U.S. DEPARTMENT OF TRANSPORTATION
PIPELINE AND HAZARDOUS MATERIALS
SAFETY ADMINISTRATION

+ + + + +

TECHNICAL PIPELINE SAFETY
STANDARDS COMMITTEE
(GAS POLICY ADVISORY COMMITTEE)
and

TECHNICAL HAZARDOUS LIQUID PIPELINE SAFETY
STANDARDS COMMITTEE
(LIQUID POLICY ADVISORY COMMITTEE)

+ + + + +

JOINT MEETING
+ + + + +
WEDNESDAY
JULY 12, 2012

+ + + + +

The Committees met in Ballroom D, Marriott Metro Center, 775 12th Street, N.W., Washington, D.C., at 9:00 a.m., THE Honorable Lula M. Ford, Chair, presiding.

PRESENT:

THE HONORABLE LULA M. FORD, Chair,
Illinois Commerce Commission

TECHNICAL PIPELINE SAFETY STANDARDS
COMMITTEE MEMBERS PRESENT:
DENISE M. BEACH, National Fire Protection
MICHAEL BELLMAN, City of Richmond
J. ANDREW DRAKE, Spectra Energy
RICHARD E. FEIGEL, Hartford Steam Boiler
SUSAN L. FLECK, National Grid
THE HONORABLE WAYNE E. GARDNER, Pennsylvania
Public Utilities Commission
RICHARD F. PEVARSKI, Virginia Utility
Protection Services, LLC
DONALD J. STURSMA, Iowa Utilities Board
RICHARD H. WORSINGER, City of Rocky Mount
JEFF C. WRIGHT, Federal Energy Regulatory
Commission
TECHNICAL HAZARDOUS LIQUID PIPELINE SAFETY
STANDARDS COMMITTEE MEMBERS PRESENT:
LANNY W. ARMSTRONG, City of Pasadena
LARRY J. DAVIED, Magellan Midstream
Partners L.P.
DENISE M. HAMSHER, Enbridge (USA) Pipeline
RICHARD B. KUPREWICZ, Accufacts,
Incorporated
CRAIG O. PIERSON, Marathon Pipe Line LLC
LARRY M. SHELTON, Sunoco Logistics
MASSOUD TAHAMTANI, Virginia State
Corporation Commission
CARL M. WEIMER, Pipeline Safety Trust

ALSO PRESENT:

JEFFREY WIESE, Associate Administrator for Pipeline Safety, Office of Pipeline Safety

LINDA DAUGHERTY, Deputy Associate Administrator for Policy and Programs, Office of Pipeline Safety

ALAN MAYBERRY, Deputy Associate Administrator for Field Operations, Office of Pipeline Safety

JOHN A. GALE, Director, Standards and Rulemaking, Office of Pipeline Safety

CHERYL WHETSEL, Technical Advisory Committee Manager, Office of Pipeline Safety

KRISTIN BALDWIN, Staff Attorney, Office of Chief Counsel

CAMERON SATTERTHWAITE, Pipeline and Hazardous Materials Safety Administration

STEPHEN KLEJST, National Transportation Safety Board

ROBERT J. HALL, National Transportation Safety Board

PETER LIDIAK, American Petroleum Institute

C-O-N-T-E-N-T-S

Page

P-R-O-C-E-E-D-I-N-G-S

(9:02 a.m.)

CALL TO ORDER/MEETING OBJECTIVES

MR. WIESE: I'm glad to see that a couple of people took my advice last night and went to Brasserie Beck on 9th. And we've been there before. It turns out that Belgian week -- I lied -- is actually next week. So for those locals who go back to Brasserie Beck next week, I'm sure you'll enjoy it.

Okay. Before we begin the session this morning, I wanted to make a couple of quick announcements, and then I'll turn to Commissioner Ford and we'll begin the meeting officially.

We did a little rearranging here. And hopefully -- I didn't get a chance to bounce it off of everybody. Hopefully it works for all of you.

As we were talking yesterday, there's -- you know, I think we've got a

good, sound framework to build on. And I do believe with IMP 2.0, my cute little way of thinking about where do we go next.

You know, there's a lot of work to do between now and next fall, when we hold that meeting. We're going to stage a series of events between now and then to try to build a consensus about where we need to go between those.

I think it's important for us to look at the landscape and what's before us in there. I think for the gas guys as well as the liquid and vice versa, we need to know what's on the landscape.

Clearly NTSB is -- we have invited them here to make a presentation this morning about the Marshall, Michigan failure that they reported on two days ago. And I think it's important for everyone to listen to that.

And with my apologies to them because we had also asked them to do the San

Bruno briefing. You know, I had asked them if we could -- we will bypass that because I think we know that one. And we've all gone through that. And we know what the issues are on the landscape we have to deal with there.

So in the spirit of making sure that we all know where we are going in about a year, we have asked the NTSB to come in. I'm going to follow that and do a joint session, follow that. Instead of doing Alan and Linda separate rooms, doing the same presentation on records, I thought we would do that here.

After we're done with those two things, we'll break up. Liquid group will stay here. Gas group will go over there, finish our agendas. And my apologies because we should have said we're going to try to adjourn around noon today. You know, it might be a little later than noon. I know that we had originally planned on a

full day's session, but I think we'll get through what we need to by noon and maybe get people out of here and back home. So I appreciate that.

Then the last thing is -- have we figured out the time? No. We'll report back to you. If you're sticking around for tomorrow, the meeting we're holding at DOT on consensus standards incorporated by reference, I'll get you a starting time.

I'll bet it's 9:00 o'clock because it's run by the attorneys and not the engineers. The engineers will want to start at 7:00 or 7:00, you know, and the attorneys aren't going to be in yet. So my guess, it will be 9:00 o'clock, but I'll get back to you on that, with apologies to my friends who are attorneys, at the DOT building, sadly.

There's a new edict, by the way -- I don't know if it affects the -- of course, you have a big room to meet in -- a

new edict in the federal government in the wake of GSA's debacle that anybody would have said was a debacle that everyone will meet in federal buildings whenever possible. So we fight desperately to keep these meetings out of federal buildings because it's so hard to get everybody in and out.

And I guess the other thing I should say is because things kind of backfired at the last minute, the hotel comped coffee for everyone out here. And so there is coffee. Please help yourself. They put us in the wrong room. We were supposed to be in a different setup.

I think those are really sort of the introductory remarks. So, with your permission, I will turn the meeting over to Chairman Commissioner Ford.

CHAIR FORD: Thank you. Good morning.

(Chorus of "Good morning")

CHAIR FORD: This is a joint

meeting of the Technical Hazardous Liquid Pipeline Safety Standards Committee and the Technical Pipeline Safety Standards Committee.

There are no published rules to consider to vote on at this meeting. The meeting is officially called to order. And before we begin the first agenda item, please turn off your cell phones. If you wish to speak, turn your card on its side. State your name before you speak for the record.

It's a pleasure for me to introduce Steve because Steve was at my MARC Conference in Des Moines, Iowa, as I mentioned earlier, along with Donald, who is an Iowan, and Phil Bennett and Tim Butters. So they did a fine job. And it was a very good conversation between all.

Steve?

MR. KLEJST: Good morning, everyone. This morning's presentation is

actually going to be done by Robert Hall. Robert is the Deputy Director of the Safety Board's Office of Railroad Pipeline and Hazard Materials Investigations.

I think it was said earlier there were to be two presentations: one on the San Bruno accident and our findings and one on our most recently completed Enbridge accident in Marshall, Michigan. And Rob played a very strong role in that investigation. And he will be doing the presentation today. So I will turn it over to Rob. Thank you.

AGENDA ITEM 1:

BRIEFING: NTSB UPDATE FROM ENBRIDGE AND SAN BRUNO ACCIDENTS

MR. HALL: As I was saying, I did bring some copies, but I was expecting to be presenting to only one group. So I don't have quite enough copies.

I have given electronic copies to PHMSA. So they will be distributing

electronic copies, but there are 14 copies here of each, the slides that I am about to use as well as a synopsis of the accident information that we published on the website yesterday, which includes the findings, probably cause, and recommendations. So I'll get those started around.

I'm going to provide an overview of the July 25th, 2010 Enbridge line 6B pipeline rupture and crude oil release that occurred in Marshall, Michigan and resulted in large environmental impacts along Talmadge Creek and the Kalamazoo River. The accident occurred just about two years ago.

The Enbridge system originates in Canada, in Edmonton, Alberta, and flows down into North Dakota through Minnesota, Wisconsin, splits in Wisconsin, one going through the upper peninsula into Michigan and then the other going down through Illinois.

The line of interest is line 6B,

which is shown in orange here, which is part of the old Lakehead system. It's where the accident occurred. And the control center is in Edmonton.

Line 6B begins in Griffith and runs to Sarnia in Canada. And the Marshall pump station, which was the closest pump station to the rupture, is about in the center of the line. The line itself, 30-inch diameter, almost 300 miles long, was constructed in 1969, double-submerged arc-welded pipe with polyethylene tape wrap-coated coating.

When we look at the events that were leading up to the rupture, the line 6B was going into a planned shutdown. And they were at the time injected at the Griffith terminal, delivering to the Stockbridge terminal, and they were going to shut the pipeline down for ten hours. They began by shutting off pumps at Griffith and La Porte. They then used a pressure control valve at

the Stockbridge terminal to increase the line back pressure from 50 psi at Stockbridge up to 200 psi at Stockbridge.

A few seconds after this increase, they shut down the stations at Niles and Mendon. And then as the pressure wave from the increase of the valve closing went back to Marshall, we had a rupture just outside the Marshall station.

The rupture occurred at 486 psi, which was well below the MOP for the line but above the pressure that it had just been operating at prior to the shutdown.

The ruptured section, located in a wetland about a half mile from the Marshall pump station, the section had been hydrostatically tested in 1969. And, as I mentioned, it was wrapped with a polyethylene tape coating, a field-applied tape coating, at the time of construction.

This is a picture of the rupture. It's about 81 inches long, 5 inches wide at

the largest point. You can also see the tape coating there at the rupture location.

The longitudinal weld seam was at approximately the 3:00 o'clock position in the ground. And the rupture was occurring just below that.

When we look at the events that kind of led up to this rupture because it was a series of events throughout the accident following the rupture to discovery, it was 17 hours and 19 minutes from the time of rupture to the time that oil was discovered on the ground. And oil was discovered on the ground by a gas utility worker, who then phoned it in to Enbridge.

The rupture occurred at 5:58 p.m. during this planned shutdown. During the shutdown, they got multiple pressure-related alarms. Pressure at the Marshall pump station went to zero. But they also got an MBS alarm, which is their mass balance system, severe leak detection alarm.

Those alarms cleared because of the shutdown. It was unusual to get a mass balance alarm in this location. They misinterpreted its column separation, but because of the shutdown, things just kind of got lost as they were moving on with activities and they did not investigate the alarm. They call it column separation, and they moved on.

They made a turnover to shift B. Now, while shift B was on duty, the first 911 calls were received about three and a half hours after the rupture. There were multiple 911 calls that were made about odor in the Marshall area about the smell of crude oil. Some people reported it as a natural gas smell, but there were multiple calls that came into the 911 center.

Firefighters were dispatched to investigate the cause of the calls. They never found anything. And, in fact, as multiple calls came into the 911 center,

they basically told people, "Well, the fire department is already on it." The 911 center didn't pass on the information to the fire department that these calls were continuing.

On shift B, they tried to start the line. After the ten hours, the planned shutdown, they tried to start the line. They got mass balance system alarm. They kept pumping or an hour. About 439,000 gallons were pumped. And they could not get pressure up in the line to get the line started. They finally shut down.

On that same shift, later on, they started again. This time they pumped for half an hour, put in an additional 244,000 gallons of oil. And again they could not get pressure to get the line started to get the pump started.

They had multiple leak alarms, volume differences, and low pressure. They all attributed it to column separation.

They also ignored restrictions and procedures that would have prevented the prolonged release.

After the '91 incident, they put in place a 10-minute restriction on pumping if you have an unknown cause for mass balance alarm.

They violated that ten-minute restriction. And that ten-minute restriction was put in place for this very reason, and they violated it.

Then we go to shift C. Shift C did contact the regional manager to have line 6B inspected. Line 6B was not inspected. In fact, the manager was "Well, we haven't had any outside calls. You know, let's go forward with it."

They gave approval to start a third time. And then at 11:17 a.m., before they started that third time, outside notification came to the control center. And at that point, they immediately shut the

remote control valves.

One of the interesting things about these three shifts, the 17 hours, one of the things we noted in our investigation was shift turnover was poor, but the three shifts were all making the same error, the same misdiagnosis. They weren't passing that down from shift to shift. They were making the same misdiagnosis.

This is an aerial photograph of the rupture area. In the center of the screen, you can see where they were excavating the pipe for the rupture. Here in the lower left, you can see a large pool of oil. And the arrow shows where Talmadge Creek is.

And this is a little bit further out showing the area and how the oil flowed to Talmadge Creek.

One of the things that we looked at in the investigation was the oil spill response. And this was particularly

troubling. They have a large quantity of oil here near the rupture location. When they went there on the initial response, they went miles downstream in Talmadge Creek, "Let's find a shot where there's no sheen, no oil, and let's set up up there." And they threw out a couple of booms.

They had an opportunity here to contain the oil near the source location, source control using well-known techniques in the literature, and it wasn't done. And they used ineffective techniques downstream, which compounded this problem, which is why we ended up with 38 miles of waterfront that was contaminated.

So that initial response was inadequate. We have environmental impacts to the water sediments and shorelines of the Kalamazoo River and Talmadge Creek.

Over the days that this spill occurred, the light factions evaporated out of the crude oil. The crude oil eventually

sank down into the sediment, where it was originally on the surface.

To date -- or, actually, this is from October, 767 million in cleanup costs. We just found out last week there's another 42 million that had been incurred. These costs will continue to incur because the cleanup is ongoing. The cleanup of this spill is five times or more than five times the next most costly on-shore spill in the PHMSA records.

There was a voluntary evacuation of 50 houses. And the Michigan Department of Community Health did a study after the fact and found 320 reports from individuals and 145 patient records of symptoms consistent with exposure to crude oil.

The safety issues that we identified in this investigation, integrity management, public awareness, emergency responses, and human factors, particularly in the control room, same safety issues that

we looked at in San Bruno, but when you start looking at these two accidents, there is a great deal in common.

We have an Integrity Management Program that failed to find a known defect. We had a Public Awareness Program. And when we talk public awareness here, we're looking specifically at those first responders that didn't understand that the pipeline was there.

The 911 center didn't understand that the pipeline was there; again, kind of a failed Public Awareness Program with the local officials. The emergency response, although somewhat different than the emergency response with PG&E, again, we had massive failures in the emergency response here in the oil spill response.

And then we had control room issues in how we dealt with those control room issues. The control room issues here were a little more severe than PG&E, but,

again, these same themes run through both investigations.

The PHMSA issues that we identified, what we consider weak integrity management regulations, particularly in the area of how you deal with cracks and what are the requirements for dealing with cracks. And there is a recommendation, very lengthy recommendation, with five parts specific to cracks and also the interaction of cracks and corrosion.

This failure occurred in an area where you had corrosion of pipe and you had cracks. Each defect on its own was not that severe, but when you combined the two, it was very severe.

When you looked at the Enbridge organization, they had an integrity management group that looked at corrosion. They had an integrity management group that looked at cracks. And they didn't talk to each other. And here you had both of them

occurring at the same place. So the regulations we felt were weak there and exploited by Enbridge.

The facility response plan regulations, we did a detailed comparison with those of EPA and Coast Guard and found that the PHMSA regulations in Part 194 are not to the same level as those of the EPA and Coast Guard. And we made a recommendation there about harmonizing with those other regulatory agencies.

We also took issue with the approval of the facility response plans. PHMSA does approve the facility response plans. The response plan was sent in and approved within two weeks, could only have received a cursory review. There were some major issues with the response plan.

The two identified contractors because in a response plan, you have to have preapproved, identified contractors for your spill response, the closest one was ten

hours away in another state. The second one listed was in Houston from Michigan. You know, that doesn't quite make sense, and that kind of stood out at us.

Recommendations. We issued a number of recommendations, two to the Secretary of Transportation. The two to the Secretary of Transportation, we are asking them to audit the facility response plan program, make sure that it's meeting the requirements of OPA 90; and a second one to look at the resources of PHMSA and make sure that response plan activities are properly resourced.

We had eight recommendations to PHMSA. As I mentioned, we had one on the crack, how you deal with cracks; another one on the 180-day notification requirements that we want pipeline companies to notify PHMSA; if they're missing the 180-day, and when they're going to have it done so that we get that requirement.

There are a couple dealing with the control room aspects. We have asked to extend OQ qualification to all the decision-makers. We had a number of decision-makers in the control room that were not OQ-qualified. We have asked for training in the control room dealing similar to what has been done in aviation in marine.

The crew resource management, which is really geared towards one aspect, is that dissenting opinions get heard. There were several dissenting opinions in Enbridge control room and in the Enbridge operations that were mystified as to why they were trying to start again with the conditions that they had. And they expressed that, but they weren't heard. That was expressed but not heard.

And then we have a couple centered around the facility response plans to PHMSA, so in those three areas, the integrity management, the control center,

and the facility response plans.

We made similar recommendations to Enbridge. API, there is a recommendation to API to develop standard for safety management system specific to pipeline companies.

We are looking very hard as the NTSB most wanted list for this year is safety management systems. We think that the pipeline industry could really benefit from a comprehensive safety management system.

Integrity management is a piece of that, but there is a lot more to safety management than integrity management. And so we are asking for a comprehensive standard to be developed.

We have also asked that API develop that standard following an ANSI process. We want to see a broad cross-section of stakeholders participating in that standard process, so not just the

pipeline companies but other stakeholders ought to be participating in that ANSI standard process.

We made a recommendation to PRCI to look at what might be the best practices for how to handle interactive threats of corrosion and cracking, to do some research there and develop some standards in that regard; and then a recommendation to the International Association of Fire Chiefs and the National Emergency Number Association, the 911 association.

This kind of parallels what we did in San Bruno. In San Bruno, we issued a recommendation to PHMSA about making sure the emergency responders have specific information about the pipelines. Now we have issued to the receiving organizations that they need to diligently and aggressively seek that information out from the pipelines. They have a responsibility, too, to get that information. And we need

to solve that problem as to the emergency responders being well-informed of the pipelines in their community.

That's what I have for my presentation. I'm here to answer questions as well as Steve Klejst.

COMMITTEE DISCUSSION AND Q&A: AGENDA ITEM 1

CHAIR FORD: Mr. Gardner?

MEMBER GARDNER: I'm a little bit perplexed. You started off your presentation pretty much laying out the scenario under which the accident occurred, but, nevertheless, at the end of the presentation, there is no further expansion on the effect of the shutdown and the pressures on I'll say the weakened pipe that was due to corrosion and a weakened well.

Could you expand on that a little bit for me, the operation of the shutdown, the rapid pressurization of the pipe? Was that a contributing factor or have you reached a conclusion that had nothing to do

with it?

MR. HALL: The shutdown was conducted in an orderly fashion, as you would expect the shutdown to be conducted. The pipe failed well below the MAOP. It should have been able to withstand what was a very moderate pressure increase coming from that backpressure regulator at the Stockbridge delivery.

So the operational aspects of the shutdown were normal. And the system should have contained that.

The accident really started in 1969 with the polyethylene tape coating. And that's really the beginning of the accident and laid in place that first latent failure that was ultimately seen.

The crack that ultimately failed was detected in 2005, mischaracterized. And the effects of corrosion were not considered coincident with the crack. We also had issues with the crack growth rate that was

used, that this crack grew by a corrosion fatigue mechanism, rather than a stress corrosion cracking mechanism, and grew much faster than what Enbridge assumed for their reinspection interval.

They were at the same time that they were conducting this shutdown also running an inspection tool through the line. They were conducting the next inspection when this occurred.

CHAIR FORD: Any other questions? Andy?

MEMBER DRAKE: Sorry. My name tag I think is in the other room.

(Laughter)

MEMBER DRAKE: It's Andy Drake with Spectra. Does this line have a history of cracking that they had identified over time and that they -- I mean, it was a risk known to them.

MR. HALL: The line did have a history of cracking. It was a known risk.

The Enbridge considered essentially the polyethylene tape coating for the 300 miles as failed.

I believe there were some -- and the numbers are in the report. I'm just trying to go from memory. I think there were some 15,000 crack or crack field defects identified in the end line inspection run and some 900 digs that were performed on line 6B. So it was a line that had some serious integrity challenges.

MEMBER DRAKE: Thank you.

MEMBER WORSINGER: Rich Worsinger from the Gas Committee. Basic question. Could you explain what column separation is for us not in the liquids side?

MR. HALL: Column separation is a condition that occurs when you drop the pressure low enough in the line that you actually vaporize some of the liquid. So you form a two-phase flow. And then in the liquid side, they refer to that as column

separation.

It typically occurs in areas where you have large elevation changes. The Marshall area really did not have any elevation changes, which was kind of one of the misnomers is that they are attributing this to column separation. Yet, there is no elevation change. There was something definitely amiss there.

Column separation also occurs when you have a leak because the pressure drops. And so there was truly column separation, but that was a result of the leak that wasn't the cause, the initial cause, of the alarm.

MEMBER KUPREWICZ: Rick Kuprewicz, Liquids. Another way to look at it, a more simplistic way maybe, is column separation in my vernacular in regulations is the line is not liquid full. That adds all kinds of complications to monitor detection, much less leak detection.

CHAIR FORD: Any other questions for Robert? Jeff?

MR. WIESE: I don't have questions so much as just -- forgive me -- just a little bit of commentary.

First of all, I want to thank you for both Steve and Rob. You have been very good to work with. You know, I appreciate the fact that we have a good working relationship. It makes things go a lot easier.

I think they have been very open to talking to us about what is going on in the agency in rulemaking. And I have been here long enough to remember when that wasn't true. So I don't want to go back there.

I appreciate very much. And I know you guys worked really hard on this. So I want to thank you for that. I particularly appreciate your coming over here.

I would quickly add because it's my job our people spent well over a man-year of effort assisting the NTSB. So we work together on these things. I think it's important for you to know that. Maybe not everyone in the Committee knows that. So I think we work well together in that regard as well.

Just a few comments on this one in general. I would say, you know, the issues that have been brought up, the reason we wanted to do this in joint session I think is obviously to all of you.

As we were thinking about 2.0, what are the things we need to be working on? How do we weave these things together better? And we have been talking about this. We have been holding workshops, whether it is on leak detection or valves.

The R&D forum, which is the 18th and 19th, next week -- it's quickly. There are too many things coming. But, you know,

there is a focus on cracks there. And I would say that people have been focused on cracks.

Stress corrosion cracking is a relatively recent phenomenon on the liquid side. You know, I think the gas side has known and been working on SCC for a long time. You know, it's not to say that cracking wasn't known, but I just wanted you to know.

I mean, there is a focus on cracking. It will continue. The tools are not perfect, you know, far from it. But that takes me to the next part, which is I think what you guys are touching on, that last summer we held a workshop on interacting threats. You know, how do we do better risk assessment?

You know, clearly -- and, by the way, for what it's worth, in my view Enbridge was looking. You know, I've seen other companies -- we won't use names, but

we had a lot of visibility -- that weren't even looking. So there's a difference in my mind between clueless and at least looking.

So this issue of interacting threat is something that we really have to get after better. And it's not just Enbridge. It's not just this other company. I see it time and time again where there's a failure, we talk to the operator, who was picking their pipeline, didn't see it. They saw one thing that they didn't think was actionable. So they move on. You know, but if they had taken a more holistic look at that, I think that they would have had an opportunity to prevent. So I don't say it to beat on people. I just think that that's an opportunity for us to improve.

On the oil spill and facility response plan, we'll have a more detailed presentation for the Liquid Committee in a little while. Alan Mayberry is going to do that.

There are some limitations on both our authority. And, you know, it's when you have come to really look at the statute, you wonder how Congress writes the things they do. You know, if an operator can check off about six or seven boxes, we must approve that plan.

So I think we just got our enforcement authority back. I think, as we talk to the NTSB, they see this as an opportunity for us to revisit our authorities in that area and perhaps do a better job with that.

Emergency response plan, control room, public awareness, these are all issues we're actively engaged in and working on. And I would just say control room rules were just beginning to take effect, you know, at the time of this accident. So a lot of progress has been made. And Enbridge really had addressed many of the things that we had found and alleged in our notice of proposed

violation.

You know, we asked Lanny and Jerry Rosendahl on purpose to be on the Committee so we can find better, smarter ways of working with the emergency response community. I am very appreciative of your service in that regard.

And we're actively working in that area. So I think there's a bright side to this. In any accident, you need to look for the silver lining. That's the opportunity to do better individually as well as a regulator and as the industry.

I'll close my rhetorical comments on two points. One is SMS. And, you know, I think integrity management is found in SMS principles. I do believe there are some gaps in it and particularly on the liquid side. We fixed a few of those as we learned from liquid and then into gas that as we come back in 2.0, that's what we need to do is fix that.

So I think the focus that you have given on that will be appropriate. It will feed progress in that regard.

My last thing -- and I say that with our friends the commissioners here, particularly for the gas side, you know, the relationship to the rate structure is not well-known, certainly not by the public.

I know that there are competing schools of thought about who should pay, ratepayer versus shareholder. And I am sure there is not one right answer there. There is a balance in there somewhere.

But I am appreciative of the commissioners' involvement. And NARUC has really taken a very active interest in that. So I am hopeful that the focus, that it's not a unidimensional look. You know, it's not just about how hard can we push the safety agenda, but it's also how do we incentivize a reinvestment in the infrastructure so we have a robust, reliable

energy delivery system in the country.

So those are all critical components. And I think my summary is what I started with yesterday when I said to you, "We have work to do."

It's important work, you know, but I'm sure that we -- I think we have shown that we have made great progress over the past ten years. And I'm sure that we'll do it again, you know, as we go forward.

So sorry for all the rhetoric, but, you know, I just thought it was important to get it before the full Committee. So thanks.

CHAIR FORD: Rick, did you have your hand up?

MEMBER KUPREWICZ: Well, I just want to comment from a public perspective. I know more about this system. There's a report to the NEB in Canada on stress corrosion cracking issues and all of that. And that's a public document.

Let's be careful here. It's easy to just think this is an Enbridge problem. And this is not an Enbridge problem. This could have happened to anybody in this room that operates a liquid line within reason.

So there are some important issues here that the NTSB has identified. And I support those wholeheartedly.

Thank you.

CHAIR FORD: Gene and then Denise?

MEMBER FEIGEL: There's always a fair amount of technical parochialism when we're looking at this sort of stuff. The downstream folks have done a lot of work on failure mechanism interactions that I think, rather than going off and inventing the same wheel again, it would pay this industry probably to get a little tighter with those folks than they historically probably have been.

MEMBER HAMSHER: I kind of debate

not saying anything, but I do want -- I think Enbridge CEO and others have expressed appreciation. I know that it has been hard work for PHMSA and both the NTSB. And we do appreciate it.

I hope you also realize we have been as open as we possibly can since day one in helping to get to the bottom of this because nobody more than Enbridge wanted to learn from here.

And it didn't take the NTSB report for us to have our own learnings. We have put many changes in place already.

And we do appreciate now this moment because now we're in a position to where we can share with industry some of the lessons learned. And I think that is the theme of what you are talking about.

So we are looking forward to being able to talk very frankly now about some things that went wrong, some things that we think would have been doing to

prevent both systematic-wise and then getting to the heart of some of the things.

I also should note for some of you that may not know that we had actually proposed replacing significant sections of this line prior to the incident. We had to redo those plans given the lengthy state PUC regulatory process. However, since that time, we configured that and are in the process of replacing that entire line in phases. Seventy-five miles of it is driven as a true integrity replacement. And that should be done, permits pending, by next year.

CHAIR FORD: Wayne?

MEMBER GARDNER: I guess without -- I have a question. And I hope I am not going to create an hysteria. And that is, how much of this legacy polyethylene-wrapped pipe is out there? Is anybody aware? No?

MEMBER KUPREWICZ: Yes. The other side is many in the industry know this

and it's not something to panic about. It's something to manage. That would be my perspective. We don't go out there and start ripping everything out just because of the coating. Otherwise you're tearing on hundreds of thousands of miles of pipeline. You need to manage it.

There are a couple of hundred thousand miles of liquid pipeline transition pipeline in the United States, give or take. A lot of it has coating issues that place it in that risk evaluation. A properly applied integrity management program would address that.

MEMBER HAMSHER: Denise Hamsher with Enbridge. Somebody may be able to weigh in. And I don't know that PHMSA nor the industry actually has a survey of the mileage. But in general, just for the public's benefit, there were many years of pipe that were put in place in the '50s that use a different type of coating that has

held up to the test of time. Coal tars is one.

And, secondly, since I think the '80s or so, there has been another type of coating called fusion bond coating. And that has continued to improve.

So this type of coating was used predominantly in the industry but for a short era period of time.

CHAIR FORD: Lanny and then --

MEMBER ARMSTRONG: Lanny Armstrong, Public Liquids. Just from an emergency response perspective, looking at this report and reading it -- I actually got the report this morning. It was perfect timing. And this is primarily for the operators.

I noticed in the report the recommendations of the International Association of Fire Chiefs and several other of the emergency response or emergency phone number group.

There's probably not a handful of fire departments in the country that could have bone very much with that, even if they were well-trained. And so our reliance in our area because we have such an industrial center, we expect the spiller to respond. And we expect them to respond with an environmental company, with well-trained people, containment capability, and our primary mission really is, number one, protect the public; number two, protect the environment as best we can.

But all of these fire departments, no matter how big they are, are very limited resource-wise with spill control. I can tell you that right up front. Resources are limited. There's just not a lot we can do with it if it's a volume spill. So that's something I think we need to engage the operators with.

Gathering information and knowing where the pipelines are, it's all important,

but once it's out of its container, we're got some real struggles.

And a lot of these places, especially in rural areas, have very limited capability anyway. So I think it's incumbent upon us to be ale to bridge that gap.

CHAIR FORD: Steve?

MR. KLEJST: Yes. Just in closing, I just wanted to thank Jeff and the PHMSA team for the invitation to participate and present today. One of the important missions that we have is to get our message out with our findings and recommendations. And a forum like this with the key decision-makers that are here today is certainly a vendue that we want to take advantage of.

And I would also like to thank PHMSA and Enbridge for the cooperation and participation that they provided during our investigation.

Just a brief overview. The Safety Board is the lead in conducting these investigations. However, we utilize what is called the party system. Those interested individuals, groups participate in the fact-finding, development of the factual information, in which PHMSA played a key role as well as Enbridge and some other key players in the system that we, the pipeline system that we, investigated this particular accident.

It is a group effort in the development of information, in which case the Safety Board then takes that information, analyzes it to produce our findings, recommendations, and probably cause.

So it is a group effort. And we do rely heavily on that in the event -- and we certainly don't want to think that we'll see any of you in a forum other than this, but it is done collectively at the initial

stages. And we do value the input from all parties, whether it be from the operator, the emergency response community, and any relative vendors.

One of our board members often says that out of tragedy comes good. And, again, this is another good example where we have a message, we have developed a probable cause in findings.

We rely on you, the industry leaders, the stakeholders in the pipeline system -- and I use "system" in the very broadest sense -- of all of those individuals that comprise the delivery of a product that is valuable to our nation to make sure that it is done with the proper risk control to provide what our citizens need in order to function in our economy.

Thank you, Jeff, for the opportunity to present today.

CHAIR FORD: Jeff?

MR. WIESE: Well, thank you,

Steve, appreciate it very much and appreciate you guys coming in.

The one thing that I'll say that I've really appreciated in the past year or two from the Board members, in particular, they focus on organizational failure, you know, in moving beyond the culture of blame to figuring out what is going wrong.

You know, Chris Hart's vice chair has a phrase that he uses. Maybe he picked it up from Steve. You know, let's assume we have good people trying to do the right thing working hard and we let them down. How did we do that? And then we have an opportunity to fix what's wrong and go forward and make it better for everyone else.

So I appreciate very much that focus that the Board has been bringing. You know, tragedy, these are clearly tragic events. Clearly the public is impacted. Every single person in here is committed to

trying to stop that.

And I guess I'll close by saying also in response to Lanny's comments, having been involved in public awareness with Denise, in particular, since -- God knows when we started that? -- a long time ago, it is tough to get the attention of the emergency responders sometimes because they're fighting all different kinds of problems on a daily basis. And across America, it's rare that it's pipeline.

Now, Lanny was in Pipeline Central. So he knows what to do. But a lot of these other people don't. So I think we're all committed trying to make sure emergency responders have what they need in order to do their job.

Thank you.

MEMBER HAMSHER: Just one more comment. Denise Hamsher.

Lanny, you talked about the kind of emergency response and deployment of

boom. And maybe the NTSB could speak to this. But I think the issue and expectation isn't that you start doing the containment. I think as a responsible party, the recommendations are there about how to improve it.

I think the issues really are awareness. And there was a lot of assumption that was with the natural gas leak, and our control room wasn't called to it.

It's identification of all the facilities and all the potential sources so that everybody could have been called right at the beginning. You might want to speak to that.

MR. HALL: Yes. The issues around the public awareness and the emergency response is really the fire department being informed, the 911 center being informed.

You know, the 911 centers have

geographic information systems that tell them where the calls are coming from. If there had been a pipeline map up on the wall, they would have seen that the calls are around the pipeline, but there was no map. There was no pipeline information in the 911 center.

We made recommendations in San Bruno again to PHMSA through the Public Awareness Program to the pipeline companies. In this accident, we made a recommendation to the fire chiefs and the 911 centers.

But there is another aspect of this. And when you start looking at how public awareness is done, you know, the pipeline companies hold these meetings for the firefighters. And they send out these notices, "Come to our meetings."

Yet, the same liquid companies -- and Enbridge told us they make it a point to talk to every landowner every year. They go to the landowners and talk to the

landowners. Why don't they go to the fire departments, instead of sending a notice saying, "Come to our meeting"? It's just a thought. You might get more information, more exchange.

CHAIR FORD: Craig?

MEMBER PIERSON: Craig Pierson, Liquids. I'm sure this question confronts NTSB on a lot of other investigations. Have you given thought to be able to push out these learnings more quickly with preliminary reports?

I know from an industry perspective, I've watched Enbridge really want to help get the information out, but I don't know that they have had that latitude.

I'm sure you're confronted with that problem on all kinds of other investigations.

MR. KLEJST: I do appreciate the industry's thirst for information. What we attempt to do is to make available our

factual reports on the public docket so that people could see this information.

And I'll just use the San Bruno case, where I was invited and was able to speak to some of the findings, not conclusions but findings, factual findings, from the initial stages of the San Bruno investigation. And people knowledgeable in the operations and the issues associated with the pipeline operations can enjoy a very reasonable conclusion as to what they need to do as far as directing assets and activities.

We attempt to bring to closure accidents as quickly as possible, but we do need to make sure that there is a thorough and rigorous examination of the data. So the timeline sometimes is a year. San Bruno has done it under a year.

The conflict with this particular accident, quite honestly, was the resource allocation. It took place in July. We

started to do our typical initial fact-finding work. San Bruno took place, not that we want to diminish the impact of this particular accident, but when we start to take a look and to account the fatalities in the San Bruno accident, that had to allocate resources, brought that accident to closure and quickly then realigned the resources to do the accident then.

This one essentially, although the timeline doesn't reflect that it was concluded in less a year if you take a look at actual person-hours in completing this investigation, but we do make available when completed and vetted by the party members the factual reports, but the conclusions, findings that would be part of the report, that does a bit greater length of time.

But, again, we do appreciate the invitations that we received to speak at professional conferences, again, to the key decision-makers that need to get this

information that could actually implement change. That's the mechanism that we operate under.

Thank you for the question.

CHAIR FORD: Thank you. Thank you, Steve. I know you have to leave. So we will close this section. And Jeff will introduce our next agenda item.

MR. WIESE: Okay.

CHAIR FORD: Thank you, Steve.

MR. WIESE: Thanks, Rob. Thanks, Steve. Okay. See you.

CHAIR FORD: Thank you.

MR. WIESE: Okay. So before we give you a break and we let you go to your separate rooms at that time and have a separate session, we had planned to conduct the same briefing in two rooms. I thought maybe it made sense to do it together.

The issues are fairly common across the industry. We're talking about the records issue in our advisory recently.

I think there is a lot of commonality. So, with your indulgence, this is probably about a 20-or-so-minute presentation. If you absolutely have to take a break, I would just take it. But we'll try to move through this quickly. And then we'll take a formal break and go in there.

So I'll really quickly introduce if you -- I'm sure by now most of you know Linda Daugherty. Linda is my Deputy for Policy and Programs. She is going to be assisted by Alan Mayberry, who, as you may know, has been my Deputy for Field Operations.

So, with that?

MS. DAUGHERTY: Good morning, everybody.

(Chorus of "Good morning")

AGENDA ITEM 3: BRIEFING - MAOP VERIFICATION "KEEPING GOOD RECORDS" AND CHANGES TO GAS TRANSMISSION ANNUAL REPORT

MS. DAUGHERTY: I get to stand up here with a mike. Alan gets to sit there. So direct all your questions to the guy that's sitting at the table.

MR. WIESE: Actually, you can sit here.

MS. DAUGHERTY: No. That's all right, Jeff.

So going really quick, we wanted to talk about a recent advisory bulletin that we had sent out. And we have had a lot of questions.

The advisory bulletin was issued to both gas and liquid operators. And it raised a lot of questions because it was prompted by some things that came out of San Bruno.

So I am going to back up a little bit, give you a little history. And Alan and I are going to play tag team here. So if something isn't clear, stop us, but we'll try to move pretty quick.

Back in January of 2011, we issued an advisory bulletin basically telling operators that "You must have good, sound records to support any MAOP or MOP calculation.

In other words, you've got base your operational decisions on good information. That came out of San Bruno.

Then in May of this year, we provided further clarification of -- and I use certain terms. We'll get into that a little bit more. Many of you know what I'm talking about here. But we'll talk about it in more detail.

We also want to talk about anticipated changes to the gas transmission annual report and then give folks an idea of what was coming in that information collection. Okay? So we have two advisory bulletins related to records and MAOP/MOP determination. Okay?

Why do we do this? Do you want

to talk a little bit about the background?

MR. MAYBERRY: Well, certainly -- this is Alan Mayberry, by the way -- you know, post-San Bruno, one of the issues there was we didn't know what we didn't know. I mean, we've heard that quite a bit. And it involved grandfather clause pipe. Pipefit was in operation at the time regulations were implemented. And they were not subject to a hydrostatic test necessarily.

And then later, you know, I guess post-San Bruno with the reauthorization of the Pipeline Safety Act earlier this year, we have a requirement to direct gas operators, in particular, to provide verification of records, then for us later to draw up regulations for how to deal with the grandfather clause because we weren't specifically directed to remove the grandfather clause.

Next. If you look at some of the

issues we have seen -- I'm speaking in terms of overseeing the five region offices and obviously what came out of San Bruno as well. But we have seen issues of unknown pipe specifications. It's probably a common one.

We're dealing with a couple of cases now with some actually liquid operators that -- you know, they know they have A.O. Smith pipe, but they just don't have that record that says, you know, that it's kind of been handed down, known but really unknown information. That kind of speaks to San Bruno where, you know, we thought, "Gosh, there's 30-inch seamless pipe," which really doesn't exist, but it's transferred from another document. So it's incorrect information. We thought we knew what it was, but it really wasn't that.

You know, there are cases where, say, you deal with replacement project and maybe file drawers that have project files

that haven't been married up with your master records per recordkeeping, housekeeping.

And then just the acquisition process, this one is probably very common, where you have acquisitions and records being lost in acquisition process or other mishaps, fire, flood, whatever the case. And we have had not many but we have had enforcement actions related to records.

Anyway, moving on, you know, I guess -- and, Linda, feel free to chime in, but, you know, what are we after? A lot of the questions we get are, well, what about this, what about that? We have to really focus on, what are we after?

In San Bruno, we really didn't know what we didn't know. There was an issue of having an invalid record that we had a transposing error that occurred at some point in time. We didn't know what we didn't know.

Operators to have an effective integrity management program need to know their system. They need to know what it's made of to understand how to deal with the various risks that are in the system.

And for suspect pipe, pipe that doesn't meet any standard, you know, we have had a couple of cases in the last several years from Rancho Cordova in -- I think I pronounced that right, where you had an issue with plastic pipe that didn't meet any standard, to San Bruno, where you essentially had a segment of pipe that ultimately failed that didn't meet a standard.

So that's what we're after, is really dealing with these, understanding the system, knowing the system, and addressing any shortcomings and information with appropriate mitigative measures such as assessments, inspections, testing perhaps, and that sort of thing.

MS. DAUGHERTY: One thing that we wanted to emphasize is that, although we have some specific examples from gas pipeline issues, San Bruno in particular, these are common processes that must be applied to every pipeline operator.

It's just as important for liquid pipeline operators to know their systems as it is for gas pipelines. So when we issued the advisory, we intentionally issued it to everyone. Okay? Whether you are an APGA company or whether you are a cross-country big diameter liquid line or whether you are a gas transmission operator, you must know your system.

We had a lot of questions that came back. One of them was, does this really apply to liquid operators? Does it? What is it?

Does it create new requirements? No. An advisory bulletin does not create new requirements. All it does is reiterate

the requirements that are already in the regulations or it provides operators guidance as far as the regulators' intent and what we believe is appropriate.

So this advisory bulletin -- I'm emphasizing it for a reason -- did not create any new requirements on any pipeline operator, but it did say you should know what your system is about.

It also clarified some terms that were first mentioned by the NTSB that we also picked up in our initial advisory bulletin. Remember, I said we issued two advisory bulletins. In the first advisory bulletin, we referenced the terms "traceable," "verifiable," and "complete." And everybody came back and said, what exactly do you mean by that?

So we provided some definitions. And I'm not going to read this to you, but basically it says a traceable record is something that you can put right back to the

piece of pipe. You know it's linked to that pipe and it's good information. It's confirmed. It's definite. Okay?

Pipe mill records. You can't get more specific than that. It's linked to a segment of pipe.

One of the issues that came out that Alan mentioned was transcribed records. A lot of operators would take original documents and transcribe them into a new document. And that might be acceptable except you have to be alert there could be transcription errors, as in the case of San Bruno. There is a potential that maybe they had a college intern typing up stuff and they typed in the wrong information. We don't know. But that can happen. And if you make an operational decision based on that information, you can have a problem.

The next one had to do with verifiable. Now, this one because of our wording, we unintentionally created a lot of

problem for a lot of folks. In the language, we said, "verifiable records." We said, "All records must meet all three of these criteria." But we said "Verifiable records must be confirmed by other complementary but separate documentation."

What we were trying to get at is if I have a document here that has half the information and I have another separate documentation, separate, totally separate document, that has that other half of the information that's needed, you can put them together as long as you have something that positively links them.

We are not requiring people to have two records if you do have one perfect record. Does that make sense? So if you have one perfect record that has all the information, can be linked back to the pipe, we are not asking you to go find a separate document to verify it.

And the complete records are

those which have a signature, have a date. By the way, I think we have handouts. That's actually the advisory bulletin. We'll hand those out.

We wanted to make sure that -- there are times you'll find a record that has some information, but you're not really sure when it was done. You're not really sure. The absolute pressures, for example, I think we used an example there was a pressure test.

Pressure tests, you test the pipe just so high it fails, but it never shows that the pipe was retested and passed at a better pressure. That is not a complete record. You've got to have something that describes the final information.

I like this. This was Alan's. He said, you know, whatever records you use, you need to be able to stand up and say it's a good record, you know.

I will tell you that one thing I

didn't mention on the slides, if we do not consider it acceptable for an operator to say, you know, Jim Bob tested that pipe 40 years ago. And I went to see him in the nursing home. And he signed an affidavit saying they pressure-tested it to 600 pounds. That's not acceptable. You can't rely on someone's memory from four years ago. It has to be something that's good and solid.

Alan, do you want to take that or do you want me to go on?

MR. MAYBERRY: Well, I think you had referred to the revised gas transmission annual report that we will use and kind of listed here as what the act required us to do. But we're going to basically take the information from the annual report that comes in next year.

And that will inform where we go later based on the information we see on how operators determine verification of MAOP.

Again, this is for the gas side. And, again, that will determine where we will go.

And just a word on where we will go. And I can't really speak for, you know, the deliberative process in developing rulemaking, but, you know, my thoughts on that are kind of sort of a bucket of risk, if you will, on high risk to low risk and measures that are taken to address each risk.

You know, from the top end of the scale, perhaps the grandfather clause, high stress San Bruno kind of pipeline to the lower risk, perhaps it's had a test but not the test, the subpart J-style test. And that might be considered, say, a lower risk, but just kind of think the general thinking, if you will.

MS. DAUGHERTY: And I do want to highlight something that Alan mentioned. In the act that was passed in January, Congress required PHMSA to direct operators to submit

information confirming that their gas transmission lines had adequate records.

We are actually planning to use information in the gas transmission, proposed gas transmission, annual report to collect that information. And that's a separate document that's going through. Is everyone confused?

COMMITTEE DISCUSSION AND Q&A: AGENDA ITEM 3

MR. MAYBERRY: I am sure there are a lot of questions, yes.

CHAIR FORD: Carl?

MEMBER WEIMER: I'm always confused. So that's normal.

Just a point of clarification because I think I am a little confused about when Congress passes something, when that goes into effect.

In talking about MAOP, I know there is stuff about the grandfather clause and records that you're working on defining when that goes into effect, but there was

also a section of that that says if a pipeline company has an overpressurization event, they need to report it to PHMSA. Is that already in effect or do you have to go through some kind of an implementation for that? I saw it on the to do list yesterday.

MS. DAUGHERTY: It is on the to do list. That specific provision we went back and reviewed with our counsel. And it is a self-executing requirement, which means that -- and, just for the public, in the act, there are two types of requirements. One says the Secretary of Transportation shall direct operators to do A, B, C.

Then there's also a second type, which says operators must. What you're talking about, the notification of overpressure events, was a self-executing. It was an operator's must. So right now there is a requirement in effect that operators must report any time where they exceed the operating pressure. I don't have

the specific data.

Now, I will say this. PHMSA does not yet -- we're working on it quickly -- have a method of receiving all of those. We are taking them in as we get them when an operator notifies us. Many are using existing processes, like safety-related condition-reporting processes. Some of our states have received notifications. And they are passing them along.

So we are trying to get a formal process in place to handle those and to provide guidance to the operators on how best to notify us.

MEMBER WEIMER: So those types of things go into effect as soon as the President signs the document?

MS. DAUGHERTY: Yes.

MEMBER WEIMER: Thank you.

CHAIR FORD: Donald?

MEMBER STURSMA: I thought I heard recently that PHMSA was creating

another web-based report for these events and when it goes into effect, you would want operators to report using that system, all events or all since the first of the year?

MS. DAUGHERTY: Yes.

MEMBER STURSMA: Okay.

MS. DAUGHERTY: But we don't have that developed yet. And we are working with the states trying to come up with something that will make sense.

CHAIR FORD: Any other questions? Rick?

MEMBER KUPREWICZ: Rick Kuprewicz. As I understand it, for the gas guys, it's MAOP plus the accumulation of the safety. Right? Okay.

MS. DAUGHERTY: Yes.

MEMBER KUPREWICZ: So those events are occurring. And they're probably more than everybody would want to think about on gas systems, not a surprise.

MS. DAUGHERTY: So noted.

CHAIR FORD: Jeff?

MEMBER WRIGHT: Jeff Wright of FERC. I noticed an interesting it's an advisory bulletin emphasizing what's already in effect. Yet, you define three times. How does that work procedurally?

MS. DAUGHERTY: It is guidance as far as intent. It is not enforceable unless we were to incorporate it into our regulations. The terms were initially used by NTSB. They said that the records must meet these criteria. And we realized real quickly we had to tell people what we believe that criterion is.

CHAIR FORD: Jeff?

MR. WIESE: There was a related discussion we were going to have on fitness for service that I think is part and parcel of this broader discussion about ensuring that the pipe in this country is fit for service.

We really don't have the time I

think today because of the agendas we need to achieve, but I'd like to in our next session. We can think about doing this a number of ways. We can do a remote session if you really want to do it sooner, but we can certainly park it for the next session when we get together and have a detailed discussion because I think even the industry itself, I think when you see the things that they are doing, they're saying basically in a lot of cases, you are running out of options. You know, you are down to running the pressure tests. You know, if you can't meet these conditions, you have got to go there.

So I know that that will spool some people up, but I think there's a good discussion to be had in fitness for service, happy to have it with you either next time or we can conduct a remote teleconference if you think it's more urgent.

CHAIR FORD: Rick?

MEMBER KUPREWICZ: You've touched on a very sensitive issue. And I'm not here as judge or jury, but sometime today could someone please tell me where within either gas or liquid federal pipeline known safety regulations, it permits the use of fitness for service or engineering conditional assessments? Because my take of this -- and I could be wrong -- my take is it is not defined in federal regulation.

MS. DAUGHERTY: May I answer that? You are correct. It is not currently defined in the pipeline safety regulations. That is something we need to look at in the future.

MR. WIESE: But I would quickly add that that broader concept for fitness for service is well-known in many other industries.

You are absolutely right. It has to be defined through regulation, but I think that is where we are headed, whether

we call it fitness for service or something else. You know, we have to have more clarity around this and less latitude, but we also understand. And that's why we're having these discussions and why we're gathering information.

As Debbie Hersman herself said, this is a heavy lift. You know, they are fortunate, the NTSB and the Congress. They are fortunate. They don't have to run through the regulatory gauntlet that we have to run through. Even if we are 100 percent behind what they're recommending, we still have to run through that gauntlet. And sometimes, you know, even internal processes within the federal government stop you from moving things you cannot prove the cost beneficial nature of. And that's difficult.

But, at any rate --

MEMBER KUPREWICZ: I don't want to sound critical. I want to support your efforts here because anything that gets

things clear is going to help all parties, including the public, understand. I think that we are very supportive of that effort. So continue with it.

MEMBER GARDNER: I think that this is a very critical topic. And I would prefer that we be more deliberate in the approach and would suggest that we defer it to a face-to-face across-the-table discussion than a teleconference, where it's always a challenge somewhat to get your input thoroughly heard.

So if we want to do something in the fall, I would suggest that we go that route.

MR. WIESE: Yes. I think we're shooting for a fall meeting because we've got to figure out how to do this. We should team up with Carl's meeting in some way. Then we have got to be in New Orleans, instead of being in Washington.

(Laughter)

MR. WIESE: But we'll get back to you. But we do anticipate a fall meeting. You know, as I say to the members, you know, we respect your time and your contributions.

I try to bring you together when we actually have work that you have to do, which is voting on some rules. There are a million reasons to bring this together because we would like to, but I try to respect your time and only bring you together when we have work we have to do.

But we'll shoot for something in the fall. And we'll start working with everyone. So thank you, Wayne.

CHAIR FORD: If there are no other questions, we may go to break and then adjourn. Fifteen minutes.

(Whereupon, the foregoing matter went off the record at 10:16 a.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Joint Meeting - TPSSC and THLPSSC

Before: Hon. Lula M. Ford

Date: 07-12-12

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter