

UNITED STATES OF AMERICA

NATIONAL TRANSPORTATION SAFETY BOARD

\* \* \* \* \*

Investigation of:

\*

\*

ENBRIDGE - LINE 6B RUPTURE IN  
MARSHALL, MICHIGAN

\*

\*

\*

Docket No.: DCA-10-MP-007

\* \* \* \* \*

Interview of: LEON ZUPAN

Crowne Plaza Hotel  
Edmonton, Alberta  
Canada

Thursday,  
November 17, 2011

The above-captioned matter convened, pursuant to notice.

BEFORE: MATTHEW NICHOLSON  
Investigator-in-Charge

APPEARANCES:

MATTHEW NICHOLSON, Investigator-in-Charge  
Office of Railroad, Pipeline, and  
Hazardous Materials Investigations  
N [REDACTED] y Board  
[REDACTED]  
Washington, D.C. 20594  
[REDACTED]

BARRY STRAUCH, Accident Investigator  
National Transportation Safety Board  
[REDACTED]

BRIAN PIERZINA, Accident Investigator  
Pipeline and Hazardous Materials Safety  
[REDACTED] ion (PHMSA)  
[REDACTED]  
[REDACTED]  
[REDACTED]

KAREN BUTLER, Supervisor  
Accide [REDACTED] ons  
P [REDACTED]  
[REDACTED]  
[REDACTED]

JAY JOHNSON, Supervisor  
Audits and Inspections  
Enbridge Pipelines  
[REDACTED]

<u>ITEM</u>	<u>I N D E X</u>	<u>PAGE</u>
Interview of Leon Zupan:		
By Mr. Strauch		5
By Ms. Butler		38
By Mr. Pierzina		55
By Mr. Johnson		62

I N T E R V I E W

1  
2 MR. NICHOLSON: Okay, this is NSTB Pipeline Case Number  
3 DCA-10-MP-007, Enbridge Energy July 2010 Crude Oil Release in  
4 Marshall, Michigan. These are the Human Factor Group interviews  
5 being conducted in the Crowne Plaza Hotel in Edmonton, Alberta,  
6 Canada. Today is Thursday, November 17th, 2011.

7 This interview is being recorded for transcription at a  
8 later date. Copies of the transcripts will be provided to the  
9 parties and the witness for review once completed.

10 For the record, Leon, please state your full name with  
11 spelling, employer name, and job title.

12 MR. ZUPAN: Leon, L-E-O-N, Anthony, A-N-T-H-O-N-Y,  
13 Zupan, Z-U-P-A-N, Senior Vice President of Operations, Enbridge  
14 Pipelines, Inc.

15 MR. NICHOLSON: Thanks. For the record, please provide  
16 a contact phone number and e-mail address that you can be reached  
17 at.

18 MR. ZUPAN: Contact phone number, area code [REDACTED]

19 [REDACTED]  
20 MR. NICHOLSON: Okay. Leon, you're allowed to have one  
21 other person of your choice present during this interview. This  
22 other person may be an attorney, friend, family member, coworker,  
23 or nobody at all. If you would, please indicate for the record  
24 whom you have chosen to be present with you during this interview?

25 MR. ZUPAN: I've chosen not to have anyone with me.

1 MR. NICHOLSON: Okay. We'll now go around the room and  
2 have each person introduce themselves. I will start and we'll  
3 progress clockwise to my left. My name is Matthew Nicholson, M-A-  
4 T-T-H-E-W, N-I-C-H-O-L-S-O-N. I am with the NTSB as the IIC. My  
5 number is [REDACTED] My e-mail is [REDACTED]

6 MR. PIERZINA: And Brian Pierzina, B-R-I-A-N, P-I-E-R-Z-  
7 I-N-A. I'm with the PHMSA [REDACTED] My  
8 e-mail is [REDACTED] and my phone number is [REDACTED]  
9 [REDACTED]

10 MR. JOHNSON: I'm Jay Johnson, Enbridge Pipelines,  
11 [REDACTED]

12 MS. BUTLER: Karen Butler, K-A-R-E-N, B-U-T-L-E-R.  
13 Email is [REDACTED] Phone number is [REDACTED] I'm  
14 the accident -- I'm the supervisor of accident investigations for  
15 PHMSA Central Region out of Kansas City.

16 MR. STRAUCH: I'm Barry Strauch with the NTSB. That's  
17 B-A-R-R-Y, S-T-R-A-U-C-H. My e-mail address is [REDACTED]  
18 and my phone number is area code [REDACTED]

19 MR. NICHOLSON: So, Leon, today, the focus is on human  
20 factors and organizational type questions. And Barry Strauch is  
21 our human factors guru, I guess, so we're going to start off with  
22 Barry's questions, I think.

23 MR. STRAUCH: Oh, okay. Thank you.

24 INTERVIEW OF LEON ZUPAN

25 BY MR. STRAUCH:

1 Q. Is it okay to call you Leon?

2 A. Leon is fine, yes.

3 Q. Okay. Can you kind of walk us through your experience  
4 and background?

5 A. I've been with Enbridge coming on 25 years. I started  
6 off in their engineering group. I have a -- don't have an  
7 engineering degree; I have a degree in science and physics. I  
8 moved into our Operations Group about a year and a half later, and  
9 then was transferred to Sarnia, Ontario as the operations manager  
10 in 1989. Returned in 1994 as the manager of shipper services, and  
11 then director of shipper services.

12 In November of 1999, I was transferred to be director of  
13 information technology. A year later, in November of 2000, I was  
14 promoted to vice president of development and services and held  
15 that role until about 7 years ago, when I was moved back to  
16 Edmonton as Vice President of Operations. In October of 2010, I  
17 was appointed to the position of senior vice president of  
18 operations with the major change of including the control center  
19 operation in my area of responsibility.

20 Q. So before October of 2010, you were not -- your area of  
21 control did not include the Operations Center?

22 A. The control center. That's correct, yeah.

23 Q. The control center. Uh-huh. Okay. But at the same  
24 time, it was also a promotion?

25 A. That's correct.

1 Q. In the promotion, do you know why the Operations Center  
2 was brought under your control in October of 2010?

3 A. We have actually had the control center under Operations  
4 and Customer Service back and forth a number of times since I've  
5 been with the company. It's always a bit of a discussion point as  
6 to whether there's a tighter link between the scheduling and the  
7 pipeline and the operations and the pipeline. And as we've looked  
8 at the situation post-Marshall, we decided that there was some  
9 benefits of having it all under an operations focus as we go  
10 forward. And so, it was my understanding that the impetus behind  
11 the change in October of last year.

12 Q. Okay. And will be some of those benefits?

13 A. Well, we have a large relationship between control  
14 center and the field, obviously, in terms of who carries out the  
15 actions both at the terminals and at the pump stations from a  
16 maintenance and emergency response perspective. We have a number  
17 of very similar circumstances in terms of compliance and training  
18 and being responsible with the regulations and the requirements to  
19 safely operate the pipeline system. And so, I think those are  
20 probably the two major focus areas.

21 And I have had some experience with our control center  
22 over the years, not directly working in it, but working with the  
23 previous members and directors of the control center. So I had  
24 some familiarity with the roles and responsibilities, as well as,  
25 obviously, the field staff that do similar roles, but not in,

1 obviously, a pipeline operations mode.

2 Q. And what was it about the Marshall incident that  
3 contributed to the move of the Operations Center to your area?

4 A. Well, I think our focus post-Marshall was really around  
5 what more do we need to do for an operational excellence  
6 perspective, not just within liquids pipelines, but as a  
7 corporation. And so, all three of the major business units within  
8 Enbridge were put under a president. They were previously under  
9 executive vice presidents, so they wanted to look at them as  
10 standalone business units accountable for the safe operations of  
11 their facilities.

12 Steve Worey (ph.) was given the role of president of  
13 liquids pipelines. Each one of the major business units was given  
14 a senior vice president role for operations both in liquids  
15 pipelines gas distribution and gas transmission, and a senior role  
16 in integrity was also created in the case of liquids pipelines, a  
17 senior vice president position under Art Meyer. And then in  
18 conjunction with that, they recognized that in order for us to  
19 continue to move the ball forward from an operational excellence  
20 perspective, we would need a resourcing plan and a way to  
21 effectively carry out any necessary changes post-incident. And so  
22 a vice president of pipeline control was created, the first time  
23 we've had the control center under a vice president who's directly  
24 responsible for just the control center, and that's Kirk Burdess  
25 (ph.), who reports up to myself.



1 Q. And who else reports to you? What other positions  
2 (indiscernible)?

3 A. We have a vice president of Canadian operations who  
4 looks after the main line systems in Canada, Cynthia Hansen. We  
5 have -- had in the past, vice president of U.S. operations, Rich  
6 Adams, who is in the U.S. And then I have a senior director of  
7 our gathering systems for both the North Dakota gathering system  
8 and Enbridge Saskatchewan group of companies that are in the feeder  
9 -- pipeline side of the business.

10 In addition to those executive vice -- or those vice  
11 president roles, I have a number of directors. I have Scott  
12 McKeckran (ph.), who you interviewed earlier in the work, as  
13 director of our safety culture initiative; Tom Zimmerman, who you  
14 probably met as part of the investigation, who is now the director  
15 of operation services; and Kevin Underhill, who is the director of  
16 environment and right of way for both the project side of our  
17 business, as well as the main line base business.

18 Q. Do the other two units have directors of safety culture  
19 as well?

20 A. No. They are embedded into their safety departments.  
21 We were actually the first out of the gate in terms of our safety  
22 culture initiative and felt that it was an important enough role  
23 that we wanted to have it a director level.

24 Q. Uh-huh. Well, why would there be a director of safety  
25 culture only in liquid pipelines and not the gas pipelines, the

1 other --

2 A. Each of the business units has different risks and  
3 they're in a different position. Each one of them made their own  
4 call as to what they needed to do and what was the most effective  
5 way to do. Because we are the largest of the three business units  
6 and we have a fairly significant impact on the environment and we  
7 had had three fatalities in the space of 2 years, we decided that  
8 it was important for us to find the right candidate who could make  
9 a significant change in how we organize our people, our management  
10 team, our employees, and further our safety cultures. So we felt  
11 Scott McKeckran was the best candidate we had and was the first  
12 choice and he had agreed to it. And I think I still agree that  
13 the director level and I feel the liquids pipelines is the  
14 appropriate way to provide that senior leadership.

15 Q. Okay. Since you've been in this position, which has  
16 been a little over a year, have you had any role in implementing  
17 changes as a result of the findings that the company has learned  
18 with regard to the Marshall incident?

19 A. As -- definitely. And I recognize that the focus of  
20 this might be more so on the control center, but, obviously, our  
21 focus on emergency response and the field component of the  
22 learnings from our Marshall and Romeoville incidents are also in  
23 my area of responsibility. But with respect to the -- I guess,  
24 the learnings that came out of our own internal investigation,  
25 most of those, I have basically worked closely with Kirk Burdess,

1 my Vice President of Pipeline Control, discussed what we saw as  
2 the common areas of focus, the key things that we needed to look  
3 at in a different manner, and to potentially make changes around.  
4 And so, Kirk has a tremendous amount of experience in this area.  
5 He was a member of our control center engineering staff, has  
6 worked with the control center in almost all of his roles in the  
7 last 20 years within Enbridge and is technically a very  
8 knowledgeable person. And with the team that we put together  
9 underneath, including a new director, Al Baumgardner (ph.), we  
10 have been able to come up with a new plan to implement necessary  
11 changes to start the process of heading towards having a world  
12 class operation in our control center.

13 Q. Okay. Could you walk us through some of the changes  
14 that you've implemented as a result of the Marshall incident?  
15 Let's start with the pipelines first.

16 A. Sure. With the pipeline control?

17 Q. Yes.

18 A. Sure. I think first and foremost, we've recognized that  
19 although it was a priority, we had focused on the need and the  
20 growth of a new control center, obviously, the regulations that we  
21 had in front of us in terms of control room management. What we  
22 had not yet implemented was the resources to get us there. So I  
23 think, first and foremost, if we wanted to make some significant  
24 changes in an area that was extremely important to the  
25 organization and one that had a number of challenges in terms of

1 its growth, in terms of the level of experience of its pipeline  
2 operators in terms of turnover, that we could no longer do that  
3 with just a manager reporting up to a vice president and having  
4 multiple responsibilities. So when we took a look at the key  
5 areas that we wanted to focus on, first of all, we felt -- I felt  
6 very strongly we had to resource that adequately. In order to  
7 make change in an organization, it takes smart people who have the  
8 time to do it and not working off the side of their desks.

9           So that was the first major change that we made and it  
10 wasn't too long before Kirk and Al were in their new roles. And  
11 Al Baumgardner had a significant amount of the experiences being a  
12 manager in the control center in the past and between the two of  
13 them working with the existing team, they were able to take the  
14 lessons learned from our internal investigation and start looking  
15 at what more we would do from a policy and procedure management,  
16 what more we need to do from training, hiring, organization  
17 structure, as well as dealing with the regulatory requirements  
18 like under control room management.

19           Q.   Okay, could you report to any specific changes that have  
20 been implement in the control room as a result of the Marshall  
21 incident?

22           A.   Well, I think first and foremost, we were concerned  
23 about morale in the control center. It was obviously a fairly  
24 significant incident for them to have gone through. A number of  
25 their coworkers were taken off duty immediately after the incident

1 occurred. And they were in a fairly intensive hiring mode already  
2 so we had a lot of operators that had a lot of responsibility in  
3 terms of if you were a senior operator and a lot of new people  
4 being trained, as well as being -- having less than the staff we  
5 wanted. So our first focus was to make sure people realized that  
6 we were there to support them, we were there to make positive  
7 changes and to deal with the issues that we had in front of us.

8           Secondly, we wanted to ensure that we were hiring the  
9 right people. So we had hired a number of individuals over the  
10 last 2 years, maybe 2-1/2 years, and our overall retention rate  
11 wasn't where we wanted it to be, so we focused on making sure  
12 that in the hiring process we have people that we think would be a  
13 long-term fit and be able to deal with the challenges of pipeline  
14 control operations in a very compliance pipeline system.

15           The next piece was really supporting the people on  
16 shift, so our view of the night of the Marshal incident was that  
17 we had people that were really trying hard to do what they thought  
18 was the right thing, but they needed more technical support, they  
19 needed more management support, they needed more technical  
20 training, and they needed to be clear about what our expectations  
21 were in terms of following procedure both in terms of the people  
22 directly under my control and pipeline control, as well the  
23 support staff in the MBS positions. So our focus was how do we  
24 ensure that they will have a plan put together that will deal with  
25 all of the significant issues that came out of that.

1           So we had a training program, we had an acquisition plan  
2 on how we were going to hire the right people, and then we took a  
3 look at the overall organizational structure. So in addition to a  
4 vice president and a director, we ended up with other managers  
5 within the control center both on the technical side, and then to  
6 support the operators, what we really wanted to focus on is,  
7 obviously, with the number of consoles that we have, which is  
8 quite different than most pipeline companies -- we have a lot of  
9 people on shift and more people than just one supervisor was going  
10 to be, in the long term, capable of having the kind of oversight  
11 that we would want to see. So they're dealing with people issues.  
12 They're dealing with technical issues. They're dealing with  
13 making sure that they have enough people available if someone gets  
14 sick to come in. And so, they had a pretty challenging role.

15           So we have gone down the path of saying we need a  
16 technical support person as well as a supervisory support person,  
17 and so that basically is doubling the amount of oversight that we  
18 would have on each shift within our control center. We're in the  
19 process of finalizing the filling of all of those roles. Some of  
20 them, we have taken senior operators and moved in and, obviously,  
21 we needed to have other operators being hired and trained to  
22 backfill for people being promoted within the control center  
23 itself. So that was the other major focus is to make sure that  
24 our operators can be successful by having the support they need 24  
25 hours a day.

1           On the technical side, we've taken a look at our  
2 relationship with all of our service providers and made sure there  
3 was a clear understanding of accountabilities between the support  
4 people, who are, in some cases, reporting up to another director,  
5 another vice president, and the people that are actually  
6 responsible for running the control center itself.

7           On the training side, we've recognized that there was  
8 what would be appear to be an apparent gap of the understanding of  
9 hydraulics and column separation based on the conversations that  
10 took place that night. And so, our first -- one of our first  
11 focuses on the training side was to make sure that hydraulic  
12 training was available and all of operators and our on-call  
13 management team were run through hydraulics training so they would  
14 understand what basically was happening. And even though we will  
15 be relying on more people to make a final decision in a situation  
16 like that, we wanted them to understand the hydraulic component of  
17 what was going on that night so that they would not come to the  
18 wrong conclusion if they ever had a situation like that in the  
19 future.

20           I think the other key point that we wanted to ensure was  
21 taking place is that the oversight of critical decisions is one  
22 that, first and foremost, if in doubt, shut the line down and  
23 leave it down. There has been, I think, in our organization, a  
24 tremendous amount of growth. With growth comes a drive to a  
25 finish line and a need to start taking on more responsibility and

1 taking over the responsibility of more assets. But our message  
2 from the top on down is that, first and foremost, we will operate  
3 these lines safely; and if we can't, we will not operate them and  
4 we will not restart them until we know exactly what's going on.  
5 So that message is, I think, very clear that we will not sacrifice  
6 safety for throughput or expediency or the ability to return a  
7 line to service.

8           Secondly, I think we've recognized that management's  
9 responsibility is not only to understand what procedure you need  
10 to have in place and to train people on those procedures, but to  
11 ensure people understand them and they're in compliance with those  
12 procedures. So whether it's a field position or whether it's a  
13 pipeline position in the control center, first and foremost,  
14 management has to take on the responsibility of ensuring that our  
15 employees are supported and they're not only trained, but we have  
16 a way of coming back and ensuring that they understand what that  
17 roles and what they should be doing based on the procedures.

18           So it's great to have procedures to show the regulators,  
19 but the real requirement in a world class operation is that all of  
20 your employees understand those procedures, why they're written,  
21 and what their expectations are, and if ever in doubt, they know  
22 that they should first ask before making assumptions or taking on  
23 any responsibility of making decision when they have, clearly, a  
24 support team around them that are there to help them on shift and  
25 off shift in terms of our on-call support.



1 Q. What specific managerial failures in the control room  
2 contributed to the accident?

3 A. You know, I think I would, first and foremost, not  
4 classify it as a managerial failure. I would say that the person  
5 that we had on call that evening, Blaine Reinbolt, in hindsight,  
6 should have had some additional training. And, in fact, we have a  
7 very clear set of guidelines now as to what responsibilities, what  
8 training and level of experience someone needs to have in order to  
9 go on call so that if we have someone who's on call that's being  
10 challenged to make those decisions, they've seen enough in the  
11 organization and have all of the training and that we feel  
12 comfortable that they -- what calls they should make and, again,  
13 in doubt, then they escalate that to the director, the vice  
14 president, or even myself, if necessary. I think we had tried our  
15 best to try to ensure that the process would lead to success, but  
16 I think when we take a look at the kind of discussions that  
17 happened that night, it was clear to us that we could have done  
18 more to train and support those people and to have an assurance in  
19 place that, if in doubt, they would have continued to escalate it  
20 rather than try to restart a pipeline.

21 Q. Well, it appears in hindsight as if the supervisors that  
22 were selected for their interpersonal leadership skills may not  
23 have had the technical skills that were needed and that by adding  
24 technical people in the restructuring that you've you tried to  
25 address that. Is that accurate?

1           A.    Yeah.  We -- you know, it would be nice to say you would  
2 have a super supervisor that has all of the people skills and all  
3 of the technical skills and has enough time in a 12-hour shift to  
4 do everything, but I think we recognize that that might get you by  
5 on most shifts, but it won't get you by when you have a challenge.  
6 And with a pipeline as complex as ours, it's very often that you  
7 will have shifts that have challenges on them that require a lot  
8 of supervisory attention.  And so we wanted to not just have those  
9 people focus technical issues and not deal with the people side of  
10 our business.

11                    It's equally important to have operators that are being  
12 supported and want to stay and want to -- and work for us and feel  
13 comfortable that they're being support not just technically, but  
14 as employees.  So we thought both of those things were important  
15 and instead of trying to find the ideal candidate who could do  
16 both, we felt that splitting those into two roles would be a more  
17 effective way.

18                    And then in terms of training, mentoring, continuing to  
19 support our employees while they're going through the training and  
20 while they become senior operators, we still have an opportunity  
21 to continue to support them in their roles in the organization.

22           Q.    What was the driver that led the organization to  
23 emphasize interpersonal skills and leadership skills instead of  
24 technical skills among the supervisors?

25           A.    Well, I would say it's not instead of, it was in

1 addition to. And in our organization, the engagement and  
2 retention of our employees is extremely important to us. We want  
3 people to stay strive and be successful within Enbridge and that  
4 means they do need to be supported in a number of different ways,  
5 including in terms of the one-on-one relationship between them and  
6 their supervisor, the support they get, the ability to deal with  
7 people issues in addition to the technical support side. That's  
8 obviously extremely important in the control center.

9           So I think our initial role was to continue to do what  
10 we've always been doing, which is you have one supervisor on shift  
11 and they basically started taking more and more responsibilities  
12 as Enbridge continued to add priorities to what was important in  
13 the operation of a control center. We've now recognized that in  
14 reviewing that, that that is, on average, more duties than the  
15 average person would be able to do, especially in challenging  
16 times, so that drove us to go down this path of having a two-  
17 supervisor one-shift process here, especially with the continued  
18 growth of our control center.

19           Q.    What was the specific retention rates that you were  
20 facing that led to some of these actions?

21           A.    Well, we had probably -- I don't have the specific  
22 percentages in front of me, but instead of, you know, hoping that  
23 9 of 10 operators would continue to stay with the company after  
24 their training period, our loss rate was higher than that, and so  
25 we were continually in a replacement and retraining mode whereas

1 the original plant, my understanding was that we would hire 10  
2 people, they would go through the training process, and now we'd  
3 have 10 people on staff to kind of support either retirement or  
4 the new initiatives that we were taking on and any other people  
5 leaving. Instead, we were losing too many of those people, so we  
6 were always in the backfill mode and we were never quite getting  
7 up to the full compliment we wanted, so that's why we focused on  
8 over hiring and a way of making sure we would have people who  
9 would want to be successful after their training.

10 Q. So now that you've addressed -- attempting to address  
11 the retention through hiring through changes that you made in  
12 hiring, could you describe what the changes were and, you know,  
13 what it takes now to be selected to be hired as a operator?

14 A. Only at a very high level. My vice president and his  
15 director have done all of the heavy in this area, and so I've  
16 gotten briefings from them about what they believe is the way  
17 forward. So they've worked with our human resources department to  
18 look at screening tools. They've looked at the exit interviews  
19 from the people that they've hired, and we do one on everyone that  
20 leaves the organization, try to understand what was wrong, was  
21 there a wrong fit, was there -- learnings that we would have to  
22 say this type of an individual generally won't do well on shift  
23 work either because of their family situation or what they see as  
24 the challenges of working 12-hour days and continuing to rotate  
25 their schedule. So that was one of them, is not only looking for

1 the technical skills when you're trying to find new employees, but  
2 also trying to find out whether shift work in this type of an  
3 environment would be a good fit for them or not. And I think we  
4 feel that the new focus that we have will allow us to be more  
5 success in retaining more of the people that we've hired.

6 Q. Now, when people are assigned to the control room,  
7 they're assigned to work with a team member, is that correct?

8 A. That's correct, yeah.

9 Q. All right.

10 A. They start off in training, and then once they finish  
11 their basic training, then they'll be assigned a person to help  
12 train them, and then when they get to the position where we feel  
13 they've mastered the skills, then it's more of a mentorship  
14 relationship and that mentorship relationship will continue until  
15 we feel that the control center operator can work independently  
16 with just the support of the supervisory team.

17 Q. And what training do operators, supervisors get to work  
18 as teams?

19 A. Well, the -- the supervisors in the control center?

20 Q. Yeah, and the operators.

21 A. Well, I think that the operator piece has kind of been  
22 covered in terms of how we bring them into the organization and  
23 what basic training they get before they go behind a console. The  
24 supervisors, we're generally looking for two things, people who  
25 have not only been good operators, but have shown the capability

1 to do more than just be an operator. So people who have  
2 initiatives in terms of looking at how our system operates, making  
3 suggestions on improvements, working well with their coworkers.  
4 So we're looking for the people skills, we're looking for the  
5 technical skills, and we're looking for the leadership skills that  
6 would allow people to work well in a control center environment.

7 Q. And once somebody becomes a supervisor, they're no  
8 longer, as I understand it, subjected to the OQ requirements, is  
9 that correct?

10 A. I don't know that.

11 UNIDENTIFIED SPEAKER: That's correct.

12 BY MR. STRAUCH:

13 Q. Okay. So what will Enbridge do then to ensure that  
14 supervisors retain the technical skills and knowledge of pipeline  
15 operations that will be required of someone who is a pipeline  
16 operator full time?

17 A. That's a question I haven't got an answer right now and  
18 it's part of our overall focus as a general answer that all of our  
19 roles in our organization are important. We need a way of  
20 ensuring that people continue to get trained and they have ongoing  
21 capacity in those areas. So the general approach that we would  
22 have is those technical supervisors would report up to a manger,  
23 and that manager's responsibility would be to performance manage  
24 those individuals both in terms of their people skills and their  
25 technical skills. Obviously, the key piece that has to happen is

1 every time you have a close call or an incident, it has to be  
2 thoroughly investigated, and if it turns out there's a gap or a  
3 lack of understanding or, potentially, even a complacency issue,  
4 then that comes out of the investigation and that's gets addressed  
5 immediately, and if it can't be addressed, then we have to move on  
6 in terms of that relationship.

7 Q. And one of the things we've learned is that the  
8 operators, certainly now, have final say in whether a pipeline  
9 will shut down, is that correct?

10 A. They have the first responsibility for shutting the  
11 pipeline down. If in doubt, shut it down. They can't overrule  
12 their supervisor or -- and they can't overrule the procedure. So  
13 if the procedure requires them to shut the line down and they  
14 haven't taken that initiative on their own, which, hopefully,  
15 would never happen, and say there is a lead type situation where  
16 the MBS analysis is indicating here's the information in front of  
17 us, then it would be the responsibility of that supervisor to  
18 ensure that the line is shut down.

19 Q. And what's to prevent a supervisor now from telling an  
20 operator to violate a procedure?

21 A. Well, to be absolutely honest with you, in a world of  
22 human people working on shift, that can always happen, so you have  
23 to be vigilant to know that that risk exists. So, first and  
24 foremost, you want to make sure that there's clarity of vision and  
25 responsibility of what we're actually trying to -- and, generally,

1 my experience is that when people make those wrong decision, they  
2 have been either given directly or indirectly the wrong motivation  
3 about what's really important. So first and foremost, you want to  
4 make sure there's clarity of vision and responsibility of about  
5 what pipeline control is all about.

6           If you have a good performance management system,  
7 particularly in a close environment like a control center, I think  
8 it becomes pretty clear whether people get it or not. Generally,  
9 you will see that in the training program as they become operators  
10 and as they move into the system. It would be very rare for  
11 someone to kind of change their views after being a successful and  
12 safe operator, so those are the kind of people we're trying to  
13 ensure are in the leadership roles, and then we have a  
14 responsibility for ensuring that they don't become complacency.  
15 Complacency is a problem with me, it's a problem with everybody in  
16 our organization, so we have to recognize that's a risk and that  
17 we have to have systems in place to make sure that they are  
18 continually reminded of what's the most important thing that we  
19 do, and then having a way of ensuring that that's happening,  
20 particularly from a close call in an incident investigation.

21           Q. Now, one of the things we've learned is that there have  
22 been new procedures implemented as a result of this accident. In  
23 light of the fact that the procedures that were already in place  
24 weren't followed, what mechanisms have been implemented to ensure  
25 that all procedures are followed at all times?



1           A.    Well, it comes from our -- starting with our supervisors  
2 and our employees to make sure there's clarity of what the  
3 responsibilities on are following the procedures.  Secondly, we  
4 would, again, be investigating any incident to make sure that the  
5 procedures are followed.  Particularly, we have an opportunity  
6 with our new process on shift change of making sure that the new  
7 shift supervisor and the new operator have a chance to see what  
8 the previous shift has done and if they flag any concerns or  
9 inconsistency, we would automatically take action at that  
10 particular point in time.  And because of the nature of our  
11 operation, something could happen on shift and, certainly, it will  
12 always be possible to have an incident that didn't result in an  
13 impact to go undetected.  So I don't think we believe that we can  
14 do things in a foolproof manner, but that means that we have to  
15 have more focus on the people that are put in charge of operating  
16 these facilities both as operators and as supervisors.

17           Q.    Uh-huh.  So can you kind of walk us through?  If the  
18 same situation in terms of mass balance alarms and so occurred  
19 tomorrow that happened during the Marshall incident, how should  
20 things operate today given all of the changes that you've just  
21 enumerated?

22           A.    So first and foremost, we have addressed the MBS analyst  
23 role and his or her responsibilities and what they can and cannot  
24 do, what their role is as the person who is providing support to  
25 the control center.  Secondly, we've revisited with all of our

1 operators what they have as a responsibility in terms of the rules  
2 and procedures. We've also revisited that with our supervisors on  
3 shift, both the technical and the people supervisors, as well as  
4 changed the responsibilities and who is on call. So first and  
5 foremost, they have to shut down. In the case of Marshall, the  
6 real situation was not so much on the shutting down, but on making  
7 the wrong calls and starting back up again. In our case now,  
8 there's a small handful of people who have that responsibility of  
9 making that call and, again, if they're in doubt, they have to  
10 escalate that to our director and our vice president, who are  
11 basically on call all the time.

12 Q. Okay, let's start with the MBS analyst. The MBS analyst  
13 had a role in the Marshall incident and said that it was a column  
14 separation and not a leak. What changes have been implemented now  
15 to make sure that the MBS analyst no longer gets involved?

16 A. That's not an area that I'm specifically responsible  
17 for. So the MBS analysts don't report to the control center.  
18 They're a service provider, so they report up to our director --  
19 manager and director of pipeline control and leak detection. So  
20 they are a service provider to the control center. They are not  
21 part of my direct team.

22 Q. Okay. But what -- or maybe -- I know they can only give  
23 certain information to the control center, MBS?

24 A. That's right.

25 Q. So I think that would address it.

1           A.    Yeah.  So if -- you know, they are the ones that we are  
2 -- who have the technical expertise to review the information and  
3 to make the call as to what they're actually seeing, whether the  
4 alarm is valid or not and what particular conditions are there.

5                    In a case like Marshall where even if they indicate it  
6 is a column separation, before we can restart, we would be looking  
7 at not only involving the supervisor -- and in particular, where  
8 we have now we've mapped out all the areas where we normally have  
9 column separation.  We have a situation where we have column  
10 separation in a line that's never had it before, we involve not  
11 only our on-call staff, but our engineering staff that support the  
12 control center, to come in and to do that analysis, along with our  
13 MBS people, to come to the conclusion as to is this really column  
14 separation or not.  And in the case of Marshall, obviously, it was  
15 in an area that normally does not see column separation, so, first  
16 and foremost, that's a flag now to our management team that why  
17 would we have column separation in an area that we haven't seen it  
18 before?

19                   And again, there is, you know -- I think if there was a  
20 ever a lesson learned about whether it's important to restart a  
21 line or not, line 6B was down long enough that I think people  
22 recognized waiting an extra even 24 hours to do a full visual  
23 inspection of the pipeline is much preferable than to have a  
24 situation where you damage the environment, you take the line of  
25 service for an extended period of time, or you put people's lives

1 at risk.

2 Q. Does it make -- I have a hard time understanding that as  
3 the person who's ultimately responsible for the safety of the  
4 control room, that one of the key elements of that control room,  
5 the MBS analyst, is not under your span of control. Could you  
6 explain to me why that doesn't make sense organizationally?

7 A. I think the reason we have it today is that we have a --  
8 we had an IT department that was responsible for these roles. We  
9 had a new appointee, a senior vice president of engineering and  
10 Integrity, who also had responsibility for this group in the past,  
11 Art Meyer, and when we took a look at the challenges that we had  
12 in front of us, I think, my view anyway, was there was a comfort  
13 value that taking this team from IT and putting it under Art would  
14 have the necessary direction not only to look at the support for  
15 the on-call or for the people who are on shift, but also our  
16 overall leak detection and our (indiscernible) programs. So it  
17 doesn't do us any good to have a world class control system if we  
18 don't have world class leak detection system and a world class  
19 operating system and the support people to go behind that.

20 So you can, you know, eventually try to put all of the  
21 support people under the control center, but eventually that  
22 breaks down as you get into server responsibilities and control  
23 systems, and so we thought that a good separation is to take  
24 someone like Art, who has responsibility in that area, who has  
25 been able to come in and show he's been able to put the team

1 together to deal with these situations. And so, first and  
2 foremost, I need to feel comfortable that under that relationship,  
3 I am getting the service I need. So does Kirk, so does Al  
4 Baumgardner, and I've made that very clear to them. Your  
5 responsibility is ensure your service providers provide the  
6 support that is required, and if there's an issue with that, then  
7 we will deal directly with that support department to make sure we  
8 are going to achieve that. And that's the way -- you know, we are  
9 not a silent organization. We're a team that needs to support one  
10 another whether you're field employee, whether you're in  
11 engineering, leak detection, or in the control center. And so,  
12 first and foremost, the responsibility to ensure that the  
13 appropriate and required level of support is going to be there no  
14 matter whether they directly report to you or not.

15 Q. Okay. Now, let's go back to changes since the Marshall  
16 incident. So the MBS analysts in your -- the supervisor was  
17 called and the supervisor who should have been -- should have  
18 questioned the actions of the controllers to defer to them,  
19 because he didn't have the technical expertise to really question  
20 them -- so now, if that scenario were to happen tomorrow, what  
21 would be different in terms of the supervisory, the supervisor's  
22 advice that he or she would provide to the operator?

23 A. So first and foremost, all of the people that would be  
24 involved now -- that were involved back then have been given  
25 upgraded training on column separation procedures, hydraulic

1 training, so that they have a better understanding of how column  
2 separation works and what you should or should not be able to see  
3 in a situation like that. There was obviously what appears to us  
4 to be a gap in that understanding. I think our supervisor who was  
5 on call that day, from my understanding of the transcripts, was  
6 going down the right path, was asking the questions, and probably,  
7 in my view, if they would have had the level of training they have  
8 now, they probably would not have been dissuaded as to what was  
9 actually going on and they would not have looked at this as, I  
10 guess, the way I've looked at it. They did not look at this as a  
11 suspected leak, they looked at it as a column separation. And  
12 although they tried to consider the fact that it was a leak, they  
13 came back and were convinced that this was column separation and,  
14 for whatever reason, they just needed to continue to pump into it  
15 and, eventually, of the world's problems would disappear. That  
16 was not the right call, very clearly, to other people in the  
17 control center, other people who were responsible at the time, but  
18 it was the call that was made.

19           So again, it shows if you want to have a control center  
20 that's world class, every one of the members has to meet those  
21 minimum thresholds and you need a belted (indiscernible) so you  
22 don't just rely on one person making a decision that could be  
23 catastrophic to your organization. You need to have the right  
24 training for that person, but you need the right support for that  
25 person as well and the right ability to escalate to more

1 knowledgeable people when an area of discrepancy comes up and  
2 people are not sure exactly what's going on.

3 Q. Okay. Why don't we suggest another possible explanation  
4 and that is that leaks -- and this a good thing -- are extremely  
5 rare events. Column separations are not. So when an MBS analyst  
6 sees a column, a situation that could be either a column  
7 separation or not, the odds are if he or she goes with the column  
8 separation, he's going to be right just because the previous or  
9 ratio or column separation to a leak is quite high, so -- and no  
10 amount of training is going to alter that, that the expectancies  
11 will always be a column separation and not a leak just because  
12 leaks are such rare events. How do you change those expectancies  
13 so that people will question it and not just through additional  
14 training?

15 A. I think it's a good question and it's probably the  
16 biggest issue that people in our business face when it comes to  
17 complacency. If I've taken the same risk every day for 20 years,  
18 then my sense that something will happen today is very, very low.  
19 And so it's the complacency component that I think is, first and  
20 foremost, a prime responsibility. That's why we have a focus on  
21 our safety culture. That's why we have a focus on compliance and  
22 our procedures, and not just what Jay is responsible for, but what  
23 we're all responsible, particularly the management team. You can  
24 always say, well, the employee didn't follow the rules, but the  
25 question becomes why didn't the employee follow the rules. Was

1 this the first time in their career that they hadn't followed  
2 those rules? Were they not given the right, not only the  
3 training, but the focus of what's really important in the  
4 organization?

5           Whenever we have an incident now, we review the incident  
6 with our executive leadership team. Any business unit has an  
7 incident, we get together once a month and all of the Operations  
8 and Integrity and Senior Management Team for Enbridge review those  
9 incidents to try to understand what's going on because they are  
10 too important for us to take lightly, and the same thing happens  
11 with any incident that happens in the control center. Each one of  
12 them is important and we recognize that people will have a human  
13 nature to be complacent, so our responsibility is to ensure that  
14 we understand that and have systems in place to come back not --  
15 not just the fact that you've been trained, but after the  
16 training, did that make sense to you.

17           One of the, I know, the new initiatives that we've had  
18 recently is safety observations and our director of our control  
19 center, Al Baumgardner, had relayed the story that, you know, how  
20 is that going to feel like to the operator to have a safety  
21 observation when the guy's operating the pipeline and -- but we  
22 said it's important, so he sat down and did it and he said it was  
23 one of the best experiences for both him and the control center  
24 because instead of trying to catch them doing something wrong,  
25 they're there to support them in understanding that this



1 important, what do you think is going on, why would you be doing  
2 that, what do we think we need to do about situations like that,  
3 and it's that safety observation focus that really helps with the  
4 complacency. Generally, if you don't watch what your people are  
5 doing, it's very easy for them to become complacent. If they  
6 realize that that's important and they're not there to watch -- to  
7 catch you do something wrong, they're there to help you be  
8 successful, you will be able to deal with, as best as you can, the  
9 risk of complacency.

10 Q. Okay. And can you just tell us a little bit about the  
11 safety observations, what it is and how often it occurs and who  
12 (indiscernible)?

13 A. Well, they just started it, and so I've only gotten the  
14 one download, this week, actually. And what that basically is, is  
15 sitting down while an operator is on shift, and you do that both  
16 in terms of the mentor relationship that we've set up, as well as  
17 people who are responsible for the control center, so that  
18 management gets involved with the actual working operations of the  
19 control center. So in this case, our director would spend a  
20 number of days in the year actually doing an observation of  
21 different components within his span of control so that he has a  
22 sense of what's going on, but he's also doing that to say is there  
23 anything more I need to do as a director to support those people  
24 to do their jobs successfully.

25 Q. So he will be doing that, this is Al Baumgardner will be

1 doing this on a regular basis?

2 A. My understanding is that, yeah, we would take on that  
3 responsibility for a number of people who are a supervisory role.

4 Q. Okay, so not just Al?

5 A. No. That would be my sense. Although, again, I've got  
6 a very good vice president and director. They are not waiting for  
7 me to tell them what to do. They are figuring it out on their own  
8 and they're letting me know what they're doing, and everything  
9 I've seen so far has been very positive. And I do provide them  
10 with advice. I still make sure I stay in tuned with where they're  
11 going and how fast they're getting there and what their challenges  
12 are, but they don't have to wait for someone to tell them what to  
13 do.

14 Q. Okay. And I understand, as per the requirement,  
15 Enbridge has a fatigue management plan in place, but that fatigue  
16 management plan does not include identification of people at risk  
17 for sleep disorders?

18 A. I don't know.

19 Q. Okay.

20 A. I know we've ruled out our fatigue management training.  
21 I know the feedback I got from my management team was that it was  
22 extremely received by both the management team and the employees  
23 themselves and was a real plus in terms of looking at fatigue  
24 management from a number of different perspectives. I'm not aware  
25 of any deficiencies at this stage.

1 Q. Okay. Well, there are several sources that could --  
2 several reasons why people could be fatigued. One is that they  
3 have either undiagnosed or an untreated sleep disorder, such as  
4 sleep apnea.

5 A. Right.

6 Q. The source of fatigue could be other medical conditions  
7 or it could be medications.

8 A. Or it could be stress.

9 Q. Let's talk about medications --

10 A. Okay.

11 Q. -- and medical conditions. Does Enbridge plan to  
12 institute a requirement that employees report to management any  
13 and all medications that they're taking?

14 A. It is my understanding that they recognize that they  
15 need to report medications that could affect their abilities --

16 Q. Okay.

17 A. -- operate safely, not all medications, obviously.

18 Q. Why not all medications. Shouldn't --

19 A. Not all medications would impact people.

20 Q. Right, but, right now, it's up to the operators to  
21 determine whether or not the medication could affect his or her  
22 performance. Shouldn't it be up to the company to make that  
23 determination?

24 A. I think if we thought it was a risk, yeah, I would agree  
25 with that.

1 Q. Okay.

2 A. If that means that people have to report that they're  
3 taking two Advil because they have a headache, then I think we  
4 would -- what we want to make sure is that our control center  
5 operators recognize that we do things that are in everybody's best  
6 interest. If the line gets so gray that they don't believe that  
7 this is in their best interest of why they're doing certain things  
8 and you can't explain to them effectively why those rules are in  
9 place, then you start losing people's trust and people's  
10 willingness to do everything else properly. So I think what we  
11 always want to do is to do the right thing, to err on the side of  
12 safety, but not to do things that you can't explain and are  
13 appearing to be unreasonable.

14 Q. Okay. Well, I'll give you another illustration.

15 A. Sure.

16 Q. There's considerable medical literature that shows an  
17 association between body mass index and sleep apnea, which is  
18 true. Yeah. If your -- if you have a BMI of 30 or above, you're  
19 considered obese, and obese people have a -- are at higher risk  
20 for sleep apnea. Does Enbridge plan on implementing a program to  
21 screen at risk people for sleep apnea?

22 A. That's good point. I'm not aware of an initiative in  
23 place at this particular time.

24 Q. Do you think there should be?

25 A. I think if it's a risk, absolutely.

1 Q. Okay. And finally, what is Enbridge's policy with  
2 regard to reports of a hostile environment, sexual harassment and  
3 so on and so forth. If a reporter -- if a supervisor has been  
4 informed by a subordinate that he or she feels that they're a  
5 hostile environment has been created, what is the supervisor's  
6 responsibility?

7 A. Well, first and foremost, we have a respectful workplace  
8 policy that all of our employees have to take the training on and  
9 it also includes the responsibility of supervisor and the need for  
10 them to report every and all incidents up to their management team  
11 and, if there is ever a concern about a conflict of interest, is  
12 to report it directly to our human resource contact.

13 Q. Under U.S. law, if a supervisor is informed of -- by a  
14 subordinate of a sexually hostile environment and the supervisor  
15 does nothing, then that supervisor is -- can be subject to all  
16 kinds of sanctions. Is that the case here in Enbridge?

17 A. Even if it wasn't the case by law, it would be our  
18 policy to do exactly that. We don't tolerate our supervisors not  
19 take their role seriously.

20 Q. Okay. We have had a report by a female employee who  
21 said that she brought sex charges to a supervisor and the  
22 supervisor told her to deal with it.

23 A. And?

24 Q. I'm asking about that. Why did that happen?

25 A. I haven't heard that and I don't know any of the details

1 on that, so I can't comment. Theoretically, if any female  
2 employee a condition forward and it was not dealt with directly  
3 with the supervisors, we would, if we found out about it, we would  
4 take action with that supervisor as to, first and foremost, to get  
5 to the facts, is that really exactly what happened. There's  
6 always the perspective of the injured party, as well as the  
7 aggrieved party, and so we would want to make sure we have a clear  
8 investigation of those particularly. We take them very seriously  
9 and we have a very low tolerance for not only violence in the  
10 workplace, but definitely sexual harassment in the workplace and,  
11 in my area of responsibility, we have taken direct action with  
12 employees who have violated that policy and, in some cases, not  
13 only disciplined them, but terminated them.

14 Q. Okay. All right, I don't have any more questions at  
15 this point.

16 MR. NICHOLSON: Karen?

17 MS. BUTLER: Okay.

18 MR. NICHOLSON: Go ahead, Karen.

19 MS. BUTLER: Okay.

20 BY MS. BUTLER:

21 Q. I think the areas of interest for me are along three  
22 areas. That would be communication -- and I don't mean  
23 communication between points and IT communications, like that.

24 A. Right. People communication?

25 Q. That's right. Integrity and disciplinary actions.

1 A. Uh-huh.

2 Q. So we know from having studied this event that there  
3 were several people at least that thought leak on that day, at  
4 least prior to the second restart. And --

5 A. I'm sorry, that though what?

6 Q. That thought leak.

7 A. That thought that --

8 Q. A leak, that there was a leak as opposed to --

9 A. Okay. I understand your question.

10 Q. -- an element of column separation that was not being  
11 filled. And they had reported them to shift leads and the shift  
12 leads simply dismissed it. What has been done with the people  
13 skills side? Because these are supposed to be people that would  
14 help them learn to listen and take action appropriately to their  
15 subordinates.

16 A. Uh-huh. Well, again, the approach that we've taken is  
17 to, first and foremost, ensure that all of our employees and  
18 supervisors are aware of our procedures, what they are responsible  
19 for, that they are not be interpreted loosely, and what their  
20 responsibilities and the various roles are. Secondly, we've taken  
21 them and retrained them so that they would understand clearly and  
22 we could say that if you have received this training, you would  
23 clearly know what things could be going on and what your  
24 responsibility were, and even if you couldn't figure it out  
25 yourself, that we are on the side of keeping the line down until

1 we can have a technical explanation of exactly what's going on.

2 In the situation that occurred that evening and into the  
3 next day, I think it was clear that people thought they knew what  
4 they were doing. They had made an assumption that was incorrect  
5 and they continued to try to look at filling the line because they  
6 thought the pressure would come back up. It's not something that  
7 I believe all of our shifts would have done, and so there was  
8 potentially inconsistency of people's understanding of their  
9 ability to make the right call and their ability to always end up  
10 with the same result, and that's why the focus on complacency and  
11 training and support is so important in the changes that we've  
12 made since the Marshall incident.

13 Q. Do you believe that supporting people involves listening  
14 to them and responding to what they tell you?

15 A. Absolutely. The whole point of having a successful  
16 relationship with your employees is that they can feel supported  
17 and they can feel trusted. And in a situation where an employee  
18 does not feel their supervisor believes them, is taking them  
19 seriously, is listening to their concerns and ignoring them is the  
20 worst situation you can have between a supervisor and an employee.

21 Q. Okay. So, to me, reiterating procedures explains to me  
22 what to do and why I should do it, in some cases, training helps  
23 me do it, but the support part I haven't heard yet that we can  
24 prevent Marshall in the future is what we're going to do for our  
25 shift leads that are supposed to be specific people oriented --



1 Now, we have a technical one and I'll talk to that in a minute --  
2 that the people-oriented individual such that they go through some  
3 specific leadership training associated with listening and  
4 responding to their subordinates.

5 A. Uh-huh.

6 Q. Has that been discussed?

7 A. Let me think about that. One of the things that I have  
8 had in place prior to the control center being my responsibility  
9 is a line supervisor training program. So we've recognized that  
10 it is important that people don't just get into supervisors, that  
11 they get specific training of the roles and responsibilities and  
12 the challenges. That is a good point. I don't know where we are  
13 with respect to taking our shift supervisors and looking at the  
14 people side of the training for that. Our supervisors and field  
15 operations have been through all of that and we have an ongoing  
16 program to run new supervisors through that, so it's a point that  
17 I will take away and take a look at.

18 Q. Okay.

19 MR. JOHNSON: Actually, I -- and I'll jump in here.  
20 There are some of them in the line supervisor training next door  
21 right now.

22 MR. ZUPAN: Okay.

23 MS. BUTLER: I would hope that there's some --

24 MR. JOHNSON: There is.

25 BY MS. BUTLER:

1 Q. -- there's some enhanced training going on for listening  
2 skills to your subordinates in understanding how to respond to  
3 that properly. And my second aspect of what we've got going on  
4 with the shift leads is their technical ability. Have the people  
5 that reported to you expressed to them -- to you that all consoles  
6 are not the same?

7 A. Absolutely.

8 Q. So what are we doing to make sure that the person we put  
9 on shift, that is the technical shift lead, is fully equipped to  
10 deal with the toughest console on the (indiscernible)?

11 A. So what we've looked at is this is still a journey. So  
12 we would have loved to have been able to change overnight and say  
13 we would have technical people that can support both the toughest  
14 lineup there and the toughest terminal. A long-term focus is to  
15 have a technical supervisor for the pipelines as well as for the  
16 terminal operations. We will not be able to get there in a short  
17 period of time because of the whole training piece.

18 Q. Completely get that.

19 A. Right. So our view is that that technical supervisor  
20 needs to be basically the brightest technical person on shift  
21 there, so they should be able to deal with the toughest line. We  
22 don't want to take someone who's operated the easiest pipeline and  
23 just assume that now they can become a technical expert. In fact,  
24 we've recognized that more so over time, that some operators are  
25 very good at operating some lines, but some of them find it so

1 challenging to operate the tough lines that, in some cases, that's  
2 part of the reasons why they left the organization. So other  
3 operators love the challenge of operating the tough lines and they  
4 do a very good job on it. So it's making sure that we put not  
5 only operators in place that can operate the toughest lines, but  
6 we also put technical people in place that can operate in the  
7 challenges of the toughest lines.

8 Q. I would ask you to consider on a go-forward basis that  
9 part of your long-term plan is that you use people that have  
10 operating experience on the toughest (indiscernible), that you  
11 have conversations around what that means so that when someone  
12 like I come in here, it can already spell out they've got it  
13 underway.

14 A. Yeah.

15 Q. Okay, so there is nothing there. All right. So then, I  
16 guess what I'm going to ask now is how many are in the pool  
17 associated with training? Because you mentioned that resources is  
18 a key to preventing Marshall from happening again.

19 A. So I was hoping you actually would have interviewed Al  
20 Baumgardner --

21 Q. Okay.

22 A. -- because the man knows all of these details inside and  
23 out. I get briefed at a high level of where we are. I don't get  
24 those briefings every week, and so I'm not in a position to give  
25 you any details specifically on that, but there are people in our

1 organization who could do that right now, if you want them to --

2 Q. Okay. We'll -- we can ask that --

3 A. Sure.

4 Q. -- if we need to. And then I would ask, the next  
5 question is do you know the methodology or what they've talked to  
6 you about that is going on behind the scenes to determine what the  
7 right number of resources is?

8 A. In general?

9 Q. Yeah.

10 A. Yeah. So what our folks have been doing is looking very  
11 closely at where the challenges are from the employees. So  
12 instead of just a management view, they've been engaging the  
13 employees to understand what they see as the challenges. Our  
14 focus on safety culture within the control center is another way  
15 of getting that information from them, and our safety perception  
16 survey is providing again information to us about what people see  
17 as the support and their roles and the roles of the people that  
18 support them. So our (indiscernible) work with the control  
19 center, I think, is one of the areas that we're trying to get  
20 another view of what people feel that they need to be supported.

21 I think Kirk and Al have done a very good job of  
22 listening to their supervisory team, their management team, and  
23 looking in great detail on each one of these areas to try to  
24 figure out what more they need to do. And again, I -- they don't  
25 see this as the destination, they see this as a journey and

1 they're -- if there's a destination, it's to maintain a world-  
2 class statute for our control center in the future. They realize  
3 we aren't there yet. They realize the challenges that we have to  
4 do that. And I think, over time, working with peers in other  
5 industry, we will continue to learn from what others have done,  
6 learn from what the regulators are saying are important, as well  
7 as from our own supervisors and employees themselves.

8 Q. Okay. I think I'd like to shift just a little bit then  
9 into you made a statement, I believe, it is clearly the controller  
10 -- or you've emphasized to the controller it's their  
11 responsibility to shut down that we've clarified that will -- in  
12 your mind, whose responsibility is it to decide when to start up?

13 A. Oh, it depends on the situation. So we have situations  
14 where that could occur, because we had a (indiscernible) at a pump  
15 station, because we had a power failure, because we had a gas  
16 alarm. So provided the right information comes back to the  
17 control center operator and the control center shift supervisor,  
18 there are a number of things that, under our normal procedures,  
19 they can make the call themselves that they understood the  
20 problem, they've corrected the problem, and now they're in the  
21 position to restart again. There case would be a power outage.  
22 There are other situations where they need to be able to explain  
23 exactly what has happened along with the technical expertise  
24 that's available to them, and if they can't, then they're not in a  
25 position to make the call. They need to escalate that to the on-

1 call person, if it's during the night, and, if necessary, to bring  
2 the engineering support in order to evaluate the situation before  
3 they restart.

4 Q. So if we have a situation where on-call thinks it's okay  
5 to restart and the shift leads do, but the operator is not  
6 comfortable, what do you think is the expectation in that case?

7 A. That the lines stays down until the operator is either  
8 comfortable or they go and get further support to make that  
9 decision.

10 Q. Do you believe it's been emphasized to the operators  
11 since the Marshall (indiscernible)?

12 A. That is my understanding, yes.

13 Q. Communication, I want to emphasize the communication  
14 that goes on between the Integrity Department and the control  
15 center. So when Integrity recognizes that we have a significant  
16 condition out there and we need to restrict pressure and they send  
17 that notification, what's done to prepare the controllers for what  
18 that impact is going to be to them?

19 A. Pre putting in the restriction or post or both?

20 Q. Pre putting in the restriction?

21 A. So I think the process, the way I understand it, is when  
22 that notification comes in, our engineering support people in the  
23 control center would receive that information, and then they would  
24 take action to explain to management, the shift supervisor, what  
25 conditions exist and what requirements need to be put in place

1 immediately, and that could involve, first and foremost, shutting  
2 the line down, if it's a serious notification that comes in in  
3 terms of anomaly on the pipeline, or a requirement to put in a,  
4 either an immediate pressure restriction or a pressure restriction  
5 when they're actually doing the investigation itself on a  
6 pipeline. So under those scenarios, those -- my understanding --  
7 and again, Al Baumgardner would be in a much better position to  
8 have an explanation of exactly how the process works. But my  
9 understanding would be then that would be explained to the shift  
10 operator and that shift operator would also explain it to the  
11 person that would be replacing them.

12 Q. Okay. So do you think that the training group is in  
13 this link at all? Like, we know that maybe we're going to be  
14 running in a lower condition than we've ever done before and we're  
15 not even sure that our control valves can handle that. Is the  
16 training group in the link such that maybe they can prepare  
17 simulators on -- simulations on short order or have they have  
18 talked about that to you?

19 A. My understanding is they can do that and that they can  
20 make that a priority and achieve that. I think it raises, you  
21 know -- we've been in an interesting situation for the last couple  
22 of years where a number of our pipelines have had limitations on  
23 them that have made them much more difficult to operate than they  
24 have under normal conditions, and so it has not been something  
25 that hasn't been anticipated and actually been dealt with for

1 quite some period of time. It is very challenging for some of the  
2 operators. I have talked to them on shift. Some of our lines not  
3 only were difficult to operate in the past, they're even more  
4 difficult with the Integrity programs that have gone on.

5           So our perspective is really on ensuring that we have a  
6 good process and procedures between not only what comes in from  
7 Integrity and what they're finding in the field, but also how our  
8 control center engineers deal with multiple issues. So we've  
9 staffed up our engineering team and the management and oversight  
10 of that team quite a bit in the last year here and we will  
11 continue to add resources as necessary to manage those types of  
12 conditions. Now, we do anticipate, with the large number of  
13 internal inspections that we're running that will continue well  
14 through 2012 -- but our goal is to have completed not only in the  
15 inspections, but our day programs be largely finished by the end  
16 of 2012, and as a result of that, we should be able to, over the  
17 next year and a half here, start returning our lines to more  
18 normal operations.

19           Q. Is there anything in place right now that would  
20 guarantee when there is a pressure restriction that somebody  
21 reviews it for whether or not training should happen before it's -  
22 -- but I realize that there are mediates that no one has control  
23 over.

24           A. Yeah. I would say very difficult to take a hypothetical  
25 situation and determine whether you need training. I think the



1 more practical approach is to, first and foremost, implement the  
2 pressure restrictions. If it turns out the line is almost  
3 impossible to operate, then at that point in time, we would have  
4 the discussion not only with the shift supervisors, but also with  
5 the engineers and our management team, and then take action as to  
6 whether it is actually still possible to safely operate the line.  
7 If it becomes a challenging operation, the I agree that's where  
8 not only just the training piece, but the on-sight support needs  
9 to come in and determine what's the best way to train our  
10 operators to operate under those circumstances and to make sure  
11 that information happens on each one of the shifts.

12 Q. Okay. You've mentioned that the control room has been  
13 in a lot of growth and we know there's been lots of pipelines  
14 going on.

15 A. Uh-huh.

16 Q. Has there been any discussion about giving a longer  
17 timeframe for when the pipeline is expected to be in service to  
18 get more resources trained up?

19 A. I think we've had enough notification. What we needed  
20 to be able to do is to show that we have the capabilities to have  
21 people in place to operate those facilities prior to them being  
22 commissioned so that we don't find ourselves in a catch-up mode.  
23 But, practically speaking, we're in a catch-up mode right now. We  
24 want to hire more people to fill up the technical supervisor roles  
25 to ensure we've got the strength to handle all of the new

1 pipelines that are coming our way. Fortunately, most of the new  
2 lines that are coming into service are not difficult to operate  
3 because they're either in start-stop mode or they're very low in  
4 terms of their overall through. But it's more of a situation  
5 where the lines that we have operated for, in some cases, decades,  
6 are the most difficult lines for us to operate and they're  
7 becoming more challenged as we manage the integrity programs and  
8 return them back to their safe operating limits by having all of  
9 the anomalies addressed. So it's more of a situation of being  
10 able to handle the complicated, the tough lines, as you mentioned  
11 earlier. It's easier, actually, to bring our new lines up and  
12 operate them because they tend to not to be the challenges that  
13 they're -- our main line is.

14 Q. So if we had enough time to -- at least we had enough  
15 notification and they're fairly simple, but they still take  
16 resources to operate, then have we looked at what could be done to  
17 hire earlier or --

18 A. Yeah. Well, as an example, we've just announced that  
19 we're going to be training (indiscernible) our (indiscernible)  
20 system in Alberta. That's a 2-year notice that we have. So it's  
21 not like 2 years is not enough, if only we had 2-1/2 years, we'd  
22 be ready for it. It's more of a situation of saying, all right,  
23 in 2 years, we need to operate this pipeline. In 16 months or 12  
24 months, we need to have this capability, we need to start hiring  
25 at this point in time. And I think our people understand that now

1 and they are feeling confident that we are starting to get to the  
2 point where we aren't having to rely on overtime and extra shifts  
3 in order to manage the situation. Some of those new hires are  
4 getting through their training program and they're now being put  
5 on shift and our starting to ease on the workload, and I think  
6 they've done a pretty good job on workforce planning to look  
7 forward to make sure we are going to have enough operators for the  
8 new lines that are coming on as well.

9 Q. Okay. Can we talk disciplinary for a minute?

10 A. Okay.

11 Q. Do you know who was involved with the initial decision  
12 to pull who off shift right away and take them out of the control  
13 room?

14 A. No.

15 Q. Okay.

16 A. You mean in terms of right after the incident?

17 Q. Yes.

18 A. No. That would have happened back in July, and I didn't  
19 take on any responsibility until October.

20 Q. Is there any additional things that have fallen to delay  
21 disciplinary actions based off of the outcome of the investigation  
22 or in the internal investigation that did fall to you or will fall  
23 to you?

24 A. It has post-October, yes. So, you know, our -- I think  
25 our formal view back (indiscernible) the NTSB is that until the

1 investigation is complete, we are not taking disciplinary action  
2 with any of the employees. We're not allowing them to necessarily  
3 continue to do the duties that they had prior to the incident, but  
4 the disciplinary actions are really being predicated based on the  
5 investigation.

6 Q. So if a shift lead that may have had some involvement or  
7 inappropriate involvement in the event has not been removed, is  
8 there still that possibility or have we have just moved on?

9 A. I think we have tried to err on the side of taking all  
10 of the people that might have been in an area of responsibility  
11 and ensuring that they have been taken off their regular duties.  
12 And other than what we've -- as you are aware today, some of the  
13 employees that were involved have decided to leave the company.  
14 Two of them have decided to take a retirement package from us, and  
15 the rest would, again, be awaiting the final determination of the  
16 investigation.

17 Q. Okay. So those two that took retirement, was that their  
18 choice or was it a forced retirement?

19 A. It was offered to them and they accepted it.

20 Q. One last thing on communications between groups. Since  
21 Integrity management reports to a different VP, if I have this  
22 right, and conceivably senior VP -- forgive me if I --

23 A. Uh-huh. There's two senior, VPs, myself and Art Meyer,  
24 that have responsibility --

25 Q. Okay.

1 A. -- for the control center, for Leak Detection Integrity.

2 Q. Okay. So what Integrity comes through and they know  
3 that in the near future, they're going to need to replace three  
4 (indiscernible) or they're going to need to have a special  
5 timeframe during an upcoming year when they get time to really go  
6 out there and they need low conditions --

7 A. Uh-huh?

8 Q. -- what have we done to make sure that that  
9 communication occurs in enough time to prepare the controller?

10 A. So our Integrity Group has heard more than on one  
11 occasion from operations about the need for prior notification.  
12 In some cases, it's just impossible. Obviously, if we get the  
13 results for a tour run tomorrow, we will take immediate action.  
14 It would be nice to plan all these things, but in some cases, the  
15 tour runs say the line's fine, and in some cases, they say we have  
16 to take action. In terms of your example of pipe replacement,  
17 those are long-term items, so --

18 Q. Right.

19 A. -- those are the easiest ones for us to manage. But  
20 whenever we're going the planning for tour runs, we have a  
21 maintenance advisory team that comes together that looks at that a  
22 year in advance. So we take all of the known capital and  
23 operating work that will happen in 2012 to plan that in advance  
24 because we do want to minimize the impacts to our customers  
25 wherever that is possible. And where it happens on an unplanned

1 basis, if we have prior notification, that goes into the next  
2 month's plan of what we will do not only to schedule the system,  
3 but to operate it. And then, of course, anything can happen on a  
4 daily basis, and so that's why we have a large group of people  
5 that are there to handle that type of change on a daily basis and  
6 on (indiscernible).

7 Q. So something that can be planned is really supposed to  
8 go through this Maintenance Advisory Team you've set --

9 A. Absolutely, yeah.

10 Q. -- and that could happen up to a year in advance for  
11 that?

12 A. That's right, yeah.

13 Q. All right. So who's on that Maintenance Advisory Team?  
14 Do you know?

15 A. We have representatives from the other department, but  
16 it's basically coordinated under -- our Vice President of Pipeline  
17 Control has the responsibility to make sure that's being done  
18 properly.

19 Q. So --

20 A. And one of the thing's they're actually interested in is  
21 if we have plan maintenance, they want to understand what impacts  
22 that will have to line. Because we do know that some of our  
23 lines, a pressure restriction will take them to a very, very  
24 tenuous operating mode and, in some cases, we might actually have  
25 to plan on shutting down under the circumstances. And then, of

1 course, we try to be efficient by planning and combining a number  
2 of different maintenance projects in the same line for the same  
3 shutdown.

4 Q. So that would make sure that the VP of Pipeline Control,  
5 which would be under you, is responsible for reaching out  
6 (indiscernible)?

7 A. He's responsible for ensuring that process is done  
8 effectively and efficiently, and I've talked to him about that and  
9 it's one of the things that he's pretty passionate about.

10 Q. Do you believe he gets the cooperation he needs from the  
11 other department?

12 A. I do.

13 Q. I believe that that's all I have. Thank you.

14 A. Okay.

15 BY MR. PIERZINA:

16 Q. Leon, early on, you mentioned your role in CCO changes,  
17 which we spent a great deal of time on, but also emergency  
18 response changes. Could you touch on those?

19 A. Sure. You know, I think we saw firsthand the difference  
20 in dealing with all of the regulators, Marshall versus Romeoville.  
21 Although we had trained our people on incident command, we had  
22 never had to implement a unified command structure with a number  
23 of federal agencies and local agencies. And what we learned at  
24 Marshall was that if you can effectively put an incident action  
25 plan in place, you can assign the roles, you can have the

1 communication upfront and the right briefings, you will largely be  
2 held as the responsible party to actually operate that. And so,  
3 it clearly showed to us the value of being more of a world class  
4 -- have world class capability in incident commanded emergency  
5 response. So we've created an emergency response group and we've  
6 started to -- well, we've staffed it up. I think we're about five  
7 people right now and working with consultants who are very well  
8 trained in this area, the response group. In fact, one of their  
9 VPs was the incident commander for VPM Mocango (ph.). They've  
10 started training our people in terms of incident response. We're  
11 -- we've got a syllabus of training programs for all of our key  
12 people to go through from an incident response perspective,  
13 including an enterprise-wide approached incident response, which  
14 is basically what happened at Marshall. We had people from all of  
15 our business units coming together. They just hadn't been trained  
16 ahead of time to know what to expect, to know what their roles  
17 are.

18           In terms of the emergency response capabilities, we've  
19 indicated that we will be probably spending in the neighborhood of  
20 50 million dollars over the next 2 years to improve our equipment,  
21 our capabilities, the development of better tools to deal with  
22 particular waterborne spills, to be able to deal with our worst  
23 case scenarios, to improve our training program to deal with our  
24 worst case scenarios, and our involvement with contractors and co-  
25 op agencies so that we know who we can rely on, timing, obviously,



1 being in the essence -- being of the essence in an emergency. So  
2 it's a fairly major initiative in operations right now and we're  
3 focusing on implementing a lot of change in the next 12 months.

4 Q. Does public awareness also fall under your purview?

5 A. It's kind of strange situation in the United States. It  
6 is part of our Public Affairs Group and, in Canada, it's part of  
7 our -- more of our right-of-way responsibilities, which is under  
8 my responsibility.

9 Q. Okay.

10 A. So I follow very closely and work with our Public  
11 Affairs Group in the United States in terms of what our Public  
12 Awareness Program is, and in particular, it's our people that are  
13 responsible for the face-to-face meetings with first responders,  
14 Fire and Police, et cetera.

15 Q. And that's kind of what I was most interested in is your  
16 face-to-face interactions with the emergency responders. Have  
17 there been any changes considered or implemented to enhance the  
18 face-to-face liaison with emergency responders?

19 A. Yeah. Obviously, we were quite surprised to see the  
20 decisions that were made in Marshall leading up to our  
21 notification. And so, we've recognized that we have to do a  
22 better job in dealing with 911 centers and dealing with -- you  
23 know, you can deal with a local volunteer fire department chief,  
24 but if he doesn't pass that information on or he doesn't  
25 understand it or she doesn't understand it, then you're

1 discharging your duty to notify, but you're not necessarily  
2 getting to a point where you know what response will occur. So  
3 our focus is to work with our industry associations to figure out  
4 -- because it's not just an Enbridge issue, it's --

5 Q. Uh-huh.

6 A. -- it's a national issue as to what we could do  
7 collectively better, particularly when it comes to dealing with  
8 911 centers. I think that's a very key area for us to figure out  
9 how to do a better job in terms of the training and support.  
10 Since there are thousands of 911 operators across our nations,  
11 it's a challenge to make sure that they -- you're able to get the  
12 right response when an order complaint comes in or a detection of  
13 a release comes in. The same thing with our local fire  
14 departments. We want to spend a lot more time making sure that  
15 they understand the various components where pipelines are and in  
16 doubt -- when in doubt, to make sure that they call us if they  
17 have any questions. So are we there yet? No. I think this is a  
18 set of requirements that's going to take us a little bit longer to  
19 implement on a national basis, at least to our own states that we  
20 have our pipeline facilities. But again, I think (indiscernible)  
21 this is something that our industry needs to take a lead role in  
22 as well.

23 Q. Do you think Enbridge would be willing to use Marshall  
24 as a training example?

25 A. We have already. So --

1 Q. Okay.

2 A. -- both in Canada and the United States, we have gone to  
3 industry associations and we've sat down and explained to them the  
4 details of what happened that aren't subject to the NTSB  
5 investigation so that -- our view is that environmental safety  
6 issues are not proprietary. There are some things that should be  
7 shared with all industry partners and that's the focus that we've  
8 taken on our major incidents.

9 Q. Okay. We were, a lot of here were on site early on in  
10 the accident and one of the things that struck me was, well, early  
11 on, there was the discussions of whether the leak took place, you  
12 know, Monday afternoon, when it was reported, or early Sunday  
13 evening and the volumes, and I recall, you know, questions  
14 concerning that coming from various agencies responding and no --  
15 you know, I think information was known early on, you know, that  
16 would have happened, but no willingness, I guess, to bring that up  
17 during those earlier emergency response meetings and I was just  
18 curious why that was.

19 A. I'm not quite sure I'm clear on the question there,  
20 Brian.

21 Q. Okay.

22 A. So when -- could you be more specific?

23 Q. Well, so there's quite a -- a couple of issues. There  
24 was questions concerning the quality of a product released, and  
25 also the timing of the accident, I think, was probably the bigger

1 one because I think it was probably clear early on that the  
2 release occurred Sunday night, yet that wasn't -- you know, while  
3 it was brought up, I think, in the meetings, it wasn't admitted to  
4 or acknowledged, I guess. Maybe that's the better word. I'm kind  
5 of just, I'm just unclear as to why that would be.

6 A. Well, I can tell you from my perspective, having been  
7 site, there was never discussion about, okay, we really don't  
8 know, we're not going to talk about this, we're not going to  
9 provide any information on this. It was really a situation we  
10 were overwhelmed by the size of this incident and our primary  
11 responsibility for the people on site was how we were going to do  
12 with the community, how we're going to do with the oil in the  
13 environment and in the water, how were we going to implement a  
14 overall focus. I did not spend really any time talking to the  
15 people in the control center side as to the details of all that I  
16 was probably not even aware of as an executive in the organization  
17 for probably a week so. You know, it was really a focus of it  
18 wasn't so much important for me to know whether it happened as --  
19 the responding in incident commander, whether it happened on  
20 Sunday night or on Monday morning. It was more about what are you  
21 going to do about the situation we have in front of us. We  
22 recognized there would be investigation and all the details would  
23 get out. In fact, I was -- when I did have time, my role was  
24 really to talk to our senior executive team to say I'd think we'd  
25 better appoint an internal investigator soon. Here's some people

1 that I think we would consider as names. And so, I can't have any  
2 responsibility for this, but I think it's important and I think  
3 we'd better start that process. But I was 110 percent response  
4 than what happened when --

5 Q. Certainly.

6 A. -- other than the whole situation of whether one of our  
7 employees might have been involved with the whole --

8 Q. (Indiscernible).

9 A. -- consumer energy incident.

10 Q. When did you first learn of the accident?

11 A. I was in Calgary preparing for a Board of Directors  
12 meeting on Monday and -- you know, it's a bit of a blur now.  
13 Sometime midday on Monday, I received a call from Tom Ferdell  
14 (ph.) indicating that we had oil in the Townridge Creek and  
15 heading towards the Kalamazoo River and that this might be a big  
16 one, in which case I informed my executive, Steve Worey, who  
17 informed Pat Daniels. We got further information that day and Pat  
18 decided that it was significant enough that we would take the jet  
19 down to Kalamazoo. And so, I went back to Edmonton and got my  
20 gear, they picked me up in Edmonton, then Pat and Steve and myself  
21 and Darcy Woobek (ph.) flew down that evening.

22 Q. Okay, thank you very much.

23 UNIDENTIFIED SPEAKER: One (indiscernible) just to bring  
24 you up to speed. Harold Looney (ph.) just did a public awareness  
25 audit of our program in July (indiscernible) out of your area and

1 we covered a lot of those issues, and I think if you talk with  
2 Harold, he'll give you a pretty good indication of what our  
3 (indiscernible) is and (indiscernible) we're going forward with  
4 it. And actually, today was the second date (indiscernible) of  
5 our first public awareness plan committee meeting, which Mike  
6 Muller (ph.) is one of the co-chairs of, and they're -- and part  
7 of the reason -- and they've got a representative from each one of  
8 the regions that report to Leon to look at how Operations can  
9 better meet with emergency officials and 911 centers and  
10 everything else. That's going on literally.

11 MR. PIERZINA: Yeah, yeah.

12 MR. JOHNSON: Today is the second day for that. So that  
13 was --

14 And just one clarification because you did ask that,  
15 Brian, and then Karen had mentioned it, and Matt had mentioned it  
16 yesterday, and maybe Leon.

17 BY MR. JOHNSON:

18 Q. If you could touch on the ring in the message that was  
19 given to all employees here --

20 A. Sure.

21 Q. -- recently?

22 A. Our CEO, who obviously took a very strong leadership  
23 position in the incident for 3-1/2 months on site, wanted to  
24 ensure that operation and integrity were first and foremost the  
25 focus of our organization. We started off ensuring that we

1 reorganize or divisions, and then he directly wanted all of his  
2 executive team to be involved in a monthly review of all of the  
3 (indiscernible) so they had a better understanding of what's going  
4 on. But he also recognized that this was something that all of  
5 our employees need to learn from.

6 In Canada, there is a tradition if you become a  
7 professional engineer at an iron ring, which represents a bridge  
8 that failed in Quebec City because it was not designed properly,  
9 and so all engineers are reminded in wearing an iron ring of their  
10 responsibility to do their jobs correctly, we use the concept by  
11 providing each of our employees and all or our new employees with  
12 a ring that really speaks to their responsibility of maintaining  
13 the integrity of our system. And even though it does contain some  
14 of the line 6B pipe as a bit of a symbolic nature, the ring is  
15 really representing that we need to take responsibility in all of  
16 our different business units, not just (indiscernible) pipelines.  
17 So our focus is that this is not something that should ever been  
18 forgotten and, in fact, our new employees will be made aware of  
19 that as they hire on in the organization.

20 Q. Very good. That was all I had.

21 MR. NICHOLSON: Okay, Barry, have you got any follow-up?

22 MR. STRAUCH: Not for me.

23 MR. NICHOLSON: Okay.

24 UNIDENTIFIED SPEAKER: I've got nothing.

25 MR. NICHOLSON: Karen?

1 MS. BUTLER: No.

2 MR. NICHOLSON: All right.

3 Okay, Leon, appreciate you coming in.

4 MR. ZUPAN: All right.

5 MR. NICHOLSON: I think, at this point we'll conclude  
6 our interview.

7 (Whereupon, the interview was concluded.)

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25



CERTIFICATE

This is to certify that the attached proceeding before the

NATIONAL TRANSPORTATION SAFETY BOARD

IN THE MATTER OF: ENBRIDGE- LINE 6B RUPTURE IN  
MARSHALL, MICHIGAN  
Interview of Leon Zupan

DOCKET NUMBER: DCA-10-MP-007

PLACE: Edmonton, Alberta, Canada

DATE: November 17, 2011

was held according to the record, and that this is the original,  
complete, true and accurate transcript which has been compared to  
the recording accomplished at the hearing as recorded.

---

Karen M. Galvez  
Transcriber