U.S. Department
of Transportation

**Pipeline and
Hazardous Materials Safety
Administration**

8701 S. Gessner, Suite 630
Houston, TX 77074

NOTICE OF PROBABLE VIOLATION
PROPOSED CIVIL PENALTY
and
PROPOSED COMPLIANCE ORDER

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

July 7, 2016

Mr. Michael Hennigan
President and CEO
Sunoco Logistics Partners L.P.
3807 West Chester Pike
Newtown Square, PA 19073

CPF 4-2016-5022

Dear Mr. Hennigan:

On March 4, 2015, the Pipeline and Hazardous Materials Administration (PHMSA), Southwest Region Office of Pipeline Safety (SW Region, OPS) received an information request for an alleged event at a West Texas Gulf Pipeline Company, OPID #22442 facility, which is operated by Sunoco Pipeline L. P. (SPLP). The alleged accident was described as having occurred while SPLP and its contractors were performing pipeline modifications at the Wortham, TX facility (the Project) and having resulted in a release of crude oil, ignition of the crude oil and a serious injury requiring in-patient hospitalization, on or about February 19, 2013 (the Accident).

Based on the information request, PHMSA, SW Region initiated an investigation into the alleged accident.

As a result of the investigation and inspection, it appears that you have committed probable violations of the Pipeline Safety Regulations, Title 49, Code of Federal Regulations. The items inspected and the probable violations are:

1. §195.204 Inspection—general.

> **Inspection must be provided to ensure the installation of pipe or pipeline systems in accordance with the requirements of this subpart. No person may be used to perform inspections unless that person has been trained and is qualified in the phase of construction to be inspected.**

SPLP failed to provide inspection and use a qualified and trained inspector to oversee maintenance related activities that were performed in February 2013 at the Wortham Station, specifically as it pertained to the tie-in of the 50-foot section of pipe.

Neither SPLP, nor the inspector's employer could provide training records to demonstrate qualifications. SPLP delegated responsibilities to the inspector for the Project, for which SPLP did not confirm the inspector had adequate training or experience.

2. §195.402 Procedural manual for operations, maintenance, and emergencies.

> **(a) General. Each operator shall prepare and follow for each pipeline system a manual of written procedures for conducting normal operations and maintenance activities and handling abnormal operations and emergencies. This manual shall be reviewed at intervals not exceeding 15 months, but at least once each calendar year, and appropriate changes made as necessary to 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:**
> >
> > > **(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.**

SPLP did not perform, nor could it provide documentation to demonstrate that it had reviewed the maintenance and normal operations procedures for effectiveness that were in use on February 19, 2013. The operator's *Hot Work Procedure HS-P-009*, *Lockout-Tagout Program HS-P-005*, and *Overview of Work Permits Procedure HS-G-012* require annual evaluations at each facility to observe the activities involving the procedures to ensure the requirements of the procedures are correct and being followed, including an audit of the various types of permits in use at the facility. There were no records showing the applicable audits had been performed at the Wortham Facility for 2012, and 2013.

3. §195.402 Procedural manual for operations, maintenance, and emergencies.

(a) General. Each operator shall prepare and follow for each pipeline system a manual of written procedures for conducting normal operations and maintenance activities and handling abnormal operations and emergencies. This manual shall be reviewed at intervals not exceeding 15 months, but at least once each calendar year, and appropriate changes made as necessary to 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:

(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.

SPLP failed to perform a post-accident review of the employee activities to determine whether the procedures were effective in this emergency, and therefore took no corrective action for the accident that occurred on February 19, 2013, at the Wortham Station.

SPLP completed a Serious Incident Investigation Report, SII Report, indicating that a "Lessons Learned" document would be developed. SPLP stated that it had not been completed. SPLP indicated that a review was not completed and no revisions were made to the procedures related to its emergency response processes, as well as the work tasks being performed that had applicable post accident requirements including: the Operator Qualification Plan, procedures for contractor oversight and project management, or the safety aspects related to the work tasks being performed when the accident occurred.

This is a repeat violation of CPF 4-2010-5010, Item 6.

4. §195.402 Procedural manual for operations, maintenance, and emergencies.

(a) General. Each operator shall prepare and follow for each pipeline system a manual of written procedures for conducting normal operations and maintenance activities and handling abnormal operations and emergencies. This manual shall be reviewed at intervals not exceeding 15 months, but at least once each calendar year, and appropriate changes made as necessary to 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:

(5) Analyzing pipeline accidents to determine their causes.

SPLP failed to perform an analysis that determined the cause(s) of this accident in accordance with their Operating Procedure OPER-PR-002, *Spill Reporting, Root Cause Analysis and Documentation.* The SII Report for the accident that occurred on February 19, 2013 as provided to PHMSA was incomplete and inconclusive.

The SII Report was incomplete in that it did not properly consider or evaluate the adequacy of the Project Work Plan, identification of the relevant OQ Tasks, or the following SPLP Procedures; Training and Qualifications of all personnel (OQ Plan), Lockout/Tagout Procedures, Isolation of Energy Procedures, Preparation of Work Plans, Hot Work, Work Permits, Welding Procedures, Mud Plug Procedures, Accident Reporting, Post Accident Drug and Alcohol Testing, Construction Specifications, Construction Inspection Qualification and Training Requirements, Control Room Records and SCADA Logs, Spill Reporting, Root Cause Analysis and Documentation, Project Drawings and P&IDs. In addition, photographs from the scene were undocumented and provided conflicting and incomplete images of the accident and evidence. All of these documents were applicable and required by SPLP's Procedure OPER-PR-002 Section 4.2.

The Investigation Team was not comprised of a group of cross functional employees as required by SPLP's Procedure OPER-PR-002 paragraph 4.3.3. None of the members of the Investigation Team had Operations and Maintenance roles or experience that would have been necessary to evaluate the accident events and causes and perform the Root Cause Analysis. There was no facility knowledge represented by the team. Members of the Inspection Team had a role in the Accident, or the Project and may not have been objective in the performance of their duties. The recommended team members for the Investigation Team in the SPLP Procedure OPER-PR-002, Table 6 were not utilized, specifically the Control Center, Field Supervision and Field Staff.

5. §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:**
>
> > **(6) <u>Minimizing</u> the potential for hazards identified under paragraph (c)(4) of this section and <u>the possibility of recurrence of accidents analyzed under paragraph (c)(5) of this section.</u>**

SPLP failed to follow OPER-PR-002, *Spill Reporting, Root Cause Analysis and Documentation* to take prompt remedial action to minimize the possibility of recurrence of accidents. The procedure states section 2.6 that the objective of the Root Cause Analysis is *"to learn, communicate and prevent recurrence."* SPLP experienced a failure in 2009 and failed to take prompt remedial action to minimize the possibility of recurrence which resulted in an accident similar in nature in February 2013.

On June 17, 2009, SPLP experienced an accident on the West Texas Gulf Pipeline at its Colorado City, TX Station during maintenance projects that were being performed to make station piping modifications. SPLP performed an investigation of the 2009 accident and provided PHMSA a copy of its July 6, 2009 Investigation Report.

In both the 2009 and 2013 accidents, SPLP stated that the cause of the accident was "failure to follow procedures." PHMSA's investigation determined that there were inadequate procedures and work plans that contributed to the accident, as well as a lack of training and qualification of the employees performing the procedures. Failure to identify the root cause of the 2009 accident allowed the recurrence of the same type of accident in 2013.

6. **§195.505 Qualification program.**

> **Each operator shall have and follow a written qualification program. The program shall include provisions to:**
>
> > **(b) Ensure through evaluation that individuals performing covered tasks are qualified;**

SPLP failed to ensure that the individuals performing the covered tasks at the Project location were qualified by failing to verify operator qualification records for its welders and inspector and other contract personnel prior to performing covered tasks.

Specifically for the welders, one had no OQ qualifications, and the other welder involved in the welding at the time of the accident had previously been qualified, but all of his qualifications for covered tasks lapsed in January 2013. The contract inspector had no current OQ qualification documentation for any tasks.

7. **§195.505 Qualification program.**

> **Each operator shall have and follow a written qualification program. The program shall include provisions to:**
>
> > **(d) Evaluate an individual if the operator has reason to believe that the individual's performance of a covered task contributed to an accident as defined in Part 195;**

SPLP failed to evaluate the performance of any of the individuals performing covered tasks at the time of the Accident to determine if their performance of a covered task contributed to the accident on February 19, 2013. SPLP did not ensure that employees were evaluated prior to allowing them to resume the performance of covered tasks after the accident occurred on February 19, 2013. Personnel involved in the accident were used to complete the tie-in welds on February 20, 2013, even though the individuals' performance was believed to have contributed to the accident, or had not been ruled out by an investigation at that time.

8. §199.105 Drug tests required.

> **b) Post-accident testing. As soon as possible but no later than 32 hours after an accident, an operator shall drug test each employee whose performance either contributed to the accident or cannot be completely discounted as a contributing factor to the accident. An operator may decide not to test under this paragraph but such a decision must be based on the best information available immediately after the accident that the employee's performance could not have contributed to the accident or that, because of the time between that performance and the accident, it is not likely that a drug test would reveal whether the performance was affected by drug use.**

SPLP failed to ensure that its employees and contractor personnel were post-accident drug tested and could produce no records for testing of any personnel involved in the accident, nor did they provide justification that ruled out their contribution to the accident. The PHMSA Form 7000-1 submitted by SPLP stated that no employees or contractors were tested after the accident.

9. §199.225 Alcohol tests required.

> **Each operator shall conduct the following types of alcohol tests for the presence of alcohol:**
>
> **(a) Post-accident. (1) As soon as practicable following an accident, each operator shall test each surviving covered employee for alcohol if that employee's performance of a covered function either contributed to the accident or cannot be completely discounted as a contributing factor to the accident. The decision not to administer a test under this section shall be based on the operator's determination, using the best available information at the time of the determination, that the covered employee's performance could not have contributed to the accident.**

SPLP failed to ensure that its employees and contractor personnel were post-accident alcohol tested and could produce no records for testing of any personnel involved in the accident, nor did they provide justification that ruled out their contribution to the accident. The PHMSA Form 7000-1 submitted by SPLP stated that no employees or contractors were tested after the accident.

10. §195.402 Procedural manual for operations, maintenance, and emergencies.

(a) General. Each operator shall prepare and follow for each pipeline system a manual of written procedures for conducting normal operations and maintenance activities and handling abnormal operations and emergencies. This manual shall be reviewed at intervals not exceeding 15 months, but at least once each calendar year, and appropriate changes made as necessary to insure that the manual is effective. This manual shall be prepared before initial operations of a pipeline 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:

(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 operator failed to have a formal written procedure for installation and operation of vapor barriers, including mudpacks or bentonite mud plugs, or similarly constructed vapor barriers for the work that occurred inside the Wortham Station in February 2013. During the PHMSA accident investigation, SPLP submitted a *Fire Clay Mud Pack Recommended Practice* dated 5/30/08 (RP), but did not have a SPLP procedure for the installation and operation of bentonite (or equal) mud plugs such as the ones installed on this Project.

11. §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:

(3) Operating, maintaining, and repairing the pipeline system in accordance with each of the requirements of this subpart and subpart H of this part.

SPLP failed to follow seven items in its *Hot Work Procedure HS-P-009* during the work performed at the Wortham Station from the fall of 2012 through post accident March 2013 in the following manner:

a. SPLP did not ensure that Hot Work permits were issued for all time frames and applicable activities related to cutting, removing and replacing a 50-foot section of pipe between February 18 and February 20, 2013 at the SPLP operated Wortham facility as required by Section 3.0,

b. SPLP delegated the responsibility to issue Hot Work permits to the Contract Inspector who was not trained or qualified in evaluating the hazards, air monitoring, fire prevention and monitoring, or issuing Hot Work Permits in accordance with the SPLP Hot Work procedure,

c. Sunoco Logistics Management has failed to coordinate corrective measures with HES to address the deficiencies in the Work Permit system,

d. SPLP did not provide a copy of the HS-P-009 procedure to its contractor or contractor personnel or ensure they were familiar with or trained on the requirements of the procedure to enable them to adhere to the SPLP Hot Work Permit Procedures,

e. SPLP failed to ensure that continuous atmospheric monitoring, or monitoring frequently enough to detect hazardous vapors was occurring in the area where the Hot Work was being performed on the removal and replacement of the 50-foot section of pipe between February 18 and February 20, 2013 at the SPLP operated Wortham facility,

f. SPLP failed to ensure that a trained fire watch was assigned during all times that Hot Work was being performed on the removal and replacement of the 50-foot section of pipe between February 18 and February 20, 2013 at the SPLP operated Wortham facility,

g. SPLP failed to perform an adequate evaluation of the Hot Work/Work Permit procedures or observation of active tasks to identify that these failures of its processes were occurring.

SPLP failed to follow its Hot Work Procedures in multiple aspects, resulting in an unsafe condition and a serious injury to an individual performing Hot Work.

12. §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:

(3) Operating, maintaining, and repairing the pipeline system in accordance with each of the requirements of this subpart and subpart H of this part.

SPLP failed to follow nine aspects of its procedures for issuing Work Permits, addressed by Overview of Work Permits Procedures Document HS-G-012 in the following manner:

a. SPLP did not ensure Work Permits were issued for all time frames and applicable activities related to cutting, removing and replacing a 50-foot section of pipe between February 18 and February 20, 2013 at the SPLP operated Wortham facility as required by Section 3.0 General Requirements;

b. SPLP failed to designate a Qualified Person to issue and monitor the Work Permit as required by Section 5.0 Procedure/Process;

c. Sunoco Logistics Management has failed to coordinate corrective measures with HES to address the deficiencies in the Work Permit system identified after the 2010 accident,

d. SPLP did not provide a copy of the HS-G-012 procedure to its contractor or contractor personnel or ensure they were familiar with or trained on the requirements of the procedure to enable them to adhere to the SPLP Hot Work Permit Procedures;

e. SPLP did not ensure that the Work Permits described and authorized the specific work planned by employees or contractors. The description of the work, "Shut Down Work Continue – Cold Cut, Welding, Bolting Up" was so general in nature it did not allow a proper hazard evaluation or identify all of the tasks to be performed for the timeframe in which the accident occurred.

f. SPLP failed to ensure that the Work Permit addressed the LOTO Program HS-P-005, and did not provide a copy of the procedure to the personnel performing the work at the time of the accident,

g. SPLP failed to ensure that the Work Permit, as issued, correctly identified the hazards. The Work Permit 418311 issued on February 19, 2013, clearly indicated that the Equipment Status was "Drained, Depressured, Safe to Open, Contains Oil, LO/TO" by the checked boxes. There was no indication of the actual condition of the piping,

h. SPLP failed to perform an adequate evaluation of the Work Permit procedures or observation of active tasks to identify that these failures of its processes were occurring,

i. SPLP failed to maintain the Work Permit records in accordance with its procedure.

SPLP failed to follow its Overview of Work Permit Procedures in multiple aspects, resulting in an unsafe condition and a serious injury to an individual performing an associated task.

13. §195.402 Procedural manual for operations, maintenance, and emergencies.

(a) General. Each operator shall prepare and follow for each pipeline system a manual of written procedures for conducting normal operations and maintenance activities and handling abnormal operations and emergencies. This manual shall be reviewed at intervals not exceeding 15 months, but at least once each calendar year, and appropriate changes made as necessary to insure that the manual is effective. This manual shall be prepared before initial operations of a pipeline 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:

(3) Operating, maintaining, and repairing the pipeline system in accordance with each of the requirements of this subpart and subpart H of this part.

SPLP failed to follow twelve provisions of its Lockout/Tagout Program covered by Procedure HS-P-005 in the following manner:

a. Failing to perform an annual audit or compliance verification at Wortham after an accident that involved a failure of the LOTO Program occurred at the Wortham facility,

b. Failing to identify and control the energy source that resulted in serious injury to a welder during the project activities,

c. Failing to provide a copy of the HS-P-005 procedure to its contractor or contractor personnel or ensure they were familiar with or trained on the requirements of the procedure to enable them to adhere to the SPLP Lockout/Tagout Program Procedures;

d. The Energy Control Procedure (ECP) required by the LOTO Program failed to identify the specific steps for shutting down, isolating, blocking and securing the system(s) or the specific requirements for testing the system to assure that all energy sources had been completely controlled,

e. Failing to establish a clear understanding of the LOTO boundaries at the facility. Employees at the job site were unaware that the 24-inch SPLP pipeline was flowing into the 20-inch WTG pipeline to maintain flow to Longview and Mid-Valley Pipeline. The Work Plan and project description indicated that the entire facility was to be isolated, where in fact; the valves were locked open to ensure flow to Longview was maintained during the facility shutdown.

f. SPLP failed to ensure that the ECP matched the Work Plan, as detailed in the Stand Alone WP #SLCC-020913-WORT-PJR. The Work Plan stated that the work was planned during a system wide shutdown of the WTG System, yet the 20-inch WTG line continued to flow to Longview from the 24-inch SPLP pipeline supplying it through the Wortham Station, through valves designated to be closed and LOTO – specifically Closure of valve MOV 618, 616, and 619. Instead – these three valves were locked open to ensure flow to the 20-inch WTG line from the 24-inch WTG line, as further confirmed by the SCADA data for the shutdown timeframe, and the Operations Summary for 2-17-13 wherein it was indicated that the valves had to be locked open to allow flow because there would be no power at the station during the shutdown in an entry time of 0548. The Operations Summary for 2-17-2013 indicated the valves were locked open at 0557 on February 18, 2013.

g. Failing to enter the LOTO Form Number on the Work Permit in the blank space next to the LO/TO checkbox as required by the LOTO Procedure, for the Work Permit issued for 2-19-2013,

h. Failing to maintain the LOTO records in accordance with its procedure,

i. Failing to demonstrate verification of LOTO was performed over multiple shifts between 2-17-2013 and 2-22-2013 by failing to document the transfer of ownership, or complete the Verification of Equipment Isolation on the ECP.

j. In accordance with the LOTO procedure, the SPLP supervisor of the department overseeing the work (Engineering – Capital Projects) must ensure that the contractors understand and comply with the restrictions of the company's ECP. SPLP failed to ensure that this occurred,

k. Appendix HS-P-005-1 to the SPLP LOTO Program required the insertion of a blank or blind in the line if working on a pressurized system where valve leaks may re-pressurize the line. SPLP allowed the use of mud plugs for which it did not have a formal procedure, and was not consistent with

its LOTO Program. The General LOTO Guide stated that "If you are unsure of the hazard, or uncomfortable determining how to control the energy source(s) talk with your supervisor," which the Sprint Pipeline Services Foreman conveyed to the SPLP Construction Manager, as stated in the SPLP SII Report. No other actions were taken on the day of the accident to address these concerns,

l. Appendix HS-P-005-1 to the SPLP LOTO Program required SPLP to inform all "affected employees, and all other employees working in or entering the work area, that LOTO is to be performed. Instruct these employees that they must not attempt to start equipment that has been locked/tagged out, and that locks/tags must not be bypassed or removed," however there were multiple attempts to operate valves immediately prior to the accident as documented in the SCADA data for 2-19-2013. There was no indication that the Pipeline Control Center personnel had reviewed or signed off on the ECP, even though they were responsible for monitoring some of the valves in the ECP.

SPLP failed to follow its Lockout/Tagout Procedures in multiple aspects, resulting in an unsafe condition and a serious injury to an individual performing an associated task.

This is a repeat violation of Lockout/Tagout Procedures covered by CPF 4-2010-5010, Item 3.

14. §195.505 Qualification program.

Each operator shall have and follow a written qualification program.

SPLP failed to follow eight provisions of its written Operator Qualification Program in the following manner:

a. SPLP failed to ensure that its contractors were aware of what tasks are [Covered Tasks] CTs and that CTs may only be performed by persons qualified under [the SPLP] program,

b. SPLP failed to ensure that its Construction Project Manager was aware of the requirements for CTs on the Wortham Project,

c. Failing to provide a copy of the HS-P-005 procedure to its contractor or contractor personnel or ensure they were familiar with or trained on the requirements of the procedure to enable them to adhere to the SPLP Operator Qualification Program Procedures;

d. SPLP failed to ensure that records were kept for employees performing covered tasks on the Wortham project, specifically the welder that was injured, and the Contract Inspector,

e. SPLP failed to ensure that records were entered into ISNetworld by its contractors having employees performing covered tasks on the Wortham project, specifically for the welder that was injured, and the Contract Inspector,

f. SPLP failed to suspend qualifications of personnel involved in the accident, even though this was identified as an action in the Serious Incident Investigation to be completed.

g. SPLP failed to follow Section 16.0 of its OQ Program to evaluate individuals performing covered tasks and maintain compliance records.

h. SPLP failed to follow Section 17.0 of its OQ Program by failing to review and modify the OQ Program, as necessary after the 2009 accident, and again after the 2013 accident to ensure compliance with the Program.

15. §195.505 Qualification program.

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

(a) Identify covered tasks;

SPLP failed to include the installation and operation of bentonite mud plugs as a vapor barrier as a covered task in its written OQ Plan for work performed in the Wortham Station in 2012 - 2013.

Proposed Civil Penalty

Under 49 United States Code, § 60122, you are subject to a civil penalty not to exceed $200,000 per violation per day the violation persists up to a maximum of $2,000,000 for a related series of violations. For violations occurring prior to January 4, 2012, the maximum penalty may not exceed $100,000 per violation per day, with a maximum penalty not to exceed $1,000,000 for a related series of violations. The Compliance Officer has reviewed the circumstances and supporting documentation involved in the above probable violation(s) and has recommended that you be preliminarily assessed a civil penalty of $1,539,800 as follows:

Item number	PENALTY
1	$43,200
2	$43,200
3	$72,000
4	$200,000
5	$368,600
6	$257,000
7	$43,900
8	$37,800
9	$37,800
10	$200,000
11	$38,100
12	$38,800
13	$77,700
14	$38,500
15	$43,200

Proposed Compliance Order

With respect to Items 1, 4, 6, and 15, pursuant to 49 United States Code § 60118, PHMSA proposes to issue a Compliance Order to SPLP. Please refer to the *Proposed Compliance Order*, which is enclosed and made a part of this Notice.

Response to this Notice

Enclosed as part of this Notice is a document entitled *Response Options for Pipeline Operators in Compliance Proceedings*. Please refer to this document and note the response options. All material you submit in response to this enforcement action may be made publicly available. If you believe that any portion of your responsive material qualifies for confidential treatment under 5 U.S.C. 552(b), along with the complete original document you must provide a second copy of the document with the portions you believe qualify for confidential treatment redacted and an explanation of why you believe the redacted information qualifies for confidential treatment under 5 U.S.C. 552(b). If you do not respond within 30 days of receipt of this Notice, this constitutes a waiver of your right to contest the allegations in this Notice and authorizes the Associate Administrator for Pipeline Safety to find facts as alleged in this Notice without further notice to you and to issue a Final Order.

In your correspondence on this matter, please refer to **CPF 4-2016-5022** and for each document you submit, please provide a copy in electronic format whenever possible.

Sincerely,

R. M. Seeley
Director, Southwest Region
Pipeline and Hazardous Materials Safety Administration

cc via e-mail: DRChalson@sunocologistics.com,
TGNardozzi@sunocologistics.com,
LEJensen@sunocologistics.com

Enclosures: *Proposed Compliance Order*
Response Options for Pipeline Operators in Compliance Proceedings

PROPOSED COMPLIANCE ORDER

Pursuant to 49 United States Code § 60118, the Pipeline and Hazardous Materials Safety Administration (PHMSA) proposes to issue to Sunoco Pipeline L. P. (SPLP) a Compliance Order incorporating the following remedial requirements to ensure the compliance of SPLP with the pipeline safety regulations:

1. In regard to Item Number 1 of the Notice pertaining to SPLP's failure to use a person that was trained and qualified in the phase of construction to be inspected, SPLP shall develop procedures that:

   a. Address the prerequisite experience, training and qualifications for personnel performing construction inspection,

   b. Identify the roles and responsibilities of the company and inspection personnel with respect to safety and adherence to company procedures when inspection is occurring within a facility that has previously been placed in service to ensure the hazards associated with the presence of hazardous liquids and associated vapors are controlled appropriately, including but not limited to:

      i. the coordination of SPLP Project personnel and contractors with SPLP Operations and Maintenance personnel,

      ii. the evaluation of inspection resource requirements and span of control for the inspection of construction activities to ensure that the activities taking place on any project have adequate inspection resources to ensure the requirements of 195.204 are met in a safe manner,

      iv. the formal communication of all applicable company procedures and requirements to contractor employees working inside existing facilities,

      iii. the Delegation of Authority of SPLP functions to personnel performing inspection where construction is occurring inside existing facilities that contain, or have contained hazardous liquids that would otherwise normally be performed by qualified SPLP employees (such as Hot Work/Work Permits and LOTO).

   c. Address the recordkeeping requirements to demonstrate adherence to the processes developed under this item.

2. In regard to Item Number 4 of the Notice pertaining to SPLP's failure to perform an analysis that determined the cause(s) of this accident, SPLP shall obtain a third party to perform a Root Cause Analysis (RCA) of the accident. In performing the RCA, SPLP shall:

   a. Submit a qualifications and experience statement for the third party organization and personnel SPLP proposes to perform the RCA for PHMSA's review and concurrence.

   b. Complete the RCA within 120 days of the Final Order and submit to PHMSA any written reports, whether draft or final, at the same time such reports are submitted to SPLP by the third party performing the RCA.

c. Implement the recommendations and corrective actions identified in the RCA. The actions shall be identified in an action plan to be submitted with a proposed timeline for implementation and submitted to PHMSA for concurrence of the actions and the timing of the implementation.

3. In regard to Item Number 6 of the Notice pertaining to SPLP's failure to ensure that individuals performing covered tasks are qualified, SPLP shall develop a process wherein all contract and project personnel are aware of the requirements for OQ covered tasks as applicable, and carry out training to all company personnel responsible for project management and contracting of companies providing construction or other services that perform covered tasks. SPLP shall design the training content and submit to PHMSA for concurrence within 30 days of the Final Order. The training shall be completed within 60 days of receiving concurrence from PHMSA on the training content.

4. With respect to Item Number 15 of the Notice pertaining to SPLP's failure to have a covered task for the installation and operation of vapor barriers in its OQ Plan, SPLP shall:

   a. Submit to PHMSA within 30 days of the Final Order, a copy of the new Covered Task Listing addressing all Operations and Maintenance tasks in SPLP's OQ Plan for review.

   b. Submit to PHMSA within 60 days of PHMSA's acceptance of the Covered Task Listing in Item 4a, documentation demonstrating the training of all project and operating personnel on the changes to the Covered Tasks Listing of its OQ Plan.

5. It is requested (not mandated) that SPLP maintain documentation of the safety improvement costs associated with fulfilling this Compliance Order and submit the total to R.M. Seeley, Director, Southwest Region, Pipeline and Hazardous Materials Safety Administration. It is requested that these costs 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 changes to pipeline infrastructure.