Management Action Plan

in response to

Common Cause Assessment
From
Serious Incident Reports

(Conger & Elsea - June 25, 2007)

Management Action Plan Approved

October 5, 2007

Management Action Plan Approval

This management action plan is in response to the Common Cause Assessment from Serious Incident Reports, commissioned by Alyeska and completed by Conger & Elsea, Inc. on June 25, 2007.

The Common Cause Assessment (CCA) report has been reviewed and accepted. A series of discussions have been held to determine the appropriate management response and action plan.

In the interim between receipt of the assessment report and the approval of this action plan, the following steps have been taken:

1. An executive management team decision was made to request further analysis of Alyeska's model for supervision within the O&M organizations. This scope of work was added to an independent review commissioned by Alyeska's Unified Plan project team and conducted by ABS Consulting Group. A report from ABS is due in October, 2007.

2. The assessment report has been reviewed by representatives from Operations & Maintenance line management; Alyeska's Loss Prevention System (LPS) team; the Oil Movements Department; and Alyeska's Process Safety Advisor. Comments and feedback has been gathered in an effort to test the validity of the assessment.

3. Feedback from the groups referenced above has been shared with Dorian Conger, of Conger & Elsea, to gather additional perspective.

The following Management Action plan describes the steps that Alyeska Management has determined will be taken in response to the assessment.

This Management Action Plan is hereby approved for execution:

Approved: Rod D. Hanson 10/5/07
Rod D. Hanson Date
HSEQ Director

Kristi J. Acuff 10/15/07
Kristi J. Acuff Date
Sr. VP EE&R

Approved: 10/5/07
Jim F. Johnson Date
Vice President, Pipeline

10/8/07
Gregory T. Jones Date
Vice President, Valdez

Approved: Michael Joynor 10/08/07
Michael Joynor Date
Vice President, Oil Movements

TK-190 Overfill Incident
Root Cause Analysis Report
And
Post Accident Review

June 22, 2010

Confidential and proprietary information protected from public disclosure under AS 40.25.120(a)(4) and the Freedom of Information Act, Exemption 4, 5 USC § 522 (b)(4) trade secrets and commercial or financial information obtained from a person and privileged or confidential.

Table of Contents

Attachments:

1) PS09 TK-190 Overfill Photos
2) PS09 Simplified Power Configuration
3) PS09 Simplified Control Module UPS Configuration
4) PS09 Normal Operational Configuration
5) PS09 Relief Event Configuration
6) PS09 UPS Panel / Breaker Photos
7) PS09 Response Configuration
8) Technical Failure Analysis Report
9) Incident Event & Causal Factor Chart
10) Incident Summary Chart
11) Incident Barrier Analysis Worksheet
12) Personnel Interview List
13) Document Review List

Ray Grubb, Investigation Team Lead — 6-22-10 Date

Rod Hanson, HSEQ Director — 6-22-10 Date

Michael Joynor, Senior VP Operations — 6-24-10 Date

Selected Excerpts from Alyeska Management Action Plan Objectives (2007) and Pump Station 9 Incident Investigation Report (2010)

Alyeska Management Action Plan Approved, October 2007

The objectives of our action plan are:

- Ensure we have the right supervisory model (including expectations, resources, and tools) for effective oversight and management of safety in the workplace.
- Ensure clear accountabilities regarding safe work planning & performance and to establish effective stewardship to ensure those accountabilities are being fulfilled.
- Utilize effective methods, including LPS, to ensure a high level of hazard recognition & mitigation during work planning and execution.
- Significantly improve our Incident Investigation Process such that we truly understand the root causes of incidents and can apply lessons learned to improve performance and avoid repeat incidents.
- Examine ways to integrate the above objectives into other, ongoing process improvement efforts where possible.

These objectives describe portions of a continuing effort to shift the overall safety culture at Alyeska. It is important to recognize that culture change takes initial action, and then continued management attention over time to sustain the changes and fully achieve the desired outcomes.

– Alyeska Pipeline Service Company, *Management Action Plan Approved*, October, 2007, page 4 of 6.

Pump Station 9 Tank Farm Overflow Incident Investigation Report, June 2010

Root Cause #2 - Previous Incident MAPs & Lessons Learned LTA (Less Than Adequate).

Over the last several years, there have been a number of incidents with resulting Management Action Plans (MAPs) intended to implement recommendations identified during the investigations. . . . Despite the efforts made to address previous incidents and to learn from previous work activities, there continues to be a pattern of significant incidents occurring. As an organization, we are not optimizing our opportunities to learn. Personnel are working hard to complete all requirements and remain in compliancer, but the completion of actions intended to prevent inc idents and the opportunities to learn from work activities have not been effective in influencing the culture or behaviors. . . . There is usually no continuity between the Incident Investigation Team and the MAP Development Team. . . . The Operations Incident Review Board has not been meeting as routinely as intended and has not effectively communicated incident learning's [sic] throughout the organization.

– Alyeska Pipeline Service Company, *TK-190 Overfill Incident Root Cause Analysis Report And Post Accident Review*, June 22, 2010, pages 12-13.