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Contra Costa Hazardous Materials Programs

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ccchazmat@cchealth.org www.cchealth.org/hazmat/

COMPLAINT, INCIDENT, AND NOTIFICATION REPORT FORM

Type (Circle One): C I N		CASE NUMBE	ER: 210729 −01				
	Bossived Times 2:52 PM	Received By: TJ Lead: TJ					
			Assigned Date:				
Incident Date: 1720/21	Incident i ime:	Assigned to:	Assigned Date:				
COMPLAINANT / REPORTING PARTY:							
Name: RP is from Facility Anonymous							
Organization: CCCFPD Cal OES # (if applicable)							
Primary Phone Number: 925-941-3300 Secondary Phone Number:							
Email:	· · · · · · · · · · · · · · · · · · ·	<u> </u>					
Address:		_					
City:		State: Zip	Code:				
FACILITY / LOCATION OF INCIDENT:							
Name: DWELLEY FARMS CUPA Facility I.D.: 77393							
Phone Number:							
Address: 515 DELTA RD		Unit:					
City: OAKLEY		State: ^{CA} Zip C	Code: 94561				
Location Description:							
INITIAL INCIDENT DESCRIPTION:							
RP STATES ICE MAKER ON OUTSIDE TRAILER HAS AN AMMONIA LEAK; AREA IS EVACUATED							
INCIDENT TYPE / DESCRIPT	TON:	<u> </u>	0000				
INCIDENT TYPE / DESCRIPTION: Community Warning System Level (Circle Highest Level): N/A 0 1 2 3							
FACILITY	ISO / MCAR	TRANSPORTATION	MISCELLANEOUS				
	□ Fatality (one or more)□ > 24 hrs. Hospital, 3 or	□ Tank Truck □ Railroad	□ Storm Drain/Creek □ Drug Lab				
□ Startup or Shutdown	more people	□ On Water	□ Disposal/Abandonment				
□ Flaring	□ Flammable Vapor Cloud	□ Pipeline	□ Odor Complaint				
☐ Upset ☐ Upset ☐ ☐ Upset ☐ ☐ Upset ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	> 5,000 lbs.						
Time Enroute to Scene: Time Arrived On Scene: Time Departed From Scene:							
REFERRED TO OTHER AGENCY:							
MCM To							



- Contra Costa Behavioral Health Services Contra Costa Emergency Medical Services Contra Costa Environmental Health & Hazardous Materials Programs •
- Contra Costa Health, Housing & Homeless Services Contra Costa Health Plan Contra Costa Public Health Contra Costa Regional Medical Center & Health Centers •

DTSC STATE FUNDING (if applicable):			STORMWATER STATUS (if applicable):					
CLU/ERER Number:			□ Actual Discharge □ Potential Discharge					
AGENCIES ON SCENE OR NOTIFIED:								
Agency Type	<u>Agency</u>	<u>O/N</u>	Contact Person	Phone Number	Case Number			
Fire Department								
Law Enforcement								
Air District								
State OES								
REPORT:								
See attached incide	nt report narrative.							
					Į			
Additional Required It	ems: Bill of Lading, F	Request for	Invoice, and Site Safe	ty Plan				

Trisha A. Johnson 10/15/2021

Report Prepared by:

Rev. August 2020

Hazardous Materials Spill Report: Cal OES Control #:21-4067

Warning Center < Warning. Center@oes.ca.gov>

Thu 2021-07-29 5:36 PM

To: ccchazmat <ccchazmat@cchealth.org>

Governor's Office of Emergency Services Hazardous Materials Spill Report
DATE: 07/29/2021 RECEIVED BY Cal OES: Peter Bantug Cal OES CNTRL #:21-4067
TIME: 1725 RECEIVED BY OSPR: NRC#:
1.a. PERSON NOTIFYING Cal OES
1. NAME: Patrick Johnston 2. AGENCY: Dwellley Family Farms 3. PHONE #: 925-270-8526 4. EXT: 5. PAGER #:
1.b. PERSON REPORTING SPILL (If different from above): 1. NAME: 2. AGENCY:
3. PHONE #: 4. EXT: 5. PAGER #:
2. SUBSTANCE TYPE: a. SUBSTANCE: / b.QTY: / Amount / Measure / c. TYPE / d. OTHER / e. PIPELINE / f. Vessel Over => 300 tons 1. Ammonia / = / Unknown / Lbs. / VAPOR / / No / No
2
3.
g. DESCRIPTION: RP states, there is a leak of ammonia on the ice generator side of their ice generator. Unknown cause. Leak has been contained and machine has been stopped. Hazmat team is on site. Maintenance team is on the way. h. CONTAINED: Stopped i. WATER INVOLVED: j. WATERWAY: k. DRINKING WATER IMPACTED: l. MARITIME VESSEL: m. KNOWN IMPACT: None
3.a. INCIDENT LOCATION: 515 Delta Rd b. CITY: Oakley c. COUNTY: Contra Costa County d. ZIP: 94561

- 4. INCIDENT DESCRIPTION:
- a. DATE: 7/29/2021 | b. TIME(Military): 1434 | c. SITE: Other |

d. CAUSE: Unknown

e. INJURIES: No | f. FATALITY: No | g. EVACUATIONS: No | h.

CLEANUP BY: Contractor

e. INJURIES #: | f. FATALS #: | g. EVACS #:

5. SUSPECTED RESPONSIBLE PARTY:

a. NAME: | b. AGENCY: Dwellley Family Farms

c. PHONE#: 925-270-8526 | d. EXT:

e. MAIL ADDRESS: 515 Delta Rd

f. CITY: Oakley | g. STATE: CA | h. ZIP: 94561

6. NOTIFICATION INFORMATION:

a. ON SCENE: Fire Dept. | b. OTHER ON SCENE:

c. OTHER NOTIFIED: Sheriff, Fire, Police

d. ADMIN. AGENCY: Contra Costa County Health Services Department

e. SEC. AGENCY:

f. ADDITIONAL COUNTY: g. ADMIN. AGENCY:

h. NOTIFICATION LIST: Cal GEM: RWQCB Unit: 5B

AA/CUPA, DTSC, RWQCB, US EPA, USFWS, AIR RESOURCES BD

CONFIDENTIAL REMARKS:

Created by Warning Center on 7/29/2021 5:25:07 PM Last Modified by Warning Center on 7/29/2021 5:36:01 PM

California State Warning Center Governor's Office Emergency Services Phone: (916) 845-8911 Warning.Center@oes.ca.gov

Link to Spill Report:

http://w3.calema.ca.gov/operational/malhaz.nsf/SpillAllDocs/2AB372AC4D2526408825872200024CC7? **OpenDocument**

ANNA ROTH, R.N., M.S., M.P.H. HEALTH SERVICES DIRECTOR

RANDALL L. SAWYER
CHIEF ENVIRONMENTAL HEALTH AND
HAZARDOUS MATERIALS OFFICER



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INCIDENT REPORT October 15, 2021

REPORT BY

Trisha A. Johnson

Hazardous Materials Specialist II/Incident Response Team Lead

INCIDENT NO.

210729-01

INCIDENT DATE

July 29, 2021

LOCATION

Dwelley Family Farms

515 Delta Rd. Oakley, CA 94561 Site ID No. 773935

ON CALL TEAM

Trisha Johnson (lead), Adam Springer, David LeCount, Devra Lewis, Michael

Duncan, and Xavier Bryant

FACILITY DESCRIPTION

On site at this location is a fruit stand and a produce packing facility.

INCIDENT SUMMARY

Shortly before 15:00, Contra Costa Health Services Hazardous Materials Programs (CCHSHMP) received a notification on Tablet Command (TC) of an anhydrous ammonia release from an ice maker at Dwelley Farms. A minute later, we received the notification from Dispatch. I called Dispatch to get information, and as I was told that Fire was not on scene yet. Additionally, I was provided information from HMS Devra Lewis, who was previously the farm's inspector, that the farm is adjacent to a residential area. With that, the main purpose of the team was to conduct community downwind air monitoring. Five members of the on call team, including Director Matt Kaufmann, were dispatched to the scene. All were instructed to head to scene using Code 3 lights and sirens. I stayed behind at the office, gathering and disseminating information that could be pertinent to response decision-making. I was on the phone with HMS Seth Heller (for community air monitoring planning), Michael Dossey (who is currently assigned as the farm's Cal APR engineer), and Patrick Johnston (farm's co-partner). East Contra Costa County Fire Protection District (ECCCFPD) had already arrived on scene when the first group of the County Health – Haz Mat Team arrived (Bryant, Kaufmann, and Lewis). Because ECCCFPD does not conduct Haz Mat entry, the team contemplated an entry to the main objective to shut down the system if there was a continuous release.

The anhydrous ammonia release involved a portable ice maker outside of the farm's produce packing facility. Per Engineer Michael Dossey, the ice machine is typically operated in the evening to prepare for packing of produce for the next day. Nevertheless, according to the on call team, the ice machine was being operated during the day that day in part to protect the picked produce from the hot temperatures prior to distribution to local markets. There was leak from the ice machine; and given the nature of the ice machine, which did not have an intermediary storage tank to direct the release ammonia, all the ammonia inside the system (approximately 1,760 pounds) was released to atmosphere. Per Dwelley Farm's Patrick Johnston, the release did not move past a 15-foot radius from



the ice machine. Additionally, the farm immediately implemented its emergency response plan which included sounding the alert for employees to evacuate to a pre-designated area and making emergency notifications to responding agencies.

Haz Mat Operations

I conferred with Assistant Director Steve Morioka of the utility and need to activate the Haz Mat Branch Operations Center (BOC). Based on the information provided from field personnel and my discussion with one of the facility owners, activation of the BOC was not necessary.

Community Air Monitoring. No community air monitoring was conducted. Based on information from the field, the ammonia in the ice machine system was released into the atmosphere.

Entry. The main objective of the entry was to mitigate the leak from the ice machine. Mr. Johnston provided information on how to best approach the ice machine from upwind. The Entry personnel consisted of HMS Lewis as main entrant with HMS Bryant as her back-up. Assistant Director Matt Kaufmann served as Safety Officer and Entry Team Leader.

HMS Lewis wore an air-purifying respirator (APR), Nomex coverall, and cryogenic gloves. APR was determined to be the most appropriate respiratory protection level being that the chemical is known; and given ammonia's properties, breakthrough can be detected in which case Lewis will immediately evacuate the area into fresh air. There was a short pre-entry briefing before Lewis proceeded to the area of the ice machine.

HMS Lewis approached the ice machine, per Mr. Johnston's recommendation, with an ammonia gas badge, radio, and phone (to speak with the refrigeration technician). The technician instructed Lewis to press two emergency stop buttons on the ice machine and valves. However, Lewis did not have tools to turn valves, so she just depressed the two emergency stop buttons. She also opened panels and observed no moisture or icing of the components. At a couple of instances, Lewis would be out-of-sight of the team. The ammonia gas badge had a reading of 11 ppm while downrange. An error had occurred that made the gas badge stop reading, so Lewis thought to leave the area as soon as possible. Once she depressed the second emergency stop button, Lewis returned to the command post/staging area.

Assistance from CalARP. CalARP Engineer Michael Dossey assisted me with obtaining information from Mr. Johnston as he has been the program point of contact for audits at the farm. We did discuss over the phone possible points of failure for the ice machine. Dossey was instrumental in assisting the facility in writing the 72-hour report.

Clearing packing facility for resumption of work. The team conducted air monitoring for ammonia in the packing facility to determine if it was safe for the workers to resume packing produce in the cooled warehouse. The warehouse is cooled by a separate refrigeration system from the ice machine. Additionally, other areas of the grounds were monitored for ammonia. With no ammonia detected in those areas, the workers safely resumed operations.

Closing of scene. The team waited for the arrival of the technician. When he arrived, the technician provided an impromptu training of the ice machine for the team. Afterwards, the team left the scene and back to the office.

Lessons Learned

Several lessons were learned from CCHSHMP's response:

1. Maintain line-of-sight during Entry, whenever possible.

In two instances during the entry, Lewis was completely out of sight. Line-of-sight is helpful in that at least the Assistant Safety Officer can monitor for hazardous conditions that may emerge and notify the Entry Team Leader if the Entry Team needs to immediately exit the downrange area. However, for entries in indoor locations, line-of-sight may not be possible. In this case, radio communications between Entry Team and Entry Team Leader and Assistant Safety Officer should be established. Because Lewis was handling a radio and phone, Bryant should have been sent downrange with her to maintain line-of-sight and communications with

AD Kaufmann. This would allow Lewis to focus on her discussion with the technician over the phone. Also, if Lewis went down, Bryant would have been available to radio back to the Entry Team Leader that she went down, and that he would drag her out to safety.

2. Do not rush pre-entry briefing

Pre-entry briefing ensures that everyone in the response is on the same page. Additionally, there is space to ask clarifying questions during the briefing. There was a disconnect between HMS Lewis and Bryant as to the direction of approach Lewis would take to reach the ice machine. Perhaps the brevity of the briefing may not have given the opportunity for clarification or provide feedback that everyone understood the plan. We do need to be measured on the length and pacing of pre-entry briefings with the demands of the incident; essentially, there should be a balance between clearly and transparently communicating the plan to all response staff and the urgency to go downrange.

ATTACHMENTS

- 1. Snapshot of 7/29/2021 Tablet Command notes of incident notification
- 2. ICS-208 HM Form Site Safety and Control Plan of Incident Response
- 3. 72-Hour Follow-Up Notification Report Form from Dwelley Farms
- 4. Incident Report Form #21072902
- 5. Invoice Request Form

REPORT PREPARED BY:

Trisha A. Johnson, Hazardous Materials Specialist II

Contra Costa Health Services Hazardous Materials Programs (CCHSHMP)