United States Environmental Protection Agency
Region X
POLLUTION REPORT

Date: Wednesday, October 31, 2007
From: Michael Boykin

Subject: Initial Polrep
Yakima Transformer Spill
7151 Rosa Hill Drive, Yakima, WA
Latitude: 46.6068210
Longitude: -120.4056290

POLREP No.:	1	**Site #:**	10ZZ
Reporting Period:	10/31/2007 - 11/01/07	**D.O. #:**	
Start Date:	10/31/2007	**Response Authority:**	CERCLA
Mob Date:	10/31/2007	**Response Type:**	Emergency
Demob Date:		**NPL Status:**	Non NPL
Completion Date:		**Incident Category:**	Removal Assessment
CERCLIS ID #:		**Contract #**	
RCRIS ID #:			

Site Description

The EPA Region 10 Emergency Response Unit was contacted by the Region 10 TSCA Program to provide assistance to the TSCA program and Yakima County at a transformer oil spill. The spill occurred at the transfer station at the Yakima County Terrace Heights Landfill from a transformer associated with a decommissioned x-ray machine.

The x-ray machine was decommissioned by a local hospital and transported to the landfill by a local waste hauler. According to the hospital this x-ray apparatus does not contain a radioactive source.

When the transformer was dropped onto the concrete floor from the transporter's trailer at the landfill's transfer station, it leaked oil and created a three foot diameter pool. County landfill workers re-loaded the transformer on the hauler's trailer to transport out of the landfill/transfer station and commenced clean-up of the oil. The workers used clay absorbent material to soak up and remove the oil and placed the oiled-absorbent into 5-gallon pails overpacked into a salvage drum labeled as containing PCB waste.

Reportedly, even though the two landfill workers donned some PPE, their hands, (porous or absorbent gloves) and possibly some of their clothing were exposed to the oil during clean-up. County workers indicated that the transformer and x-ray machine parts were labeled with a sticker that indicated that the hazardous materials/components had been removed. There was no label or documentation from the hospital indicating if the transformer contained PCBs or not. One of the county workers developed a rash on their hands and presented at a hospital for diagnosis and care. The rash was suspected to have been related to the oil exposure.

According to the transportation company, the suspect transformer was transported to and disposed of at the Richland Landfill. Further discussions with the transportation company indicates that oil contamination may have occurred to the transportation workers' clothing, vehicles, trailer, and possibly to the workers' families and residences during and after transportation.

Current Activities

October 31, 2007
1. An EPA OSC and two STARTs mobilized to Yakima from Seattle.
2. EPA met with Yakima County Landfill Manager and Foreman and two representatives from the Yakima Valley Regional Medical Center at the Yakima County Terrace Heights Landfill. Reviewed details of the incident and clean-up actions taken.
3. START conducted photo and logbook documentation of the transfer station where the spill occurred and the salvage drum, pails, and absorbent used in the clean-up of the spill.
3. START collected 5 discrete samples of absorbent material, one each from each of the five 5-gallon plastic pails overpacked in a salvage drum.
4. START conducted Clor-n-Soil testing of the 5 samples and determined that 2 of the samples had

PCBs detected greater than or equal to 50 parts per million.
5. The five samples were submitted to the analytical laboratory for SW 846 Method 8082 analyses.
6. EPA set up a visit to the transporter's residence and place of business for Nov 1 to sample vehicles, trailer, clothing, and other surfaces in West Richland.
7. EPA OSC discussed potential risk messages with the local health district and the Landfill manager for the Landfill manager to discuss with workers that may have been exposed. Because the landfill workers who cleaned up oil had donned PPE and practiced good hygiene measures it is believed that their risk of exposure was minimal.

November 1, 2007
1. EPA and START mobilized to West Richland to assess and collect samples at transporter's residence.
2. START conducted photo and logbook documentation of the transporter's vehicle, trailer, stained clothing, and residence.
3. START collected 15 wipe samples from the metal bed and walls of the trailer, of the truck steering wheel, the driver's floor mat, the wheels and metal framework of the dolly used to move the transformer, the leg of a chair splashed with oil, and the soles of both workers' work boots.
4. START collected 2 bulk samples consisting of the palm cut-out of two different work gloves stained with oil and used by the worker to move the transformer.
5. A sofa that may have been splashed with oil was placed in the den of the transporter's residence but no samples were collected. The OSC advised the transporter to minmize his family's contact with the sofa until sample results have been received.
6. The transporter's oiled sweatshirt was not sampled or held by the START due to adequate samples being collected from the gloves and boots.
7. Clothing was not collected from the transporter assistant because he had laundered his clothing already. Boots were returned once the soles were wipe sampled because they were the only work boots for both workers.
8. All samples were dropped at the analytical laboratory for Method 8082 analyses.
9. Preliminary results for the two absorbent samples that were field analyzed yesterday (positive for PCBs by Clor-n-Soil) were determined to be non-detect for PCBs by the analytical laboratory. Results for the other three absorbent samples were non-detect for PCBs also.

Planned Removal Actions

There are no planned removal activites at this time as we await analytical results from the laboratory. If all of the results are non-detect by Friday morning then EPA and START will demobilize. If any of the results come back with PCBs detected then further assessment and development of a clean-up plan between the hospital, landfill, transporter, and EPA will follow.

Next Steps

Await analytical results and once received, communicate results to all affected parties

Key Issues

1. Lack of access to the transformer and/or transformer oil for sample collection and analyses meant that we had to rely on oil-stained clothing, absorbent, and surfaces for samples to submit for analyses to determine presence/absence of PCBs.
2. Miscommunications between the various parties as to the status of the transformer, the presence of hazardous constituents in the transformer oil, and the amount of oil staining that occurred to clothing, vehicles and workers caused delays in getting optimal samples to the lab for timely analyses.