

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

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: 12/09/2022
INCIDENT TIME: 16:47
FACILITY: Martinez Refining
Company LLC

PERSON TO CONTACT FOR ADDITIONAL INFORMATION
Michael Marlowe Phone number 831.332.2820

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?

If the answer is yes, complete the following:

SUMMARIZE INVESTIGATION RESULTS BELOW OR ATTACH COPY OF REPORT:

Primary Cause of Flaring Event including Detailed Description of the Cause and Contributing Factors:

VLO Control Valve malfunctioned and closed causing a high liquid level in the V-598

For CCHSHMP Use Only:

Received By: AS
Date Received: 2/22/23
Incident Number: 221209-01
Copied To:
Event Classification Level: 1

Overhead Accumulator. The increase triggered the shutdown of the J-125 Wet Gas Compressor (WGC) and consequently, as designed, opened CV-341 A/B to vent to the flare to protect downstream equipment and personnel.

The board operator stabilized the unit and maintained levels in the columns. Next, an outside operator opened the bypass on CV-352 to manage the level on the OHA and verified that all valves went to the correct position. He then initiated the start up the WGC J-125. To minimize flaring, there was a dedicated valve person manually manning the bypass on CV-352. Instrument technicians troubleshot the control valve and found water in the instrument airline that went to the positioner. The water was drained, and the WGC was restarted, the WGC shutdown system tested, and then the WGC was brought up to normal operating speed and the flaring stopped.

Immediate Corrective Actions Taken:

Operations sent an operator out to lower the level on the overhead accumulator using the level controller bypass on CV-352, and operators lowered the feed rate to the cat cracker unit. At the BFWS Air System, the instrument air and plant air systems were segregated to prevent further water issues with the instrument air system.

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

The most plausible explanation for the water in the instrument airline was an increased LOP IAS dew point in the Air System. One kemp dryer was not getting up to temperature to dry off the moisture in the desiccant. The wet desiccant was not able to absorb moisture from air, and water got into the pneumatic valve positioner associated with the VLO Control Valve downstream. At the FWS Air System, the instrument air and plant air systems were segregated to prevent further water issues with the instrument air system. The old kemp air dryer was bypassed. Electricians did a health check and operators checked all bleeders at dryers, receivers, and air manifolds.

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

Currently evaluating the need to add or adjust alarms on the instrument air system.