

STATE OF CALIFORNIA
PESTICIDE EPISODE INVESTIGATION REPORT

DEPARTMENT OF PESTICIDE REGULATION
 ENFORCEMENT BRANCH

PR-ENF-127 (REV. 8/07)

Page 1 of

RECEIVED BY ACWM	RECEIVED FROM CPCS	R	DATE/TIME RECEIVED 04/30/2018	<input type="checkbox"/> AM <input type="checkbox"/> PM	PERSON NOTIFIED DFA _____	DATE
TYPE OF EPISODE <input checked="" type="checkbox"/> HUMAN EFFECTS # 1 <input type="checkbox"/> PROPERTY LOSS \$ _____			PRIORITY INVESTIGATION <input type="checkbox"/> YES # _____ <input checked="" type="checkbox"/> NO		DFG _____	
ENVIRONMENTAL EFFECTS <input type="checkbox"/> ENVIRONMENTAL EFFECTS <input type="checkbox"/> OTHER					DHS _____	
OTHER I.D. NO. ACWM #4241	COUNTY OF OCCURRENCE Los Angeles	DATE OF OCCURRENCE MO 04 DAY 29 YR 2018	TIME 15:30	<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	DIR _____	
EPISODE LOCATION Own Residence					EPA _____	
					CAC _____	
					OTHER _____	

INJURED/COMPLAINANT INFORMATION

COMPLAINT SIGNED <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A	DR. VISITED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	EXTENT OF INJURY/ILLNESS <input type="checkbox"/> Fatal <input type="checkbox"/> Serious <input checked="" type="checkbox"/> Symptoms <input type="checkbox"/> Exposed Only	ACTIVITY OF PERSON EXPOSED/INVOLVED <input type="checkbox"/> Mixer/Loader <input type="checkbox"/> Applicator <input type="checkbox"/> Field worker* <input type="checkbox"/> Public* <input checked="" type="checkbox"/> Other* Explain Public	
N	AGE 70	SEX M	WHS NO. 2018-246	WORKDAYS LOST
ADDRESS	CITY	Z P	PHONE	
MEDICAL FACILITY NAME Veterans Affairs Medical Center	<input type="checkbox"/> TREATMENT PROVIDED <input checked="" type="checkbox"/> OBSERVATION ONLY	HOSPITALIZED <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	DATE/TIME ADMITTED N/A	DATE/TIME DISCHARGED N/A
PHYS Dr. [REDACTED]	ADDRESS 5901 East 7th Street, Long Beach, CA 90822	PHONE 562-826-8000		
SIGNS/SYMPTOMS EXPERIENCED Burning of lips, lower abdomen discomfort				
EMPLOYER	ADDRESS	PHONE		

PROTECTIVE MEASURES USED	HANDS	INHALATION	OTHER	ENGINEERING CONTROLS
EYES <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Goggles <input type="checkbox"/> Faceshield <input type="checkbox"/> Eye/Sun Glasses <input type="checkbox"/> None	<input type="checkbox"/> Cloth/Leather Gloves <input type="checkbox"/> Chem. Resistant Gloves <input checked="" type="checkbox"/> None	<input type="checkbox"/> Dust Mask <input type="checkbox"/> 1/2 Face Respirator <input type="checkbox"/> Full Face Respirator <input type="checkbox"/> SCBA <input type="checkbox"/> None	<input type="checkbox"/> Work Clothes <input type="checkbox"/> Coveralls <input type="checkbox"/> Chem. Resistant Clothes <input type="checkbox"/> Chem. Resistant Boots <input type="checkbox"/> Head Covering <input type="checkbox"/> Other	<input type="checkbox"/> Closed System <input type="checkbox"/> Enclosed Cab <input type="checkbox"/> Enc. Cab w/Air Purification <input checked="" type="checkbox"/> Other <input type="checkbox"/> None

ENVIRONMENTAL OR PROPERTY DAMAGE

DESCRIPTION OF DAMAGE N/A	AMOUNT/VALUE N/A
OWNER N/A	ADDRESS N/A
	PHONE N/A

ALLEGED RESPONDENT(S)	<input type="checkbox"/> PCA	<input type="checkbox"/> DEALER	<input type="checkbox"/> PILOT	<input type="checkbox"/> GROWER	<input type="checkbox"/> AGENCY	<input type="checkbox"/> OTHER*
NAME N/A	PHONE N/A	LICENSE/PERMIT NO. N/A	RECOMMENDATION MADE <input type="checkbox"/> YES # _____ <input type="checkbox"/> NO			
ADDRESS N/A	EMPLOYER'S NAME N/A		PHONE N/A			
CITY N/A	STATE N/A	ZIP N/A	EMPLOYER'S ADDRESS N/A			
EXPLAIN* N/A	CITY N/A	STATE N/A	ZIP N/A			

PESTICIDE NAME/MANUFACTURER	EPA REGISTRATION NUMBER	CATEGORY	DOSE/DILUTION/VOLUME	TREATMENT DATE	COMMODITY/SITE TREATED
Spectracide Weed Stop for Lawns	2217-887-8845	Caution			

EQUIPMENT TYPE/MAKE/MODEL/DESCRIPTION

SUMMARIZE THE EPISODE INCLUDING A DETAILED DESCRIPTION OF EVIDENCE TAKEN (Use Episode Report Supplement Form PR-ENF-127A If Additional Space Is Needed)

On April 30, 2018, I received a Pesticide Incident Report (PIR) (Attachment #1) from the California Poison Control System. The PIR stated that on April 29, 2018, _____, a 70 year old male, was treated at Veterans Affairs Medical Center in Long Beach for mouth burning and irritation as well as lower abdominal discomfort.

On April 30, 2018, at 14:20, I called _____ and left a message requesting a call back.

On May 1, 2018 at 10:20, I called _____ and left a message requesting a call back.

On May 3, 2018 at 16:00, I called _____ and left a message requesting a call back.

As I am unable to contact _____, this investigation is now closed.

REPORT PREPARED BY (NAME/TITLE) Anne Roderick Ag. Comm./ Wts. & Meas. Inspector II	DATE PREPARED 05/03/2018	REPORT REVIEWED/APPROVED BY (NAME/TITLE)	DATE APPROVED
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**PESTICIDE EPISODE INVESTIGATION
SUPPLEMENTAL REPORT**

PR-ENF-127A (REV. 8/07)

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REPORT/TYPE

 NARRATIVE CONTINUATION SUPPLEMENTAL REPORT OTHER REPORT _____

REMARKS

Attachment:

1. PIR 2018-240 for
2. Label for Spectracide Weed Stop for Lawns Plus Crabgrass Killer (EPA Reg. No. 2217-887-8845)

REPORT PREPARED BY (NAME/TITLE) Anne Roderick Ag. Comm./ Wts. & Meas. Inspector II	DATE PREPARED	REPORT REV EWED/APPROVES BY (NAME/TITLE)	DATE/APPROVED
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