

Mr. Leonard Mallett
Vice President of Operations
TE Products Pipeline Company, LLC
P.O. Box 2521
Houston, TX 77252-6500

Re: CPF No. 3-2005-5018

Dear Mr. Mallett:

Enclosed is the Final Order issued in the above-referenced case. It makes findings of violation and assesses a civil penalty of \$345,000. The penalty payment terms are set forth in the Final Order. This enforcement action closes automatically upon payment. Your receipt of the Final Order constitutes service of that document under 49 C.F.R. § 190.5.

Thank you for your cooperation in this matter.

Sincerely,

Jeffrey D. Wiese
Associate Administrator
for Pipeline Safety

Enclosure

cc: Ivan Huntoon, Director, Central Region, PHMSA

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

§ 195.54 Accident reports.

(a) Each operator that experiences an accident that is required to be reported under § 195.50 shall as soon as practicable, but not later than 30 days after discovery of the accident, prepare and file an accident report on DOT Form 7000–1, or a facsimile.

Specifically, the Notice alleged that Respondent failed to file a DOT Form 7000–1 report regarding the June 28, 2002, accident at TEPPCO’s Todhunter facility (Todhunter Accident) within 30 days of the incident. In its Response, Respondent acknowledged that it had failed to file the report within 30 days of the accident. Accordingly, after considering all of the evidence, I find that Respondent violated 49 C.F.R. § 195.54 by failing to file a DOT Form 7000-1 report within 30 days of the Todhunter Accident.

Item 2A: The Notice alleged that Respondent violated 49 C.F.R. § 195.402(a), which states:

§ 195.402 Procedural manual for operations, maintenance, and emergencies.

(a) *General.* Each operator shall prepare and follow for each pipeline system a manual of written procedures for conducting normal operations and maintenance activities and handling abnormal operations and emergencies. This manual shall be reviewed at intervals not exceeding 15 months, but at least once each calendar year, and appropriate changes made as necessary to insure that the manual is effective. This manual shall be prepared before initial operations of a pipeline system commence, and appropriate parts shall be kept at locations where operations and maintenance activities are conducted.

Specifically, Item 2A alleged that Respondent failed to follow its own written policy for documenting the use of a lockout/tag out procedure by completing the relevant section of the TEPPCO Safe Work Permit form.¹ On June 26, 2002, two days before the accident, Respondent closed certain valves in connection with the piping modification project, but without completing the relevant sections of the form. In its Response, TEPPCO acknowledged that it failed to document the use of the lockout/tag out procedure, as described in the Notice. Accordingly, after considering all of the evidence, I find that Respondent violated 49 C.F.R. § 195.402(a) by failing to follow its own written policy for documenting the use of a lockout/tag out procedure by completing the relevant section of the TEPPCO Safe Work Permit form.

¹ The term “Respondent,” as used in this Final Order, includes Respondent’s contractors. The workers who were performing the header installation were contract workers subject to the same training and qualification requirements as TEPPCO’s permanent employees. 49 C.F.R. § 195.10 states:

§ 195.10 Responsibility of operator for compliance with this part.

An operator may make arrangements with another person for the performance of any action required by this part. However, the operator is not thereby relieved from the responsibility for compliance with any requirements of this part.

Item 2B: The Notice alleged that Respondent violated 49 C.F.R. § 195.402(a), as quoted above, by failing to follow its own written procedures for implementing the company’s emergency plan when the butane release occurred in the Todhunter Accident. Specifically, the Notice alleged that on June 28, 2002, two of the contractor’s workers, while working in an excavation trench, were in the process of removing bolts that retained a “blind”² between two flanges when gas began to leak out. The men exited the trench and notified their supervisor. The supervisor instructed them to let the gas leak until it stopped and then to go back and remove the blind. The workers subsequently re-entered the trench and proceeded to remove the blind, causing the leak to intensify and form a butane vapor cloud. The workers continued working within the cloud until they began to suffer the effects of butane asphyxiation.

The Notice further alleged that the supervisor then returned to the excavation site and ordered the workers from the hole. The supervisor himself then entered the vapor cloud without appropriate protective gear and attempted to reinstall and tighten the bolts to stop the leak. One of the workers then re-entered the vapor cloud to assist the supervisor, who was suffering the effects of butane asphyxiation. Shortly afterward, the worker who re-entered the butane cloud collapsed and died. The coroner’s report indicated that the worker, Mr. Jones, died of acute butane asphyxiation.

The Notice alleged that under its Emergency Procedures, Respondent was required to take the following actions upon the release of a hazardous product or when an imminent danger to employees on duty existed:

- The notification of all persons who “might be in imminent danger from the escaping product” that an emergency existed;
- The immediate reporting of the emergency, in accordance with a specific sequence;
- A prohibition on personnel entering the affected area until all escaping product was under control; and
- The proper repair of facilities following the emergency. Such repairs must be conducted “utilizing the necessary equipment, trained personnel aware of and familiar with the hazards to public and personnel safety, and appropriate repair materials.”³

In its Response, TEPPCO presented three arguments why the provisions of its Emergency Plan cited in the Notice were not applicable to the Todhunter Accident. First, TEPPCO argued that the initial release of butane did not constitute an “emergency” as long as the workers were attempting to stop the leak. Only after the supervisor had unsuccessfully attempted to control the

² According to TEPPCO, a “blind” or “skillet” is “a safety device used as an extra precaution in pipelines that have been shut down. It is designed to ensure that gas is contained in the pipeline in case the flow of gas has not been properly terminated.” Response, at 1-2.

³ TEPPCO Pipeline Emergency Procedures, Page 7 item 2(f), Page 8 item (i), and Page 17 item IV.

leak himself did he identify the situation as an “emergency,” “assess and control the release site,” notify the proper parties, and attempt to prevent possible further injury, damage, or the spread of petroleum liquids. Response, at 4.

Second, TEPPCO contended that its attempts to repair the leak did not constitute “a repair following an emergency,” as provided in its Emergency Plan, because the workers’ actions “in attempting to re-secure the skillet were undertaken prior to and in the midst of an emergency.” Response, at 4. Third, it argued that the prohibition on personnel entering “the affected area” was not applicable since the three contract workers were already in the area.

I find all of these arguments unpersuasive. As for TEPPCO’s argument that the initial release of butane did not constitute an “emergency” under its Emergency Plan, the facts are that the release of butane quickly formed a visible vapor cloud that was extremely hazardous and caused dizziness and disorientation in the two workers and their supervisor, none of whom had self-contained breathing apparatus. The Emergency Plan clearly defines an “emergency” as a leak and/or hazard to a worker.⁴ This occurred as soon as the butane escaped and formed a vapor cloud.

As for its argument that the Emergency Plan did not apply to a repair being undertaken “prior to or in the midst of” an emergency, Respondent’s Pipeline Emergency Procedures required that all repairs be conducted with appropriate equipment and by trained personnel who were aware of the hazards involved. Both logic and Respondent’s own written procedures dictated that all repairs be undertaken in accordance with the Emergency Plan after an emergency had commenced. In this case, as discussed above, an emergency existed as soon as the butane vapor cloud formed. Therefore, the Emergency Plan applied to the repairs undertaken subsequent to the release, especially those undertaken in the “midst” of such an emergency.

As for its argument that the Emergency Plan’s prohibition on workers entering a hazardous area did not apply because the workers were already there, such a contention is specious at best. If a butane vapor cloud creates an area too dangerous for persons to enter, then the area is obviously too dangerous for persons to remain in it.

Accordingly, after considering all of the evidence, I find that Respondent violated 49 C.F.R. § 195.402(a) by failing to follow its own procedures for implementing the Emergency Plan when the hazardous leak occurred.

Item 2C: The Notice alleged that Respondent violated 49 C.F.R. § 195.402(a), as quoted above, by failing to follow its own written procedures for providing Emergency Plan training to the workers involved in the Todhunter Accident. On page 5, the Emergency Plan requires all operating and maintenance employees to receive training to acquaint them with the Emergency Plan.

In its Response, TEPPCO acknowledged that it “could not provide documentation that this

⁴ TEPPCO Emergency Plan, Page 1.

training was ongoing.” In its Supplemental Response, TEPPCO argued that its Emergency Plan did not “expressly require any particular documentation of training...” nor did § 195.402(a) require it. Respondent further argued that as employees of a company that specialized in providing repair, maintenance, and construction services to liquid pipeline companies, the three workers involved must have had some training and contended that the allegation in the Notice was based on an assumption by PHMSA that daily briefings given to these workers did not constitute an appropriate mode of training. Finally, TEPPCO asserted that PHMSA failed to produce any direct evidence that the contract workers hadn’t received any training and therefore that the agency failed to meet its burden of proof on this item.

We find these arguments unpersuasive. While TEPPCO had an established training program for its own employees that included training on the Emergency Plan, it is clear from the record that the three workers involved in this accident were not given such training. Moreover, TEPPCO’s own procedures did not authorize the use of daily briefings as a substitute for actual worker training. Second, Respondent’s Emergency Plan states, “A record shall be maintained of the initial training of *all appropriate operating and maintenance personnel* to make them acquainted with the emergency procedures” (Emphasis added). Because the contract employees were involved in performing work on TEPPCO’s hazardous liquid pipeline, they were clearly “appropriate” personnel who should have received training on how to respond to emergencies such as the release of butane vapors in the Todhunter Accident. Finally, with respect to the “burden of proof” argument, PHMSA did not allege that the three workers had no training at all, only that the established mode of emergency training that Respondent provided to its other personnel was not given to these contract personnel.

Accordingly, after considering all of the evidence, I find that Respondent violated 49 C.F.R. § 195.402(a) by failing to follow its own procedures for providing Emergency Plan training to the three workers involved in the Todhunter Accident.

Item 2D-1: The Notice alleged that Respondent violated 49 C.F.R. § 195.402(a), as quoted above, by failing to utilize Section 3.2(e) of API Publication 2200, entitled “Repairing Crude Oil, LPG and Products Pipelines,” as required by Procedure M-245 of TEPPCO’s own Operating and Maintenance Procedures. Section 3.2(e) requires the development of a written work plan for repairs, including proper drain down procedures and equipment, where necessary.

In its Response, TEPPCO contended that the piping modification project was not a “repair” and therefore that the company was not responsible for following API 2200. In its Supplemental Response, TEPPCO also argued that there was “no mention of API Publication 2200 or 2201 in Procedure M-245” and that, as a result, the API publication was inapplicable.

We find these arguments unconvincing. In the context of Respondent’s own operating procedures, a project requiring modifications or revisions to a working pipeline, including a tie-in and header, would invoke the repair section of Respondent’s manual (i.e., there is no construction section). Section 3.1 of API 2200 contains a general statement of its applicability to “piping revisions, replacements, or repairs....” The term “repair” is sometimes used as

shorthand when referring to the modification and replacement of piping or piping revisions such as a manifold installation because they all involve taking steps such as area assessment, development of work plans, consideration of flow and pressure conditions, shut down and drain down (if required), excavation, welding materials and practices, etc.

In addition, Respondent's statement that there was no mention of API 2200 or 2201 in Procedure M-245 is incorrect. The relevant version of Procedure M-245 is designated at the top of each page as "Revision Number 1, Revised date January 31, 2002." Respondent may have subsequently revised Procedure M-245 to remove the API references but the version that was in effect at the time of the accident specifically included references to API 2200 and 2201. The evidence shows that TEPPCO failed to develop a written work plan for the installation of the new header at the Todhunter facility, as required under Section 3.2(e) of API Publication 2200.

Accordingly, after considering all of the evidence, I find that Respondent violated 49 C.F.R. § 195.402(a) by failing to utilize Section 3.2(e) of API Publication 2200, entitled "Repairing Crude Oil, LPG and Products Pipelines," as required by Procedure M-245 of TEPPCO's own Operating and Maintenance Procedures.

Item 2D-2: The Notice alleged that Respondent violated 49 C.F.R. § 195.402(a), as quoted above, by failing to utilize Section 6.2(k) of API Publication 2200, as required by Procedure M-245 of TEPPCO's own Operating and Maintenance Procedures. Section 6.2(k) requires that an excavation and its surrounding area be tested and continuously monitored with a combustible gas indicator or oxygen monitor, or both, to determine that the atmosphere is safe in which to work. At the time of the accident, neither a combustible gas indicator nor an oxygen monitor was in use.

In its Response, Respondent did not contest the allegation that at the time of the accident, neither of the specified devices was in use. As stated in Item 2D-1 above, the API publication was required to have been utilized. Accordingly, after considering all of the evidence, I find that Respondent violated 49 C.F.R. § 195.402(a) by failing to utilize Section 6.2(k) of API Publication 2200, as required by Procedure M-245 of TEPPCO's own Operating and Maintenance Procedures.

Item 2D-3: The Notice alleged that Respondent violated 49 C.F.R. § 195.402(a), as quoted above, by failing to utilize Section 2.1 of API Publication 2200, as required by Procedure M-245 of TEPPCO's own Operating and Maintenance Procedures. Section 2.1 requires accountability to be specifically assigned to a responsible and experienced employee to act as a temporary supervisor if it is necessary for the designated supervisor or repair team leader to be absent. At the time of the Todhunter Accident, the supervisor had departed the area and left the other two workers without supervision.

In its Response, Respondent did not contest the allegation that the supervisor departed the area and left the other two workers without supervision. As stated in Item 2D-1 above, the API publication was required to have been utilized. Accordingly, after considering all of the

evidence, I find that Respondent violated 49 C.F.R. § 195.402(a) by failing to utilize Section 2.1 of API Publication 2200, as required by Procedure M-245 of TEPPCO's own Operating and Maintenance Procedures.

Item 3A: The Notice alleged that Respondent violated 49 C.F.R. § 195.403(a), which states:

§ 195.403 Training.

(a) Each operator shall establish and conduct a continuing training program to instruct operating and maintenance personnel to:

(1) Carry out the operating and maintenance, and emergency procedures established under 195.402 that relate to their assignments;

(2) Know the characteristics and hazards of the hazardous liquids or carbon dioxide transported, including, in case of flammable HVL, flammability of mixtures with air, odorless vapors, and water reactions;

(3) Recognize conditions that are likely to cause emergencies, predict the consequences of facility malfunctions or failures and hazardous liquids or carbon dioxide spills, and take appropriate corrective action;

(4) Take steps necessary to control any accidental release of hazardous liquid or carbon dioxide and to minimize the potential for fire, explosion, toxicity, or environmental damage;

(5) Learn the proper use of firefighting procedures and equipment, fire suits, and breathing apparatus by utilizing, where feasible, a simulated pipeline emergency condition; and

(6) In the case of maintenance personnel, to safely repair facilities using appropriate special precautions, such as isolation and purging, when highly volatile liquids are involved.⁵

Specifically, the Notice alleged that TEPPCO failed to instruct the two laborers subsequently involved in the Todhunter Accident that they needed to carry out all operating and maintenance procedures related to their assignments, as outlined in subsections 1-6 of § 195.403. This would have involved training on the safe repair of pipelines, including such topics as isolation, purging, and threat recognition. In its Response, Respondent did not contest this allegation. Accordingly, after considering all of the evidence, I find that Respondent violated 49 C.F.R. § 195.403(a) by failing to instruct the two laborers subsequently involved in the Todhunter Accident to carry out all operating and maintenance procedures related to their assignments.

Item 3B: The Notice alleged that Respondent violated 49 C.F.R. § 195.403(c), which states:

§ 195.403 Training.

(a)

(c) Each operator shall require and verify that its supervisors maintain a thorough knowledge of that portion of the procedures

⁵ This section was amended after the accident on September 11, 2003 (68 FR 53528).

established under § 195.402 for which they are responsible to ensure compliance.

Specifically, the Notice alleged that Respondent failed to verify that the supervisor involved in the Todhunter Accident had maintained a thorough knowledge of the applicable operations, maintenance, and emergency procedures established under § 195.402 for which he was responsible. Just as it failed to train the two laborers, TEPPCO never trained the contract supervisor on the applicable operations, maintenance, and emergency procedures for which he was responsible and, as a result, could not verify that he maintained such knowledge.

In its Response, TEPPCO did not deny that the supervisor failed to follow the company's emergency procedures but argued that his failure to follow them did not prove he was unaware of them. Instead, it reiterated its argument that the daily briefings constituted adequate training for the supervisor. As we have already stated, however, daily briefings are no substitute for actual training in the applicable procedures.

Moreover, § 195.403(c) required Respondent to verify the thoroughness of the supervisor's training and knowledge. This might typically involve a documented review, written test or other form of verification. Despite PHMSA's request, TEPPCO was unable to provide any training records for the supervisor. Accordingly, after considering all of the evidence, I find that Respondent violated 49 C.F.R. § 195.403(c) by failing to verify that the supervisor involved in the Todhunter Accident had maintained a thorough knowledge of the company's operations, maintenance, and emergency procedures for which he was responsible.

Item 4: The Notice alleged that Respondent violated 49 C.F.R. § 195.422(a), which states:

§ 195.422 Pipeline repairs.

(a) Each operator shall, in repairing its pipeline systems, insure that the repairs are made in a safe manner and are made so as to prevent damage to persons or property.

Specifically, the Notice alleged that TEPPCO violated § 195.422(a) by failing to insure that the piping modification project was conducted in a safe manner. It further alleged that the company failed to administer a pipeline repair program that included adequate planning and oversight of the work of the contractor involved in the Todhunter Accident.

In its Response, TEPPCO stated that the "contractor's laborers and supervisors were uniquely responsible for the June 28, 2002 accident," yet acknowledged that TEPPCO was ultimately responsible for the work activities of its contractor.⁶ In its Supplemental Response, Respondent again contended that the piping modification project did not constitute a "repair." Respondent

⁶ In its Response, TEPPCO acknowledged that it was aware of the "import" of 49 C.F.R. § 195.10, which states: "An operator may make arrangements with another person for the performance of any action required by this part. However, the operator is not thereby relieved from the responsibility for compliance with any requirement of this part."

also argued that the allegation appeared to be based on an erroneous assumption by PHMSA that the requirement to “insure” repairs were made in a safe manner somehow meant that Respondent “guaranteed” the repairs would be made safely by its contractor. TEPPCO contended that such a reading of § 195.422 was “absurd” and would impose liability “without regard to fault.” Supplemental Response, at 8.

As discussed in Item 2D-1 above, the piping modification project constituted a “repair” for purposes of invoking Respondent’s obligation to follow its own appropriate safety practices, since a working pipeline was involved. As for the notion that requiring Respondent to insure repairs are made in a safe manner amounts to an unrealistic guarantee that would automatically impose liability upon Respondent for every accident regardless of fault, we disagree. Under the regulation, Respondent is obligated to take all practical steps to take care that work projects are conducted in a safe manner.

In this case, Respondent failed to take even basic steps that it could easily have taken. Among other things, Respondent failed to require that a rescue harness and line be provided, failed to require that a breathing apparatus be provided for the workers, failed to provide training on threat recognition and response, and failed to provide supervision for the two workers while their regular supervisor was away. Accordingly, after considering all of the evidence, I find that Respondent violated 49 C.F.R. § 195.422(a) by failing to insure that the piping modification project was conducted in a safe manner.

These findings of violation will be considered prior offenses in any subsequent enforcement action taken against Respondent.

ASSESSMENT OF PENALTY

The Notice stated that Respondent was subject to a civil penalty not to exceed \$100,000 per violation for each day of violation, up to a maximum of \$1,000,000 for any related series of violations. These penalty maximums were established by the Pipeline Safety Improvement Act of 2002, Pub. L. 107-355, § 8(b)(1), 116 Stat. 2992. In its Supplemental Response, TEPPCO pointed out that the Todhunter Accident occurred prior to the effective date of this increase. Respondent is correct. Accordingly, under 49 U.S.C. § 60122 (2002), Respondent is subject to a civil penalty not to exceed \$25,000 per violation for each day of the violation, up to a maximum of \$500,000 for any related series of violations.

Although the Notice incorrectly stated the applicable penalty cap amounts, the error is harmless because, with one exception (Item 2A discussed below), all of the violations for which the Notice proposed a penalty over \$25,000 were continuing violations that occurred for two, three, or more days while the piping modification project was taking place. For example, the failure to file the accident report continued for 11 months. The penalty for each violation (multiplied by the number of days of violation) has been considered individually, as discussed more fully below.

49 U.S.C. § 60122 and 49 C.F.R. § 190.225 require that, in determining the amount of the civil penalty, I consider the following criteria: the nature, circumstances, and gravity of the violation, including adverse impact on the environment; the degree of Respondent's culpability; the history of Respondent's prior offenses; the Respondent's ability to pay the penalty and any effect that the penalty may have on its ability to continue doing business; and the good faith of Respondent in attempting to comply with the pipeline safety regulations. In addition, I may consider the economic benefit gained from the violation without any reduction because of subsequent damages, and such other matters as justice may require.

With respect to Item 1, the Notice proposed a civil penalty of \$25,000 for Respondent's failure to file a DOT Form 7000-1 report on the Todhunter Accident within 30 days of the accident, in accordance with § 195.54(a). Timely filing of accident reports notifies appropriate authorities about pipeline accidents; such data directly contributes to the effectiveness of PHMSA's pipeline safety programs. Respondent provided no information that would warrant a reduction in the civil penalty amount proposed for this item in the Notice. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of \$25,000 for violating 49 C.F.R. § 195.54(a).

With respect to Item 2A, the Notice proposed a civil penalty of \$30,000 for Respondent's failure to follow its own procedures for documenting the use of a lockout/tag out procedure. Proper lockout/tag out is an important part of conducting work on a pipeline in a safe manner because it enables workers to know when pressures are isolated. While this violation arguably continued for three days after the valves were closed on June 26, 2002, until the accident occurred on June 28, 2002, the notice only cited June 28, 2002. Therefore, a reduction in the civil penalty amount proposed in the Notice to the one-day maximum of \$25,000 is warranted for this item. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a reduced civil penalty of \$25,000 for this violation of 49 C.F.R. § 195.402(a).

With respect to Item 2B, the Notice proposed a civil penalty of \$25,000 for Respondent's failure to follow its own procedures for implementing the Emergency Plan and notification process when the hazardous leak of butane occurred. The immediate implementation of an operator's emergency plan is critical when an emergency occurs. In this case, the safety of the workers at the site of the piping modification was compromised by this violation. Workers were exposed to butane and one worker died as a result of butane asphyxiation. Respondent has presented no information that would warrant a reduction in the civil penalty amount proposed in the Notice for this item. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of \$25,000 for this violation of 49 C.F.R. § 195.402(a).

With respect to Item 2C, the Notice proposed a civil penalty of \$60,000 (\$20,000 x 3 days) for Respondent's failure to follow its own procedures for providing Emergency Plan training to the three workers involved in the Todhunter Accident. Adequate training of workers on an operator's emergency plan is key to their ability to react to hazards and implement the Emergency Plan. In this case, the safety of the workers at the site of the piping modification was compromised by this violation. Workers were exposed to butane and one worker died as a result

of butane asphyxiation. Respondent has presented no information that would warrant a reduction in the civil penalty amount proposed in the Notice for this item. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of \$60,000 for this violation of 49 C.F.R. § 195.402(a).

With respect to Item 2D-1, the Notice proposed a civil penalty of \$60,000 (\$20,000 x 3 days) for Respondent's failure to utilize Section 3.2(e) of API Publication 2200, entitled "Repairing Crude Oil, LPG and Products Pipelines," as required by section M-245 of its Operating and Maintenance Procedures. The development of a written work plan, including proper drain down procedures where necessary, is an essential part of performing pipeline work in a safe manner. In this case, the safety of the workers at the site of the piping modification was compromised by this violation. Workers were exposed to butane and one worker died as a result of butane asphyxiation. Respondent has presented no information that would warrant a reduction in the civil penalty amount proposed in the Notice for this item. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of \$60,000 for violating 49 C.F.R. § 195.402(a).

With respect to Item 2D-2, the Notice proposed a civil penalty of \$40,000 (\$20,000 x 2 days) for Respondent's failure to utilize Section 6.2(k) of API Publication 2200, as required by section M-245 of its operating and maintenance procedures. Monitoring the work area with a combustible gas indicator or oxygen monitor, or both, is key to determining whether the atmosphere is safe for work to be performed. In this case, the safety of the workers at the site of the piping modification was compromised by this violation. Respondent has presented no information that would warrant a reduction in the civil penalty amount proposed in the Notice for this item. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of \$40,000 for violating 49 C.F.R. § 195.402(a).

With respect to Item 2D-3, the Notice proposed a civil penalty of \$25,000 for Respondent's failure to utilize Section 2.1 of API Publication 2200, as required by Procedure M-245 of its Operating and Maintenance Procedures. In this case, leaving the two workers without supervision compromised their safety. Respondent has presented no information that would warrant a reduction in the civil penalty amount proposed in the Notice for this item. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of \$25,000 for violating 49 C.F.R. § 195.402(a).

With respect to Item 3A, the civil penalty proposed for this violation was subsumed in the civil penalty proposed for Item 2C. Accordingly, refer to Item 2C above for the civil penalty discussion related to this item. No further penalty is assessed here.

With respect to Item 3B, the Notice proposed a civil penalty of \$60,000 (\$20,000 x 3 days) for Respondent's failure to verify that the supervisor involved in the Todhunter Accident maintained a thorough knowledge of the applicable operations, maintenance, and emergency procedures in accordance with § 195.403(c). Supervisors must have the knowledge and training to recognize safety issues and take steps to protect workers from hazards. Respondent has presented no

information that would warrant a reduction in the civil penalty amount proposed in the Notice for this item. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of \$60,000 for violating 49 C.F.R. § 195.403(c).

With respect to Item 4, the Notice proposed a civil penalty of \$25,000 for Respondent's failure to ensure that the piping modification project was conducted in a safe manner. Respondent failed to take even basic steps that it could easily have taken. Among other things, Respondent failed to require that a rescue harness and line be provided, failed to require that a breathing apparatus be provided for the workers, failed to provide training on threat recognition and response, and failed to provide supervision to the two workers while their supervisor was away. Respondent has presented no information that would warrant a reduction in the civil penalty amount proposed in the Notice for this item. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of \$25,000 for violating 49 C.F.R. § 195.422(a).

Finally, in its Supplemental Response, Respondent cited a previous pipeline enforcement case, *In re Ergon Trucking, Inc.*, CPF No. 3-2001-5012 (2002), for the proposition that any good faith effort on the part of a pipeline operator merits a reduction in civil penalties. While it is true that good faith efforts to comply is one factor PHMSA must consider in penalty assessments,

PHMSA applies this factor to actions taken by an operator *before* a violation occurs, not actions taken by an operator in response to enforcement proceedings. The fact that Respondent had an Emergency Plan for its permanent workers does not constitute good faith when it failed to execute those plans and procedures with respect to the contract workers involved in this accident.

Moreover, the *Ergon Trucking* case arose from a routine periodic inspection, not an accident involving a death. Finally, Ergon Trucking is a small trucking company that operates a 33-mile pipeline and had total revenues of \$30,000,000 in the same year that TEPPCO had total revenues of \$4,255,832,000. Accordingly, we find that the levels of the proposed penalties are not unreasonable in this case.

For the reasons discussed above, having reviewed the record and considered the assessment criteria, I assess Respondent a total civil penalty of **\$345,000**.

Payment of the civil penalty must be made within 20 days of service. Federal regulations (49 C.F.R. § 89.21(b)(3)) require this payment be made by wire transfer, through the Federal Reserve Communications System (Fedwire), to the account of the U.S. Treasury. Detailed instructions are contained in the enclosure. Questions concerning wire transfers should be directed to: Financial Operations Division (AMZ-341), Federal Aviation Administration, Mike Monroney Aeronautical Center, P.O. Box 25082, Oklahoma City, OK 73125; (405) 954-8893.

Failure to pay the \$345,000 civil penalty will result in accrual of interest at the current annual rate in accordance with 31 U.S.C. § 3717, 31 C.F.R. § 901.9 and 49 C.F.R. § 89.23. Pursuant to those same authorities, a late penalty charge of six percent (6%) per annum will be charged if

payment is not made within 110 days of service. Furthermore, failure to pay the civil penalty may result in referral of the matter to the Attorney General for appropriate action in a United States District Court.

Under 49 C.F.R. § 190.215, Respondent has a right to submit a petition for reconsideration of this Final Order. Should Respondent elect to do so, the petition must be received within 20 days of Respondent's receipt of this Final Order and must contain a brief statement of the issue(s). The filing of a petition automatically stays the payment of any civil penalty assessed. However if Respondent submits payment for the civil penalty, the Final Order becomes the final administrative decision and the right to petition for reconsideration is waived. The terms and conditions of this Final Order shall be effective upon receipt.

Jeffrey D. Wiese
Associate Administrator
for Pipeline Safety

Date Issued