“Tank 190 Report Completed” – Alyeska Pipeline Service Company
“Keeping You Posted” E-mail, July 1, 2010

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KYP #10-030
July 1, 2010

This message is from Mike Joynor, Senior Vice President of the Operations Division.

The team investigating the recent overflow of Tank 190 at Pump Station 9 has completed its report and determined that a combination of causes led to the incident:

Root cause 1: Several technical and design issues were identified.

Root cause 2: Past incidents on TAPS resulted in investigations, root cause determinations and recommendations that were developed into action items. However these actions have not consistently resulted in organizational changes in performance.

Contributing cause 1: Knowledgeable employees focused on power and control restoration and experienced a loss of situational awareness – a behavior paramount to safely responding to abnormal conditions.

Contributing cause 2: Safe Operating Committees – a standard process to review procedures – either weren’t done or were inadequate.

Contributing cause 3: There were gaps and conflicts in some procedural requirements and administrative controls. There were questions as to who (OCC, onsite supervision, or Fairbanks-based shutdown coordination) held primary control and process oversight during the shutdown.

The investigation team included Ray Grubb, Quality Assurance Supervisor (as team lead); Whitney Grande, Senior Health and Safety Manager; Scott James, Facility Engineering Supervisor; Brendan LaBelle-Hamer, Pump Station 1 Operations and Maintenance Supervisor; Andres Morales, Valdez Maintenance Manager; and Tom Stokes, Operations Business Strategy Manager.

"I want to thank all those employees who worked on and participated in the investigation and who responded to the event," said Mike Joynor, Senior Vice President of the Operations Division. "I also want to thank those who are still at Pump Station 9, working on the ongoing cleanup of the tank farm."

Along with identifying causes, investigation team members made recommendations. In response to root cause 1, they suggested several technical design reviews. Regarding root cause 2, the team suggested improvements to the incident investigation and analysis process, action planning, and management follow-through and assurance. They also gave recommendations tied to the contributing causes.

A management safety board will oversee the development of an action plan based on the recommendations. The safety board includes John Baldridge, Senior Director Pipeline Operations; Betsy Haines, Oil Movements Director; Dan Roberts, OCC Manager; Rod Hanson, HSEQ Director; and Tom Stokes, Operations Business Strategy Manager.

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"We are committed to learning from this incident and moving forward with these findings," Joynor said. "Once the action plan is developed, weÂ’ll look to managers and supervisors to make sure our workforce is talking about how we need to do work differently in light of this event and these findings."

Alyeska initially shut down the pipeline May 25 for a planned six-hour window to do various work, including testing Pump Station 9’s fire command system. During the fire system testing a back-up power system failure led to a loss of visibility to the Safety, Integrity, Pressure Protection System (SIPPS). As designed, this then triggered the opening of the relief valves and the flow of oil into Tank 190 to protect pipeline integrity.

During efforts to restore power systems at Pump Station 9, Tank 190 overflowed crude oil into a containment area surrounding the tank. There were no injuries or impact to the environment. The pipeline remained shut down for approximately 77 hours. Approximately 4,500 barrels of crude oil spilled to the containment basin.

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