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Attorneys for Santa Clara Valley Transportation Authority

UNITED STATES BANKRUPTCY COURT

FOR THE DISTRICT OF DELAWARE

In re PROTERRA INC., et al., Debtor.	Case No. 23-11120 (BKS) (Jointly administered) **Hearing Date: Sept. 16, 2026 at 1:00 p.m. ET** **Obj. Deadline: Aug. 21, 2026 at 4:00 p.m. ET**

DECLARATION OF NAUNIHAL SINGH IN SUPPORT OF SANTA CLARA VALLEY TRANSPORTATION AUTHORITY'S MOTION FOR LEAVE TO AMEND CLAIM NO. 1113

I, Naunihal Singh, declare as follows:

1. I am Chief Operations Officer for Santa Clara County Valley Transportation Authority ("VTA"). The following facts are true of my own knowledge except those facts averred upon information and belief and as to those facts I believe them to be true and correct.

2. VTA entered into two contracts for the purchase of electric buses from Debtor Proterra, Inc. ("Proterra"). Contract No. P16130 was for the purchase of "(1) 5 Forty Foot Low Floor Full Battery Electric Transit Buses and Charging Equipment; (ii) an option to purchase up to 2 automatic conductive en route charges; and (iii) an option to purchase up to 25 additional buses of the same configuration…." (the

"Contract No. 1"). Contract No. P16265 was for the purchase of "5 Forty Foot Full Battery Electric Transit Buses, Charging Equipment, Spare Parts, Specialty Tooling, Training Materials, and Training Labor" (the "Contract No. 2").

3. The 10 buses Proterra manufactured and sold to VTA were plagued with problems that resulted in them frequently being out of service and requiring excessive repairs and maintenance. Attached hereto as **Exhibit 1** is a true and correct copy of a report prepared based upon VTA records showing "Proterra Part Failure Analysis", which I am informed and believe and thereupon allege accurately reflects portions of the negative performance of the ten Proterra buses owned by VTA.

4. Bus #9505 was purchased under Contract No. 2, and beginning in May 2023 was out of service due to ongoing issues, including a failure to hold a charge in the battery. On September 1, 2023, Bus #9505 caught fire while in a VTA maintenance facility (the "Burned Proterra Bus" and the "Bus Fire"). VTA employees pushed the Burned Proterra Bus out of the facility thereby avoiding damage to the structure and other vehicles, but some employees required treatment for smoke inhalation.

5. The thermal event involving Proterra Bus #9502 was identified on April 2, 2024, as part of the Fire Cause Analysis team's inspection (the "Thermal Event"), which caused melting of the defroster flexible ducting; this event did not result in a fire, but contributed to VTA's conclusion that the Proterra buses are unsafe for their intended use. Investigation, including necessary removal of parts from three (3) separate Proterra buses, revealed that the issues with the defroster unit that was the apparent cause of the Bus Fire were found in two (2) additional buses.

6. Following investigation, VTA therefore concluded that the Burned Proterra Bus is not salvageable or repairable for safe operation including the transport of members of the public and VTA personnel. In fact, the significant risk of personal injury to VTA personnel and/or the public posed by the Proterra buses in

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light of the performance the Burned Proterra Bus and the Thermal Event, and the investigation that noted similar issues in another Proterra bus, has resulted in the entire fleet being removed from service. All 10 Proterra buses are therefore a total loss to VTA.

7. A true and correct copy of the May 28, 2024, written report from Fire Cause Analysis is attached hereto as **Exhibit 2**. As indicated in **Exhibit 2**, including the photos, the Burned Proterra Bus was largely destroyed by the Bus Fire.

8. There was significant delay in scheduling the examination of the remains of the Burned Proterra Bus, due to the number of persons/representatives that were required to attend. In addition to VTA, Proterra and its counsel were included in scheduling, the attorneys for the unsecured creditors committee were included (now counsel for the Liquidating Trustee), insurance company representatives for multiple interested parties, and the persons performing the testing and analysis. In order to determine the cause of the fire, portions of the Burned Proterra Bus were dismantled carrying the possibility that the testing itself would be destructive. It was critical to include all necessary parties to avoid a claim that evidence was destroyed without the opportunity for a potentially liable party to conduct its own review and testing.

9. Having arrived at the cause of the fire resulting in the complete destruction of the Burned Proterra Bus, VTA then needed to examine whether the issue could be reliably, safely, and economically fixed in the remaining buses, so they could be returned to use in the VTA fleet. Several issues were at the forefront for VTA in performing this review:

a. VTA Employee Safety. Given that the fire on the Burned Proterra Bus was located in extremely close proximity to the driver's seat, and burned with such intensity and speed. This concern also extended to maintenance personnel, since VTA workers already suffered smoke inhalation from the Burned Proterra Bus.

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b. Passenger Safety. Very close behind the concern for the personnel that would be in close proximity to the Proterra buses on a routine basis was concern for the passengers of the buses, and their ability to safely exit in case of an emergency. The fire on the Burned Proterra Bus was adjacent to the seating reserved for elderly and disabled riders, those most likely to need more time and assistance to safely exit in the event of an emergency.

c. Community Protection. VTA operates bus routes through the heart of highly populated communities including San Jose. A fire of the type which occurred on the Burned Proterra Bus occurring in a densely populated urban area would create tremendous exposure for injuries to persons and property. The risk to the occupants, residences and buildings also mandated against imposing the risk associated with the Proterra buses for operation by VTA.

10. Based upon the foregoing information, VTA concluded that there were no adequate safety measures that could be reasonably and economically employed to allow any of the Proterra buses to be returned to use in its fleet without exposing its employees, passengers, and the greater public to unacceptable risk. Having pulled all the Proterra buses from operations after the Burned Proterra Bus was destroyed, VTA finally determined in early 2026, that none of the Proterra Buses could be returned to service. VTA investigated whether the Proterra Buses had any scrap value, and determined they did not.

11. The need to remove all Proterra buses from operations to protect the health and safety of its employees and members of the public was the fault of Proterra without any contribution by VTA. VTA therefore seeks to file an amended Proof of Claim calculated as follows: Total contract price for Proterra buses paid under Contract No. 1 (as amended) in the amount of $3,653,934.90; the total contract price for Proterra buses paid under Contract No. 2 in the amount of $4,840,654.08; with the

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sum scheduled by the Debtor as unsecured and undisputed totaling $11,571.26 [Docket #338 at p. 257].

12. As Chief Operating Officer of VTA I am authorized to negotiate with the Liquidating Trustee or counsel therefor to attempt to resolve any objections to VTA's claims, and can be reached through VTA's counsel at the contact information contained at the top of this document for that purpose.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief. Executed on August 7, 2026, at San Jose, California.

8/7/2026

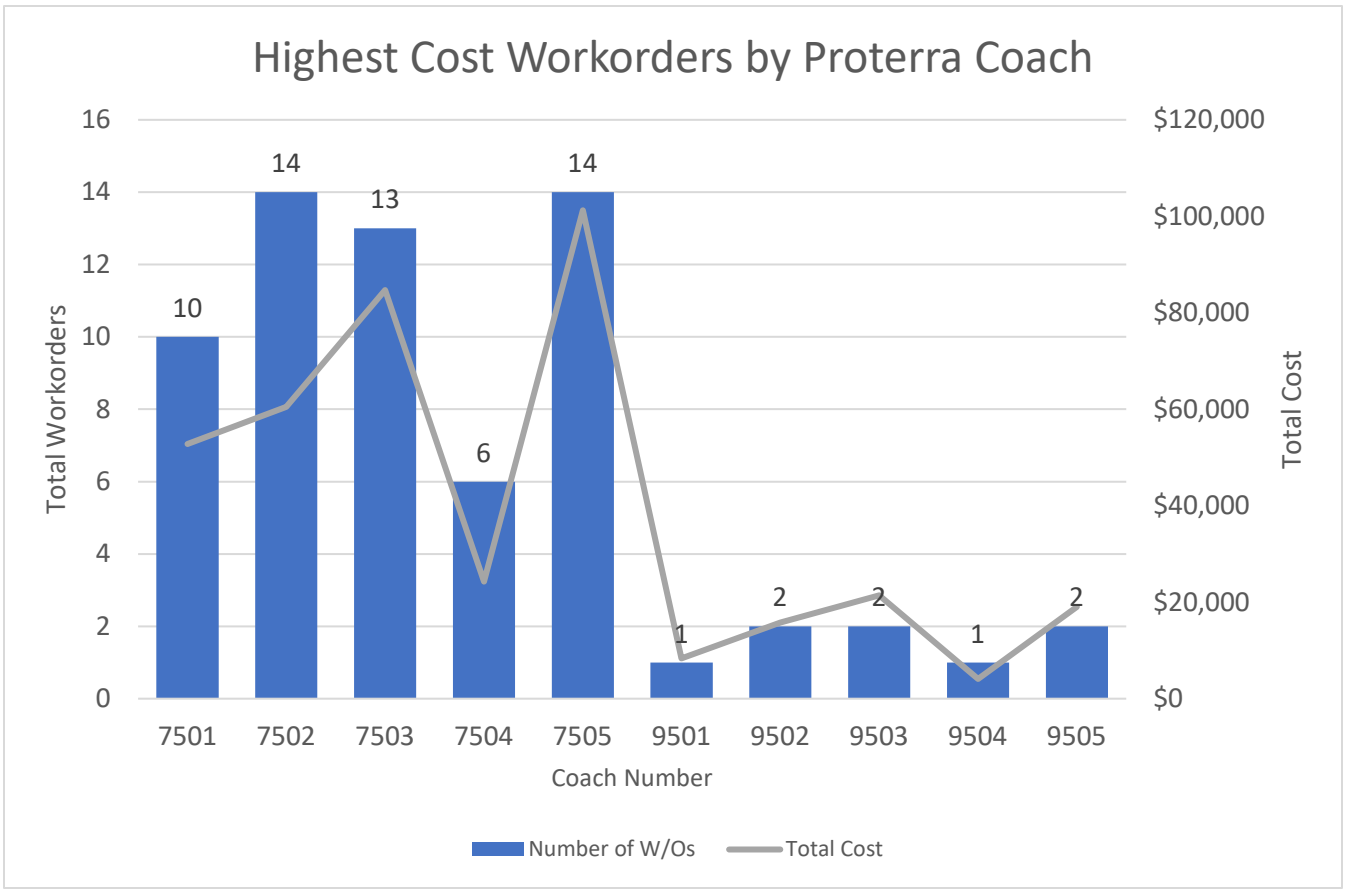
NAUNIHAL SINGH

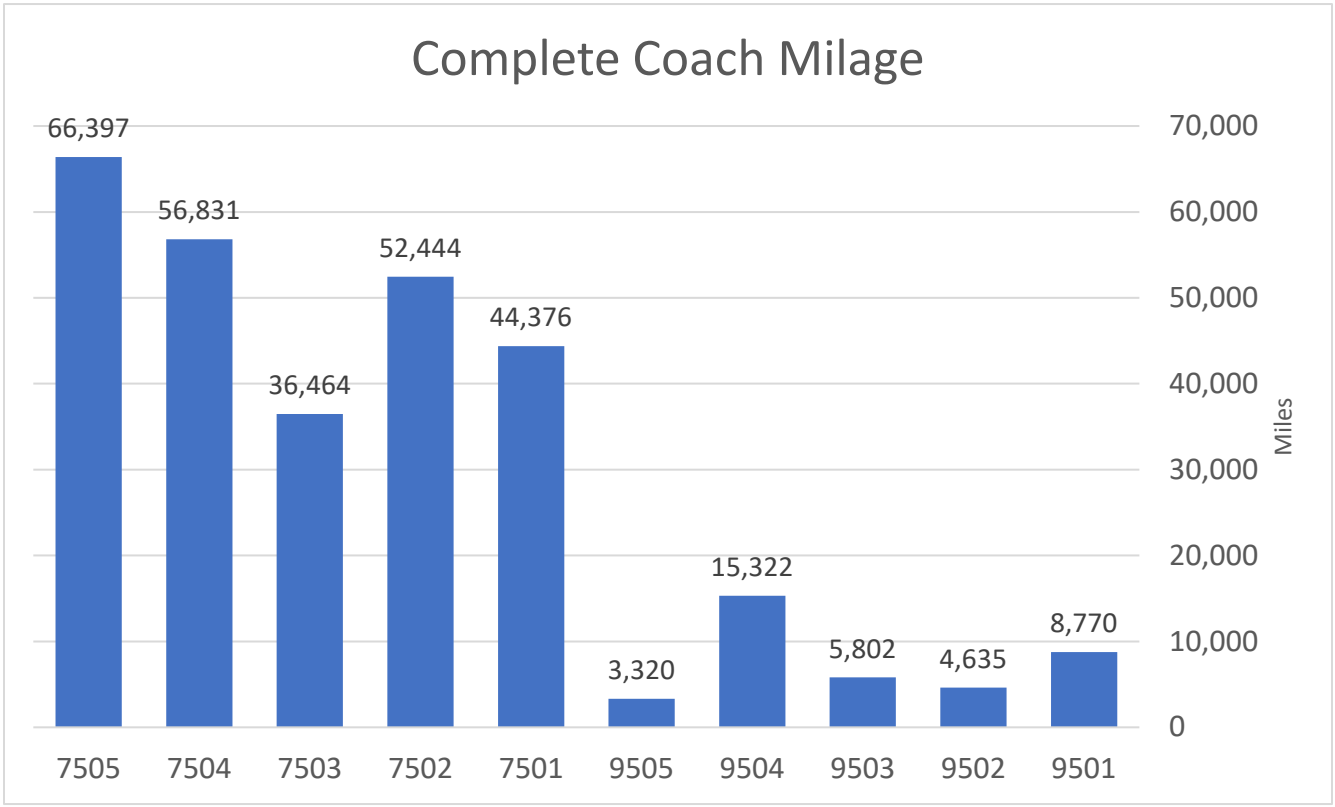
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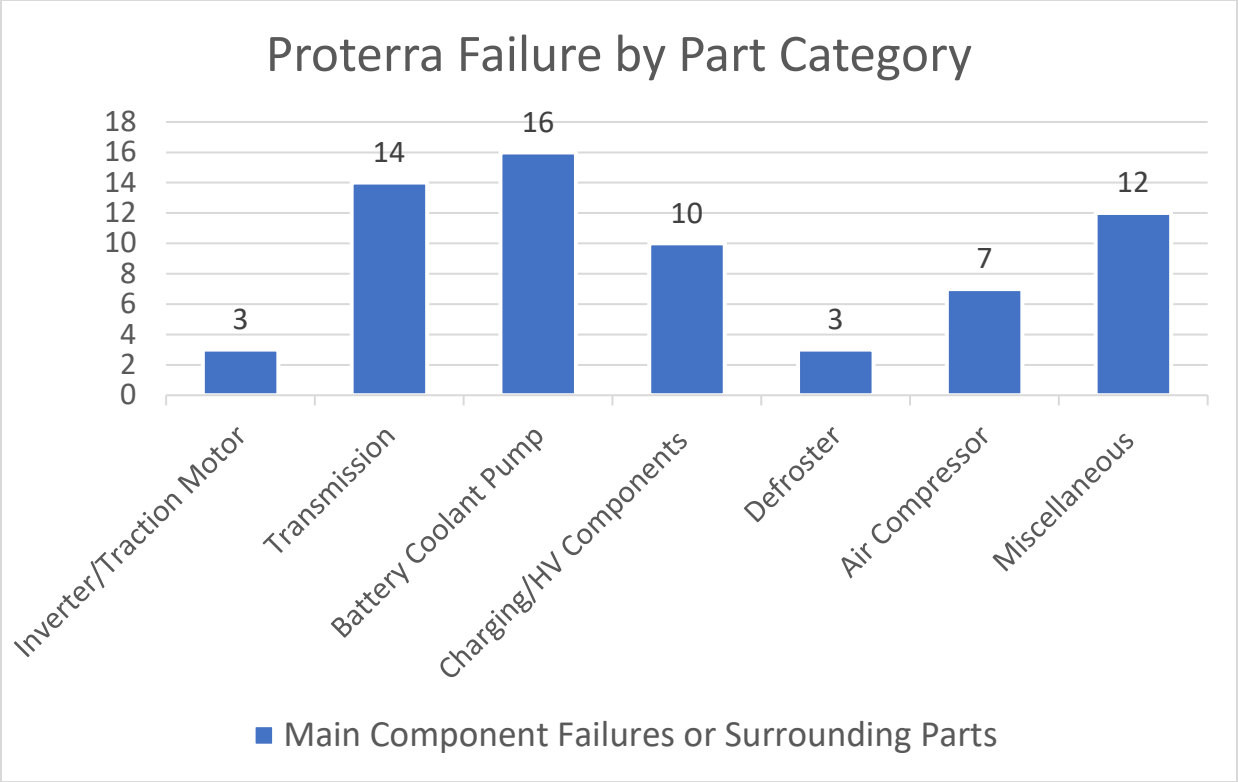
EXHIBIT 1

Proterra Part Failure Analysis

(Data pulled from all Proterra Workorders over $2000)

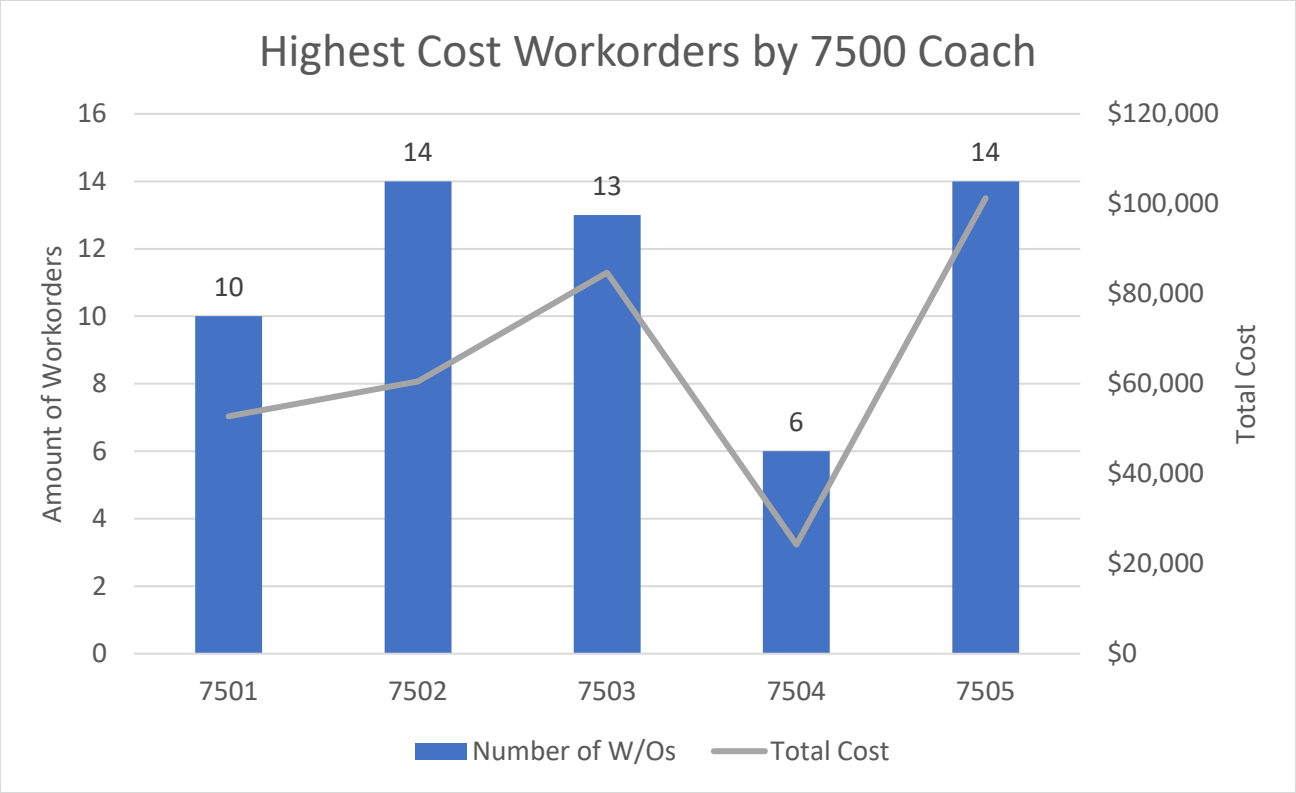

Highest Cost Workorders by Proterra Coach
Total Workorders
Total Cost
Coach Number
7501 7502 7503 7504 7505 9501 9502 9503 9504 9505
10 14 13 6 14 1 2 2 1 2
0 2 4 6 8 10 12 14 16
$0 $20,000 $40,000 $60,000 $80,000 $100,000 $120,000
Number of W/Os
Total Cost

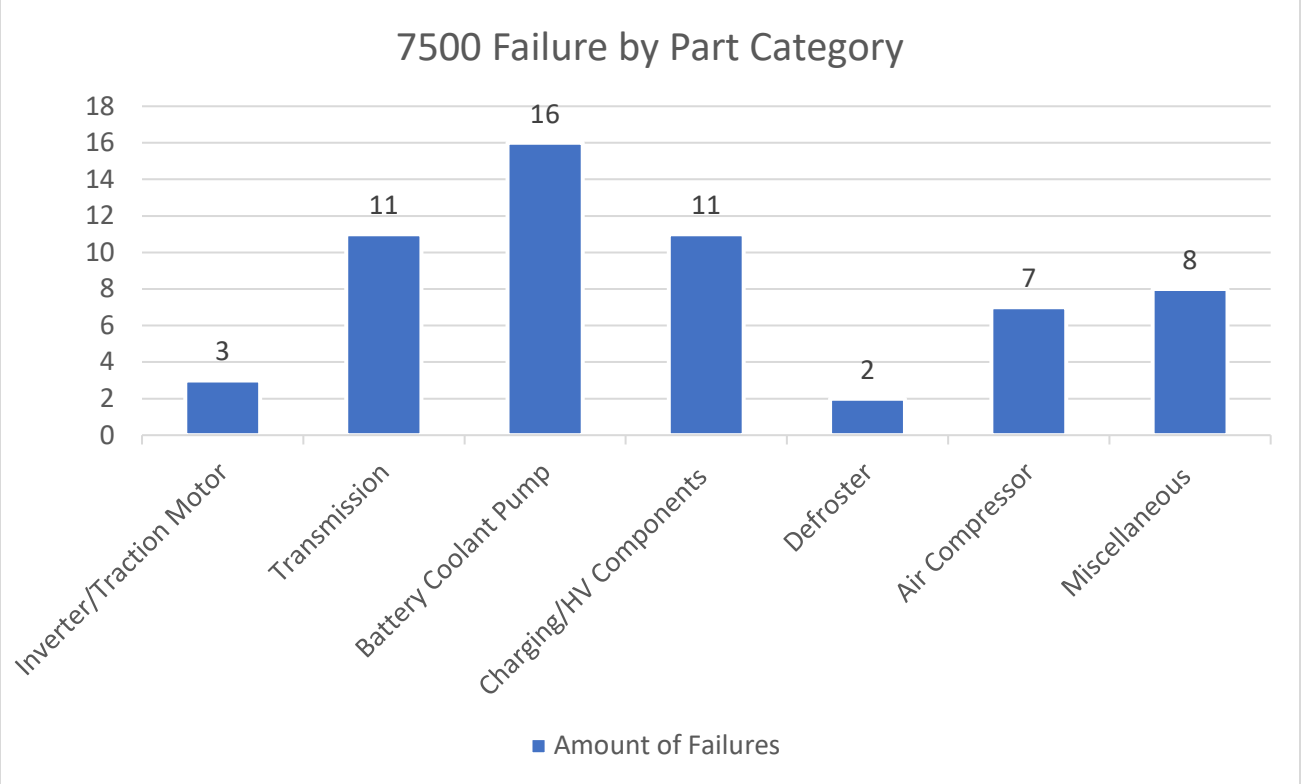

Complete Coach Milage
Miles
7505 7504 7503 7502 7501 9505 9504 9503 9502 9501
66,397 56,831 36,464 52,444 44,376 3,320 15,322 5,802 4,635 8,770
0 10,000 20,000 30,000 40,000 50,000 60,000 70,000



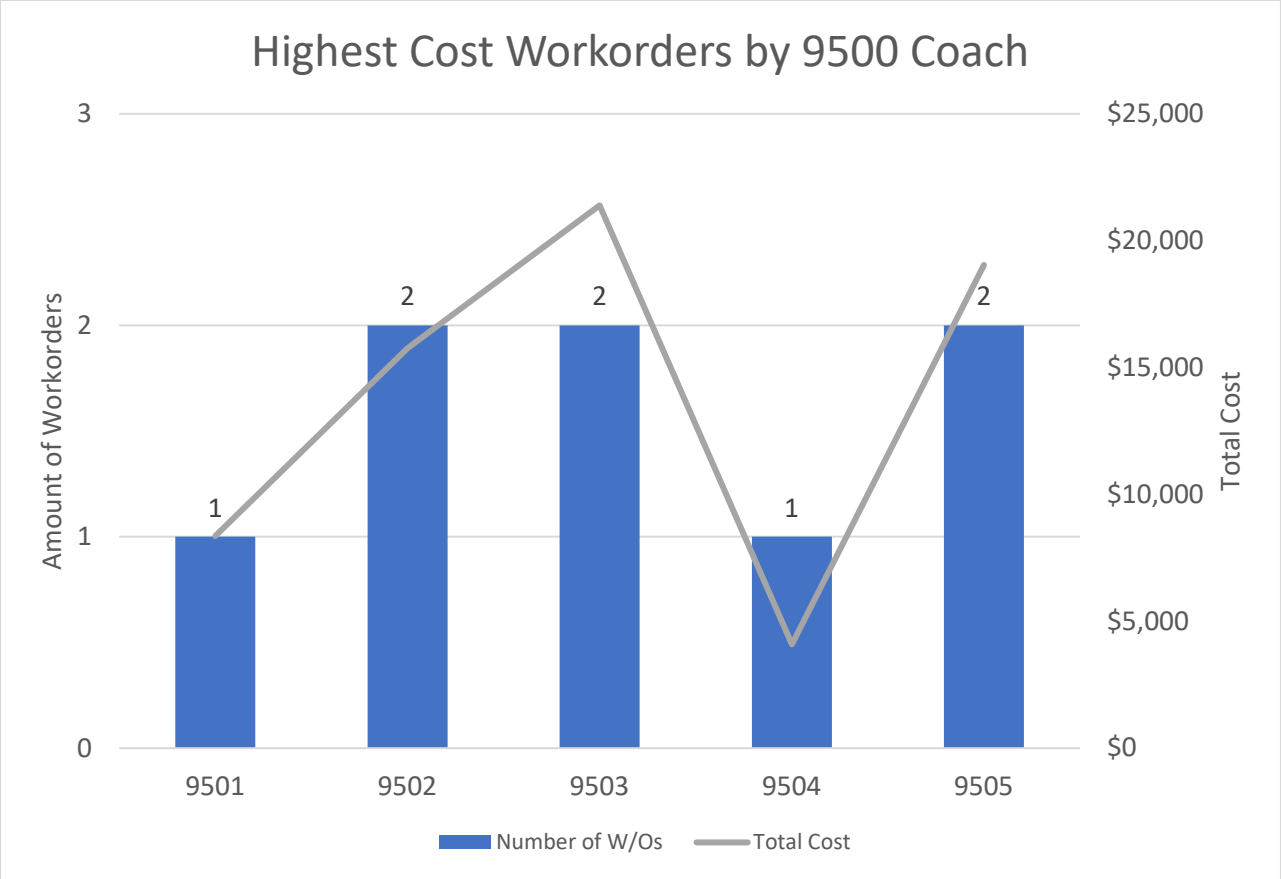
Part Category	Workorders
Inverter/Traction Motor	3
Transmission & Surrounding Parts	14
Battery Coolant Pump	16
Charging/HV Components	10
Defroster	3
Air Compressor	7
Miscellaneous	12
Total	65

Proterra 7500 Series





Proterra 9500 Series



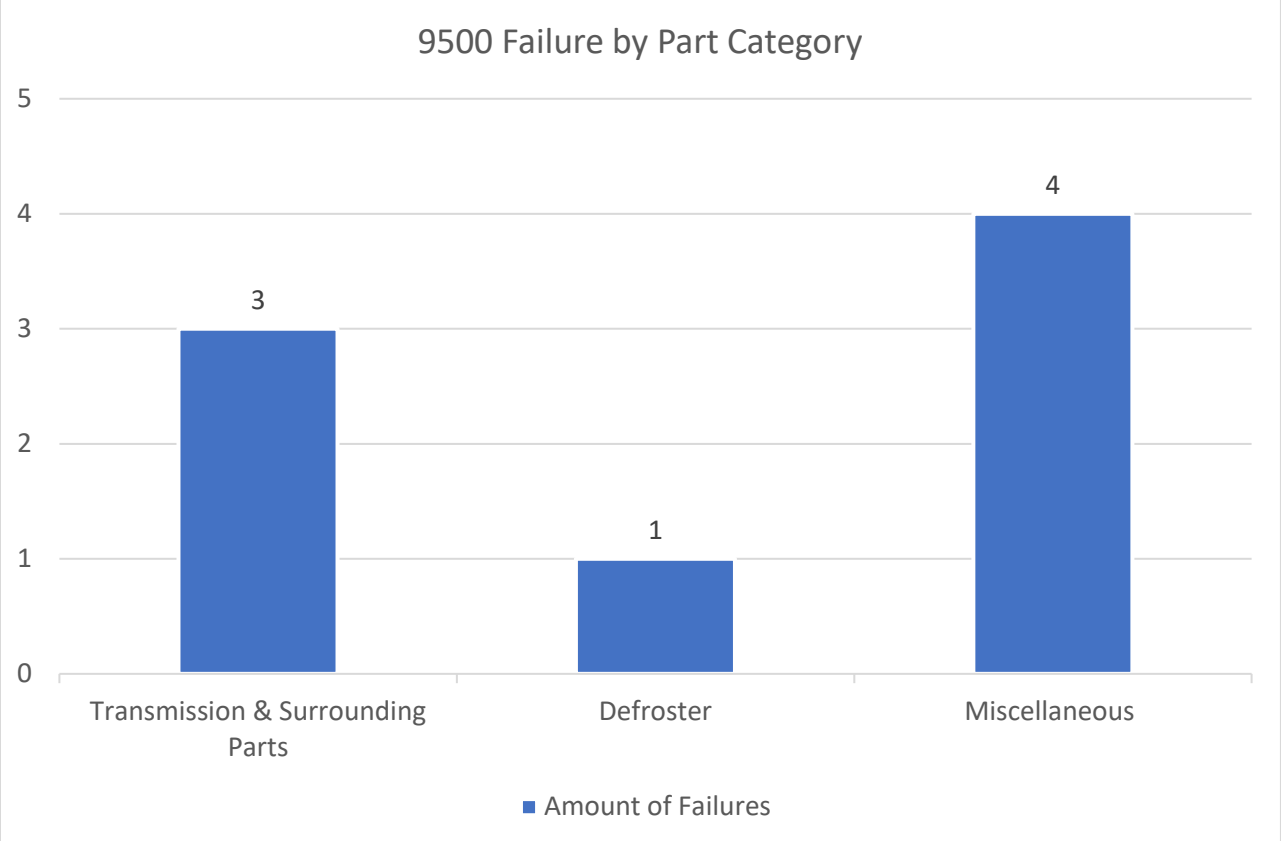


EXHIBIT 2

May 28, 2024

Matt Tachis
180 Montgomery Street
Suite 2100
San Francisco, CA 94104-4231

Insured:	**Santa Clara Transportation Authority**
Claim No.:	**002.060214.00; WTW Reference No.: 278798**
Loss location:	**39900 Zanker Road, San Jose, CA 95134**
FCA No.	**23-33695**
Case:	**Santa Clara County Valley Transportation Vehicle Fire**
DOL:	**September 01, 2023**

Engineering Supplemental

Background

The subject bus (motor coach) was identified as motor coach 9505 with a listed vehicle identification number of 7JZTH12J2KL000148 and a commercial permanent exempt license plate number of 1615595. The motor coach was a 2019 Proterra model ZX5 E2 RR electric transit bus with an 800-volt lithium battery system, as well as low voltage (12-volt) batteries.

It was reported that the bus had been out of service since March of 2023 due to various maintenance and parts issues. It was reported that the bus would not always charge due to computer communication issues. On the day of the fire, it was brought into bay 6 of building E to inspect and address the coolant system used to cool the batteries during charging and discharging events. It is believed that most of the bus electrical systems were active when the fire occurred.

The fire was first observed by workers who saw flames protruding through the grill of the defroster. They lowered the bus and tried to suppress the fire using an ABC dry powder portable fire extinguisher. These attempts were unsuccessful. The fire department was notified, and the

bus was manually pushed back out of the bay to prevent the fire from spreading to building E. The fire was extinguished by the fire department.

A thermal event had occurred on another bus (9502) that caused melting of the defroster flexible ducting; however, this event did not result in a fire. A preliminary report dated January 4th, 2024[1] (23-33695-01-RJW) of the findings to date was generated after the initial inspection of the bus. This supplement report covers the findings from additional examinations of defroster units that failed, which includes the defroster from the subject bus

Inspection and Testing

On April 2nd, 2024, a joint inspection of the defroster units that were taken into evidence, as well as other articles of evidence collected to date during this investigation. The following is a list of the articles of evidence made available for this joint evidence examination:

- JF#1 Damaged exemplary defrost unit from bus 9502.
- JF#2 Defrost unit from subject bus.
- JF#3 Debris from dashboard
- JF#4 Body around passenger headlight
- JF#5 Fuses from high voltage compartment
- JF#6 Sections of wire from middle of bus
- JF#7 Defroster from 9503
- JF#8 Diffusers from 9502

Inspection of item JF#1 (Damaged exemplary defrost unit from bus 9502) revealed smoke staining from pyrolysis (thermal decomposition of materials) on the outboard ends of louvers and sides of the exhaust port as shown in Figure 1.

[1] Note that the first draft report is improperly dated January 4th, 2023.



Figure 1 Image of defroster unit removed from bus 9502 showing smoke staining.

Figure 2 and Figure 3 show oxidation of steel components and the discoloration and melting of electrical insulators on the ring terminal wire connectors that are connected to the heating elements on the passenger side of the defroster unit from bus 9502. The insulator on the ring terminal wire connector appears to be made of nylon (Polyvinyl chloride [PVC] insulators are typically of solid colors whereas nylon insulators can be semi transparent). Both nylon and PVC are commonly used in ring terminal wire connectors with operating temperatures between 50 °C and 110 °C. These types of connectors can be purchased with fluoropolymer base material [e.g. Teflon] which has a higher temperature rating. The insulation on the wires appears to be made of fluoropolymer base material which can have decomposition temperatures above 250 °C.

The evidence of heating in Figures 2 and 3 show that the driver's side of the defroster unit experienced significantly more thermal energy than the passenger side. This damage may have occurred due to airflow or airflow patterns within the defroster unit.

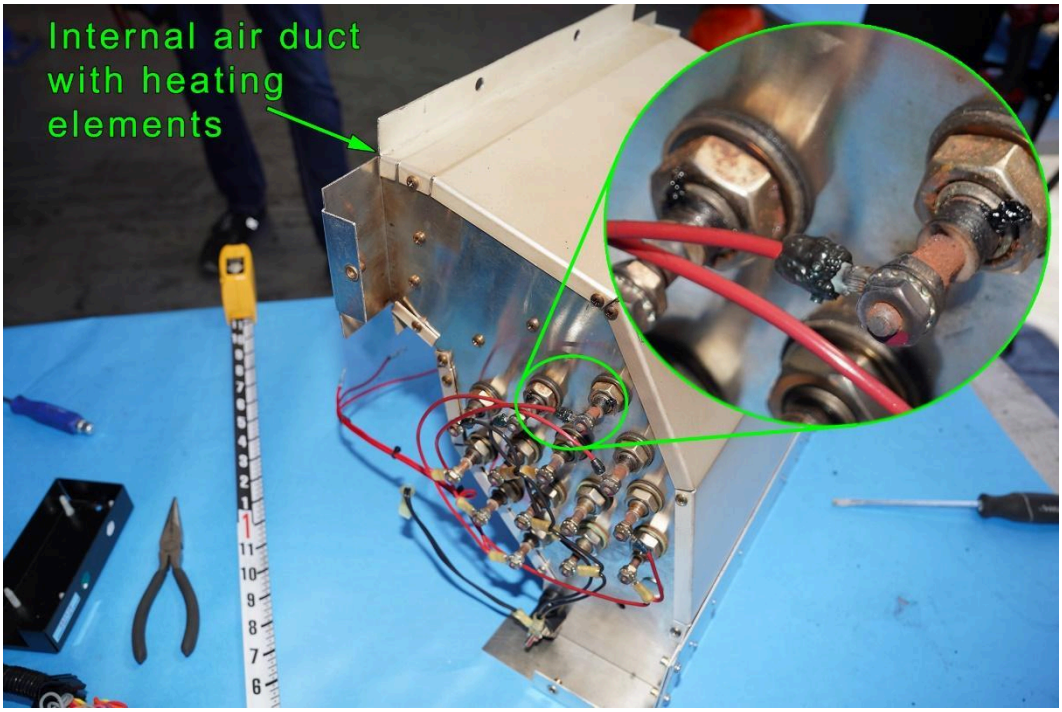


Figure 2 View of aluminum alloy internal air duct with heating elements; showing electrical connections on passenger side of the defroster unit from 9502.

Figure 3 shows the location of a temperature sensor at the top of the defroster unit that is inserted down into the air stream above the heating elements.

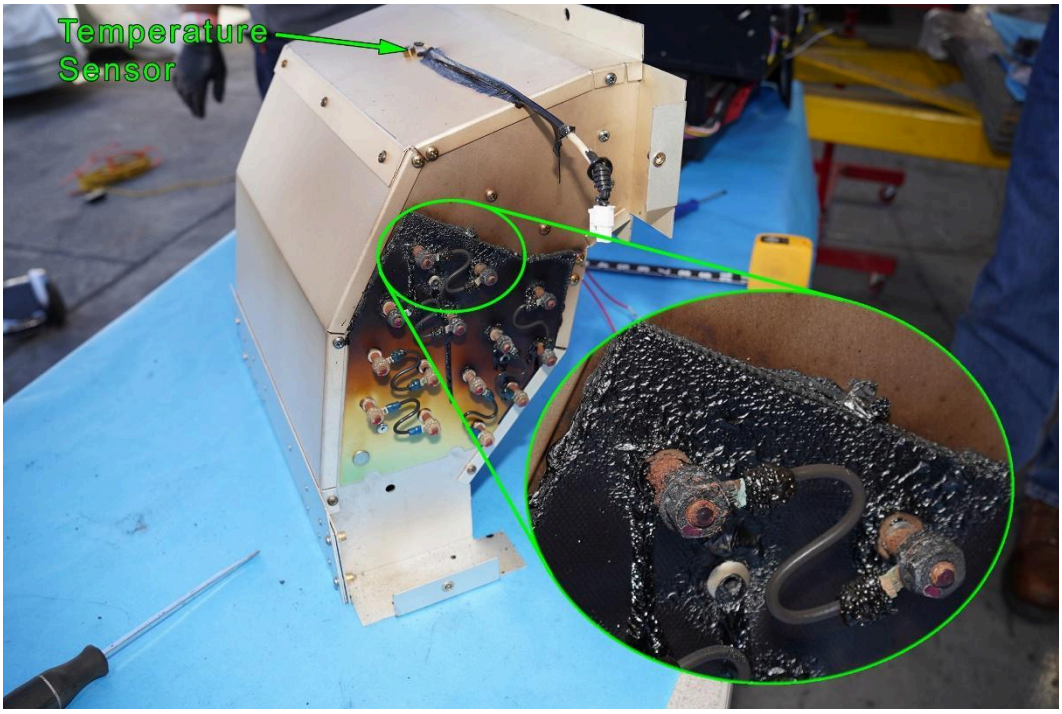


Figure 3 View of electrical connections on driver's side of the defroster unit from 9502.

Inspection of item JF#2 (Defrost unit from subject bus) remains are shown in Figure 4 prior to disassembly of the unit. The steel housing of the defroster unit experienced significant oxidation from exposure to high temperatures from the fire. Figure 5 shows the subject defroster unit with the top and forward-facing cover removed. The interior aluminum duct/diffuser that supports the heating element has been melted by the fire along with the power relays that service the heating elements. The aluminum alloy duct/diffuser (see Figure 6) uses directional vanes to distribute the inlet airflow across the heating elements as shown by the diffuser from bus 9502. This design may have been implemented to direct the air from the two blowers or air mover used in the defroster unit.

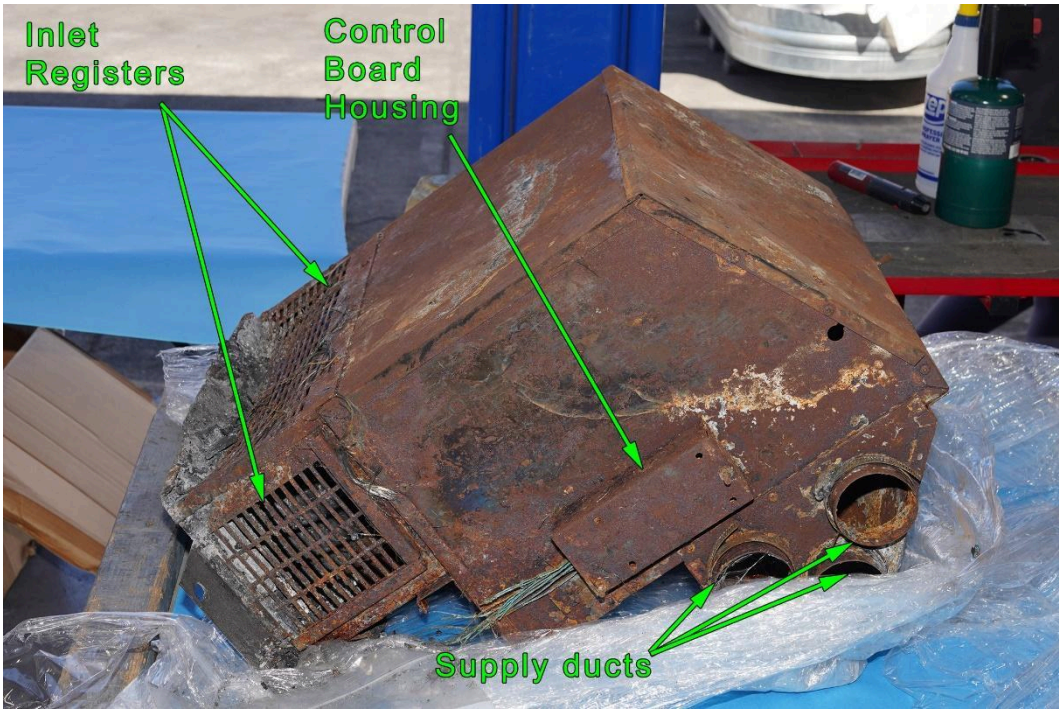


Figure 4 Remains of subject defroster from Bus 9505

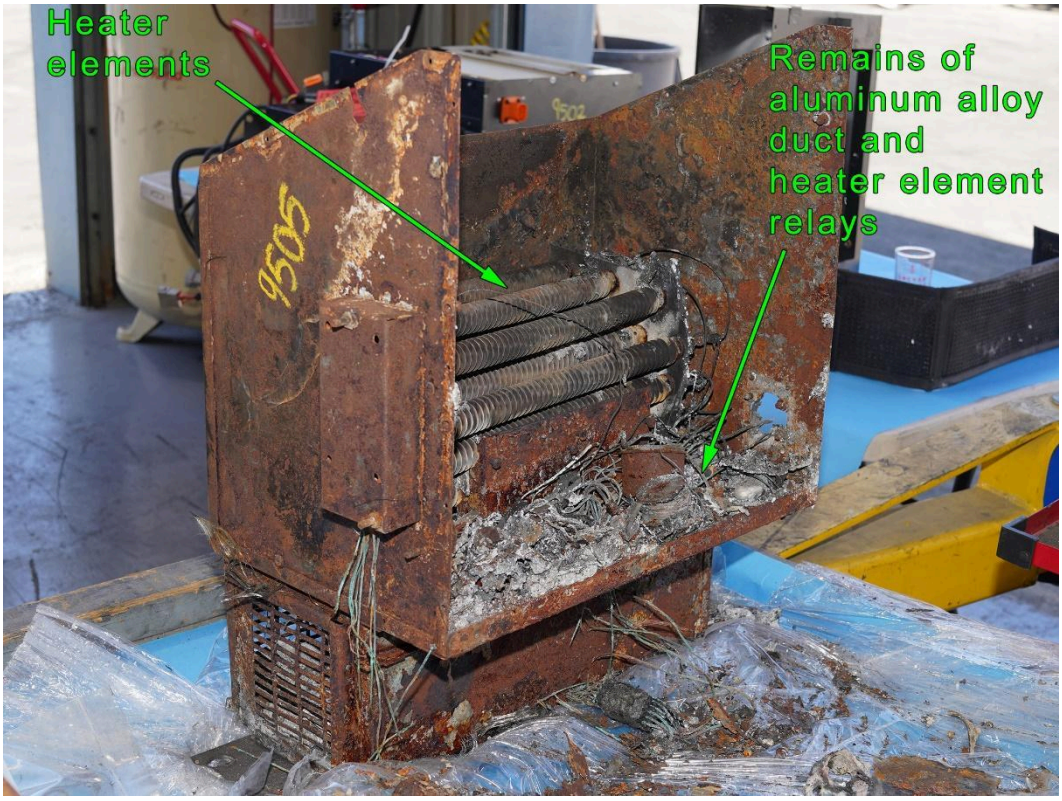


Figure 5 A view of the internal components of the subject defroster unit from Bus 9505.

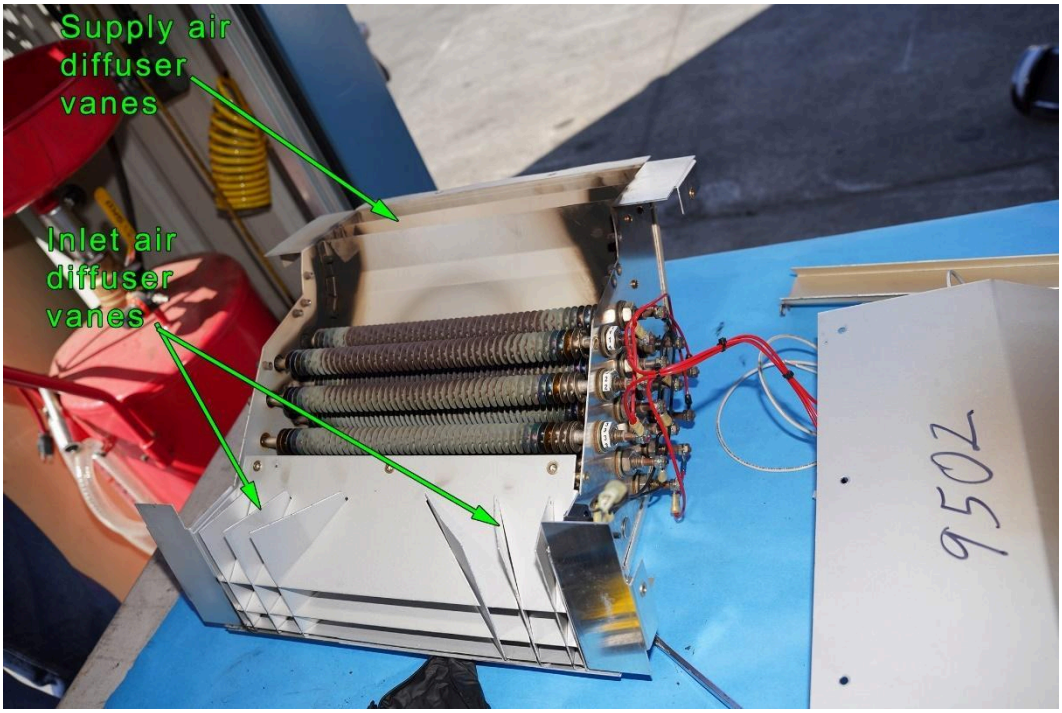


Figure 6 Image of the duct/diffuser from bus 9502 shown construction of the duct/diffuser.

The inward angle of the inlet or return diffusing vanes suggest that the air flow may concentrate more air flow toward the middle of the defroster heating elements however the plenum (see Figure 7) and the various discharge ports of the plenum may also affect the air flow patterns.

Two squirrel cage blowers (centrifugal blowers) are used to move air through the defroster units. These blowers are separated by approximately four inches as shown in Figure 8. There is an inlet air temperature sensor inserted into the inlet register to monitor air inlet temperature.

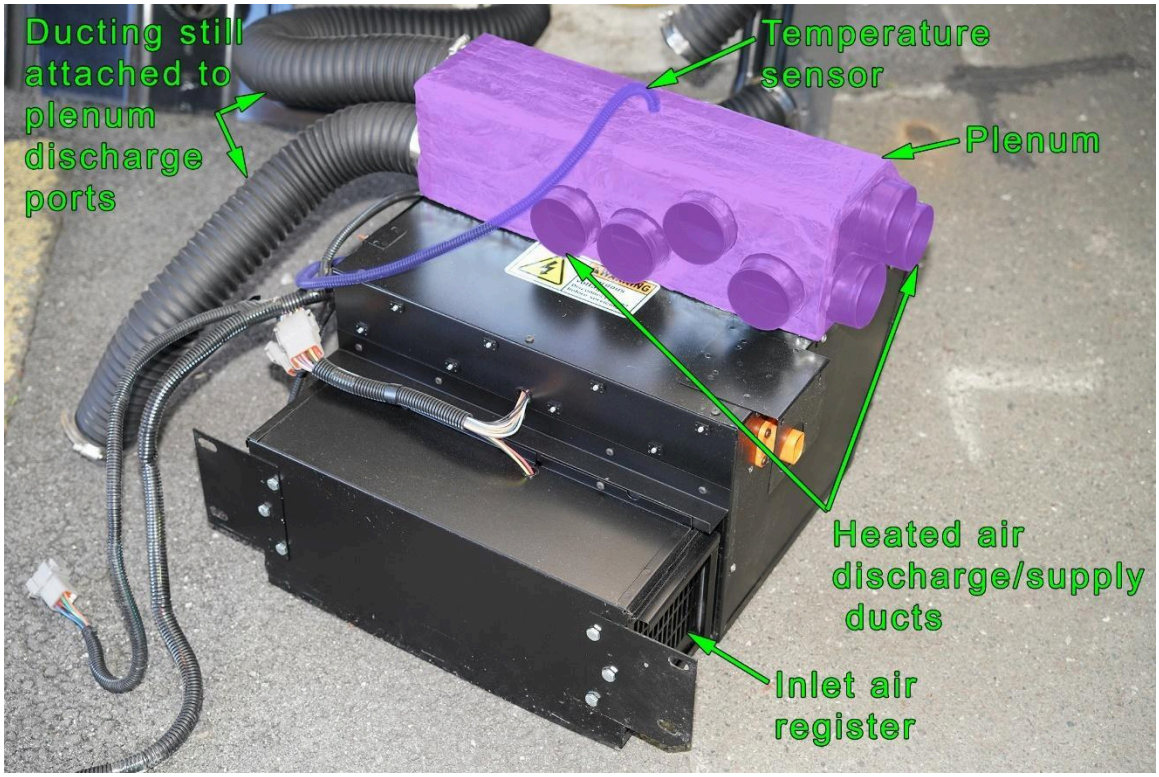


Figure 7 View of defroster unit removed from bus 9502 with the supply or discharge plenum highlighted in purple and the plenum temperature sensor highlighted in blue.

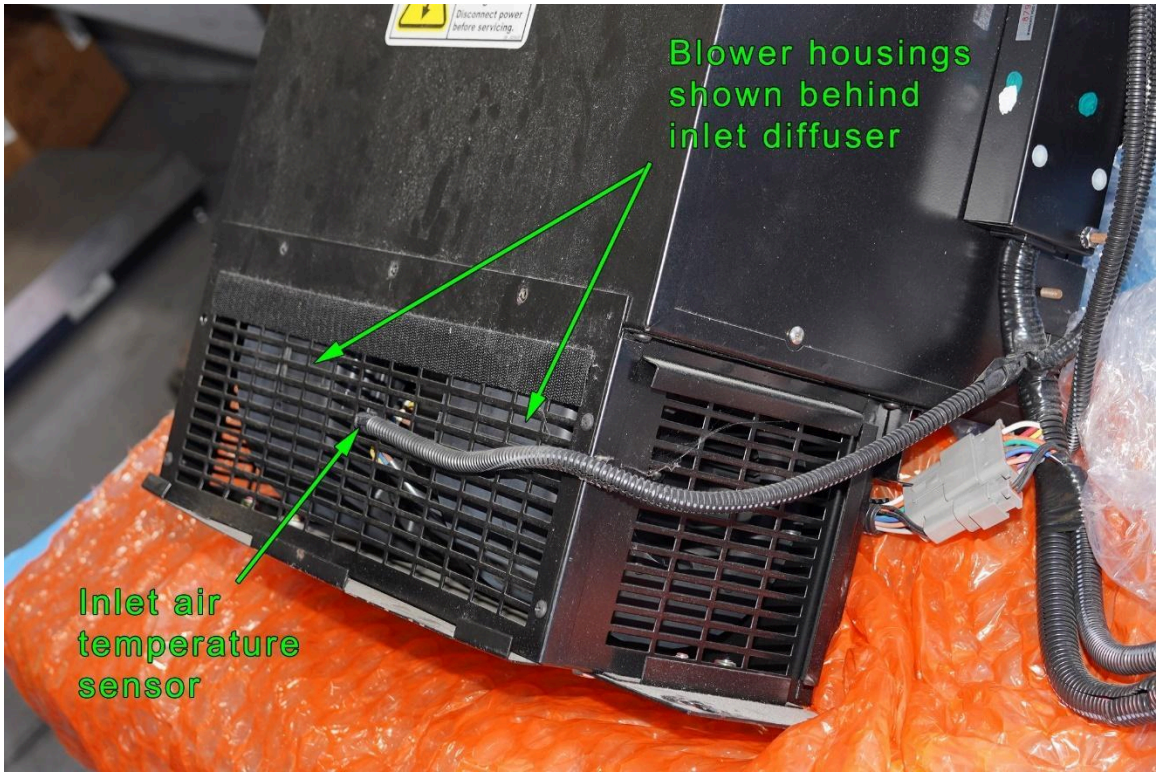


Figure 8 Air mover blowers shown behind inlet air register.

Inspection of item JF#3 Debris from the dashboard) (see Figure 9) was found to contain various fire damaged items from the front of the coach including large panels from the display board. The electrical conductors recovered were fragile from the high temperature experienced by the fire. There were no electrical failures found that would have been the cause of this fire.

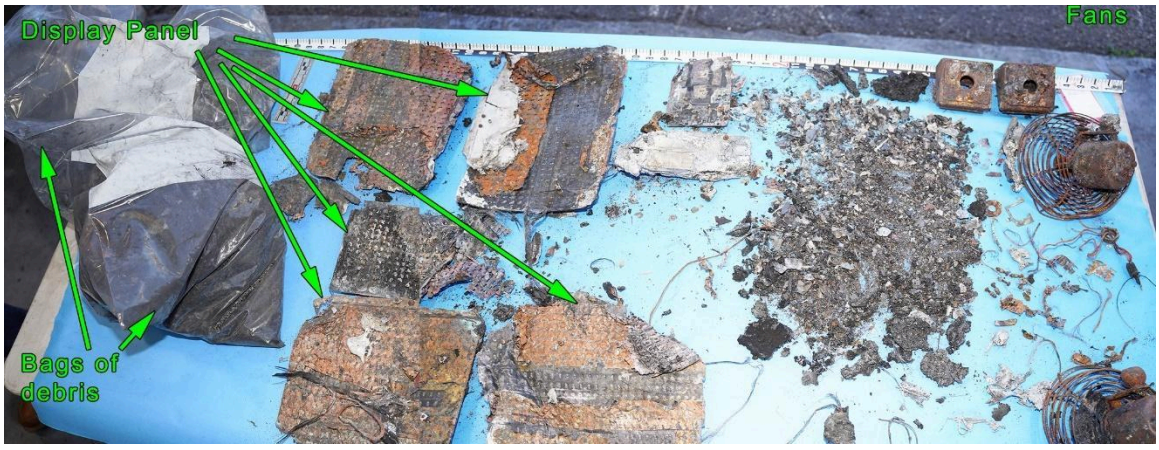


Figure 9 Item collected from the front of the coach.

Inspection of item JF#4 (Body around passenger headlight) did not reveal any electrical faults as cause of this fire. As shown in Figure 10 and Figure 11, the defroster unit is set much closer to the right hand corner where the right hand headlight is located. Also shown are the remains of

other equipment from the midline, of the forward section of the coach, to the left hand side. Figure 12 shows the burn patterns on the exterior of the subject bus and the approximate location where the defroster was located inside the bus. Figure 13 shows the burn patterns on the front and sides of the subject bus as a result of the fire. The left-hand windshield pillar experienced significantly more damage than the right-hand windshield pillar. The roof of the subject bus experienced structural collapse toward the center, possibly from heavy components mounted above this area.



Figure 10 subject coach 9505 driver and dashboard area as viewed from the doorway. Note that the defroster unit sits near the right hand front corner and headlight area.



Figure 11 An inside view of the subject bus right hand headlight area and defroster unit showing the close proximity of the defroster to the head light.

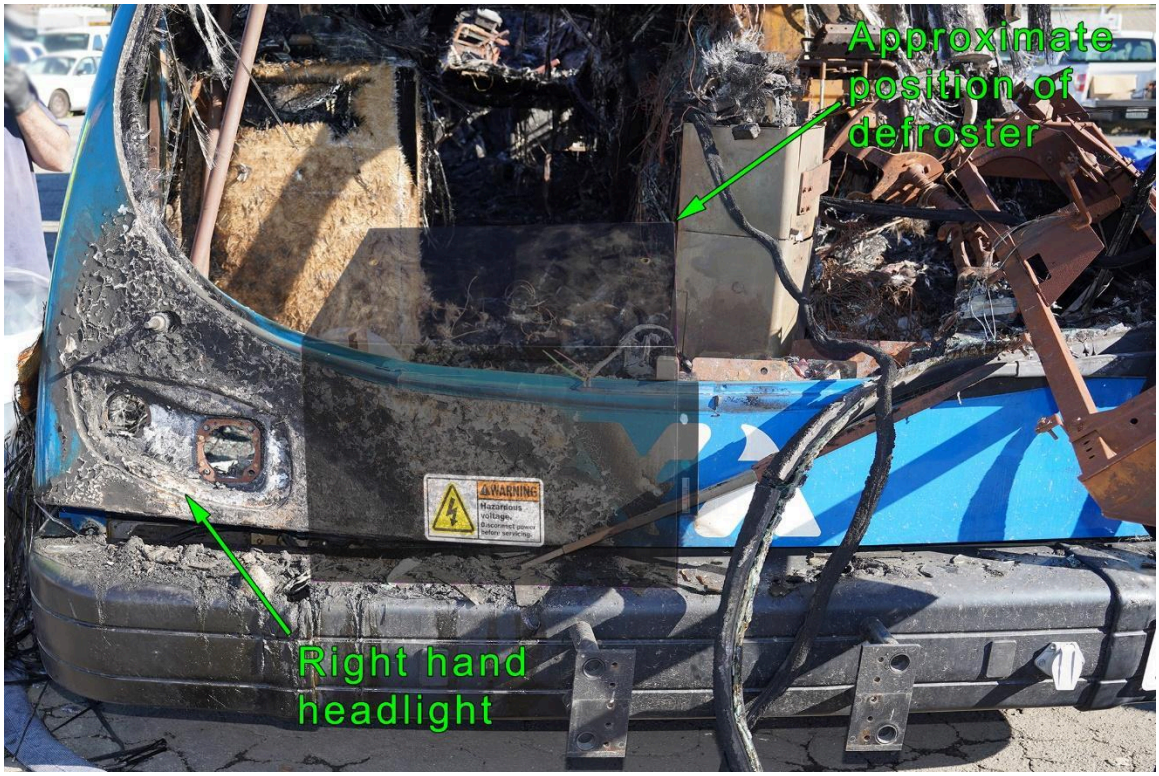


Figure 12 A composite image of the view from the exterior of the subject bus showing the approximate location of the defroster unit to the head light and the associated burn pattern on the exterior of the bus.



Figure 13 View of the subject bus 9505 showing the burn patterns from the fire damage.

Inspection of item JF#5 (Fuses from high voltage compartment) revealed that all the fuses collected were found intact and closed (did not fuse open).

Inspection of item JF#6 (Sections of wire from the middle of the bus) did not reveal any electrical faults associated with the cause of this fire.

Inspection of item JF#7 (Defroster from 9503). Attempts were made to test this unit in the field, but it would not produce heat under testing conditions. It was collected as evidence in this matter; however, it was discovered in the field that the control board experienced a thermal event on like components as shown in Figure 14. These components were marked with the same part number ULN2003A made by Texas Instruments. It appears they were being used to power the coil on the relays that powered the heating elements in the defroster units. The thermal effects experienced by these integrated circuits may have occurred from excessive current due to loading or over voltage.

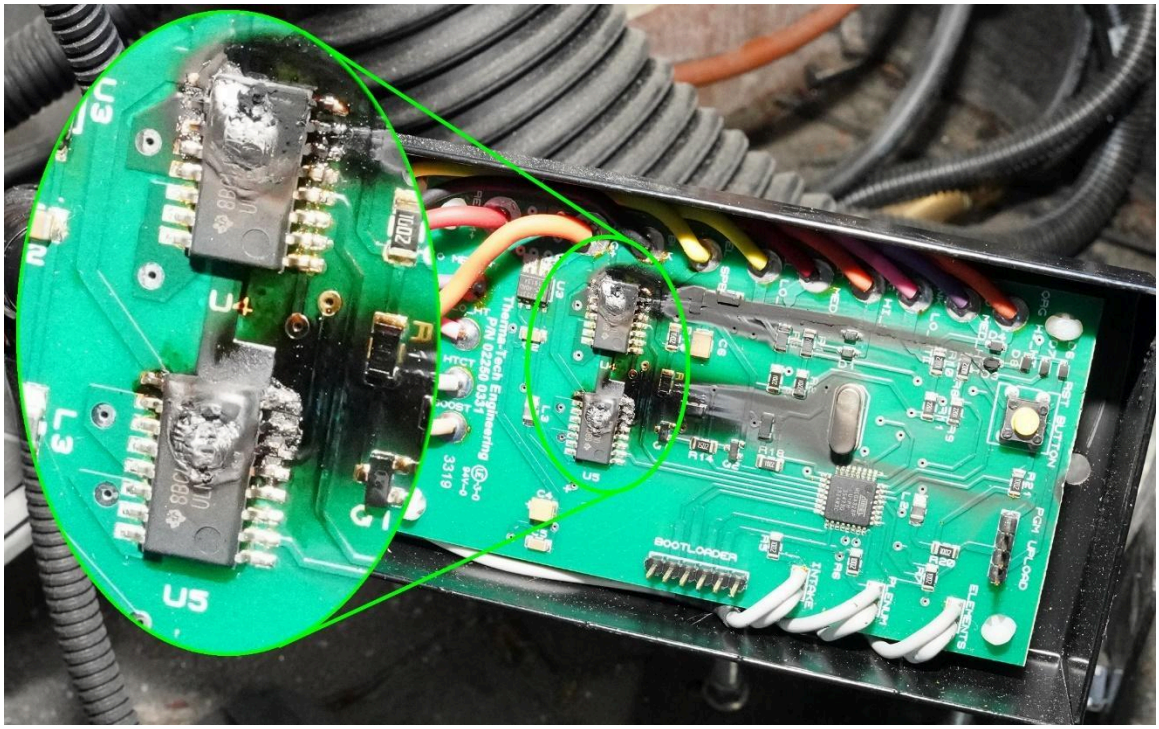


Figure 14 Failed component on control board for 9503 defroster unit.

Inspection of item JF#8 (Diffusers from 9502) was shown in the details for item JF#1.

Discussion

As indicated in the previous report; Fire patterns indicate that the fire started in, at, or near the defroster unit of the subject motor coach. Witness statements, which are bolstered by their fire suppression activities, indicate that the fire was in or at the defroster unit.

It is recognized that the defroster unit was designed with an expected 10 kilowatts (kW) of heating power with an airflow in excess of 400 cubic feet per minute. Based on current information, the unit had a thermal sensor at the top of the defroster unit, and one attached to the grill of the air inlet for the defroster. Specifications indicate that the elements were powered from the nominal 800-volt DC systems of the subject motor coach. However, the direct current (DC)

blower fan is believed to be operated by the 12/24 -volt DC system with a lifespan of not less than 10,000 hours.

The possible fire causes associated with the defroster unit include:

- A loose or failed electrical connection(s).
- Full or partial loss of airflow
    - Blocked airflow
    - Failure of blower motor
    - Failure of motor control unit (if so equipped)
- Failure of temperature control system
- Failure of upper-level thermal cutoff (if so equipped)
- Overvoltage or overpowering of heater elements.
    - Failure of heat regulation
        - It is recognized that the defroster is serviced by the 800-volt DC system through a 30-amp fuse which can supply 24 kW of power.

Results of this inspection indicate that a control failure allowed the heating elements to continue to operate beyond the desired set points. The temperature control system uses an inlet and outlet air temperature sensor to control the desired heat for the coach. It also uses an additional thermal sensor located in the inner diffuser above the heating elements that limit heater operation should a loss of air flow occur. All these controls are dependent on the control board to prevent high temperature events. There was no independent thermal cutoff (TCO) device found during these inspections. Heat, Ventilation, and Air-Conditioning (HVAC) equipment, as well as many other heated airflow processing equipment, utilize independent operating TCO devices to shut down critical systems (heating elements, motors, etc.) in the event that high temperatures develop to prevent damage to the equipment or fire.

It is unknown if there is a TCO device or system designed for 800-volt DC equipment, but TCO can be utilized to remove power from high-voltage relay coils, which typically operate at lower voltages. It is also noted that control boards can experience single point failures that might result in the failure to control output signals or power controls.

The failures observed in this inspection indicate that a properly operating system should prevent undesired thermal events from blockage of inlet (return) or supply (discharge) systems or failure of the blower motor if properly design; However, a control board failure may not only fail to respond to these events it may also result in a runaway or locked on heating elements without blower operation.

Conclusions

Fire patterns indicate that the fire most likely started at or in the defroster unit of the subject motor coach. Damage patterns in the exemplar defroster unit that was previously removed for maintenance showed damage from a high temperature in the incipient stage of a thermal event. Lack of an independent thermal cutoff device, separate from the control board can allow heater element operations to occur that will result in high temperatures that may result in a fire.

Please advise if you would like further clarification regarding this investigation.

Submitted by,

Kirk Staggs,
Engineering Associate
Fire Cause Analysis
kirk.staggs@fcafire.com

John P. White, PE, IAAI-CFI, MSc
VP of Engineering Services
Quality Review
Fire Cause Analysis