NOTICE OF PROBABLE VIOLATION
and
PROPOSED CIVIL PENALTY

OVERNIGHT EXPRESS DELIVERY

October 6, 2022

Mr. Dave Wortman
Vice President Supply and Transportation
Kiantone Pipeline Corporation
15 Bradley Street, PO BOX 780
Warren, Pennsylvania 16365

CPF 1-2022-050-NOPV

Dear Mr. Wortman:

From July 8, 2021 through July 9, 2021, representatives of the Pipeline and Hazardous Materials Safety Administration (PHMSA), Office of Pipeline Safety (OPS), pursuant to Chapter 601 of 49 United States Code (U.S.C.) investigated your release of crude oil in Warren, Pennsylvania.

On July 8, 2021, at approximately 12:20 a.m. EST, an accidental release of crude oil occurred at Kiantone Pipeline Corporation's (Kiantone) facilities in Warren, Pennsylvania, due to an overflow of Tank 652 at its Cobham Tank Farm (the Accident). The overflow resulted in a release of 2,672 barrels (bbl) of crude oil into a secondary containment area, some of which flowed through an open dike drain valve into a firewater retention pond.

The night preceding the Accident, an electrical storm with heavy rains caused a loss of commercial power to the facility at 6:50 p.m. EST (Power Loss). The Power Loss initiated the uninterruptible power supply (UPS) to maintain communications with the control center while all other electrical equipment in the Cobham Tank Farm was inoperable, including lights, pumps, and motor operated valves (MOV). The UPS operated for nearly two hours before being depleted.

Commercial power was temporarily restored for thirty-two seconds at 9:00 p.m. The restoration of power caused the remotely operated inlet valves to Tanks 650, 651 and 652 to begin opening, but the valve operation ceased when power was lost again. Tanks 650, 651, and 652 were all

connected to the same manifold. Because Tank 652 now had a partially opened inlet valve and Tank 651 was in the process of receiving product, Tank 652 started to receive product as well. This temporary and inadvertent valve operation was undetected by the control center, due in part, to the loss of communication following depletion of the UPS. Moreover, the control center's procedures called for manual monitoring of only Tank 651 because it was the only tank that was scheduled to be receiving product. Consequently, the receiving of product in Tank 652 and resulting overflow of product from Tank 652 was not detected until 12:55 a.m., on July 8, 2021, when the pump house blender (PHB) noticed oil coming from the vents of the tank. Kiantone provided three NRC reports 1310023, 1310399 and 1310456, with the first report on July 8, 2021 at 03:13 a.m.

Representatives of the Pipeline and Hazardous Materials Safety Administration (PHMSA), Office of Pipeline Safety (OPS), pursuant to Chapter 601 of 49 United States Code (U.S.C.) investigated the Accident.

As a result of the investigation, it is alleged that you have committed probable violations of the Pipeline Safety Regulations, Title 49, Code of Federal Regulations (CFR). The items investigated and the probable violations are:

1. § 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 ensure 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.**

Kiantone failed to follow its manual of written procedures for conducting normal operations. Specifically, Kiantone failed to follow its Operations, Maintenance & Emergency Response Procedures Manual (O&M), Procedure 11.6.3 – Activities During Receipt of Crude Oil at Tank Farm (Procedure 11.6.3)

During the investigation, PHMSA reviewed Kiantone's procedures. Kiantone's O&M Procedure 11.6.3 required verification that tanks not scheduled to receive product do not show unexpected loss or gain of inventory. However, during the Power Loss and UPS depletion, Kiantone did not verify that tanks, including Tank 652, which was not scheduled to receive product at Cobham Park Tank Farm, did not show an unexpected loss or gain of inventory nor did Kiantone obtain level gauge readings from each tank within the active manifolded system according to its operating procedures. Consequently, when Tank 652 started receiving product due to a partially opened inlet valve, it went undetected until the tank overflowed.

Therefore, Kiantone failed to follow its O&M Procedure 11.6.3.

2. § 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 ensure 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.**

Kiantone failed to follow its manual of written procedures for conducting normal operations. Specifically, Kiantone failed to follow its O&M Procedure Section 5.7.10 – Tank Farm Dike Drain Operations (Dike Drain Procedure) which required personnel to be present at the Tank Farm Facility while any dike drain is manually open for draining and required returning the valve to the closed position when draining is complete.

Kiantone's O&M Section 5.7.10 – Tank Farm Dike Drain Operations (Dike Drain Procedure) stated, in relevant part:

> 4. Logs the valve open in the dike drain log and periodically monitors discharge. KPL/URC personnel must be present at the Tank Farm Facility while any dike drain is manually open for draining.
> 5. Return valve to closed position when draining is complete and document in the dike drain log

During the investigation, PHMSA reviewed Kiantone's Dike Drain Procedure, which stated that the responsibility of a Pump House Operator included being "present at the Tank Farm Facility while any dike drain is manually open for draining" in order to periodically monitor the discharge and "[r]eturn[ing] [the] valve to the closed position when draining is complete and document[ing] [it] in the dike drain log." Kiantone failed to follow this provision when Kiantone personnel manually opened a dike drain valve at approximately 9:50 PM EST to release storm water, failed to accurately log this opening, and subsequently failed to close the dike drain valve once draining was complete.

Moreover, during the Power Loss, Kiantone did not periodically monitor the discharge into the diked area while the dike drain was open. Thus, when an abnormal operating condition caused crude oil to overflow from Tank 652, the open dike drain permitted crude oil to release from the associated secondary containment. The opening of the dike drain valve and failing to monitor it during draining rendered the secondary containment area ineffective and resulted in an unplanned discharge into the fire water retention pond.

Therefore, for the reasons above, Kiantone failed to follow its Dike Drain Procedure, as required by § 195.402(a).

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 ensure 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.**

Kiantone failed to follow its O&M Procedure Section 18.1 - Abnormal Operations (AO Procedures).

Kiantone's O&M Section 18.1 stated, in relevant part:

> Once abnormal operations have ended, operators at the Pipeline Control Center and/or the Pipeline Manager will monitor pipeline operations to be sure the abnormal condition has been corrected and the pipeline is operating safely. The Pipeline Manager is responsible to review the actions of personnel who responded to an abnormal operation to determine:
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> - Whether the response was timely and appropriate, to ensure protection of persons and property.
> - Whether employee actions followed company-approved procedures.
> - Whether any deficiencies exist in Kiantone O&M procedures, safety equipment, or pipeline monitoring and/or control systems.

During the Power Loss, malfunction of Tank 652's inlet valve (442-MOV-102) caused crude oil to release from the tank. During PHMSA's investigation, it was discovered that a malfunction of Tank 652's inlet valve had previously occurred during a power outage and depletion of the UPS on June 30, 2021. After the previous malfunction, Kiantone did not conduct a proper review of the abnormal operation to determine all the deficiencies in procedures, safety equipment, and monitoring or control systems. Kiantone did not correct a previously discovered equipment malfunction prior to the Accident, as required by O&M Section 18.1, resulting in recurrence of the malfunction and the release of product.

Therefore, Kiantone failed to follow O&M Section 18.1, as required by § 195.402(a).

4. § 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 ensure 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.

Kiantone failed to follow its manual of written procedures for handling abnormal operations. Specifically, Kiantone failed to follow its AO Procedure 18.1.2 and the reporting instructions on its associated AO Conditions Form #18.1.1 regarding reporting of abnormal operations.

Kiantone's AO Procedure 18.1.2 for abnormal operations required, "KPL Operators [to] [c]ompletely fill out the Abnormal sheet on the computer." The reporting instruction on the AOC Form #18.1.1 required, "[d]ocumentation and notification of an abnormal operation must be done correctly to prevent additional operational problems." The form also noted that after the form is completed, follow-up action will be completed, and the records would be maintained.

During the investigation, PHMSA discovered that during the previous June 30, 2021 power loss incident, the inlet valves to all three tanks at the Cobham Park Tank Farm opened unintentionally. Kiantone did not correctly investigate and document the unintentional valves opening in its 'Description of Abnormal Operation' portion of the AOC Form for the event nor did Kiantone generate a different AOC report to describe that occurrence. An AOC report was only generated for the Loss of Communication. In addition, there were not sufficient preventative and mitigative measures implemented to prevent a reoccurrence of unintentional valve opening. The failure to prevent or mitigate this AOC subsequently resulted in the overflow of Tank 652.

Therefore, Kiantone failed to follow its AOC Procedure 18.1.2, as required by § 195.402(a).

5. § 195.52 Immediate notice of certain accidents.

(a) ***Notice requirements*****. At the earliest practicable moment following discovery, of a release of the hazardous liquid or carbon dioxide transported resulting in an event described in § 195.50, but no later than one hour after confirmed discovery, the operator of the system must give notice, in accordance with paragraph (b) of this section of any failure that:**

(1) …

(2) Resulted in either a fire or explosion not intentionally set by the operator;

Kiantone failed to give notice at the earliest practicable moment of a failure that resulted in a fire as required by § 195.52(a)(2) .

During the investigation PHMSA discovered that Kiantone had previously experienced a tank fire while cleaning Tank 648 at its Cobham Park Tank Farm on September 15, 2018. This unintentional tank fire to Tank 648 released hazardous liquid and therefore was a reportable event under the criteria established in § 195.50(a). This accident was never reported to the National Response Center (NRC).

Therefore, Kiantone failed to comply with the reporting requirements of § 195.52(a)(2).

6. § 195.54 Accident Report.

> **(a) Each operator that experiences an accident that is required to be reported under § 195.50 must, as soon as practicable, but no later than 30 days after discovery of the accident, file an accident report on DOT Form 7000-1.**

Kiantone failed to file an accident report on DOT Form 7000-1, as soon as practicable, but no later than 30 days after its discovery of an accident that was required to be reported under § 195.50.

During PHMSA's investigation of the Accident site on July 8, 2021, it was determined that on September 15, 2018, Kiantone experienced a tank fire while cleaning Tank 648 in Cobham Park Tank Farm. A 7000.1 accident report was never filed for the fire event. The tank was severely damaged as a result of the fire.

Therefore, Kiantone failed to comply with the accident reporting requirement of § 195.54(a).

Proposed Civil Penalty

Under 49 U.S.C. § 60122 and 49 CFR § 190.223, you are subject to a civil penalty not to exceed $239,142 per violation per day the violation persists, up to a maximum of $2,391,412 for a related series of violations. For violation occurring on or after May 3, 2021 and before March 21, 2022, the maximum penalty may not exceed $225,134 per violation per day the violation persists, up to a maximum of $2,251,334 for a related series of violations. For violation occurring on or after January 11, 2021 and before May 3, 2021, the maximum penalty may not exceed $222,504 per violation per day the violation persists, up to a maximum of $2,225,034 for a related series of violations. For violation occurring on or after July 31, 2019 and before January 11, 2021, the maximum penalty may not exceed $218,647 per violation per day the violation persists, up to a maximum of $2,186,465 for a related series of violations. For violation occurring on or after November 27, 2018 and before July 31, 2019, the maximum penalty may not exceed $213,268 per violation per day, with a maximum penalty not to exceed $2,132,679. For violation occurring on or after November 2, 2015 and before November 27, 2018, the maximum penalty may not exceed $209,002 per violation per day, with a maximum penalty not to exceed $2,090,022.

We have reviewed the circumstances and supporting documentation involved for the above probable violations and recommend that you be preliminarily assessed a civil penalty of $675,402 as follows:

Item number	PENALTY
1	$225,134
2	$225,134
3	$225,134

Warning Items

With respect to items 4, 5, and 6, we have reviewed the circumstances and supporting documents involved in this case and have decided not to conduct additional enforcement action or penalty

assessment proceedings at this time. We advise you to promptly correct these items. Failure to do so may result in additional enforcement action.

Response to this Notice

Enclosed as part of this Notice is a document entitled *Response Options for Pipeline Operators in Enforcement Proceedings*. Please refer to this document and note the response options. All material you 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).

Following the receipt of this Notice, you have 30 days to submit written comments, or request a hearing under 49 CFR § 190.211. 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. If you are responding to this Notice, we propose that you submit your correspondence to my office within 30 days from the receipt of this Notice. This period may be extended by written request for good cause.

In your correspondence on this matter, please refer to **CPF 1-2022-050-NOPV**, and, for each document you submit, please provide a copy in electronic format whenever possible.

Sincerely,

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

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