ATTACHMENT C
30-DAY FOLLOW-UP NOTIFICATION REPORT FORM
CONTRA COSTA HEALTH SERVICES HAZARDOUS MATERIALS PROGRAMS

For CCHSHMP Use Only:
Received By:
Date Received: 10/30/24
Incident Number: 24090201
Copied To:
Event Classification Level: 2

INSTRUCTIONS: A hardcopy and an electronic copy of this report is to be submitted for all Public Health Advisory – Level 2 and Public Protective Actions Required – Level 3 incidents or when requested by CCHSHMP. See Attachment C-1 for suggestions regarding the type of information to be included in the report. Attach additional sheets as necessary. This form is also to be used for update reports after the initial 30-day report has been submitted. Forward the completed form to:

ATTENTION:
Hazardous Materials Programs Director
Contra Costa Health Services Hazardous Materials Programs
4585 Pacheco Boulevard, Suite 100
Martinez, CA 94553

INCIDENT DATE: 09/02/2024
INCIDENT TIME: 10: 24 AM
FACILITY: **Corteva Agriscience LLC – Pittsburg Operations**

PERSON TO CONTACT FOR ADDITIONAL INFORMATION

Paula Alba Green Phone number: (925) 432-5585

PROVIDE ANY ADDITIONAL INFORMATION THAT WAS NOT INCLUDED IN THE 72-HOUR REPORT WHEN THE 72-HOUR REPORT WAS SUBMITTED, INCLUDING MATERIAL RELEASED AND ESTIMATED OR KNOWN QUANTITIES, COMMUNITY IMPACT, INJURIES, ETC.:

I. INCIDENT INVESTIGATION RESULTS

Is the investigation of the incident complete at this time? ___X___Yes _____ No
If the answer is no, when do you expect completion of the Investigation? _N/A___

If the answer is yes, complete the following:

SUMMARIZE INVESTIGATION RESULTS BELOW OR ATTACH COPY OF REPORT:

At 10:24 AM on September 02, 2024, a site logistics operator was conducting rounds along a rail spur leased by Corteva, located near the facility fence line and Arcy Lane road. The operator detected a smell and saw evidence of a potential release from a rail car placed on the rail spur. The operations team investigated the railcar and determined that it was the source of an active release. Contra Costa Fire Protection District (CCCFPD) was notified at 11:03 AM and a CWS level 2 notification was sent. The county hazmat incident response team arrived on site at around 12:08 PM, and first approached the rail car to investigate at around 1:47 PM. They were unable to open the dome lid to search for the release on the first attempt, but a second team successfully opened the dome lid at 5:22 PM. Upon assessing the release once the dome lid was opened, the responding agencies determined that there was no risk for impact to the local community and declared all clear for the public health advisory at 7:02 PM. They then demobilized and departed the site. A leak repair cap was installed to stop the release at 1:43 AM on September 3rd, 2024.

SUMMARIZE PREVENTATIVE MEASURES TO BE TAKEN TO PREVENT RECURRENCE INCLUDING MILESTONE AND COMPLETION DATES FOR IMPLEMENTATION:

Preventative measures (Root Cause 1):

- Failure analysis from the valve manufacturer is still pending. However, because connections and the dome of the railcar remained sealed from transportation after arriving at the Pittsburg site, Corteva believes that we have adequate information to close out investigation without further corrective action; however, we await any guidance that may be forthcoming from the valve manufacturer.

Preventative measures (Root Cause 2):

- Update and ensure third party personnel are trained on the daily railcar switching procedure.
- Update monthly Toxic Inhalation Hazard (TIH) railcar inspection procedure to include verification of TIH railcar track placement acceptability.
- Update logistics indoctrination training to include TIH railcar placement requirements.

Preventative measures (Root Cause 3):

- Update monthly railcar inspection procedure to ensure changes in railcar conditions that could correspond to a possible release are reviewed and escalated.
- Ensure all personnel responsible for railcar inspections are properly trained.

STATE AND DESCRIBE THE ROOT-CAUSE(S) OF THE INCIDENT:

Root Cause 1: Mechanical failure of the pressure relief device.

Root Cause 2: Routine procedure to place TIH material railcars on specific tracks was not followed by third party responsible for railcar movements.

Root Cause 3: Procedure for monthly inspections for TIH material railcars was insufficient to identify minor releases and training was inadequate.