unused cylindor would be brought into use. (Two gas cylinders are installed in a cabinet located under Hood 21, but only one cylinder is used at any given time). This change was made since processing difficultios were being encountered at this particular hood and it was possible that an impure Nickel Carbonyl gas might be a source of the difficulty. The 8-4 shift purged the gas line with five (5) portions of gas to assure that all mas from the cylinder formerly used had been displaced. Each portion of gas was exhausted from the bell jar by using the "roughing" pump.

After the 4-12 shift had relieved the 8-4 shift and finding both valves in the gas line closed the question arose as tog mether or not the section of line between the closed valves had been purged. It was then decided to purso the gas line to assure that it was adequately cleaned.

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llovember 29, 1949

The operator bled Nickel Carbonyl gas into the bell jar until the pressure increased from 28 to 26 inches mercury, on the Bourdon vacuum gauge. At this point the operator opened the vent valve and then storted exhausting the Nickel Carbonyl gas-air mixture by using the "roughing" pump. The Technical loanse had instructed the operator to rough out the gas and then vent the bell jar; evidently the instructions were misunderstood and the operations were performed in reverse order.

An explosive mixture of air and Nickel Carbonyl developed and exploded in the bell jar. The explosion was of sufficient force to completely disintegrate the glass bell jar and force the rubber gloves inside out so that they extended into the operating gallery. Several pieces of glass pieced the gloves and were thrown into the operating gallery. One glove apparently brushed the operator's head (he was in a crouched position in front of the hood), and he received a superficial laceration to the scalp, possibly from a piece of glass.

Neither the operator nor the Senibr Supervisor on shift realized that it was possible to devolop an explosive mixture. The Technical learner realized the possibility and gave instructions as to the order of operations, but apparently was not understood by the operator.

Observations:

- 1. The heating unit was off.
- 2. Gas lines were not broken in charging cylinders. Cylinders were switched by opening and closing valves only.
- 3. Examination of the hood after the explosion revealed that some oil (approximately 5 cc) was on the bottom of the hood adjacent to the bell jar base.
- 4. No definite purging procedure had been written for changing cylinders.
 - 5. This type of purging is not a routine job.
 - 6. The possibility of explosion had not been stressed. Emphasis had been placed on the texic properties of the gas and carbon monoxide liberated on decomposition.
 - It is apparent that the information turned over at shift change was insufficient; in that there had been a misinterpretation of information.

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8. The normal operating procedure is written and in use.

Recommondations:

Specific

- 1. Hen should be thoroughly acquainted with material being handled.
- 2. Procedures must be written for all oforations whether routine or not, and theroughly covered with operators and supervision.
- 3. A study be made to determine use of an inert cas rather than air to purgo system.

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Hovember 29, 1949

Valves on this mystem, both from cylinder and vent, be locked out. Clearance be made through supervision for unlocking valves.

Responsibility

- 1 1 Lack of instruction and procedure.
- 2 1 Operator not following instructions as givon.

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INVESTIGATING COMMITTEE

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