U.S. Department
Of Transportation
**Pipeline and
Hazardous Materials
Safety Administration**

820 Bear Tavern Road, Suite 103
West Trenton, NJ 08628
609.989.2171

NOTICE OF PROBABLE VIOLATION
and
PROPOSED CIVIL PENALTY

OVERNIGHT EXPRESS DELIVERY

September 29, 2015

J. Andrew Drake
Vice President, Operations & EHS
Texas Eastern Transmission, LP (Spectra Energy Corp)
5400 Westheimer Court
Houston, TX 77056-5310

CPF 1-2015-1025

Dear Mr. Drake:

On May 22 and 23, 2014, a representative of the Pipeline and Hazardous Materials Safety Administration (PHMSA), Office of Pipeline Safety (OPS), pursuant to Chapter 601 of 49 United States Code conducted an investigation into an incident that occurred on the Texas Eastern Transmission, LP (Spectra Energy Corp)[1] (hereafter referred to as Spectra Energy) 30-inch diameter natural gas transmission pipeline known as Line 10, approximately 2 miles from Carmichael, Pennsylvania, on May 16, 2014, at 11:15 a.m. eastern daylight time (EDT), which resulted in property damage of 186,437 dollars (Incident).

Based on the results of a 2011 in-line inspection, Spectra Energy decided to excavate Line 10 to evaluate identified anomalies. On May 16, 2014, Spectra Energy uncovered the casing of Line 10 (the pipe that surrounded the carrier pipe) at the east side of Jacob Ferry Road. The safe excavation pressure for the identified anomaly was 963 pounds per square inch gauge (psig). A Spectra Energy welder (welder) prepared a cutting band machine with an attached oxyacetylene torch to cut the casing. The welder installed a 30" cutting band on the non-standard 34" casing using a nylon strap. The cutting band was set to cut from the 1 o'clock to 11o'clock position on the casing.

During the cutting process, the welder operated the crank for the band cutter from the 9 o'clock position and adjusted the torch speed based on the sound. However, the welder heard popping sounds once the cut passed the 4 o'clock position on the casing. The welder reversed direction of the torch to regain the cut when a hissing sound was heard and a significant flame was observed from the cut. The fire was immediately extinguished by on-scene personnel and the pipeline section was isolated and depressurized. There were no injuries, fatalities or supply issues reported.

Spectra Energy notified the National Response Center (NRC Report # 1082994) of the gas leak and fire on May

[1] Texas Eastern Transmission, LP (Spectra Energy Corp) is a subsidiary of Spectra Energy Partners, LP (Spectra Energy).

16, 2014, at 12:58 pm (EDT).

During the remediation process, Jacobs Ferry Road was closed to traffic from May 16 - 24, 2014, which included replacing 66.6 feet of pipe at the crossing. This crossing is located in Class 1[2], non-high consequence area.[3]

On June 11, 2014, Spectra Energy submitted DOT Form PHMSA F 7100.2, Rev. 12-2012 for the Incident (Incident Report).

The Incident Report stated that the welder was removing a portion of the casing when the oxy-acetylene torch punctured the pressurized carrier pipe, resulting in a pinhole leak. An estimated one thousand cubic feet of natural gas was released and ignited. The carrier pipe was operating at 846 psig at the time of the release. The Incident Report identified a failure to follow procedures as a causal factor in the incident.

As a result of the investigation, it appears that you have committed probable violations of the Pipeline Safety Regulations, Title 49, Code of Federal Regulations. The items inspected and the probable violations are:

1. §192.605 Procedural manual for operations, maintenance, and emergencies.

(a) *General.* Each operator shall prepare and follow for each pipeline, a manual of written procedures for conducting operations and maintenance activities and for emergency response. For transmission lines, the manual must also include procedures for handling abnormal operations. This manual must be reviewed and updated by the operator at intervals not exceeding 15 months, but at least one each calendar year. This manual must be prepared before operations of a pipeline system commence. Appropriate parts of the manual must be kept at locations where operations and maintenance activities are conducted. . . .

Spectra Energy failed to follow its written procedure, *Standard Operating Procedures, Volume 7-Welding, Procedure number: 7-2090, Procedure Name: Safety Requirements, Date: 05/12/2014, Subsection 4.8 Removal of Split Casings,* while removing the casing on Line 10.

According to Spectra Energy, it only used the *Standard Operating Procedures, Volume 7- Welding, Procedure number: 7-2090, Procedure Name: Safety Requirements, Date: 05/12/2014, Sections 4, 5 and 8* for the work performed at Jacob Ferry Road. Under *Section 4, Subsection 4.8 Removal of Split Casings*, it states that "[w]elders shall take the following precautionary measures when using a cutting torch to remove split casing in an effort to minimize the risk of damaging or burning through the carrier pipe (emphasis added)." However, the following precautionary measures stated in *Subsection 4.8* of the procedure were not taken when removing the casing:

1. "Prior to cutting, verify the gap between the carrier pipe and casing pipe. An oxy-acetylene torch may be used for cutting on casings with gaps 2 [inches] and greater. Consult the Metallurgical Services Department to determine the appropriate removal method for casings with gaps less than 2 [inches]."

2. "Use an oxy-acetylene gouging tip on the cutting torch to direct the blow of the torch at an angle to the carrier pipe rather than directly at the carrier pipe."

First, Spectra Energy could not provide any documentation that demonstrated it verified the distance between the casing and carrier pipe prior to cutting. During the investigation, PHMSA gathered information about the location of the Incident, the carrier pipe, and the casing. The outside diameter (O.D.) of the casing was 34 inches and the O.D. of the carrier pipe was 30 inches. Based on those

[2] As defined in §192.5(b)(1), a class 1 location is an offshore area or any class location unit that has 10 or fewer buildings intended for human occupancy.
[3] The location of the crossing did and does not meet the definition of a high consequence area in §192.903.

measurements, the space between the casing and carrier would be less than 2 inches. According to *Subsection 4.8*, Spectra Energy should have "[consulted] the Metallurgical Services Department to determine the appropriate removal method for [the casing since the gap was less than 2 inches]." However, Spectra could not provide any documentation that showed it conducted the required consultation to determine the appropriate removal method.

Second, Spectra Energy could not provide any documentation that it used an oxy-acetylene gouging tip. During a May 29, 2014 meeting between a PHMSA inspector and Spectra Energy, the PHMSA inspector requested that Spectra Energy provide information pertaining to the type of torch and associated tools being used to cut the casing. Following the meeting on May 29, 2014, Spectra provided a written response by e-mail stating that a standard torch tip was used to remove the casing, not a "gouging tip," as required by its procedure.

Consequently, Spectra Energy's failure to follow its procedure, *Standard Operating Procedures, Volume 7- Welding, Procedure number: 7-2090, Procedure Name: Safety Requirements, Date: 05/12/2014, Subsection 4.8 Removal of Split Casings*, was a casual factor in this Incident.

2. §199.202 Alcohol misuse plan.

Each operator must maintain and follow a written alcohol misuse plan that conforms to the requirements of this part and DOT Procedures concerning alcohol testing programs. The plan shall contain methods and procedures for compliance with all the requirements of this subpart, including required testing, recordkeeping, reporting, education, and training elements.

Spectra Energy failed to follow its written alcohol misuse plan, in accordance with §199.225(a)(1), as prescribed in §199.202. Pursuant to §199.225(a)(1), as soon as practicable following an accident,[4] each operator must test each surviving covered employee[5] for alcohol, if that employee's performance of a covered function[6] either contributed to the accident or cannot be completely discounted as a contributing factor to the accident.

Spectra Energy defines the maximum time frame in which an employee must be tested for alcohol following an accident in its written alcohol misuse plan.

Spectra Energy's written alcohol misuse plan, *Section VI. Alcohol Misuse Prevention Program*, states: "Post-Accident Testing: . . . A post-accident alcohol test shall be conducted on each employee as soon as possible but no later than 8 hours after the accident . . . . (emphasis added)."

By e-mail dated May 29, 2014, Spectra Energy identified at least two employees who were involved in cutting the casing. In another e-mail dated June 4, 2014, Spectra Energy produced a list of employees who completed a post-accident drug and alcohol test, and included the date and time when the test was completed. The PHMSA inspector noted that all employees, including the two identified employees involved in cutting the casing, were tested for alcohol nearly twenty-six (26) hours after the Incident.

In a subsequent e-mail dated June 18, 2014, Spectra Energy stated the following: "By the time the

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[4] *See* §199.3 Definitions. *Accident* means an incident reportable under Part 191 of this chapter involving gas pipeline facilities or LNG facilities, or an accident reportable under Part 195 of this chapter involving hazardous liquid pipeline facilities.

[5] *See* §199.3 Definitions. *Covered employee, employee, or individual to be tested* means a person who performs a covered function, including persons employed by operators, contractors engaged by operators, and persons employed by such contractors.

[6] *See* §199.3 Definitions. *Covered function* means an operations, maintenance, or emergency-response function regulated by part 192, 193, or 195 of this chapter that is performed on a pipeline or on an LNG facility.

segment was completely blown down around 5 PM, nearly 6 hours had passed since the event had begun. Alcohol testing was not performed that evening due to oversight. As soon as the omission was noted, the testing was performed, although outside the 8-hour window."

Spectra Energy failed to conduct a post-accident alcohol test on each employee within the maximum 8-hour time frame as specified in its written alcohol misuse plan, *Section VI. Alcohol Misuse Prevention Program.*

3. **§199.225 Alcohol tests required.**

Each operator shall conduct the following types of alcohol tests for the presence of alcohol:
(a) *Post-accident.* (1) . . .
(2)(i) If a test required by this section is not administered within two hours following the accident, the operator shall prepare and maintain on file a record stating the reasons the test was not promptly administered. If a test required by paragraph (a) is not administered within eight hours following the accident, the operator shall cease attempts to administer an alcohol test and shall state in the record the reasons for not administering the test. . . .

Spectra Energy failed to prepare and maintain a record stating the reasons for not promptly administering a test within two hours following the accident[7] that occurred on May 16, 2014, as prescribed in §199.225(a)(2)(i).

During the investigation, Spectra Energy produced a list of employees who completed a post-accident drug and alcohol test including the date and time when the test was done in an e-mail dated June 4, 2014. The PHMSA inspector noted that all employees, including the two identified employees involved in cutting the casing, were tested for alcohol nearly twenty-six (26) hours after the Incident. The PHMSA inspector requested an explanation for why the alcohol tests were administered more than twenty-four hours after the Incident. Spectra Energy replied to the PHMSA inspector's request by an e-mail dated June 18, 2014, stating:

> "We are aware of the regulatory requirements for drug and alcohol testing following reportable incidents. The immediate focus after the pin hole leak occurred was to make the pipeline segment safe by isolating and blowing down the pipeline segment without causing undue hardship on the affected customers. By the time the segment was completely blown down around 5 PM, nearly 6 hours had passed since the event had begun. Alcohol testing was not performed that evening due to oversight. As soon as the omission was noted, the testing was performed, although outside the 8-hour window. Appropriate training across Spectra Energy is planned to ensure this does not recur."

Subsequently, the PHMSA inspector requested Spectra Energy to provide a copy of a record detailing why the testing was not administered within the specified timeline as required under section 199.225(a)(2)(i). Spectra Energy sent an e-mail dated July 1, 2014, in which it stated that it "is using the June 18 email [above] as its record for describing why the alcohol testing was not administered within 2 hours of the incident." However, the e-mail dated June 18, 2014 was created more than a month after the Incident, in response to the PHMSA inspector's request for more information. After two hours had passed, Spectra was required to document "the reasons the test was not promptly administered." Spectra's June 18 email is not a qualifying record, as it was not prepared following the expiration of the two-hour testing window, and not maintained in Spectra's files and available at the time of the PHMSA inspection.

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[7] *See* §199.3 Definitions. *Accident* means an incident reportable under Part 191 of this chapter involving gas pipeline facilities or LNG facilities, or an accident reportable under Part 195 of this chapter involving hazardous liquid pipeline facilities.

Proposed Civil Penalty

Under 49 United States Code, § 60122, you are subject to a civil penalty not to exceed $200,000 per violation per day the violation persists up to a maximum of $2,000,000 for a related series of violations. For violations occurring prior to January 4, 2012, the maximum penalty may not exceed $100,000 per violation per day, with a maximum penalty not to exceed $1,000,000 for a related series of violations. The Compliance Officer has reviewed the circumstances and supporting documentation involved in the above probable violations and has recommended that you be preliminarily assessed a civil penalty of $239,200 as follows:

Item number	PENALTY
1	$172,800
2	$33,300
3	$33,100

Response to this Notice

Enclosed as part of this Notice is a document entitled *Response Options for Pipeline Operators in Compliance Proceedings*. Please refer to this document and note the response options. All material submitted in response to this enforcement action may be made publicly available. If you believe that any portion of your responsive material qualifies for confidential treatment under 5 U.S.C. 552(b), along with the complete original document you must provide a second copy of the document with the portions you believe qualify for confidential treatment redacted and an explanation of why you believe the redacted information qualifies for confidential treatment under 5 U.S.C. 552(b). If you do not respond within 30 days of receipt of this Notice, this constitutes a waiver of your right to contest the allegations in this Notice, and authorizes the Associate Administrator for Pipeline Safety to find facts as alleged in this Notice without further notice to you and to issue a Final Order.

In your correspondence on this matter, please refer to **CPF 1-2015-1025,** and for each document you submit, please provide a copy in electronic format whenever possible.

Sincerely,

Byron E. Coy
Director, Eastern Region
Pipeline and Hazardous Materials Safety Administration
Office of Pipeline Safety

Enclosure: *Response Options for Pipeline Operators in Compliance Proceedings*