NOTICE OF PROBABLE VIOLATION
and
PROPOSED CIVIL PENALTY

OVERNIGHT EXPRESS DELIVERY

January 18, 2018

Mr. Mark Cluff
VP Safety & Operational Discipline
Williams Field Services
One Williams Center
Tulsa, Oklahoma 74172

CPF 1-2018-5008

Dear Mr. Cluff:

On February 17, 2015, 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, investigated an accident that occurred on February 11, 2015, at the Williams Field Services Houston M&R facility located at 933 Western Avenue in Houston, Pennsylvania.

The accident resulted in an overpressure situation at the station and the release of approximately 51 barrels of ethane.

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 violation(s) are:

1. **§199.105 Drug tests required.**

   Each operator shall conduct the following drug tests for the presence of a prohibited drug:

   (b) Post-accident testing. As soon as possible but no later than 32 hours after an accident, an operator shall drug test each employee whose performance either

contributed to the accident or cannot be completely discounted as a contributing factor to the accident. An operator may decide not to test under this paragraph but such a decision must be based on the best information available immediately after the accident that the employee's performance could not have contributed to the accident or that, because of the time between that performance and the accident, it is not likely that a drug test would reveal whether the performance was affected by drug use.

Williams failed to conduct post-accident drug tests on each employee, whose performance either contributed to the accident or cannot be completely discounted as a contributing factor to the accident, for the presence of a prohibited drug as soon as possible but no later than 32 hours after an accident. Specifically, Williams failed to conduct drug testing of the Senior Pipeline Controller who was controlling pipeline operations during the accident.

Williams Post-Accident Delayed Testing Report Form 00222, Revision 1 dated Jan 2014 states that "Within 36 hours of the incident, a drug test was administered" to the Senior Pipeline Controller. Thus, Williams failed to drug test an employee whose performance either contributed to the accident or whose performance cannot be completely discounted as a contributing factor to the accident, within 32 hours.

2. **199.225 Alcohol tests required.**

   Each operator shall conduct the following types of alcohol tests for the presence of alcohol:

   (a) Post-accident. (1) As soon as practicable following an accident, each operator shall test each surviving covered employee for alcohol if that employee's performance of a covered function [a] either contributed to the accident or cannot be completely discounted as a contributing factor to the accident. The decision not to administer a test under this section shall be based on the operator's determination, using the best available information at the time of the determination that the covered employee's performance could not have contributed to the accident.

Williams failed to test, as soon as practicable following an accident, each surviving covered employee for alcohol if that employee's performance of a covered function either contributed to the accident or cannot be completely discounted as a contributing factor to the accident. Specifically, Williams failed to test the Senior Pipeline Controller, who was performing a covered function during the accident, for alcohol.

Williams defined the maximum time frame in which an employee must be tested for alcohol following an accident in its written Department of Transportation Anti-Drug and Alcohol Misuse Plan dated January 2014.

> Section 11.0 Types of Alcohol Tests, paragraph 11.1 Post-Accident Alcohol Testing states in part that: "As soon as practical following an accident, Williams will test each surviving subject employee for alcohol it that employee's performance of a covered function either contributed to the accident, or cannot be

[a] Per 199.3 - 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.

> completely discounted as a contributing factor to the accident. The decision not to administer a test under this section will be based upon Williams' determination, using the best available information at the time of the determination, that the subject employee's performance could not have contributed to the accident."

In Exhibit A, Subject Employees, Williams listed covered employees as "each employee or contractor of Williams who performs an operating, maintenance, or emergency response function regulated by 49 CFR part 192, 193, or 195 on a pipeline include, but are not limited to:

> …(9) controlling or operating gas or hazardous liquid flow or pressure in a pipeline;"

Lastly, Williams Post-Accident Delayed Testing Report Form 00222, Revision 1 dated Jan 2014 states that "This Form must be completed and a copy of the form returned to the Drug Plan Manager within twenty-four (24) hours of a Reportable Accident if all Post-Accident Tests were not administered within two (2) hours or within eight (8) hours of the Reportable Accident."

For the accident that occurred on February 11, 2015, the Williams Post-Accident Delayed Testing Report Form 00222, Revision 1, dated Jan 2014, under the section *TESTING DELAYED BEYOND EIGHT (8) HOURS AND CANCELLED THEREFORE,* states that:

> Immediately following the incident, our focus was on ensuring we maintained the integrity of the pipeline facility; we were in the throes [Sic] of evaluating what had occurred and the severity of the incident. It was not until the morning following the incident that we realized that we could not exclude the [Senior Pipeline] controller's actions from contributing to the incident.

The Senior Pipeline Controller was controlling pipeline operations during the accident. Thus, Williams failed to test the Senior Pipeline Controller, who was performing a covered function during the accident, for alcohol.

3. **§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.

   (c) *Maintenance and normal operations*. The manual required by paragraph (a) of this section must include procedures for the following to provide safety during maintenance and normal operations:

   (1) …

   (3) Operating, maintaining, and repairing the pipeline system in accordance with each of the requirements of this subpart and subpart H of this part.

Williams failed to follow its manual of written procedures for ensuring that repairs are made in a safe manner to prevent damage to persons and property, in accordance with § 195.422. Specifically, Williams failed to follow procedures for Lockout/Tagout and the control of hazardous energy sources as outlined in their *System Integrity Plan, Procedure 5.05-ADM-025*. The procedures were not followed during maintenance work at the Houston M&R facility to replace a faulty solenoid valve on valve MOV17, resulting in an overpressure situation at the station.

During the investigation, the PHMSA inspector reviewed Williams' procedures, records, accident report, and root cause failure investigation report.

Section 2.1 of the Williams *System Integrity Plan, Procedure 5.50-ADM-025*, states that "Lockout/Tagout will be performed when servicing or maintaining equipment in which the unexpected energization, startup, or the release of stored energy could cause injury to personnel."

The Ohio Valley Midstream Root Cause Failure Analysis report dated March 19, 2015, states in part that:

1. "Executive Summary: …It was determined that the ultimate root cause of this incident was an ineffective control scheme at the Houston metering station. Additional contributing factors/missed opportunities to this incident included a breakdown in communication between Pipeline Control and **onsite technicians and a failure to lock-out/tag-out all potentially hazardous sources of energy**." [Emphasis Added].

3.1 "Safety Goal Impacted: …Unintended Valve Actuation/Failure to Control Energy Sources: Williams Pipeline Controller sent a remote open command to the meter run inlet valve (MLV-001) while local Operations Technicians were still involved in replacement of a damaged solenoid coil on a downstream meter run isolation valve (HV-017). It is understood that this confusion stemmed from a phone call Williams Pipeline Control received from Sunoco's Pipeline Control, informing Williams that they were ready to flow. Ops Techs had completed a Permit to Work prior to the valve solenoid replacement. **Lock Out/Tag Out on all potentially hazardous energy sources had not been implemented prior to the valve repair.** [Emphasis Added]"

4. "The Houston Station meter run overpressure deviation incident was due in large part to an ineffective spec break pressure control system design. One that over relied on operational procedures and manual operation during startup rather than effective engineering controls via system PLC interlocks, permissives, and sequencing. Sufficient communication between Pipeline Control and Operations personnel onsite or **the proper lock-out/tag-out of all potentially hazardous energy sources could have prevented this particular incident** [Emphasis Added]. While effective administrative controls could have prevented this incident, a similar overpressure incident could have occurred at any time when comparable operational parameters were in effect. Operational data reviewed during the course of the investigation revealed several other instances of meter run overpressure]"

Thus, Williams failed to follow procedures for Lockout/Tagout and the control of hazardous energy sources.

Proposed Civil Penalty

Under 49 U.S.C. § 60122 and 49 CFR § 190.223, you are subject to a civil penalty not to exceed $209,002 per violation per day the violation persists, up to a maximum of $2,090,022 for a related series of violations. For violations occurring prior to November 2, 2015, the maximum penalty may not exceed $200,000 per violation per day, with a maximum penalty not to exceed $2,000,000 for a related series of violations. The Compliance Officer has reviewed the circumstances and supporting documentation involved in the above probable violation(s) and has recommended that you be preliminarily assessed a civil penalty of $192,900 as follows:

Item number	PENALTY
1	$21,600
2	$21,600
3	$149,700

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 submit 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.

Please submit all correspondence in this matter to Robert Burrough, Director, PHMSA Eastern Region, 820 Bear Tavern Road, Suite 103, West Trenton, New Jersey 08628. Please refer to **CPF 1- 2018-5008** on each document you submit, and whenever possible provide a signed PDF copy in electronic format. Smaller files may be emailed to robert.burrough@dot.gov. Larger files should be sent on a CD accompanied by the original paper copy to the Eastern Region Office.

Additionally, if you choose to respond to this (or any other case), please ensure that any response letter pertains solely to one CPF case number.

Sincerely,

Robert Burrough
Director, Eastern Region
Pipeline and Hazardous Materials Safety Administration

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