SENT VIA FACSIMILE

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

July 5, 2012

Mr. Richard Adams, Vice President, U.S. Operations
Enbridge Energy, Limited Partnership
City Center Office
1409 Hammond, Avenue
Superior, WI 54880-5247

CPF 3-2012-5013

Dear Mr. Adams:

On July 2, 2012, this office issued a Notice of Probable Violation and Proposed Civil Penalty (Notice) to Enbridge in this case, addressed to you at the above address. The Notice set forth various allegations of violation and proposed a total civil penalty of $3,699,200.

It has now come to my attention that there were several typographical errors in the letter that need to be corrected. First, three of the individual penalty amounts were misstated, even though the total proposed amount was correct. The correct penalty amounts are as follows:

Item #21 : $32,500
Item #22 : $23,700
Item #23 : $18,700.

Second, Item 21 in the Notice did not include the proper CFR citation. The alleged violation was for 49 C.F.R. § 195.52(b)(6), not (b)(7).

These errors have been corrected in the attached Notice, which includes a new issuance date of today, July 5. Enbridge has 30 days from the date of receipt of this letter to respond to the Notice, in accordance with 49 C.F.R. § 190.209. If you have any questions about any of this, please feel free to contact me.

Sincerely,

David Barrett
Director, Central Region
Pipeline and Hazardous Materials Safety Administration

NOTICE OF PROBABLE VIOLATION
and
PROPOSED CIVIL PENALTY

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CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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Mr. Richard Adams
Vice President, U.S. Operations
Enbridge Energy, Limited Partnership
City Center Office
1409 Hammond, Avenue
Superior, WI 54880-5247

CPF 3-2012-5013

Dear Mr. Adams:

Beginning on July 26, 2010, representatives of the Pipeline and Hazardous Materials Safety Administration (PHMSA) pursuant to Chapter 601 of 49 United States Code investigated a crude oil release that began on July 25 from Enbridge Energy, Limited Partnership's (Enbridge) 30-inch diameter Line 6B pipeline near Marshall, Michigan (Accident). The Accident ultimately resulted in a spill of more than 20,000 bbls of crude oil and the contamination of approximately 38 miles of the Kalamazoo River.

The pipeline failed despite a series of In-Line Inspections (ILI) that Enbridge had performed on the line in conjunction with the company's Integrity Management Program (IMP). Multiple corrosion and crack-like anomalies on the pipe joint that failed on July

25, 2010, had been reported from the previous ILI runs, but Enbridge did not conduct any field examination of the reported anomalies prior to Accident. On the day of the failure, another crack detection ILI was being performed on Line 6B, and the tool actually remained in the pipeline until after the line was restarted on September 27, 2010.

The pipeline ruptured at approximately 17:58 EDT (all times are Eastern Daylight Time unless otherwise noted) on July 25, 2010, approximately 0.6 miles downstream of the company's Marshall pumping station, while the Control Center (CCO) in Edmonton, Alberta (Canada), was in the process of executing a scheduled 10-hour shutdown of the pipeline (Scheduled Shutdown). As soon as the failure occurred, the CCO received multiple alarms and indications of abnormal operations on Line 6B, but the company did not execute its suspected-leak or emergency procedures. Instead, Enbridge allowed the pipeline to remain idle as part of the Scheduled Shutdown for approximately 10 hours, during which time a new shift came on duty at the CCO, which brought in a new set of controllers, supervisors, and support personnel.

At approximately 04:00, on July 26, 2010, Enbridge initiated the scheduled start-up of Line 6B (First Restart). Within minutes, the CCO received multiple alarms and indications of abnormal operating conditions, which indicated that the pressure at the Marshall pumping station had not increased as expected and the imbalance between the volume of product injected into the pipeline and the volume of product being delivered from the pipeline exceeded established thresholds. Again, Enbridge did not execute its suspected leak or emergency procedures. Instead, Enbridge continued to pump crude oil into the line while the controller, supervisors, and support personnel evaluated the situation.

After approximately one hour, the CCO abandoned the First Restart and shut down Line 6B, when typical pressure and flow response for this pipeline configuration had not occurred. According to Enbridge records, an additional 10,460 bbls of crude oil was injected into the pipeline during the First Restart.

The lack of typical pressure and flow conditions for this pipeline configuration and alarms were again reviewed by CCO supervisors and support personnel. One of the CCO Shift Leads contacted the On-Call Manager and informed him of the situation. After further discussion, Enbridge managers decided to re-start the line again. At approximately 07:20 on July 26, 2010, the Line 6B controller initiated another start-up of the line (Second Restart), and again received multiple alarms and indications of abnormal operating conditions. After pumping for another 31 minutes and still not seeing the expected pressure increase at the Marshall pumping station, the controller shut down Line 6B again. According to Enbridge records, an additional 5,831 bbls of crude oil were injected into the pipeline during the Second Restart. By this time the prospects of a suspected leak had been openly discussed by various CCO personnel, yet the Enbridge

procedures for a suspected leak were not executed.

The CCO halted the Second Restart at approximately 07:51. Soon thereafter, another scheduled CCO shift change occurred, which brought in another set of new controllers, supervisors, and support personnel. During this second shift change, Enbridge staff and managers discussed the two restart attempts, resulting in the Line 6B controller conducting further investigation into the historical operating information on the line but taking no action to deal with a spill.

At 11:18 on July 26, roughly 17 hours after the failure occurred, the CCO received an emergency call from an employee of a local gas company, Consumers Energy, reporting oil in a creek near Marshall, Michigan. Remotely operated valves on each side of the reported leak location (2 upstream and 2 downstream) were closed by the CCO, and this isolated approximately three miles of pipeline on either side of the rupture. Emergency Notifications were provided; resulting in the dispatch of Enbridge field personnel. Enbridge field personnel confirmed the spill and contacted the CCO at 11:43. Enbridge field personnel began deploying local emergency response resources in addition to mobilizing additional company and contract emergency response resources. The National Response Center (NRC) was notified at 13:33 (NRC Report #948903).

On July 28, 2010, PHMSA issued a Corrective Action Order to Enbridge requiring corrective actions to protect the public, property, and the environment. Amongst other things, the Corrective Action Order required a pressure reduction, verification of pipeline integrity, integration of information, and provisions for ensuring ongoing safe operation considering all risk factors.

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. §195.452 Pipeline integrity management in high consequence areas.

(h) ***What actions must an operator take to address integrity issues?***

(1) *General requirements.* An operator must take prompt action to address all anomalous conditions the operator discovers through the integrity assessment or information analysis. In addressing all conditions, an operator must evaluate all anomalous conditions and remediate those that could reduce a pipeline's integrity….

(2) *Discovery of condition*. Discovery of a condition occurs when an operator has adequate information about the condition to determine that the condition presents a potential threat to the integrity of the pipeline. An operator must promptly, but no later than 180 days after an integrity assessment, obtain

sufficient information about a condition to make that determination, unless the operator can demonstrate that the 180-day period is impracticable.

Enbridge failed within 180 days after an integrity assessment of Line 6B to obtain sufficient information about anomalous conditions presenting a potential threat to the integrity of Line 6B. Enbridge conducted a high-resolution MFL integrity assessment of Line 6B on October 13, 2007. Enbridge received a vendor report on June 4, 2008 regarding this ILI run. The 180 day deadline was April 10, 2008. Enbridge did not demonstrate that the 180 day period was impracticable. Enbridge implemented pressure restrictions as of July 17, 2009, a period of approximately 462 days after the deadline to have sufficient information to identify anomalous conditions. After another year, on July 15, 2010, the company submitted a Long Term Pressure Reduction Notification to PHMSA on July 15, 2010 in which the date of discovery was reported by Enbridge as July 17, 2009.

2. §195.452 Pipeline integrity management in high consequence areas.

(h) What actions must an operator take to address integrity issues?
(4) Special requirements for scheduling remediation

Beginning with the 2004 USWM ILI, Enbridge did not schedule remediation of corrosion anomalies involving the longitudinal weld seam of pipe joint #217720 within 180 days of discovery of the conditions as required by **§195.452(h)(4)(iii)(H).** Enbridge also did not remediate crack-like anomalies on the same pipe joint (longitudinal in orientation) that could impair the integrity of the pipeline reported by the 2005 USCD ILI as required by **§195.452(h)(4)(iv)** in accordance with **(Appendix C)(VII)(D)**. Enbridge could not demonstrate that the company attempted or scheduled any remediation of the corrosion or crack anomalies that were identified by the assessments.

The reported corrosion and crack like anomalies on pipe joint #217720, on Line 6B, were not selected for excavation, and the pipe joint ultimately ruptured in service on July 25, 2010, resulting in a crude oil release of over 20,000 bbls, and significant environmental damage, as the released product migrated to a creek, which in turn flowed into the Kalamazoo River.

3. §195.452 Pipeline integrity management in high consequence areas.
(i) What preventive and mitigative measures must an operator take to protect the high consequence area?
(1) General requirements. An operator must take measures to prevent and mitigate the consequences of a pipeline failure that could affect a high consequence area. These measures included conducting a risk analysis of the pipeline segment to identify additional actions to enhance public safety or environmental protection….

(2) Risk analysis criteria. In identifying the need for additional preventive and mitigative measures, an operator must evaluate the likelihood of a pipeline release occurring and how a release could affect the high consequence area. This determination must consider all relevant risk factors, including, but not limited to:
(i) Terrain surrounding the pipeline segment, including drainage systems such as small streams and other smaller waterways that could act as a conduit to the high consequence area;
(ii) Elevation profile;
(iii) Characteristics of the product transported;
(iv) Amount of product that could be released;

In preparing the risk analysis, Enbridge failed to consider all relevant risk factors associated with the determination of the amount of product that could be released from a rupture on Line 6B. Enbridge's risk analysis process assumed a pipeline rupture of this magnitude would be identified by instrumentation (SCADA and Leak Detection System) within 5 minutes, and that it would take an additional 3 minutes to close remotely operated valves on either side of the rupture. The amount of product that could be released is clearly impacted by different operating scenarios including transient conditions such as those associated with start-ups and shutdowns or personnel response to abnormal operating conditions.

Prior to the release, Enbridge estimated the worst case scenario release at the M.P. 608 location to be 1,670 bbls initial volume out, plus 1938 bbls stabilization loss (drain down) for a total of 3,608 bbls.

The actual failure scenario demonstrates the rupture was not recognized by Enbridge, and the isolation valves were not closed, until approximately 17 hours after it occurred. An additional 16,431 bbls of product was injected into the ruptured pipeline, causing the total spill volume to greatly exceed Enbridge's worst case discharge scenario for this location.

4. §195.452 Pipeline integrity management in high consequence areas.

(j) What is a continual process of evaluation and assessment to maintain a pipeline's integrity?
(2) Evaluation. An operator must conduct a periodic evaluation as frequently as needed to assure pipeline integrity. An operator must base the frequency of evaluation on risk factors specific to its pipeline, including the factors specified in paragraph (e) of this section. The evaluation must consider the results of the baseline and periodic integrity assessments, information analysis (paragraph (g) of this section), and decisions about remediation, and preventive and mitigative actions (paragraphs (h) and (i) of this section).

Enbridge did not properly consider the results of corrosion and cracking assessments nor did Enbridge integrate the information from these assessments to properly assure overall pipeline integrity. Witness interviews and prior ILI assessment results of Line 6B, including 2004 USWM, 2005 USCD, 2007 MFL, and 2009 USWM demonstrate that Enbridge has a long history of performing integrity assessments using ILI tools. These assessment results were evaluated independently and not integrated in a fashion that assures pipeline integrity.

5. §195.401 General requirements.

(b) Whenever an operator discovers any condition that could adversely affect the safe operation of its pipeline system, it shall correct it within a reasonable time. However, if the condition is of such a nature that it presents an immediate hazard to persons or property, the operator may not operate the affected part of the system until it has corrected the unsafe condition.

Enbridge failed to correct a condition that could affect the safe operation of a pipeline within a reasonable time following discovery. Enbridge discovered the condition as a result of SCADA/instrumentation alarms and events that alerted within seconds and minutes of the rupture, including a 5-minute MBS (Material Balance System) alarm, a Unit Shutdown on Low Suction Pressure, Low Pressure Alarms, and an abnormal and abrupt pressure drop (to 0 psig) at Marshall pumping station. Enbridge's Line 6B ruptured approximately 0.6 miles downstream of the Marshall pumping station at approximately 17:58 on July 25, 2010, as a Scheduled Shutdown was being executed by the CCO.

These SCADA/instrumentation alarms and events indicate conditions that could adversely affect the safe operation of the pipeline unless and until they are determined to be the result of known conditions that do not affect the safe operation of the pipeline (are not the result of a leak). The expected initial corrective action is to notify appropriate company and emergency response personnel to investigate and mitigate the effects of any unsafe conditions. This was not done until approximately 17 hours after discovery of the conditions.

6. §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 commence, and appropriate parts shall be kept at locations where operations and maintenance activities are conducted.

(d) Abnormal operation. The manual required by paragraph (a) of this section must include procedures for the following to provide safety when operating design limits have been exceeded;

(1) Responding to, investigating, and correcting the cause of;

(i) Unintended closure of valves or shutdowns;

(ii) Increase or decrease in pressure or flow rate outside normal operating limits;

(iii) Loss of communications;

(iv) Operation of any safety device;

(v) Any other malfunction of a component, deviation from normal operation, or personnel error which could cause a hazard to persons or property.

(3) Correcting variations from normal operation of pressure and flow equipment and controls.

(4) Notifying responsible operator personnel when notice of an abnormal operation is received.

Enbridge did not follow established written procedures for responding to, investigating, and correcting the cause of pressure outside of normal operating limits (LPM Invalid Pressure Alarms) that were indicated during the Scheduled Shutdown. Enbridge also did not notify responsible personnel in accordance with the procedure. The Line 6B controller initiated the Scheduled Shutdown at approximately 17:55 EDT. Beginning at 17:58, Line Pressure Monitor (LPM) Invalid Pressure alarms at Marshall pumping station began to initiate and then clear within a few seconds. This alarm occurs when the SCADA system senses one or more pressure transmitters at 0 psig, and clears when the pressure goes above 0 psig. This cycle repeated six times before finally occurring and remaining active at 18:02. This alarm is designated by Enbridge as a Severity Level 6 (S6 – Severe) Alarm.

Enbridge has not developed a specific written procedure for responding to an LPM Invalid Pressure Alarm, but has instead developed a written procedure for required actions based on alarm severity. For an S6 – Severe Alarm, the procedures require the controller to: (1) Notify the Shift Lead; (2) Advise on-site/on-call personnel; (3) Create a FACMAN (Enbridge term for Facility Management record-keeping system used to documents abnormal operating conditions). Enbridge failed to take any of these required actions.

7. §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 commence, and appropriate parts shall be kept at locations where operations and maintenance activities are conducted.

(d) Abnormal operation. The manual required by paragraph (a) of this section must include procedures for the following to provide safety when operating design limits have been exceeded;

(1) Responding to, investigating, and correcting the cause of;

(i) Unintended closure of valves or shutdowns;

(ii) Increase or decrease in pressure or flow rate outside normal operating limits;

(iii) Loss of communications;

(iv) Operation of any safety device;

(v) Any other malfunction of a component, deviation from normal operation, or personnel error which could cause a hazard to persons or property.

(3) Correcting variations from normal operation of pressure and flow equipment and controls.

(4) Notifying responsible operator personnel when notice of an abnormal operation is received.

Enbridge did not follow established written procedures for responding to, investigating, and correcting the cause of pressure outside of normal operating limits (Low Pressure Alarms) that were indicated during the Scheduled Shutdown. Enbridge also did not notify responsible personnel in accordance with the procedure. The Line 6B controller initiated the Scheduled Shutdown at approximately 17:55 EDT on July 25, 2010. Beginning at 17:58, a Low Suction Pressure alarm initiated, then cleared within 5 seconds, then recurred and remained active 10 seconds later. This alarm occurs when the suction pressure drops below 25 psig, and clears when the suction pressure exceeds 25 psig. This alarm is designated by Enbridge as a Severity Level 4 (S4 – Warning) Alarm.

Enbridge has not developed a specific written procedure for responding to a Low Suction Pressure Alarm, but has instead developed a written procedure for required actions based on alarm severity. For an S4 – Warning Alarm, the procedures require (1) Discretionary controller response to alarm dependent on operating conditions, (2) Notify the Shift Lead if unsure of response, (3) If multiple S4 alarms are active for a related issue, the response and severity may be raised, (4) FACMAN creation may be required, (5) Advise on-site/on-call personnel if required. Enbridge did not take any of the above actions, or any other actions, in response to this alarm. The fact the Marshall suction pressure abruptly dropped to 0 psig, which was unexpected and abnormal, dictates follow-up investigative actions in accordance with the procedure, in order to determine the reason/source of the Alarm.

8. §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 commence, and appropriate parts shall be kept at locations where operations and maintenance activities are conducted.

(d) Abnormal operation. The manual required by paragraph (a) of this section must include procedures for the following to provide safety when operating design limits have been exceeded;

(1) Responding to, investigating, and correcting the cause of;

(i) Unintended closure of valves or shutdowns;

(ii) Increase or decrease in pressure or flow rate outside normal operating limits;

(iii) Loss of communications;

(iv) Operation of any safety device;

(v) Any other malfunction of a component, deviation from normal operation, or personnel error which could cause a hazard to persons or property.

(3) Correcting variations from normal operation of pressure and flow equipment and controls.

(4) Notifying responsible operator personnel when notice of an abnormal operation is received.

Enbridge did not follow established written procedures for responding to, investigating, and correcting the cause of an unintended shutdown (Marshall Unit 2 is in Sequence off Alarm) that was indicated during the Scheduled Shutdown. Enbridge also did not notify responsible personnel in accordance with the procedure. The Line 6B controller initiated the Scheduled Shutdown at approximately 17:55 EDT on July 25, 2010. At 17:58, a Marshall Unit 2 is in Sequence Off alarm occurred, which indicated the Programmable Logic Controller (PLC) for Marshall pumping station stopped Unit 2 based on a condition sensed by the station control logic, which in this circumstance, was low suction pressure. This alarm is designated by Enbridge as a Severity Level 4 (S4 – Warning) Alarm. Enbridge's written procedure for Pump Unit Lockout – Station, requires the controller to enter lockout information in FACMAN. No FACMAN was created in response to this alarm.

9. §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 commence, and appropriate parts shall be kept at locations where operations and maintenance activities are conducted.

(e) Emergencies. The manual required by paragraph (a) of this section must include procedures for the following to provide safety when an emergency condition occurs;

(4) Taking necessary action, such as emergency shutdown or pressure reduction, to minimize the volume of hazardous liquid or carbon dioxide that is released from any section of a pipeline in the event of a failure.

(7) Notifying fire, police, and other appropriate public officials of hazardous liquid or carbon dioxide pipeline emergencies and coordinating with them preplanned and actual responses during an emergency, including additional precautions necessary for an emergency involving a pipeline transporting a highly volatile liquid.

Enbridge did not take necessary action to minimize the volume of hazardous liquid released in the event of a failure or notify police during an emergency. These actions are required by the Enbridge Emergency Notification procedure. The Enbridge Suspected Column Separation procedure requires the Shift Lead to execute the Emergency Notification procedure. Suspected Column Separation was identified and reported to the Shift Lead by CCO Support Personnel (MBS Analyst) shortly after the Scheduled Shutdown.

The Line 6B controller initiated the Scheduled Shutdown at approximately 17:55 EDT on July 25, 2010. At 18:03, an MBS 5-Minute Alarm for the Griffith to Marshall section of Line 6B occurred. This alarm is designated by Enbridge as a Severity Level 6 (S6 – Severe) Alarm. The alarm was reported to the Shift Lead by the controller, and MBS Support (analysis of the leak detection alarm) was requested by the Shift Lead. The MBS Analyst reported back to the controller (via telephone) and the Shift Lead (in person), that the MBS model was indicating column separation (a condition in which the pressure on the pipeline is less than the vapor pressure of the product) existed on the pipeline.

Enbridge has a written procedure, Suspected Column Separation, which requires the Shift Lead to execute the Emergency Notification procedure. The Shift Lead did not execute the Emergency Notification procedure, which would have resulted

in notifications to Regional Management (and field personnel), police, and the CCO Admin On-Call or Designate.

10. §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 commence, and appropriate parts shall be kept at locations where operations and maintenance activities are conducted.

(e) Emergencies. The manual required by paragraph (a) of this section must include procedures for the following to provide safety when an emergency condition occurs;

(4) Taking necessary action, such as emergency shutdown or pressure reduction, to minimize the volume of hazardous liquid or carbon dioxide that is released from any section of a pipeline in the event of a failure.

(7) Notifying fire, police, and other appropriate public officials of hazardous liquid or carbon dioxide pipeline emergencies and coordinating with them preplanned and actual responses during an emergency, including additional precautions necessary for an emergency involving a pipeline transporting a highly volatile liquid.

Enbridge did not take necessary action to minimize the volume of hazardous liquid released in the event of a failure or notify police during an emergency. These actions are required by the Enbridge Emergency Notification procedure. The Enbridge procedure Leak Triggers – SCADA Data requires that if one or two leak triggers occur, then the Suspected Leak procedure must be executed. If three or more triggers occur, then the Confirmed Leak procedure must be executed. Neither the Suspected Leak procedure nor the Confirmed Leak procedure was executed by the CCO in response to the Leak Triggers that occurred shortly after the Scheduled Shutdown.

The Line 6B controller initiated the Scheduled Shutdown at approximately 17:55 EDT on July 25, 2010. The pipeline ruptured at approximately 17:58, approximately 0.6 miles downstream of the Marshall pumping station, resulting in a sudden drop in upstream discharge pressure (to 0 psig). Multiple alarms and events were received within seconds of the rupture. These included low suction pressure at Marshall Pumping Station, a unit shutdown at Marshall pumping station, and invalid pressure(s) at Marshall pumping station. A 5 Minute MBS alarm occurred on the Griffith to Marshall section of Line 6B at 18:03. These alarms and events constitute Leak Triggers.

Enbridge procedure, Leak Triggers – SCADA Data, defines leak triggers as "unexplained abnormal operating conditions or events that indicate a leak". This procedure requires that either the Suspected Leak procedure or the Confirmed Leak procedure be executed depending on the number of leak triggers that are identified. Neither the Suspected Leak procedure nor the Confirmed Leak procedure was executed by the CCO in response to the leak triggers that occurred when the pipeline ruptured. Following either procedure would have led to the execution of the Emergency Notification procedure by the Shift Lead, and notifications would have been provided to Regional/Field personnel, police, and the CCO Admin On-Call or Designate.

11. §195.440 Public awareness

(c) The operator must follow the general program recommendations, including baseline and supplemental requirements of API RP 1162, unless the operator provides justification in its program or procedural manual as to why compliance with all or certain provisions of the recommended practice is not practicable and not necessary for safety.

Enbridge did not evaluate the effectiveness of its public awareness program (PAP) in accordance with the written procedures. Enbridge's PAP requires the Public Awareness Manager to informally assess the effectiveness of public awareness efforts on an annual basis. Enbridge could not demonstrate this was being performed. The investigation identified a number of instances where actions taken by members of the PAP target audience were not in accordance with the program message (e.g. not associating the odor with that of a possible crude oil release, not contacting Enbridge's Emergency Number in response to the odor complaints, and entry into the spill area by untrained individuals).

12. §195.401 General requirements.

(b) Whenever an operator discovers any condition that could adversely affect the safe operation of its pipeline system, it shall correct it within a reasonable time. However, if the condition is of such a nature that it presents an immediate hazard to persons or property, the operator may not operate the affected part of the system until it has corrected the unsafe condition.

Enbridge operated Line 6B prior to correcting an unsafe condition that presented an immediate hazard to persons or property. Enbridge's Line 6B ruptured approximately 0.6 miles downstream of the Marshall pumping station during the Scheduled Shutdown. Enbridge attempted the First Restart after an approximate 10 hour shutdown. Enbridge was unable to build pressure at the Marshall pumping station and multiple alarms occurred within minutes of initiating

operation. Alarms continued throughout the operation but the attempted restart was not terminated until after approximately one hour of operation.

Approximately 10,600 bbls of crude oil was injected into the pipeline during this period. The release resulted in a number of local residents being displaced, contamination of approximately 38 miles of the Kalamazoo River, and contamination of affected fish and wildlife.

13. §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 commence, and appropriate parts shall be kept at locations where operations and maintenance activities are conducted.

(e) Emergencies. The manual required by paragraph (a) of this section must include procedures for the following to provide safety when an emergency condition occurs;

(4) Taking necessary action, such as emergency shutdown or pressure reduction, to minimize the volume of hazardous liquid or carbon dioxide that is released from any section of a pipeline in the event of a failure.

During the First Restart, Enbridge did not take necessary action to minimize the volume of hazardous liquid released in the event of a failure. An emergency was indicated by multiple leak alarms which occurred shortly after initiation of the First Restart. The MBS Leak Alarm procedure requires that if a leak detection (MBS) alarm occurs, the Pipeline controller is to Notify the Shift Lead, and Record the AOC (Abnormal Operating Condition) in FACMAN. The procedure then requires the Shift Lead to assess the alarm, and take action based on the assessment.

The MBS Alarms during the First Restart (as indicated by SCADA information) are as follows:

04:12:11	5-Minute MBS Alarm occurred for the Griffith - Marshall section
04:16:44	20-Minute MBS Alarm occurred for the Griffith - Marshall section
04:22:11	5-Minute MBS Alarm Exceeded 10 minute limit
04:26:44	20-Minute MBS Alarm Exceeded 10 minute limit
04:26:54	20-Minute MBS Alarm occurred for the Marshall – Sarnia section
04:26:54	5-Minute MBS Alarm occurred for the Marshall – Sarnia section
04:31:28	2-Hour MBS Alarm occurred for the Griffith – Marshall section

04:36:54	20-Minute MBS Alarm Exceeded 10 minute limit
04:36:54	5-Minute MBS Alarm Exceeded 10 minute limit
04:41:28	2-Hour MBS Alarm Exceeded 10 minute limit
04:47:07	2-Hour MBS Alarm occurred for the Marshall – Sarnia section
04:57:07	2-Hour MBS Alarm Exceeded 10 minute limit
05:08–07:12	All MBS Alarms cleared following shutdown at 05:00

Recorded telephone transcripts and witness interviews indicate that the Line 6B Controller contacted the Shift Lead at 04:23, but did not specifically report that MBS alarms had occurred. He reported that he had started the Mendon (upstream) pump approximately 10 minutes earlier, and was not seeing the expected pressure increase at Marshall pumping station. He did mention to the Shift Lead that the MBS was starting to react to some flow in the area. No FACMAN was created to record the AOC.

The MBS Leak Alarm procedure requires the Shift Lead to assess an MBS alarm. If there is any doubt about the reliability of the leak detection model, the procedure requires the Shift Lead to execute the MBS Alarm – Analysis by MBS Support procedure. This procedure requires that if after 10 minutes, the analysis of the alarm is not complete then the pipeline is to be shutdown. The pipeline was not shutdown until 48 minutes after the first MBS alarm occurred.

14. §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 commence, and appropriate parts shall be kept at locations where operations and maintenance activities are conducted.

(d) Abnormal operation. The manual required by paragraph (a) of this section must include procedures for the following to provide safety when operating design limits have been exceeded;

(1) Responding to, investigating, and correcting the cause of;

(i) Unintended closure of valves or shutdowns;

(ii) Increase or decrease in pressure or flow rate outside normal operating limits;

(iii) Loss of communications;

(iv) Operation of any safety device;

(v) Any other malfunction of a component, deviation from normal operation, or personnel error which could cause a hazard to persons or property.

(3) Correcting variations from normal operation of pressure and flow equipment and controls.
(4) Notifying responsible operator personnel when notice of an abnormal operation is received.

During the First Restart, Enbridge did not follow established written procedures for responding to, investigating, and correcting the cause of pressure outside of normal operating limits (Suspected Column Separation). Enbridge also did not notify responsible personnel in accordance with the Suspected Column Separation procedure. SCADA information indicated there was zero pressure at Marshall pumping station upon the First Restart, which was indicative of Suspected Column Separation. Enbridge procedure, Suspected Column Separation, requires that if the column cannot be restored within 10 minutes, the controller must: (1) Notify Shift Lead; (2) Shut down the specific line; (3) Sectionalize; (4) Isolate; and (5) Execute the Abnormal Operations Condition Reporting procedure. Witness interviews indicate that Enbridge consistently interpreted the 10 minute requirement to apply from the time the immediate upstream pump was started. Telephone records indicate the Line 6B controller notified the Shift Lead at 04:23, just prior to expiration of the 10 minutes that were allowed from the start of the upstream pumping station (Mendon). SCADA information indicates the pipeline was not shut down until approximately 05:00 exceeding the 10 minute requirement. The pipeline was then sectionalized. Two additional requirements of the controller in the Suspected Column Separation procedure were not completed: the pipeline was not isolated; and the Abnormal Operations Condition Reporting procedure was not executed.

15. §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 commence, and appropriate parts shall be kept at locations where operations and maintenance activities are conducted.
(e) Emergencies. The manual required by paragraph (a) of this section must include procedures for the following to provide safety when an emergency condition occurs;
(4) Taking necessary action, such as emergency shutdown or pressure reduction, to minimize the volume of hazardous liquid or carbon dioxide that is released from any section of a pipeline in the event of a failure.
(7) Notifying fire, police, and other appropriate public officials of hazardous liquid or carbon dioxide pipeline emergencies and coordinating with them preplanned and actual responses during an emergency, including additional

precautions necessary for an emergency involving a pipeline transporting a highly volatile liquid.

During the First Restart, Enbridge did not take necessary action to minimize the volume of hazardous liquid released in the event of a failure or notify police during an emergency. These actions are required by the Enbridge Emergency Notification procedure. The Enbridge Suspected Column Separation procedure requires the Shift Lead to execute the Emergency Notification procedure.

Telephone records indicate that the Line 6B controller reported problems getting pressure at Marshall pumping station to the Shift Lead at 04:23, just prior to expiration of the 10 minutes that were allowed from the start of the upstream pumping station (Mendon). The Shift Lead monitored the pressure at Marshall pumping station, and observed pressures that were indicative of Column Separation.

The Shift Lead did not execute the Emergency Notification procedure, which would have resulted in notifications to Regional Management (and field personnel), police, and the CCO Admin On-Call or Designate.

16. §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 commence, and appropriate parts shall be kept at locations where operations and maintenance activities are conducted.

During the First Restart, Enbridge used a draft procedure for starting up a pipeline with column separation instead of following a prepared and approved procedure for Suspected Column Separation. The approved procedure requires the line to be shut down, isolated, and notifications to management, field personnel, and emergency responders. However, the draft/unapproved procedure that was used included provisions for calculating an amount of time that would be needed to integrate the column based on calculations of the volume drained from the pipeline, and the injection rate of product into the pipeline. This action resulted in extended operation of the pipeline, additional product being injected into the pipeline, and increased the amount of product released.

Witness interviews indicate the unapproved procedure had also been used previously, on a different pipeline, in May of 2010. The investigation has

established that the Line 6B controller's pod-mate (the person who operates pipelines on the adjacent console) brought forward the unapproved procedure from May 2010 via an e-mail that had been used previously in the control room, and the Shift Lead who was attempting to assist the Line 6B controller used this unapproved procedure to justify continued operation of Line 6B. The process used violated the prepared and approved written procedures.

17. §195.401 General requirements.

(b) Whenever an operator discovers any condition that could adversely affect the safe operation of its pipeline system, it shall correct it within a reasonable time. However, if the condition is of such a nature that it presents an immediate hazard to persons or property, the operator may not operate the affected part of the system until it has corrected the unsafe condition.

Enbridge operated Line 6B prior to correcting an unsafe condition which presented an immediate hazard to persons or property. Enbridge attempted the First Restart, which was terminated after approximately one hour, when pressure did not build properly at the Marshall pumping station and multiple alarms occurred. Enbridge then attempted the Second Restart, after the circumstances of the failed First Restart were discussed among CCO Supervisors, support personnel, and On-Call Management. The Second Restart was terminated after approximately 30 minutes, due to continued problems trying to build pressure at Marshall and additional alarms.

Approximately 5,831 bbls of crude oil was injected into the pipeline during the Second Restart. The attempt to operate the pipeline delayed corrective actions and allowed additional oil to drain from the rupture during stabilization. The release resulted in a number of local residents being displaced, contamination of approximately 38 miles of the Kalamazoo River, and contamination of affected fish and wildlife.

18. §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 commence, and appropriate parts shall be kept at locations where operations and maintenance activities are conducted.

(d) Abnormal operation. The manual required by paragraph (a) of this section must include procedures for the following to provide safety when operating design limits have been exceeded;

(1) Responding to, investigating, and correcting the cause of;

(i) Unintended closure of valves or shutdowns;

(ii) Increase or decrease in pressure or flow rate outside normal operating limits;

(iii) Loss of communications;

(iv) Operation of any safety device;

(v) Any other malfunction of a component, deviation from normal operation, or personnel error which could cause a hazard to persons or property.

(3) Correcting variations from normal operation of pressure and flow equipment and controls.

(4) Notifying responsible operator personnel when notice of an abnormal operation is received.

During the Second Restart, Enbridge did not take necessary action to minimize the volume of hazardous liquid released in the event of a failure or notify police during an emergency. These actions are required by the Enbridge Emergency Notification procedure. The Enbridge Suspected Column Separation procedure requires the Shift Lead to execute the Emergency Notification procedure. SCADA information indicated there was suspected column separation (due to zero pressure) at Marshall pumping station when the Second Restart commenced. Enbridge has a specific written procedure for Suspected Column Separation. If the column cannot be restored within 10 minutes, the procedure requires the controller: (1) Notify Shift Lead; (2) Shut down the specific line; (3) Sectionalize; (4) Isolate; and (5) Execute the Abnormal Operations Condition Reporting procedure.

SCADA information demonstrates that suspected column separation at Marshall pumping station persisted through the entire Second Restart process. The controller, with Shift Lead oversight, commenced the Second Restart at approximately 07:20. Unit 4 at Mendon pumping station was started at 07:32. SCADA indicated that Unit 4 at Mendon was online at 07:35. The column was not restored, which by procedure required the Line 6B controller to shut down the pipeline within 10 minutes. The Line 6B controller finally began to shut down the line at 07:50. The pipeline was then sectionalized. Two additional requirements of the controller in the Suspected Column Separation procedure were not completed: the pipeline was not isolated; and the Abnormal Operations Condition Reporting procedure was not executed.

19. §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 commence, and appropriate parts shall be kept at locations where operations and maintenance activities are conducted.

(e) Emergencies. The manual required by paragraph (a) of this section must include procedures for the following to provide safety when an emergency condition occurs;

(4) Taking necessary action, such as emergency shutdown or pressure reduction, to minimize the volume of hazardous liquid or carbon dioxide that is released from any section of a pipeline in the event of a failure.

(7) Notifying fire, police, and other appropriate public officials of hazardous liquid or carbon dioxide pipeline emergencies and coordinating with them preplanned and actual responses during an emergency, including additional precautions necessary for an emergency involving a pipeline transporting a highly volatile liquid.

During the Second Restart, Enbridge did not take necessary action to minimize the volume of hazardous liquid released in the event of a failure or notify police during an emergency. These actions are required by the Enbridge Emergency Notification procedure. The Enbridge Suspected Column Separation procedure requires the Shift Lead to execute the Emergency Notification procedure. SCADA information indicates there was suspected column separation at Marshall pumping station when the Second Restart commenced. Enbridge's procedure requires the Shift Lead to execute the Emergency Notification procedure if the column cannot be restored within 10 minutes.

SCADA information indicates the Second Restart commenced at 07:20, and was terminated at 07:50 when the column could not be restored. Telephone records and witness interviews indicate the Shift Lead monitored operations during the Second Restart but did not execute the Emergency Notification procedure as required by the Suspected Column Separation procedure.

20. §195.52 Telephonic notice of certain accidents.

(a) 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, the operator of the system shall give notice, in accordance with paragraph (b) of this section, of any failure that:

(1) Caused a death or a injury requiring hospitalization;

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

(3) Caused estimated property damage, including cost of cleanup and recovery, value of lost product, and damage to the property of the operator or others, or both, exceeding $50,000;

(4) Resulted in pollution of any stream, river, lake, reservoir, or other similar body of water that violated applicable water quality standards, caused a discoloration of the surface of the water or adjoining shoreline, or deposited a sludge or emulsion beneath the surface of the water or upon adjoining shorelines; or

(5) In the judgment of the operator was significant even though it did not meet the criteria of any other paragraph of this section.

Enbridge failed to accurately report required accident information at the earliest practicable moment following discovery to the National Response Center (NRC). The rupture, which occurred at 17:58, on July 25, 2010, was reported to Enbridge to have impacted the Talmadge Creek at 11:18, on July 26, 2010. Telephone records and witness interviews indicate CCO personnel were actively investigating the problems with Line 6B that had been encountered during the two previous shifts when the first report of product in Talmadge Creek was received. Enbridge provided NRC Report #948903 at 13:33 on July 26, 2010.

PHMSA issued Advisory Bulletin ADB 02-04 on August 30, 2002, to advise owners and operators of gas distribution, gas transmission, and hazardous liquid pipeline systems and LNG facilities of the need to promptly contact the NRC after a pipeline incident is discovered and to file additional telephonic reports if there are significant changes in the number of fatalities or injuries, product release estimates or the extent of damages. No supplemental telephonic reports were filed with the NRC to correct and/or augment the initial information that was provided by Enbridge.

21. §195.52 Telephonic notice of certain accidents.

(b) Information required. Each notice required by paragraph (a) of this section must be made to the National Response Center either by telephone to 800-424-8802 (in Washington, DC, 202-267-2675) or electronically at http://www.nrc.uscg.mil and must include the following information:

(4) The time of the failure.

(6) All other significant facts known by the operator that are relevant to the cause of the failure or extent of the damages.

Enbridge failed to accurately report the time of failure and other significant facts relevant to the extent of damages associated with a pipeline rupture which

occurred at 17:58, on July 25, 2010. Enbridge provided NRC Report #948903 at 13:33 on July 26, 2010, for the accident which occurred at 17:58, on July 25, 2010. NRC Report # 948903 incorrectly reported the time the accident was discovered as 09:45 local incident time. It also reported the material had not reached the Kalamazoo River yet, and that the release was secured.

Witness interviews indicate CCO personnel on shift had been actively investigating the abnormal conditions with Line 6B, and had already discovered that the SCADA information indicated the rupture had likely occurred when the pipeline was shutdown the night before. Witness interviews indicate soon after NRC Report #948903 was filed, it became evident the release was not secured, as oil was moving down the Kalamazoo River. The impacts to people, property, and the environment were immediately obvious when emergency response actions were initiated.

No additional telephonic reports were filed with the NRC to correct and/or augment the initial information that was provided by Enbridge.

22. §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.

Enbridge failed to report currently available accident information on DOT Form 7000-1 within 30 days of discovery of the accident. The accident which occurred on July 25, 2010, near Marshall, MI, resulted in the estimated release of over 20,000 bbls of crude oil, and estimated property damages exceeding $750 million.

Enbridge filed Report #20100181- 15259 on August 25, 2010. The Report indicates the local time and date of the accident was 11:41 on July 26, 2010, when it had been clear within hours of discovery that the failure date and time was approximately 17:58 on July 25, 2010.

The Report also did not indicate the number of general public evacuated, even though daily EPA Pollution Reports indicated the number of residences that were evacuated, and Enbridge paid for alternative lodging for these evacuees as necessary. The estimated pressure at the point and time of the accident was reported as .00 psig, when the actual operating pressure at the point and time of the failure is indicated by available SCADA information as approximately 475 psig. Other fields within the report concerning SCADA and CPM information were inaccurately reported, such that the report indicates SCADA based information did not assist with detection of the accident, the CPM system was not fully functional at the time of the accident, and the CPM system did not assist

with detection of the accident. In actuality, all of these systems were fully functional and provided the proper indications of the accident.

23. §195.54 Accident reports.

(b) Whenever an operator receives any changes in the information reported or additions to the original report on DOT Form 7000-1, it shall file a supplemental report within 30 days.

Enbridge did not submit supplemental reports within 30 days of receiving changes or additions to the information originally reported on DOT Form 7000-1 in Report #20100181-15259. Enbridge submitted the Original Form 7000-1 accident report on August 25, 2010, and Supplemental Reports on December 20, 2010, February 22, 2011 (2 reports submitted on this date), and March 6, 2012. The Supplemental Reports submitted to date contain inaccurate information. The correct information has been known by the operator for some time.

A witness interview on December 5, 2011 indicated that Enbridge determined the total costs of damages associated with the Line 6B rupture were currently $720 million. The value included in the February 22, 2011 report was $550 million. It is unknown at what point the $720 million value was determined by Enbridge, but the reported value was not updated until March 6, 2012, approximately 3 months after the interview.

The reported costs are all contained in the "Estimated other costs" (8f) line item, rather than the appropriate cost categories provided. Additional cost details are contained in a Supplemental Narrative, but still not allocated according to the prescribed cost categories. Known details, such as the number of people evacuated, the estimated spill volume, the pressure at the point and time of the accident, SCADA, CPM, and other reporting elements were not updated well over 18 months after the accident occurred.

24. §195.505 Qualification program.

Each operator shall have and follow a written qualification program. The program shall include provisions to:

(c) Allow individuals that are not qualified pursuant to this subpart to perform a covered task if directed and observed by an individual that is qualified;

Enbridge allowed an unqualified individual to perform covered tasks (operating a pipeline) without direct observation by a qualified individual. A previously qualified controller, who had been off duty for an extended period of time, was operating the Line 6B console, and a qualified controller was assigned to oversee

the operations. The individual must be under the direct supervision of a qualified pipeline controller according to the Enbridge's written procedures.

Witness interviews indicate that during the shift on July 25, 2010, from approximately 5:30 MST to 17:30 MST, the qualified pipeline controller, even though seated adjacent to the un-qualified pipeline controller, was performing other tasks, and not directing and observing line operations, as required by the written procedures. After initiating a scheduled shutdown of Line 6B at 14:56 MST, a number of control center alarms (leak triggers), including a 5-minute Material Balance System (MBS) alarm, multiple low pressure alarms, and a Marshall pumping station cascade shutdown occurred, indicating potential integrity issues with the pipeline. The unqualified pipeline controller did not respond to the alarms in full accordance with the operator's written procedures, and the qualified pipeline controller's oversight of the operations was insufficient to ensure that the required actions were taken.

Proposed Civil Penalty

Under 49 United States Code, § 60122, you are subject to a civil penalty not to exceed $100,000 for each violation for each day the violation persists up to a maximum of $1,000,000 for any 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 $3,699,200 as follows:

Item number	PENALTY
1	$97,800
2	$1,000,000
3	$85,300
4	$1,000,000
5	$100,000
6	$100,000
7	$41,200
8	$100,000
9	$100,000
10	$100,000
12	$100,000
13	$100,000
14	$100,000
15	$100,000
16	$100,000
17	$100,000
18	$100,000
19	$100,000
21	$32,500
22	$23,700

Item number	PENALTY
23	$18,700
24	$100,000

Warning Items

With respect to item(s) 11 and 20, 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 item(s). Be advised that failure to do so may result in Enbridge being subject to additional enforcement action.

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. Be advised that all material you submit in response to this enforcement action is subject to being 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 3-2012-5013** and for each document you submit, please provide a copy in electronic format whenever possible.

Sincerely,

David Barrett
Director, Central Region
Pipeline and Hazardous Materials Safety Administration

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

cc: Mr. Mark Maki
Enbridge Energy Partners, LP
Enbridge Pipelines (Lakehead) L.L.C

Mr. Steve Wuori
Enbridge Pipelines Inc.