AUGUST 1, 2012

Mr. Michael J. Hennigan
President and Chief Executive Officer
Sunoco Logistics Partners, LP
1818 Market Street, Suite 1500
Philadelphia, PA 19103-3615

Re: CPF No. 4-2010-5010

Dear Mr. Hennigan:

Enclosed please find the Final Order issued in the above-referenced case. It makes findings of violation, assesses a civil penalty of $415,000, and specifies actions that need to be taken by Sunoco Logistics Partners, LP, to comply with the pipeline safety regulations. The penalty payment terms are set forth in the Final Order. When the civil penalty has been paid and the terms of the Compliance Order completed, as determined by the Director, Southwest Region, this enforcement action will be closed. Service of the Final Order by certified mail is deemed effective upon the date of mailing, or as otherwise provided under 49 C.F.R. § 190.5.

Thank you for your cooperation in this matter.

Sincerely,

Jeffrey D. Wiese
Associate Administrator
for Pipeline Safety

Enclosure

cc: Mr. David A. Justin, Vice President, Operations, Sunoco Logistics Partners, LP
Mr. David C. Kurland, Esq., Counsel for Sunoco Logistics Partners, LP
Mr. Rod Seeley, Director, Southwest Region, OPS
Mr. Alan Mayberry, Deputy Associate Administrator for Field Operations, OPS

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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

In the Matter of	)	
Sunoco Logistics Partners, LP,	)	**CPF No. 4-2010-5010**
Respondent.	)	

FINAL ORDER

From June 18, 2009, through July 17, 2009, pursuant to 49 U.S.C. § 60117, representatives of the Pipeline and Hazardous Materials Safety Administration (PHMSA), Office of Pipeline Safety (OPS), investigated an accident that occurred on the West Texas Gulf Pipeline System, operated by Sunoco Logistics Partners, LP (Sunoco Logistics or Respondent), at the company's Colorado City Station in Colorado City, Texas, on June 17, 2009. On that date, a fire occurred during a pipeline repair project involving the replacement of a section of pipe; a spill of approximately 3416 barrels of crude oil occurred at the same location. The West Texas Gulf Pipeline System includes approximately 582 miles of pipelines transporting crude oil in Texas and Oklahoma.[1]

As a result of the investigation, the Director, Southwest Region, OPS (Director), issued to Respondent, by letter dated March 11, 2010, a Notice of Probable Violation, Proposed Civil Penalty, and Proposed Compliance Order (Notice). In accordance with 49 C.F.R. § 190.207, the Notice proposed finding that Sunoco Logistics had committed various violations of 49 C.F.R. Part 195 and proposed assessing a total civil penalty of $415,000 for the alleged violations. The Notice also proposed ordering Respondent to take certain measures to correct the alleged violations.

Sunoco Logistics responded to the Notice by letter dated April 11, 2010 (Response). Respondent contested most of the allegations and requested a hearing. A hearing was subsequently held on September 23, 2010, in Houston, Texas, with an attorney from the Office of Chief Counsel, PHMSA, presiding. At the hearing, Respondent was represented by counsel. After the hearing, Sunoco Logistics provided additional written material for the record, by letter dated November 23, 2010 (Closing).

[1] PHMSA Violation Report at 1.

FINDINGS OF VIOLATION

The Notice alleged that Respondent violated 49 C.F.R. Part 195 as follows:

Item 1: The Notice alleged that Respondent violated 49 C.F.R. § 195.52(a)(2), which states:

> **§ 195.52 Telephonic notice of certain accidents**.[2]
> (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:
> (2) Resulted in either a fire or explosion not intentionally set by the operator;. . .

The Notice alleged that Respondent violated 49 C.F.R. § 195.52(a)(2) by failing to give telephonic notice to the National Response Center at the earliest practicable moment after a fire occurred at the Colorado City Station on June 17, 2009, during a project involving the removal and replacement of a section of 24-inch diameter pipe that functioned as the suction and fill line for a crude-oil breakout tank designated as Tank No. 10 (Line 10 Project).

Sunoco Logistics undertook the Line 10 Project to replace a five-foot section of pipe due to corrosion in the pipe wall. Once the pipe had been "cold cut" open and the corroded five-foot section of pipe removed, petroleum was allowed to drip out of both sides of the open pipe into catch pans and mud was packed into both sides of the pipe opening to isolate the petroleum from the repair work involving torches. During the torch-beveling process, which was part of preparing the new pipe for welding, at least one mud pack failed. This allowed some form of petroleum to escape past the mud and flammable petroleum vapors were ignited by the torch.

At this point, all personnel involved in the beveling process left the area immediately to escape the fire. The project leader then returned with a fire extinguisher and the fire was extinguished within about 15 minutes.[3] Sunoco Logistics ceased the repair work and contacted the West Texas District Manager in Abilene, Texas, who dispatched a Safety and Health Specialist to the Colorado City Station to investigate the fire.

In its Responses and at the hearing, Sunoco Logistics argued that it was not required to report the accident under 49 C.F.R. § 195.52(a)(2) because the regulation only applies to those involving the "release" of petroleum and that there was no release of crude oil in liquid form until the large oil spill that occurred after the fire was put out.[4] Respondent further argued that it was not required to report the fire because it was petroleum vapor that had ignited, not petroleum in

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[2] The regulation quoted here was in effect at the time of the alleged violation. It was later amended on November 26, 2010 (75 FR 72907).

[3] Statement of Felix M. Ramos, June 24, 2009, at 2. PHMSA Violation Report, Exhibit G.

[4] Response at 2. Respondent did timely report the large spill that occurred at the same location later that day.

liquid form.

Sunoco Logistics acknowledged that releases of highly volatile liquids (HVLs) that vaporize upon release are required to be reported, but stated that this was not relevant since crude oil does not meet the regulatory definition of a HVL. Respondent also cited a 2002 rule preamble that discounted the need for reporting the release volume of vaporized non-HVL hazardous liquids and stated that PHMSA's published administrative decisions relating to the failure to report a release involving hazardous liquid vapors had only involved HVLs.[5]

In evaluating Respondent's argument that this fire was not required to be reported, it must first be recognized that the pipeline safety regulations in 49 C.F.R. Part 195 are not limited to pipeline safety risks arising solely from products in a liquid state. In § 195.2, the definition of "hazardous liquid" means "petroleum, petroleum products, or anhydrous ammonia." It does not state that petroleum or petroleum products must be in a liquid state. For many years, PHMSA's regulations have specifically required hazardous liquid pipeline operators to address the safety threats posed by hazardous and/or flammable vapors incident to the transportation of hazardous liquids by pipeline. For example, § 195.438 prohibits "smoking and open flames in each pump station area and each breakout tank area where there is a possibility of the leakage of a flammable hazardous liquid or of the presence of flammable vapors."[6] In this case, Respondent's own internal investigation of the Line 10 Project accident concluded that the petroleum fire occurred "due to crude oil or crude oil vapors" passing around the mud plug.[7]

With respect to Respondent's reference to the 2002 rule preamble, the cited statement was made in connection with a discussion of the typical spill volume where small amounts of product are drained and immediately cleaned up during routine maintenance activities.[8] Nothing in the rule warrants a conclusion that an unintended petroleum fire is not reportable. A fire occurring on a pipeline that transports flammable petroleum is a particularly hazardous type of pipeline accident and the fact that Respondent ceased the repair work and launched an investigation by its Safety and Health Specialist demonstrates that Respondent's project leader considered the accident to be significant at the time it occurred.[9] In addition, Respondent's assertion that the published administrative decisions regarding a failure to report release incidents involving hazardous liquid vapors involved only HVL pipelines is incorrect.[10]

In its Response and Closing (collectively, Responses) and during the hearing, Sunoco Logistics acknowledged that petroleum vapor had been released from the pipe opening due to the failure of

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[5] Closing at 3-4.

[6] Many petroleum-based hazardous liquids are volatile and form vapor when exposed to the atmosphere depending on the temperature and the properties of the particular substance.

[7] *Investigation Report for Colorado City Station Oil Spill*, July 6, 2009, at 4. Response, Attachment 3.

[8] 67 F.R. 832 (Jan. 8, 2002).

[9] The last "catch-all" item in the list of criteria for reporting in § 195.52(a)(5) is an accident that "[i]n the judgment of the operator was significant even though it did not meet the criteria of any other paragraph of this section."

[10] *In the Matter of Alyeska Pipeline Service Company*, Consent Agreement and Order, C.P.F. No. 5-2007-5041 (Nov. 16, 2011) (available at www.phmsa.dot.gov/pipeline/enforcement).

the mud plug and that the vapor subsequently ignited. The purpose of accident reporting goes well beyond the need to keep statistics on spill volumes. Accident reporting provides a means for prompt response and investigation of significant accidents that put pipeline personnel and the public at risk during pipe repairs and replacements. Both federal and state regulators depend on data from these accident reports to evaluate operator performance and manage their inspection programs, and to identify trends that may require changes or additions to the regulations to ensure safety. Respondent's argument that an unintentional petroleum fire need not be reported runs counter to the Part 195 regulations and would be inconsistent with pipeline safety standards or regulations.

Accordingly, after considering all of the evidence and the legal issues presented, I find that Respondent violated 49 C.F.R. § 195.52(a)(2) by failing to give telephonic notice to the National Response Center at the earliest practicable moment after an unintentional petroleum fire occurred at the Colorado City Station on June 17, 2009.

Item 2: The Notice alleged that Respondent violated 49 C.F.R. § 195.50(a), which states:

> **§ 195.50 Reporting accidents.**
>
> An accident report is required for each failure in a pipeline system subject to this part in which there is a release of the hazardous liquid or carbon dioxide transported resulting in any of the following:
>
> (a) Explosion or fire not intentionally set by the operator. . . .

The Notice alleged that Respondent violated 49 C.F.R. § 195.50(a) by failing to submit a written accident report after the unintentional June 17, 2009 petroleum fire described in Item 1 above. Specifically, the Notice alleged that Sunoco Logistics failed to submit an accident report on DOT Form 7000-1 or a facsimile as soon as practicable but not later than 30 days after the fire occurred, as set forth in § 195.54(a).

In its Responses and at the hearing, Sunoco Logistics repeated the argument made in Item 1 above that reporting was only required for accidents involving the "release" of a hazardous liquid and that no release of crude oil in liquid form had occurred; the company argued that it was petroleum vapor that had ignited and that it was not petroleum in liquid form. For the reasons discussed in Item 1 above, I find such an argument unpersuasive.

Accordingly, after considering all of the evidence and the legal issues presented, I find that Respondent violated 49 C.F.R. § 195.50(a) by failing to timely submit a written accident report after an unintentional petroleum fire occurred at the Colorado City Station on June 17, 2009.

Item 3: The Notice alleged that Respondent violated 49 C.F.R. § 195.402(c)(3), which states:

> **§ 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.

The Notice alleged that Respondent violated 49 C.F.R. § 195.402(c)(3) by failing to follow its own written procedures for operating, maintaining, and repairing its pipeline system in conducting the Line 10 Project at the Colorado City Station. Specifically, the Notice described 10 instances where the acts or omissions of Respondent and its personnel in conducting the project were not consistent with all of the applicable procedures.[11]

With respect to the alleged failure to follow all of its Lockout/Tagout requirements, in its Response and at the hearing, Sunoco Logistics admitted that it had failed to follow several aspects of the Lockout/Tagout procedures designed to ensure local control (as opposed to remote or automated control) of the Tank No. 10 valve. In this case, the Lockout/Tagout procedure was only partially performed and not all circuit breakers or switches were opened inside an electrical cabinet before locking and tagging the cabinet door, making it possible for the flow valve to be opened by the controller. Once opened, the valve could not be closed by the controller. The failure to fully accomplish Lockout/Tagout allowed crude oil to flow into Line No. 10, which was open for the corrosion repair project, and resulted in the 3,416 barrel oil spill.

With respect to the alleged failure to communicate the job status to appropriate personnel in the control center in accordance with applicable procedures, Sunoco Logistics acknowledged that communication was not effective on June 17, 2009, the day of the accident. Sunoco's LTR/Work Plan procedure states that "whenever the project schedule changes more than four (4) hours then the LTR originator, or the on-site project manager, shall request that the Scheduler approve of the changes in the Work Plan, and the [Pipeline Operations Manager/Pipeline Controller] shall then be notified of all approved changes in the Work Plan." The Line 10 Project was originally scheduled for June 16, 2009, but was delayed until June 17, 2009. This was not communicated to the operations control center in Sugarland, Texas, by the LTR originator or the on-site project manager via a Timeline Request Form, as required by the procedure. Respondent stated that communication between the field and control center did occur on June 15 and June 16, 2009, but this communication was related to the Synder Manifold Project, not the Line 10 Project.

With respect to the alleged failure to generate a detailed work plan for the Line 10 Project in accordance with applicable procedures, Sunoco Logistics argued that the work plan for the Line

[11] The first and last instances listed in the Notice both involved a failure to follow Lockout/Tagout requirements and have been combined for purposes of this discussion. Similarly, the second and the fifth instances listed under Line Time Request (LTR)/Work Plan violations in the Notice both involved communications between the control center and the maintenance personnel at the station and have been combined here.

10 Project appeared on page one of the LTR/Work Plan in the Project Overview/Description section. That page, however, consists of an overview of the scope of both the Snyder Manifold Project and the Line 10 Project and page two is a detailed work plan for the Snyder Manifold Project. This document does not include a detailed work plan for the Line 10 Project. Moreover, Respondent's own internal investigation cited a "lack of project work plans" as a contributing cause to the events of June 17, 2009.[12]

With respect to the alleged failure to generate two separate work plans for the Snyder Manifold Project and the Line 10 Project, Sunoco Logistics pointed out that both projects were conducted at the same facility and its written procedures did not specifically require a separate work plan for each one. While generating two work plans would likely have been a far better approach because independent verification of the completion of the Line 10 Project would have prevented any assumption by the control center that both projects had been completed, Respondent is correct that its written procedures did not specifically require a separate work plan for each project.

With respect to the alleged failure to assign fire watchers in accordance with applicable procedures, Sunoco Logistics pointed out that there was some inconsistency among the statements of the personnel present concerning whether fire watchers had been assigned.[13] According to the record in this case, four of the seven witnesses interviewed were not sure who was assigned to be a fire watcher. Far from demonstrating compliance, the witness statements demonstrate that fire-watcher responsibilities were not clearly assigned by the supervisor, as does the fact that the entire crew fled the fire and the fire extinguishers were not manned.

With respect to the alleged failure to conduct a pre-job safety meeting in accordance with applicable procedures, Sunoco Logistics explained that a pre-job safety meeting was conducted by the project leader as a "tailgate" and several personnel later described it as a safety briefing.[14] Respondent acknowledged, however, that the tailgate meeting was not documented and did not create a record of the subjects covered or of the personnel present for meetings each shift.

With respect to the allegation that Respondent failed to follow procedure HS-G-012, which required that Work Permit No. 253852 for the Line 10 Project be issued by the Colorado City Station operator and not the on-site project leader, Sunoco Logistics acknowledged that the work permit was issued by the on-site project manager.

With respect to the alleged failure to complete a "hot work" permit checklist in accordance with section 5 of the Lockout/Tagout procedure, Sunoco Logistics argued that the requirements for hot work were integrated into its standard work permit. Respondent, however, did not refute the allegation that a hot work permit checklist was not completed in accordance with section 5 of the Lockout/Tagout procedure.

With respect to the allegation that the project leader did not conduct a hazard assessment prior to starting the Line 10 Project in accordance with applicable procedures, in its Responses and at the

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[12] *Investigation Report for Colorado City Station Oil Spill*, July 6, 2009, at 1. Response, Attachment 3.

[13] Closing at 6.

[14] *Id.* at 7.

hearing, Sunoco Logistics argued that it did complete a hazard assessment on June 15, 2009. However, the hazard assessment provided by Respondent was for the Snyder Manifold Project, not the Line 10 Project.

Overall, the evidence shows that Sunoco Logistics failed to follow all applicable procedures in conducting the Line 10 Project. To the extent any of Respondent's explanations may be relevant to the issue of culpability, they will be addressed in the Assessment of Penalty section below.

Accordingly, after considering all of the evidence and the legal issues presented, I find that Respondent violated 49 C.F.R. § 195.402(c)(3) by failing to follow all applicable procedures for operating, maintaining, and repairing its pipeline system in conducting the Line 10 Project at the Colorado City Station.

Item 4: The Notice alleged that Respondent violated 49 C.F.R. § 195.402(c)(13), which states:

> **§ 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) . . .
>
> (13) Periodically reviewing the work done by operator personnel to determine the effectiveness of the procedures used in normal operation and maintenance and taking corrective action where deficiencies are found.

The Notice alleged that Respondent violated 49 C.F.R. § 195.402(c)(13) by failing to follow its own procedures for determining the effectiveness of company procedures used in normal operation and maintenance and taking corrective action where deficiencies were found. Specifically, it alleged that Sunoco Logistics failed to conduct annual field audits of Lockout/Tagout work done by operator personnel at the Colorado City Station for 2008 and 2009, as set forth in its own Procedure HS-P-005.

In its Responses and at the hearing, Sunoco Logistics argued that its failure to conduct annual field audits for 2008 and 2009 at the Colorado City Station was due to its use of a "sampling" approach and that not all stations in each geographic district where Lockout/Tagout work had been done were audited every year.

The Lockout/Tagout procedure in effect during the relevant period states the following at page 18 in relevant part:

> The [Lockout/Tagout (LOTO)]'s required by this program will be reviewed at least annually by [Health, Environment, and Safety Department (HES)] to assure that the procedures and the requirements of this program are being followed. This review will be supplemented by:
>
> - Work site inspections conducted by HES, and any reports of program deficiencies made by Sunoco Logistics' supervisors; and,
> - A review of LOTO records, including site-specific ECPs [Energy Control Procedures] used or developed during the course of the year, and
> - A review of LOTOs being used at the facility.
>
> The periodic review will be designed to correct any deviations or inadequacies observed.[15]

This procedure requires Respondent to conduct annual field audits of all Lockout/Tagouts done by its personnel and does not exclude any facilities from being audited. Notably, Respondent followed this procedure for all facilities for three consecutive years in 2005, 2006, and 2007 but did not follow it in 2008 and 2009 for the Colorado City Station, the period leading up to the June 17, 2009 accident.[16] Respondent did not provide any documentation of a decision by the company to change to a sampling approach in the 2008 period.

Accordingly, after considering all of the evidence and the legal issues presented, I find that Respondent violated 49 C.F.R. § 195.402(c)(13) by failing to follow its own procedures for conducting annual field audits of Lockout/Tagout work done by operator personnel at the Colorado City Station for 2008 and 2009.

Item 5: The Notice alleged that Respondent violated 49 C.F.R. § 195.402(e), which states, in relevant part:

> **§ 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

[15] PHMSA Violation Report, Exhibit C.

[16] Respondent provided a Lockout/Tagout audit record to PHMSA dated 7/2009 but this record was for a specific project (project number 935004-isolate idle line 1-2-3-18/Booster pump) and was not an annual field audit for Lockout/Tagout work at the station.

> 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:
>
> (1) . . .
>
> (2) Prompt and effective response to a notice of each type emergency, including fire or explosion occurring near or directly involving a pipeline facility, accidental release of hazardous liquid or carbon dioxide from a pipeline facility, operational failure causing a hazardous condition, and natural disaster affecting pipeline facilities.
>
> (3) Having personnel, equipment, instruments, tools, and material available as needed at the scene of an emergency. . . .

The Notice alleged that Respondent violated 49 C.F.R. § 195.402(e) by failing to follow its own procedures for having emergency response personnel, equipment, instruments, tools, and material available as needed at the scene of an emergency, when approximately 3,416 barrels of crude oil were released at the Colorado City Station on June 17, 2009 and hydrogen sulfide gas was present in the spill area. Specifically, the Notice alleged that Sunoco Logistics personnel were in the spill area without appropriate personal protective equipment (PPE), including full-faced self-contained breathing apparatus (SCBA) or goggles plus a half-faced SCBA, as required by the company's "Hydrogen Sulfide Initial Response Action Checklist."

In its Responses and at the hearing, Sunoco Logistics argued that it did employ all emergency response equipment needed at the spill site and that it had protected the response personnel by monitoring the air and keeping personnel away from hazardous areas.[17] Respondent stated that all of its personnel stayed upwind during the release and were not exposed to hydrogen sulfide or other toxic or flammable gasses. While there were four SCBAs at the Colorado City Station, Respondent stated that it elected to take the approach of using the prevailing winds instead of using the SCBAs and that it considered PPE to be "the last defense."[18] Respondent stated that a company employee was assigned the task of monitoring the wind direction during the time of emergency response. Respondent stated that while hydrogen sulfide did trigger monitors on the north side of the spill site, they were not triggered on the south side and that since no personnel were working at that time on the north side, the company did not believe there was any reason for the use of SCBAs.

On June 17, 2009, the day the 3,416 barrel spill occurred, work on the Line 10 Project had ceased due to the petroleum fire that had occurred earlier in the day. Due to inadequate communications with the control center, the failure to properly conduct Lockout/Tagout, and the other issues described in this Order, a large volume of crude oil suddenly began flowing from the open pipe at approximately 4:30 p.m. at the location where the five-foot section had been cut out, triggering the oil spill emergency. Respondent's personnel escaped from the immediate area of the pipe opening to avoid the oil, but were not evacuated from the spill area. Hydrogen sulfide alarms began sounding in the area almost immediately. The personnel were

[17] Closing at 9.

[18] Response at 7.

instructed to quickly build berms, using shovels to attempt to contain the crude oil which was flowing rapidly. The hand-digging of ditches was not effective in containing the oil and, at approximately 7:30 p.m., Sunoco Logistics engaged its contractor, BJB, to bring in additional backhoes and other equipment to contain the oil. Air monitoring services were provided by NOVA subcontractor, who arrived at the accident site at approximately 9:30 p.m.[19]

Hydrogen sulfide gas is one of the most toxic substances in crude oil transportation and can cause fatalities. It is colorless, heavier than air, and highly flammable. Respondent's Hydrogen Sulfide Initial Response Action Checklist outlines several response requirements for a release involving hydrogen sulfide:

1. Keep people away. Avoid contact with gas.
2. Wear a full faced self-contained breathing apparatus (SCBA) or goggles and a half faced SCBA.
3. Shut off ignition sources and call the fire department.
4. Evacuate area in case of large discharges.
5. Stay upwind.
6. Notify local health and pollution control agencies.
7. Protect water intakes.[20]

In its Responses and at the hearing, Sunoco Logistics contended that it protected response personnel by monitoring the air and keeping personnel away from the hazardous area on the north side of the spill area. Shortly after the spill began, however, an employee was instructed to bring the backhoe which was parked on the south side of the spill area to the north side to scoop dirt up to contain the oil, while the wind was blowing from South to North. In addition, two of Respondent's employees' personal hydrogen sulfide monitors alarmed several times after the release began, yet, according to their statements, these two employees remained in the area and worked on the west side of the spill area until the spill was stopped approximately two hours after the spill emergency began.[21]

During the hearing, Respondent's Senior Health and Safety Specialist who responded to the fire and crude oil spill stated that after arriving at the scene, he drove his truck around the facility taking air readings at several locations, but without proper respiratory equipment. As a result, he could not have known what the hydrogen sulfide level was in the immediate area of the spill site. During the ensuing investigation, PHMSA requested that Respondent provide the actual field readings from all air monitoring equipment used at the station to ascertain the validity of Respondent's claim that no employees were exposed to hydrogen sulfide. Sunoco Logistics, however, failed to provide any actual field reading records and stated that its air monitoring devices were not equipped with memory chips.

Item 2 of the Hydrogen Sulfide Initial Response Action Checklist, as reproduced above, requires

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[19] PHMSA Violation Report, Exhibit G.

[20] PHMSA Violation Report, Exhibit D.

[21] Other employees stated that they were at various locations within the station, attempting to contain crude oil spill by hand shovels which they retrieved from their trucks.

that personnel wear full-faced SCBA or goggles plus a half-faced SCBA and makes no exception for personnel who are upwind. None of the Respondent's personnel interviewed were using SCBA. At least two employees who did have personal hydrogen sulfide monitors remained in the area and kept working despite those alarms triggering. The company's own Hydrogen Sulfide Initial Response Action Checklist does not allow the use of respirators and other PPE only as a "last defense," as stated in its Response. Even if all personnel were upwind in accordance with Item 5 of the checklist, the procedures were not satisfied because Respondent did not have the discretion to only follow some items in the checklist procedure and not others. Under the hydrogen sulfide emergency procedures, PPE must be combined with other safety measures to ensure the safety of emergency response personnel.

Accordingly, after considering all of the evidence and the legal issues presented, I find that Respondent violated 49 C.F.R. § 195.402(e) by failing to follow applicable procedures for having emergency response personnel, equipment, instruments, tools, and material available as needed at the scene when approximately 3,416 barrels of crude oil were released at the Colorado City Station on June 17, 2009, and hydrogen sulfide gas was present in the spill area.

Item 6: The Notice alleged that Respondent violated 49 C.F.R. § 195.402(e)(9), which states:

> **§ 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. . .
>
> (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:
>
> (1) . . .
>
> (9) Providing for a post accident review of employee activities to determine whether the procedures were effective in each emergency and taking corrective action where deficiencies are found.

The Notice alleged that Respondent violated 49 C.F.R. § 195.402(e)(9) by failing to follow its own procedures for conducting a documented post-accident review of employee activities to determine whether the company's emergency response procedures were effective in responding to the June 17, 2009 accident. The Notice further alleged that Sunoco Logistics failed to perform a properly documented post-accident review after the June 17, 2009 accident, using the required "Standard Incident Debriefing Form" in Figure 8.3.1 of the procedure. Finally, the Notice alleged that a company employee stated to the OPS inspector that Sunoco Logistics had terminated three employees who had violated Sunoco's safety procedures but did not conduct any further review of employee activities regarding emergency response.

In its Responses and at the hearing, Sunoco Logistics acknowledged that it did not timely complete the Standard Incident Debriefing Form in accordance with the applicable procedure.[22]

Accordingly, after considering all of the evidence, I find that Respondent violated 49 C.F.R. § 195.402(e)(9) by failing to follow its procedures for conducting a documented post-accident review of employee activities that occurred in response to the June 17, 2009 accident.

Item 7: The Notice alleged that Respondent violated 49 C.F.R. § 195.505(c), which states:

> **§ 195.505 Qualification program.**
> Each operator shall have and follow a written qualification program. The program shall include provisions to:
> (a) . . .
> (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;

The Notice alleged that Respondent violated 49 C.F.R. § 195.505(c) by allowing individuals that were not qualified under its Operator Qualification (OQ) program to perform covered tasks without being directed and observed by an individual that was qualified. Specifically, the Notice alleged that Sunoco Logistics' Senior Pipeliner responsible for overseeing the replacement of the five-foot section of pipe in the manifold pit where the accident occurred was not always present in the pit area and was instead at different places around the station during the performance of the covered task and therefore could not directly observe the work of the non-qualified individuals.

In its Responses and at the hearing, Sunoco Logistics stated that there were four qualified employees performing the function of directing and observing four unqualified employees and that these qualified employees never lost visual contact with the unqualified employees and could intervene should an abnormal operating condition occur. Respondent contended that this allegation in the Notice was based on questionable inferences drawn from incomplete facts, vague and conflicting witness statements, and unsupported speculation.

During the hearing, OPS pointed out that it was impossible for three of the qualified individuals to observe and direct the non-qualified individuals during the cold-cutting process because the former were situated near the maintenance shop cutting a new section of pipe from a 25-30 foot long pipe section. The available diagrams and photographs demonstrate that the maintenance shop is not located in close proximity to the manifold pit area and it was not possible to visually observe from the maintenance shop what was going on inside the pit area, which was congested with above-ground pipelines. In addition, the fourth qualified individual, the project leader, was not always present at the manifold pit work area. He was at different locations around the site during the performance of the cold-cutting work where direct observation and direction of the

[22] Respondent also contended in its Closing that it had conducted a formal investigation of the root causes of the accident and had provided PHMSA with a copy of its July 6, 2009 Investigation Report, but acknowledged that it did not "explicitly address" the effectiveness of emergency response. Closing at 10.

non-qualified individuals was not possible.[23] While Respondent is correct that not all witness statements were entirely consistent, the preponderance of the evidence shows that the unqualified employees performing the covered task of cold-cutting the pipe during the period approximately from 11:00 a.m. to 1:00 p.m. on June 17, 2009, were not being observed and directed at all times by qualified employee.

Accordingly, after considering all of the evidence and the legal issues presented, I find that Respondent violated 49 C.F.R. § 195.505(c) by allowing individuals that were not qualified under its OQ program to perform covered tasks without being directed and observed by an individual that was qualified.

These findings of violation will be considered prior offenses in any subsequent enforcement action taken against Respondent.

ASSESSMENT OF PENALTY

Under 49 U.S.C. § 60122, Respondent is subject to an administrative civil penalty not to exceed $100,000 per violation for each day of the violation, up to a maximum of $1,000,000 for any related series of violations.[24] In determining the amount of a civil penalty under 49 U.S.C. § 60122 and 49 C.F.R. § 190.225, I must consider the following criteria: the nature, circumstances, and gravity of the violation, including adverse impact on the environment; the degree of Respondent's culpability; the history of Respondent's prior offenses; the Respondent's ability to pay the penalty and any effect that the penalty may have on its ability to continue doing business; and the good faith of Respondent in attempting to comply with the pipeline safety regulations. In addition, I may consider the economic benefit gained from the violation without any reduction because of subsequent damages, and such other matters as justice may require. The Notice proposed a total civil penalty of $415,000 for the violations cited above. As noted in the preceding Findings of Violation section, I found that Respondent committed all of the violations alleged in Items 1 through 7.

Item 1: The Notice proposed a civil penalty of $10,000 for Respondent's violation of 49 C.F.R. § 195.52(a)(2) by failing to give telephonic notice to the National Response Center at the earliest practicable moment after an unintentional petroleum fire occurred at the Colorado City Station on June 17, 2009.

Accident reporting is a longstanding regulatory requirement and is a key part of pipeline safety. The absence of reporting is serious because it can adversely impact the oversight process. Making a telephonic report is not a costly or burdensome requirement and Respondent is fully

[23] The project leader stated, "During this process, I went over the pipe yard to check on the work of (BJB welder), vacuum truck, and the 4" drain valve. All workers on this project have skills and experience to qualify to do this project..."

[24] Effective January 3, 2012, the maximum administrative civil penalties for violations of the federal pipeline safety regulations were doubled to $200,000 per violation with a maximum of $2,000,000 for a related series of violations (The Pipeline Safety, Regulatory Certainty, and Job Creation Act of 2011 (Pub. L. 112-90)). Because the violations in this case occurred prior to the increase, the higher maximums do not apply.

culpable for its failure to provide telephonic notice since there was no impediment to doing so. Respondent's argument that reporting was not required was not persuasive. Respondent has presented no information or arguments that warrant a reduction in the penalty amount proposed in the Notice. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of $10,000 for violation of 49 C.F.R. § 195.52(a)(2).

Item 2: The Notice proposed a civil penalty of $10,000 for Respondent's violation of 49 C.F.R. § 195.50(a), for failing to timely file a written report after an unintentional fire occurred at the Colorado City Station on June 17, 2009.

As stated above in Item 1, accident reporting is a critical requirement of the pipeline regulatory program. Respondent has presented no information or arguments that warrant a reduction in the penalty amount proposed in the Notice. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of $10,000 for violation of 49 C.F.R. § 195.50(a).

Item 3: The Notice proposed a civil penalty of $200,000 for Respondent's violation of 49 C.F.R. § 195.402(c)(3), for failing to follow all applicable procedures for operating, maintaining, and repairing its pipeline system in conducting the Line 10 Project at the Colorado City Station. The Line 10 Project involved pipe replacement, a significant repair that exposed numerous workers to potential risks. The failure to follow all applicable procedures had serious consequences in this case and resulted in a major accident and spill. The failure to fully accomplish Lockout/Tagout allowed crude oil to flow into Line No. 10, which was open for the corrosion repair project, and was a major cause of the 3,416 barrel oil spill. Poor communications and a lack of detailed work plans contributed to the accident. Hazard assessments, safety briefings, and emergency assignments were not executed properly. The failure to properly execute the project was not attributable to the actions of low-level personnel but involved failures by company supervisors to ensure safety. Respondent is fully culpable for the failure to ensure proper procedures were followed.

Respondent has presented no information or arguments that warrant a reduction in the penalty amount proposed in the Notice. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of $200,000 for violation of 49 C.F.R. § 195.402(c)(3).

Item 4: The Notice proposed a civil penalty of $22,500 for Respondent's violation of 49 C.F.R. § 195.402(c)(13), for failing to follow its own procedures for conducting annual field audits of Lockout/Tagout work done by operator personnel at the Colorado City Station for 2008 and 2009.

The 3,416 barrel oil spill was a direct consequence of the failure to fully accomplish Lockout/Tagout. If Respondent had performed the annual field audits of Lockout/Tagout work in 2008 and 2009—the time period leading up to the accident—the deficiencies that manifested themselves on June 17, 2009 may have potentially been identified and corrected. Respondent presented no justification for its failure to conduct these field audits.

Respondent has presented no other information or arguments that warrant a reduction in the penalty amount proposed in the Notice. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of $22,500 for violation of 49 C.F.R. § 195.402(c)(13).

Item 5: The Notice proposed a civil penalty of $37,500 for Respondent's violation of 49 C.F.R. § 195.402(e), for failing to follow procedures for having emergency response personnel, equipment, instruments, tools, and material available as needed at the scene when approximately 3,416 barrels of sour crude oil were released at the Colorado City Station on June 17, 2009.

Respondent's failure to ensure that all personnel in the vicinity of toxic hydrogen sulfide vapors were equipped with appropriate PPE, including respirators, is a particularly serious offense. While it is fortunate that no serious injuries occurred, the company's own procedures were clear that PPE was required and Respondent is fully culpable for putting these personnel at risk.

Respondent has presented no information or arguments that warrant a reduction in the penalty amount proposed in the Notice. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of $37,500 for violation of 49 C.F.R. § 195.402(e).

Item 6: The Notice proposed a civil penalty of $35,000 for Respondent's violation of 49 C.F.R. § 195.402(e)(9), for failing to follow its own procedures for conducting a documented post-accident review of employee activities that occurred in response to the June 17, 2009 accident.

The performance of a documented post-accident review of response activities is a key part of ensuring that lessons learned from accidents are actually incorporated into the emergency response procedures for a pipeline facility. This accident, in particular, offers many lessons for how emergency response should and should not proceed. Prompt and properly documented debriefing is a key part of ensuring that lessons learned lead to improved safety in the future. Respondent is culpable for failing to conduct this review promptly and revise its emergency response procedures and response training program as needed.

Respondent has presented no information or arguments that warrant a reduction in the penalty amount proposed in the Notice. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of $35,000 for violation of 49 C.F.R. § 195.402(e)(9).

Item 7: The Notice proposed a civil penalty of $100,000 for Respondent's violation of 49 C.F.R. § 195.505(c), for allowing individuals who were not qualified under its OQ Program to perform covered tasks without being directed and observed by an individual that was qualified.

Pipeline tasks covered by an OQ program that are performed by unqualified individuals create serious risks if not performed under the direct supervision of a qualified individual, particularly for a significant repair project involving pipe replacement. Pipelines transport hazardous substances under pressure and even small errors can cause future failures and spills. In this case,

having qualified individuals present elsewhere at the station did not equate to direct supervision. Respondent is culpable for failing to ensure its unqualified workers were directly supervised by qualified individuals at all times.

Respondent has presented no information or arguments that warrant a reduction in the penalty amount proposed in the Notice. Accordingly, having reviewed the record and considered the assessment criteria, I assess Respondent a civil penalty of $100,000 for violation of 49 C.F.R. § 195.505(c).

In summary, having reviewed the record and considered the assessment criteria for each of the Items cited above, I assess Respondent a total civil penalty of **$415,000**.

Payment of the civil penalty must be made within 20 days of service. Federal regulations (49 C.F.R. § 89.21(b)(3)) require such payment to be made by wire transfer through the Federal Reserve Communications System (Fedwire), to the account of the U.S. Treasury. Detailed instructions are contained in the enclosure. Questions concerning wire transfers should be directed to: Financial Operations Division (AMZ-341), Federal Aviation Administration, Mike Monroney Aeronautical Center, P.O. Box 269039, Oklahoma City, Oklahoma 73125. The Financial Operations Division telephone number is (405) 954-8893.

Failure to pay the $415,000 civil penalty will result in accrual of interest at the current annual rate in accordance with 31 U.S.C. § 3717, 31 C.F.R. § 901.9 and 49 C.F.R. § 89.23. Pursuant to those same authorities, a late penalty charge of six percent (6%) per annum will be charged if payment is not made within 110 days of service. Furthermore, failure to pay the civil penalty may result in referral of the matter to the Attorney General for appropriate action in a district court of the United States.

COMPLIANCE ORDER

The Notice proposed a Compliance Order with respect to Items 2, 3, 5, and 6 in the Notice for violations of 49 C.F.R. §§ 195.50(a), 195.402(c)(3), 195.402(e), and 195.402(e)(9), respectively.[25] Under 49 U.S.C. § 60118(a), each person who engages in the transportation of hazardous liquids or who owns or operates a pipeline facility is required to comply with the applicable safety standards established under chapter 601. Pursuant to the authority of 49 U.S.C. § 60118(b) and 49 C.F.R. § 190.217, Respondent is ordered to take the following actions to ensure compliance with the pipeline safety regulations applicable to its operations:

1. With respect to the violation of § 195.50(a) (**Item 2**), Respondent must submit an accident report on DOT form 7000-1 or facsimile for the June 17, 2009 accident at the Colorado City Station within 90 days of receipt of this Order.

2. With respect to the violation of § 195.402(c)(3) (**Item 3**), Respondent must incorporate the lessons learned from its investigation of the June 17, 2009

[25] In paragraph 3 on page 8 of the Notice, the Proposed Compliance Order item regarding Notice Item 5 was incorrectly labeled as Notice Item 4.

accident into its training program and provide this training to its employees within 90 days of receipt of this Order.

3. With respect to the violation of § 195.402(e) (**Item 5**), Respondent must ensure that deficiencies identified during its review of emergency preparedness measures in response to the accident are addressed in its emergency response training program and provide this training to its employees within 90 days of receipt of this Order.

4. With respect to the violation of § 195.402(e)(9) (**Item 6**), Respondent must document a post-accident review of employee activities that occurred in response to the accident and submit this report to the Director, Southwest Region, PHMSA, 8701 South Gessner, Suite 1110, Houston, TX 77074 within 90 days of receipt of this Order.

5. It is requested, but not required, that Respondent maintain documentation of the safety improvement costs associated with fulfilling this Compliance Order and submit the total to the Director. Costs should be reported in two categories: (1) total cost associated with preparation/revision of plans, procedures, studies, and analyses; and (2) total cost associated with replacements, additions, and other physical changes to pipeline facilities and infrastructure.

The Director may grant an extension of time to comply with any of the required items upon a written request timely submitted by the Respondent and demonstrating good cause for an extension.

Failure to comply with this Order may result in the administrative assessment of civil penalties not to exceed $100,000 for each violation for each day the violation continues or in referral to the Attorney General for appropriate relief in a district court of the United States.

Under 49 C.F.R. § 190.215, Respondent has a right to submit a petition for reconsideration of this Final Order. Should Respondent elect to do so, the petition must be sent to: Associate Administrator, Office of Pipeline Safety, PHMSA, 1200 New Jersey Avenue, SE, East Building, 2nd Floor, Washington, DC 20590, with a copy sent to the Office of Chief Counsel, PHMSA, at the same address. PHMSA will accept petitions received no later than 20 days after receipt of service of this Final Order by the Respondent, provided they contain a brief statement of the issue(s) and meet all other requirements of 49 C.F.R. § 190.215. The filing of a petition automatically stays the payment of any civil penalty assessed. Unless the Associate Administrator, upon request, grants a stay, all other terms and conditions of this Final Order are effective upon service in accordance with 49 C.F.R. § 190.5.

_____ _____

Jeffrey D. Wiese
Associate Administrator
for Pipeline Safety

Date Issued