

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

For CCHSHMP Use Only:	
Received By:	<u>HS</u>
Date Received:	<u>2/9/2023</u>
Incident Number:	<u>230113-01</u>
Copied To:	_____
Event Classification Level:	<u>2</u>

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:

RECEIVED

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

FEB 09 2023
Contra Costa Health
Hazardous Materials

INCIDENT DATE: January 13, 2023
INCIDENT TIME: Approximately 17:20 (Event Discovered and Initially reported as 17:30)
FACILITY: Shell Catalysts & Technologies Pittsburg – 2840 Willow Pass Road, Bay Point, CA

PERSON TO CONTACT FOR ADDITIONAL INFORMATION
Jeff Luengo Phone number 925-313-9862

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.:
No new information.

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?

If the answer is yes, complete the following:

SUMMARIZE INVESTIGATION RESULTS BELOW OR ATTACH COPY OF REPORT:

A high-pressure airline was manually added to the silo to help break up compacted alumina and help move it to the units. This was left on and unattended for several hours.

The pressure gauge at the top of the silo malfunctioned at an unknown time before the event. This allowed the extra high-pressure air to build in the silo and eventually released air and alumina through the emergency vent.

The Silo was near its high fill level allowing pressurized aerated alumina to easily escape through the vent. The silo’s high-level alarm did not properly function or send a signal to the control room to alert the operators there was a possible issue at the silo.

30-DAY REPORT, PAGE 2

INCIDENT DATE: 1/13/23 _____
FACILITY: Shell Catalyst - Pittsburg_

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

Immediate and completed actions:

- 1) Plant air disconnected
- 2) Silo pressure gauge replaced
- 3) Silo not used until investigation completed

Long Term (3-6 months):

- 1) Adjust high fill level of silo to allow more head space buffer for settlement of aerated material.
- 2) Evaluate high level alarm malfunction and if there is a better style gauge/alarm for this service (aerated powder).

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

- 1) Pressure gauge malfunctioned, letting silo build pressure.
- 2) High pressure air added to silo and left unattended.
- 3) (Contributing Factor) High level alarm did not function.
- 4) (Contributing Factor) Normal "high" fill level of silo did not leave enough head space buffer for settlement of material.