

**JUL 07 2009**

Mr. Randy L. Barnard  
Vice President - Operations and Gas Control  
Williams Gas Pipeline Company, LLC  
2800 Post Oak Boulevard  
Houston, TX 77056

**Re: CPF No. 5-2004-1016**

Dear Mr. Barnard:

Enclosed is the Final Order issued in the above-referenced case. It makes a finding of violation and assesses a reduced civil penalty of \$50,000. The Order also finds that you have addressed the inadequacy in your procedures that was cited in the Notice of Amendment. Therefore, when the civil penalty has been paid, this enforcement action will be closed. The penalty payment terms are set forth in the Final Order. 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: Chris Hoidal, Director, Western Region, PHMSA  
Anne F. Soiza, Director, WUTC Pipeline Safety

**CERTIFIED MAIL – RETURN RECEIPT REQUESTED [7005 1160 0001 0046 9747]**

**U.S. DEPARTMENT OF TRANSPORTATION  
PIPELINE AND HAZARDOUS MATERIALS SAFETY ADMINISTRATION  
OFFICE OF PIPELINE SAFETY  
WASHINGTON, D.C. 20590**

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<b>In the Matter of</b> )	
)	
<b>Williams Gas Pipeline Company, LLC,</b> )	<b>CPF No. 5-2004-1016</b>
<b>a/k/a Williams Gas Pipeline – Northwest,</b> )	
)	
<b>Respondent.</b> )	
_____ )	

**FINAL ORDER**

Pursuant to 49 U.S.C. § 60117, representatives of the Pipeline and Hazardous Materials Safety Administration (PHMSA)<sup>1</sup>, Office of Pipeline Safety (OPS), and the Washington Utilities and Transportation Commission (WUTC)<sup>2</sup> conducted an investigation of a July 15, 2003 abnormal operation on a 26-inch gas transmission pipeline operated by Williams Gas Pipeline Company, LLC (Williams or Respondent) in Pierce County, Washington. The pipeline is part of Respondent’s Northwest Pipeline, a large gas transmission system spanning Oregon, Washington, Idaho, Colorado, Wyoming and Utah.

As a result of the investigation, the Director, Western Region, OPS (Director), issued to Respondent, by letter dated September 28, 2004, a Notice of Probable Violation, Proposed Civil Penalty, and Notice of Amendment (Notice). In accordance with 49 C.F.R. § 190.207, the Notice proposed finding that Respondent had violated 49 C.F.R. § 192.619(b) and proposed assessing a civil penalty of \$100,000 for the alleged violation. The Notice also proposed, in accordance with 49 C.F.R. § 190.237, that Respondent amend its Operating and Maintenance Procedures.

Respondent responded to the Notice by letter dated October 21, 2004 (Response). Respondent contested the allegation and requested a hearing. A hearing was held on December 15, 2004, in Lakewood, Colorado, with an attorney from the Office of Chief Counsel, PHMSA, presiding.

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<sup>1</sup> Effective February 20, 2005, the Pipeline and Hazardous Materials Safety Administration (PHMSA) succeeded the Research and Special Programs Administration as the agency responsible for regulating safety in pipeline transportation and hazardous materials transportation. See, section 108 of the Norman Y. Mineta Research and Special Programs Improvement Act (Public Law 108-426, 118 Stat. 2423-2429 (November 30, 2004)). See also, 70 Fed. Reg. 8299 (February 18, 2005) re delegating the pipeline safety authorities and functions to the PHMSA Administrator.

<sup>2</sup> The WUTC serves as interstate agent for OPS in Washington State.

## **FINDING OF VIOLATION**

**Item 1:** The Notice alleged that Respondent violated 49 C.F.R. § 192.619(b) which states:

**§ 192.619 Maximum allowable operating pressure; Steel or plastic pipelines.**

(a) ....

(b) No person may operate a segment to which paragraph (a)(4) of this section is applicable, unless over-pressure protective devices are installed on the segment in a manner that will prevent the maximum allowable operating pressure from being exceeded, in accordance with § 192.195.

Item 1 of the Notice alleged that Williams violated § 192.619(b) by failing to install over-pressure protective devices on its 26-inch gas transmission pipeline in a manner that would prevent the maximum allowable operating pressure (MAOP) from being exceeded. Specifically, it alleged that on July 15, 2003, during preparations for an in-line inspection tool run on the line, an overpressure event occurred between the Sumner and Snohomish Compressor Stations for approximately three hours (Incident). In its Response, Williams admitted that the MAOP was exceeded but argued that the event was not caused by inadequate over-pressure protection but by the mechanical failure of an over-pressure protection device.

### ***Background***

Several months before the Incident, this same line experienced a serious failure. On May 1, 2003, a 46-foot section of Respondent's line near Lake Tapps, in Pierce County, Washington, ruptured with significant force, causing pipe fragments to be thrown approximately 250 feet from their original position. A nearby elementary school, a supermarket, and several houses within an approximately 4-mile radius were evacuated. Fortunately, the May 1 incident did not result in an ignition of gas or any injuries.

The day after the May 1<sup>st</sup> rupture, pursuant to 49 U.S.C. § 60112, PHMSA issued a Corrective Action Order (CAO) to Williams, requiring the company to take immediate corrective action to protect life, property and the environment.<sup>3</sup> Among other actions, the CAO required Williams to limit the pressure on the pipeline to no more than 80% of the MAOP. Prior to the May 1 failure, the pipeline had an MAOP of 674 psig but with the 80% restriction, it was limited to 539 psig. During the Incident, the pressure on the line reached 701 psig, or 130%, of the MAOP set by the CAO.

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<sup>3</sup> In the Matter of Williams Gas Pipeline – Northwest, Corrective Action Order, CPF No. 5-2003-1003H (May 2, 2003), 2003 WL 25429847.

## *Discussion*

In its Response and at the hearing, Williams argued that it committed no violation of § 192.619(b) because the Incident was caused by the mechanical failure of an over-pressure protection device, not “inadequate overpressure protection,” as alleged in the Notice. I find Respondent’s argument unpersuasive for several reasons.

First, the evidence shows that Respondent’s pressure control equipment was configured in such a way that it failed to prevent the MAOP from being exceeded. During the July 15, 2003 pigging preparations, Williams isolated the pipeline sections upstream and downstream from the Sumner Station (Station) by closing a ball valve at the Station. By closing this valve, Williams inadvertently isolated a small sensing line that was used for a pressure control valve on a seldom-used crossover line connecting the isolated 26-inch line and a parallel 30-inch line. The isolation of this sensing line caused the control valve to detect the pressure on the wrong side of the ball valve and to open, allowing high-pressure gas from the 30-inch line into the crossover. When the high-pressure gas reached a second “monitor” control valve on the crossover, that valve failed to close due to the malfunction of a pilot and gas moved into and over-pressured the 26-inch line. Had the sensing line been configured properly, it would not have detected the low-pressure side of the ball valve and would not have opened. After the Incident, Williams moved the sensing line to a location where the pressure could be properly monitored.

Second, the drawings that the company provided to the personnel who were involved in making the pigging preparations did not show the existence or location of any sensing lines. Had the drawings included this information, Williams personnel would have been in a better position to understand the configuration of its pressure control equipment and to take appropriate action to prevent the MAOP from being exceeded. After the Incident, Williams modified the Sumner Station drawings to reflect the presence of the sensing lines.

Third, the record contains information suggesting that the monitor control valve failed to close when a pilot malfunctioned as a result of dirt inside the sensing line.<sup>4</sup> A pilot is a device that senses line pressure and sends a signal to open or close a valve at a pre-set pressure. Although OPS did not allege that Williams failed to follow procedures for inspection, testing or maintenance of the control valve pilot or the sensing line, the presence of dirt inside the line indicates that the overpressure protection device may not have been installed in a manner that prevented the MAOP from being exceeded.

Fourth, and perhaps most importantly, Williams admitted that its over-pressure protection equipment failed due to human error. In a November 21, 2003 letter to the WUTC, Williams acknowledged that the MAOP was exceeded “because of human error.”<sup>5</sup> Specifically, Williams

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<sup>4</sup> See PHMSA Violation Report, Ex. 16. Letter from Williams to WUTC at 2 (Nov. 21, 2003) (Williams “found dirt in the tubing after the device failed”); and Violation Report, Ex. 4. Letter from Bettis (pilot manufacturer) to Williams (Aug. 5, 2003) (Bettis “suspect[ed] root cause was plugged tubing...”)

<sup>5</sup> Letter from Williams to WUTC at 1 (Nov. 21, 2003).

explained that three factors contributed to the over-pressure event: the failure of an overpressure valve to close, incomplete drawings, and the location of the pressure sensing line.<sup>6</sup>

Therefore, it is clear that the Incident was not caused simply by the mechanical failure of an over-pressure protection device. The evidence shows that the pressure sensing line was improperly configured, that company personnel did not have access to accurate drawings that would have alerted them to the improper configuration, that there was probably dirt in the sensing line that may have interfered with operation of the pilot, and that human error was at least partly responsible for the malfunctioning of the company's over-pressure protection equipment. Accordingly, upon consideration of all of the evidence, I find that Respondent violated 49 C.F.R. § 192.619(b) by failing to install over-pressure protective devices on its pipeline in a manner that would prevent the MAOP from being exceeded.

### **ASSESSMENT OF PENALTY**

Under 49 U.S.C. § 60122, Respondent is subject to an administrative civil penalty not to exceed \$100,000 per violation for each day of the violation, up to a maximum of \$1,000,000 for any related series of violations.

49 U.S.C. § 60122 and 49 C.F.R. § 190.225 require that, in determining the amount of a 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.

Notice Item 1 proposed a civil penalty of **\$100,000** for violation of 49 C.F.R. § 192.619(b) for Respondent's failure to install overpressure protective devices in a manner that would prevent the MAOP from being exceeded. In its Response, Williams argued that the proposed \$100,000 penalty was not warranted because the company self-reported the Incident and because the failure was caused by the mechanical failure of an over-pressure protection device.<sup>7</sup>

As for the company's argument on self-reporting, it should be remembered that Williams was expressly prohibited by the CAO from exceeding an MAOP of 539 psig. Under paragraph six of the Required Corrective Action section of the CAO, Williams was obliged to obtain approval from the Director in order to "remove or modify" the pressure restriction.<sup>8</sup> Thus, it can hardly be

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<sup>6</sup> Id. at 2.

<sup>7</sup> Response at 1.

<sup>8</sup> In the Matter of Williams Gas Pipeline – Northwest, Corrective Action Order at 4, CPF No. 5-2003-1003H.

argued that Williams should be given credit for “voluntarily” reporting the fact that it had violated one of the key provisions of a recently issued CAO.

This is particularly true in light of the circumstances surrounding the issuance of the CAO. The pressure restriction in the CAO was an important safety requirement intended to prevent additional pipeline ruptures on the Williams Northwest Gas Pipeline system. The pressure restriction provided a certain measure of safety until Williams could perform various testing and inspection to determine the condition of its pipeline and make any necessary repairs. By exceeding the MAOP without permission and before diagnostic and repair activities could take place, Williams overrode a key barrier to the prevention of additional failures. Additionally, as discussed above, the overpressure did not occur simply because of the failure of a single overpressure protection device but because Williams failed to install the equipment in a manner that enabled it to function properly and because Williams did not provide accurate drawings to its personnel.

On the other hand, the record shows that Williams did take several actions following the May 2003 release but before the Incident in an effort to reduce the likelihood of future failures. For example, Williams adjusted its pressure control equipment in an attempt to ensure that the reduced MAOP would not be exceeded and installed a new monitor control valve pilot with a reduced set point.<sup>9</sup> Respondent also conducted testing and evaluation of its pipeline beyond what was required in the CAO. Respondent collective efforts show that the company made good-faith attempts prior to the Incident to comply with the reduced MAOP and to prevent future releases.

Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a reduced civil penalty of **\$50,000** for violating 49 C.F.R. § 192.619(b).

### **AMENDMENT OF PROCEDURES**

Item 2 of the Notice alleged inadequacies in Respondent’s Operations, Maintenance and Emergencies Manual and proposed to require amendment of Respondent’s procedures for complying with § 192.739. Specifically, the Notice alleged that Respondent’s procedures for the operation and maintenance of pressure control equipment were inadequate.

By letter dated November 3, 2004, Respondent submitted copies of its amended procedures, which the Director has reviewed. Accordingly, based on the results of this review, I find that Respondent’s original procedures as described in the Notice were inadequate to ensure safe operation of its pipeline system, but that Respondent has corrected the identified inadequacies. Therefore, no need exists to issue an Order Directing Amendment.

Under 49 C.F.R. § 190.215, Respondent has a right to submit a Petition for Reconsideration of this Final Order. The petition must be received within 20 days of Respondent’s receipt of this

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<sup>9</sup> PHMSA Violation Report, Ex. 16. at 3.

Final Order and must contain a brief statement of the issue(s). The filing of the 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 are effective on receipt.

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Jeffrey D. Wiese  
Associate Administrator  
for Pipeline Safety

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Date Issued