



U.S. Department  
of Transportation

Western Region  
Pipeline Safety

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Research and  
Special Programs  
Administration

August 28, 2002

Mr. Allan C. Beshore  
Investigator-in-Charge  
National Transportation Safety Board  
Office of Railroad, Pipeline and Hazardous Materials Investigation  
Washington, D.C. 20594

Dear Mr. Beshore:

I am responding to your August 6, 2002, request for our agency's conclusions regarding the National Transportation Safety Board (NTSB) Party investigation of the Olympic pipeline rupture in Bellingham, Washington. These comments are based on the facts and findings revealed during the course of the investigation. Additionally, I have attached a report prepared by our in-line inspection consultant which serves to supplement the conclusions numbered 9, 10 and 12 below.

As a member to the NTSB Party investigative team, we offer the following conclusions for your consideration:

- 1) The Olympic pipeline was damaged by mechanical equipment sometime prior to the release date.
- 2) Equipment operators at the construction site knew where the OPL pipeline crossed the project site and after making the change in their project design, did not notify OPL of the water system design change nor of the additional water line crossings of the OPL line at the ultimate rupture location.
- 3) The equipment operator who caused the damage to the OPL pipeline either did not know they were hitting the pipeline and therefore, was not following proper practice of utilizing excavation spotters or the equipment operator knew they had hit the Olympic pipeline and made a conscious decision to not notify OPL.
- 4) OPL did not have management systems in place to adequately and safely direct personnel in the performance of their duties regarding the safe operation of a pipeline facility.
- 5) OPL did not adequately train personnel regarding the use of or changes to operations and maintenance procedures.

- 6) OPL did not adequately update their procedural manuals to include the addition of the Bayview Products Terminal prior to commissioning that facility.
- 7) OPL personnel changed out the pilot operator parts on relief valve, RV 1919, without reviewing appropriate manufacturer's documentation.
- 8) OPL personnel did not have nor did they follow a management-of-change procedure when changing out RV 1919 pilot operator parts.
- 9) The internal in-line inspection device (ILI) that OPL chose to perform the survey required by the Washington Department of Ecology's (WA-DOE) 1996 order did not provide deformation data that was easy to interpret and quantify.
- 10) The caliper ILI device that OPL chose to run is capable of finding pipeline deformation anomalies, however, the ILI report resolution of two hundred fifty feet (250') of pipe for one inch (1") of log makes it very difficult to accurately locate a specific anomaly in relationship to nearby girth welds.
- 11) The ILI findings of the WA- DOE and OPL were not provided to Federal OPS.
- 12) The caliper vendor analyst believed that the anomaly identified at the rupture location was a weld and, therefore, did not report it to OPL.

Thank you for the opportunity to provide our comments. Please contact my office at 303-231-5701 if you have any questions regarding our response.

Sincerely,



Chris Hoidal, P.E.  
Director, Western Region OPS

cc: Stacey Gerard, Associate Administrator of Pipeline Safety