U.S. Department
of Transportation

Pipeline and Hazardous Materials
Safety Administration

1200 New Jersey Ave., SE
Washington, DC 20590

JUL 29 2011

Mr. Mike Joynor
Senior Vice President, Operations
Alyeska Pipeline Service Company
900 East Benson Boulevard
P.O. Box 19660
Anchorage, Alaska 99519-6660

Re: CPF No. 5-2010-5001

Dear Mr. Joynor:

Enclosed please find the Final Order issued in the above-referenced case. It withdraws the allegation of violation and the proposed civil penalty of $41,300. Therefore, this enforcement action is now 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,

for Jeffrey D. Wiese
Associate Administrator
for Pipeline Safety

Enclosure

cc: Mr. Alan Mayberry, Deputy Associate Administrator for Field Operations, Pipeline Safety
Mr. Chris Hoidal, Director, Western Region, PHMSA
Mr. Dennis Hinnah, Deputy Director, Western Region, PHMSA
Ms. Sheila Doody Bishop, Esq., Counsel for Alyeska Pipeline Service Company

CERTIFIED MAIL - RETURN RECEIPT REQUESTED [7005 1160 0001 0075 9282]

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

In the Matter of	)	
Alyeska Pipeline Service Company,	)	**CPF No. 5-2010-5001**
Respondent.	)	

FINAL ORDER

On January 15, 2009, Alyeska Pipeline Service Company (Alyeska or Respondent), the operator of the Trans Alaska Pipeline System (TAPS), an 800-mile-long hazardous liquid pipeline system, experienced a tank overpressure and vapor-relief event at Pump Station #1 (PS-1), the central collection point for crude oil being transported by TAPS from the North Slope of Alaska (Incident). PS-1 received an influx of natural gas from one of BP Exploration Alaska, Inc.'s (BPXA) oil transit lines (OTLs) as a result of pigging operations. [1] This event caused the relief vents on Alyeska's Breakout Tanks TK-110 and TK-111 to open and release flammable vapors.[2]

On March 13, 2009, pursuant to 49 U.S.C. § 60117, a representative of the Pipeline and Hazardous Materials Safety Administration (PHMSA), Office of Pipeline Safety (OPS), conducted an investigation of the Incident. As a result of the investigation, the Director, Western Region, OPS (Director), issued to Respondent, by letter dated February 2, 2010, a Notice of Probable Violation and Proposed Civil Penalty (Notice). In accordance with 49 C.F.R. § 190.207, the Notice proposed finding that Alyeska had violated § 195.402, and proposed assessing a civil penalty of $41,300 for the alleged violation.

Alyeska responded to the Notice by letter dated March 10, 2010 (Response). Alyeska contested the allegation of violation and requested a hearing, which was subsequently held on September 23, 2010, in Anchorage, Alaska, with an attorney from the Office of Chief Counsel, PHMSA, presiding. At the hearing, Respondent was represented by counsel. After the hearing, Respondent provided a post-hearing statement for the record, by letter dated October 25, 2010 (Closing).

[1] TAPS transports crude oil from production facilities at Prudhoe Bay to a marine terminal in Valdez, Alaska. http://www.alyeska-pipe.com (last accessed on December 28, 2010).

[2] BPXA was using a cleaning pig to displace crude oil from one of the transit lines. Field residue gas was used to push the pig. When the pig stalled, gas flow bypassed the pig, ultimately entered PS-1, and flared from the relief vents on TK-110 and TK-111. *See* Alyeska TAPS Pump Station # 1 Sadlerochit Stream Gas Excursion Incident Investigation Report (February 23, 2009), at 1.

WITHDRAWAL OF ITEM

Item 1: The Notice alleged that Respondent violated 49 C.F.R. § 195.402, 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....
>
> (d) *Abnormal operation.* The manual required by paragraph (a) of this section must include procedures for the following to provide safety when operating design limits have been exceeded:
>
> (1) Responding to, investigation, and correcting the cause of:
>
> (i) Unintended closure of valves or shutdowns;
>
> (ii) Increase or decrease in pressure or flow rate outside normal operating limits;
>
> (iii) Loss of communications;
>
> (iv) Operation of any safety device
>
> (v) Any other malfunction of a component, deviation from normal operation, or personnel error which could cause a hazard to persons or property.

In the Notice and at the hearing, OPS alleged that Alyeska failed to follow its own manual of written procedures for abnormal operations by neglecting to verify or confirm system integrity prior to restarting the pipeline.[3] Specifically, OPS alleged that the January 15, 2009 event involved an abnormal condition created by an influx of natural gas into TAPS from BPXA's pigging operations, causing the relief vents at Alyeska's breakout tanks at Pump Station #1 to open and release natural gas.[4]

In support of this contention, OPS cited Alyeska's procedures, which listed an abnormal operating condition as an "[u]nintended shutdown of the pipeline for reasons other than maintenance and protection of equipment" and "component malfunction, deviation from normal operation, or personnel error which adversely affects systems or equipment subject to DOT jurisdiction."[5] Since the overpressure and vapor release event was certainly a deviation from normal operations and prompted an unintended shutdown, OPS alleged that Alyeska should have followed its procedures for handling abnormal conditions, which required personnel to "verify system integrity and dispatch linewide reconnaissance as appropriate" and "restore normal operations once system integrity is confirmed."[6]

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[3] Notice, at 2.

[4] *Id.*

[5] Alyeska Pipeline Service Company, *OM-1, Section 3*, paragraph 3.1.1.

[6] *Id.*, at 3.1.3.

OPS asserted that Respondent should have conducted a visual inspection of the tanks prior to restarting the system. According to OPS, Alyeska restarted the pumps within 18 minutes of the time the venting ceased, but without properly verifying or confirming system integrity. OPS questioned whether Alyeska could have truly verified system integrity per its abnormal operating procedures in such a short period of time. In support of the Notice, OPS relied on the following evidence: (1) PHMSA's Pipeline Failure Investigation Report, dated November 12, 2009; (2) three photographs of tank venting and pressure relief devices; (3) a copy of Alyeska's Procedural Manual for Operations, Maintenance and Emergencies (OM-1); (4) the External Tank Inspection Report, dated January 18, 2009; (5) the Event Notification, dated January 15, 2009; and (6) the Alyeska TAPS Pump Station # 1 Sadlerochit Stream Gas Excursion Incident Investigation Report, dated February 23, 2009.

In its Response dated March 10, 2010, Alyeska disputed that the Incident was an abnormal operating condition, arguing that "all automated systems and operations and protocols at TAPS Pump Station # 1 worked per design to shutdown the pump station and protect personnel and equipment."[7] However, at the hearing, Alyeska modified its response by acknowledging that the Incident was indeed an abnormal operating condition but maintained that the company had not violated its abnormal operating procedures. On the contrary, Alyeska contended that its Operations Control Center followed *OM-1, Section 3.1*, by adequately verifying system integrity in coordination with personnel at PS-1 prior to restart.[8]

At the hearing, the presiding official asked Respondent what actions it specifically took immediately after discovering the overpressure and vapor event. Alyeska stated that its Operations Control Center verified that the control systems were fully operational, while PS-1 personnel observed the condition of the tanks prior to restarting the system.[9] Respondent stated that its personnel confirmed that there was no obvious damage to the tanks, that the flow meters were functioning normally, that the control system was fully operational, and that it verified the status of station equipment through the station control panel. There were no injuries or equipment damage. In addition, Alyeska conducted an API 653 tank inspection two days after the Incident. Alyeska found these actions to be appropriate under its OM-1 procedure to verify system integrity.

At the hearing, OPS focused on whether there was any evidence in the case file showing that Alyeska had performed a visual inspection to confirm system integrity. In response, Alyeska maintained that Mr. Timothy Rupp, the lead technician at PS-1 on the day of the Incident, completed the visual inspection before restarting the system. Although Mr. Rupp was listed as a participant in the investigation in the company's investigation report,[10] Alyeska did not present Mr. Rupp as a witness at the hearing but, at the presiding official's request, submitted an affidavit of his statement shortly after the hearing.[11] In that affidavit, dated October 19, 2010,

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[7] Response, at 2.

[8] Alyeska Hearing Presentation, at 7.

[9] Closing, at 2.

[10] *See* Alyeska TAPS Pump Station # 1 Sadlerochit Stream Gas Excursion Incident Investigation Report (February 23, 2009), at 5.

[11] *See* Closing, Affidavit of Timothy Rupp, dated October 19, 2010.

Mr. Rupp stated that upon discovery of the unplanned event, he immediately contacted BPXA and requested closure of the 12-inch valve to block the flow from the OTLs into the tanks.[12] Mr. Rupp also stated that he had observed the condition of the tanks and did not see any physical damage from the overpressure and vapor release event.[13] He admitted that he viewed the tanks in the twilight on the North Slope, but "despite the low ambient light, [he used] the reflection of the flare on the snow [which] made it easy to see the tanks."[14] Finally, Mr. Rupp stated that when the venting had ceased (approximately 11 minutes after the initial event), he returned to the office to discuss start-up with the company's Operations Control Center.[15]

Finally, Alyeska stated at the hearing that the allegations in the Notice were primarily based on Alyeska's own report, rather than any independent investigation conducted by PHMSA. Alyeska argued that OPS used conclusions in the Alyeska investigation report that had been made for the purpose of self-improvement to support its Notice.

Post-Hearing Request for Production of Records

On September 28, 2010, after the hearing, OPS submitted a Request for Production of Records (Request) seeking additional information from Alyeska. Specifically, OPS sought any records that included Mr. Rupp's statements, if any, or actions he took on the day of the Incident. On October 18, 2010, Alyeska submitted its objection to the Request, stating that 1) the agency did not have regulatory authority for post-hearing discovery; 2) OPS had a copy of the Alyeska investigation report since its March 2009 investigation and yet had failed to seek additional information in the time that transpired between the OPS investigation and the hearing; 3) Alyeska had agreed to provide an affidavit of Mr. Rupp's statement in its Closing, per the presiding official's request; and 4) since Mr. Rupp was part of the investigation team, any statements he may have made were incorporated into the Alyeska investigation report. The presiding official responded on November 9, 2010, denying the Request. Specifically, the presiding official stated that OPS had had ample opportunity to seek additional evidence prior to the hearing and that Alyeska had submitted an affidavit from Mr. Rupp on October 25, 2010, as part of its Closing, and gave OPS an opportunity to file a reply to any additional information presented.[16]

Shortly thereafter, OPS filed a Post-Hearing Submittal, dated November 18, 2010, stating that further prosecution of the matter was inappropriate and that the Notice should be withdrawn.[17] Although OPS indicated that it believed deficiencies still existed in Alyeska's procedures for handling abnormal operations, it concluded that these defects should not necessarily be resolved in this enforcement matter.[18]

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[12] *Id.* at 2.

[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] See Post-Hearing Scheduling Letter, dated October 8, 2010.

[17] OPS Post-Hearing Submittal, at 3.

[18] *Id.*

Conclusion

I have reviewed OPS' request to withdraw the Notice. I find it appropriate to grant this request and for those reasons, the allegation of violation and proposed civil penalty are withdrawn.

for Jeffrey D. Wiese
Associate Administrator
for Pipeline Safety

JUL 29 2011
Date Issued