

DOT US Department of Transportation
PHMSA Pipeline and Hazardous Materials Safety Administration
OPS Office of Pipeline Safety
Eastern Region

Principal Investigator Alex Dankanich
Region Director Byron Coy
Date of Report November 12, 2014
Subject Failure Investigation Report – Buckeye Macungie Tank 228 Overfill

Operator, Location, & Consequences

Date of Failure June 17, 2012
Commodity Released Gasoline
City/County & State Emmaus, Lehigh County, Pa.
OpID & Operator Name 1845 Buckeye Partners, LP
Unit # & Unit Name 321 Macungie,
SMART Activity # 140297
Milepost / Location Macungie Tank Farm, 5131 Buckeye Road, Emmaus, PA 18049
Type of Failure Overfill of Atmospheric Low Pressure Breakout Tank
Fatalities None
Injuries None
Description of area impacted Tank Dike Containment Area
Total Costs \$87,000

Executive Summary

At approximately 06:00 hours on Sunday June 17, 2012, Tank 228 in the Buckeye Macungie Station located in Emmaus, Lehigh County, Pennsylvania, was overfilled. Tank 228 is designated as a break-out tank and is thus regulated under CFR 49, Part 195.

The overflow was caused by inaccurate calibration of the level gauging and alarm system on Tank 228. As a result, the Tank Side Gauge was reading approximately 18 inches lower than the actual product level in the tank. During the process of filling the tank on June 17, the control room operator received a “Safe Fill” and “Independent Hi-Hi Alarm” indicating that the safe fill level in the tank had been exceeded. Product flow was diverted to another tank. Shut down and volume calculations were conducted, which indicated a safe fill level and therefore a field inspection of the tank was not

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immediately performed. The extent of the overflow situation was not identified until the morning of June 18, when personnel smelled an odor of gasoline and noticed product staining near the vents on Tank 228.

Approximately 100 barrels of gasoline was released into tank dike area on Operator-controlled property. Tank 228 is located in a designated high consequence area (HCA). There were no injuries or fatalities, evacuations, or supply disruptions as a result of the incident.

An inspector from PHMSA Eastern Region was dispatched to the location on August 21, 2012, conduct an investigation into the cause of the release.

System Details

The Buckeye Macungie Terminal facility, located in Macungie, PA, consists of 27 breakout tanks that are regulated under CFR 49, Part 195 of the code of Federal Regulations (Appendix A-page 1-2). The terminal facility receives and temporarily stores refined products for delivery to market by pipeline and trucks. Line 620 supplies refined product from the Linden, NJ, station into the Macungie Station. At the Macungie station, product can either be routed to breakout tanks, or bypass the station and continue to other downstream storage locations or sent directly to customers. The outbound line 714 takes product from the Macungie station to the Sinking Springs Station and is controlled by the Breinigsville Control Center personnel. The Breinigsville control center has SCADA control over the entire Buckeye pipeline system and receives alarms that are announced at the various Buckeye Terminal facilities.

Tank 228 is an atmospheric low pressure breakout tank measuring 110 feet in diameter by 48 feet high, and it has an internal floating roof and a steel cone roof (Appendix A-page 3-4). Tank 228 was constructed in 1974 and is equipped with a tank level alarm system comprised of a GSI system and Hi-Hi Level Switch. The GSI is a software-based system that receives data from the tank side gauge, encoder, and transmitter mounted on the tank. The Hi-Hi Level Switch is located on the roof of the tank.



Events leading up to the Failure

Prior to the tank overflow that was discovered on June 17, 2012, Tank 228 was in normal service. Below is a summary of the events. A complete timeline can be found in Appendix D.

- a. June 16, 2012: The tank was receiving product from Line 620.
- b. June 17, 2012:
 - i. 05:50: The Macungie Night Shift Operator was preparing to swing the tank switch valve when he heard the Hi-Hi level alarm.
 - ii. 05:52: The alarm was received into SCADA and acknowledged by the Control Center Desk 13 Day Controller (CC13) in the Breinigsville SCADA control center. The Macungie night operator made a tank swing in the manifold from Tank 228 to Tank 222.
 - iii. 05:53: "Safe Fill Alarm" for Tank 228 was acknowledged by the Controller.
 - iv. 05:55: Tank 228 status changed to inactive.

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- v. 05:55-06:15: The CC13 Controller called the Macungie Night Shift Operator to check tank volume calculations. The Macungie Night Shift Operator acknowledged the “Safe Fill Alarm.”
- c. June 17, 2012, 06:50 to 15:00:
 - i. 06:50: Shift change. The Macungie Night Shift Operator reviewed the “Safe Fill Alarm” with the incoming day operator, including the reading on the GSI computer, which showed 3000 barrels of space remaining in the tank before overfill.
 - ii. 11:30: The Control Center (CC) received an odor complaint on Tank Farm Road. The CC Shift Lead called the Macungie Day Operator to report the odor complaint. The CC Shift Lead reminded the Macungie Day Operator about the Hi-Hi Alarm on Tank 228.
 - iii. 12:00: The CC Shift Lead and Controller at CC13 shut down Line 620 as a result of the odor complaint. The Macungie Day Operator did a drive by investigation of Tank 228 and did NOT notice product coming out of the tank vents or smell an odor.
 - iv. 12:30: The Macungie Day Operator sent a “chit chat” message to the CC Shift Lead and Controller at CC13 that everything appeared to be good throughout the tank farm. The CC Shift Lead called the Macungie Day Operator to confirm the report.
 - v. 13:30: Macungie Station returned to normal operations and returned Line 620 to service.
 - vi. 15:00: The Macungie Afternoon Operator came on shift and was informed by the Macungie Day Operator that there was an odor complaint during the day. The Macungie Afternoon Operator checked the Tank Book and saw that Tank 228 was close to Safe Fill Height. The Macungie Afternoon Operator was on his way to Tank 222, which is near Tank 228. No odor or release was noticed at Tank 222. The Macungie Afternoon Operator did not visit Tank 228.
- d. June 18, 2012:
 - i. 09:00: A Macungie pipeliner went to Tank 228 to prepare an outbound product movement. The pipeliner noticed an odor of gasoline. He inspected the tank shell gate valve pit and discovered product in the pit. He called the Macungie Day Shift Operator to report a potential release. Responding personnel noticed staining by the tank shell vents.
 - ii. 14:14: The release was reported to the NRC and PA DEP (Appendix B – NRC 1014928).

Emergency Response

On June 18, 2012, at approximately 09:00, a Macungie pipeliner smelled gasoline at the base of Tank 228 and discovered product in the Tank 228 valve pit. The pipeliner called Macungie station to report a potential release. When additional personnel arrived on site, product staining was noticed on the tank shell near the tank overflow vents. Buckeye’s Emergency procedures and OPA plan were successfully implemented in response to the release. There were no fires or injuries as a result of the event, and the environmental impact was minimal due to product containment. An estimated 100 barrels of gasoline was released into the containment dike area surrounding Tank 228. It has been estimated that approximately 26.5 barrels were recovered during the cleanup operation. Notification to the NRC was made on June 18, 2012, at 14:18. The Pennsylvania DEP was also notified.

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Summary of Return-to-Service

Upon completion of the spill remediation activities, the tank gauge level and alarm levels for Tank 228 were recalculated and adjusted to the appropriate levels. Tank 228 was then placed back in service. All other tanks at the Macungie tank farm were also checked to ensure gauge and alarm level accuracy. Monitoring wells have been installed in the tank dike as part of the remediation effort. No other remediation activities are planned.

In addition to the corrective actions taken immediately following the incident, Buckeye has identified additional corrective actions to be implemented to prevent reoccurrence. These actions are outlined in below and can also be found in Appendix D.

Additional Corrective Actions Identified by Buckeye:

1. Tank Gauging Procedures
 - a. Reinstate Monthly Hand Gauging of all tanks at Macungie Station.
 - b. Reinstate hand gauging to verify accurate gauge level during maintenance events on the Tank Gauging system at Macungie Station.
2. Check and evaluate all individual tank gauging systems at Macungie Station to ensure proper tank levels are being read through to GSI and SCADA.
3. Include Independent Hi-Hi Alarm Setting Calculation Guidance in 195 O&M Manual F-37 as policy and procedure for checking and/or re-setting Hi-Hi Alarms.
4. Ensure that Macungie Station Operations Personnel are trained on OQ task 412, Tank Operations.

Investigation Details

PHMSA Eastern Region received NRC report #1014928 on June 18, 2012, regarding an unintentional overfill of breakout Tank 228 at the Buckeye Macungie PA tank farm. On August 21, 2012, a formal accident investigation was initiated by PHMSA to determine the cause of the incident. Approximately 100 barrels of gasoline overflowed from the tank vents at the top of the tank during filling of the tank that took place on June 17, 2012. The overfill was not discovered until Buckeye personnel noticed an odor on June 18, 2012, while they were preparing to tap water from Tank 228. The operator inspected the tank shell gate valve pit and discovered product in the pit.

The investigation revealed that the set points of alarms and the tanks gauging system had not been accurately set or checked for at least one year. The tank side gauge and the GSI tracking system were reading about 18 inches lower than actual levels in the tank. The independent Hi-Hi magnetrol alarm level was set 7 inches too high. As a result, the tank gauge was showing the tank level to be at “max safe fill” at the same time the Hi-Hi alarm was received and the tank was in an overfill condition.

During the course of the investigation, PHMSA reviewed all applicable records and procedures related to the accident. The operating history for Tank 228 is provided below.

Four employees directly involved with the incident were submitted for Drug and Alcohol testing immediately following the accident per DOT Drug and Alcohol Testing Regulations. The results of the testing were negative.

Tank 228 Operating History:

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1974 – Tank 228 was constructed and placed into service. Tank 228 was last strapped (actual volume calculated) at this time. Over-fill height was established at 49'7".

1997 – Independent Magnetrol Hi-Hi Alarm System installed on tank. Hi-Hi Alarm set at 49'2".

2003 – Secondary seal installed on tank. This addition lowers the tank overfill level by 5 inches to 49'2". The Hi-Hi alarm set point was recalculated to be 48'7", which was 7 inches lower than the 49'2" set point established in 1997. There were no records available to confirm that the Hi-Hi level switch was reset to 48'7".

2010 – April – A change order (651345) was initiated for line 620. Safety control devices were adjusted to account for the rate change and set for 9,500 BPH (Barrels Per Hour).

2010 – May – The Hi-Hi switch on Tank 228 was lowered 2" to a new Hi-Hi Alarm Level of 48'5"

2012 – January 13 – Maintenance work was performed on the Gauging System on Tank 228 due to icing issues related to the gauge tape/side gauge. There were no records to indicate that Hand Gauging of the tank was performed, as required per procedures, to ensure the accuracy of the Gauging System.

2012 – March 31 – A measurement discrepancy of 1,299 barrels was identified on Tank 228 following the tank refill with summer grade product on April 1, 2012. This volume discrepancy was not investigated as required per Buckeye's Measurement Manual A-01, 16.1 Transportation Stock Variations.

2012 – April 13 – Side Gauge Rocker Knob and Negator Motor was replaced. There were no records to indicate that Hand Gauging of the tank was performed, as required per procedures, to ensure the accuracy of the Gauging System.

2012 – June 8 – The encoder and transmitter were changed on the tank gauging system. There were no records to indicate that Hand Gauging of the tank was performed, as required per procedures, to ensure the accuracy of the Gauging System.

2012 – June – As part of the Tank Overfill Investigation conducted by Buckeye, the Hi-Hi Alarm setting was measured at 49'0". Buckeye has confirmed that this setting was 7 inches above the correct setting of 48'5".

Findings and Contributing Factors

As a result of the accident investigation conducted by PHMSA, it was determined that the cause of the accident was due to Incorrect Operation pertaining to the failure to accurately calibrate the level gauging and alarm system on Tank 228. The investigation revealed that monthly tank gauging was not being conducted as outlined in Section A-01 and subsection 11.1 of the Measurement Manual.

The investigation also revealed that the Macungie Terminal recently discontinued the practice of hand gauging tank volumes when side gauge maintenance activities occur. This recent practice is inconsistent with the requirements outlined in Buckeye's O & M Manual (Appendices E and F).

In addition, the measurement discrepancy of 1,299 barrels that was identified on March 31, 2012, during a refill operation on Tank 228, was not investigated. Buckeye's Measurement Manual A-01, Section 16.1 (Transportation Variations) requires that variations greater than +/-0.25% for pipeline and marine receipts shall be investigated and the results documented (Appendix G).

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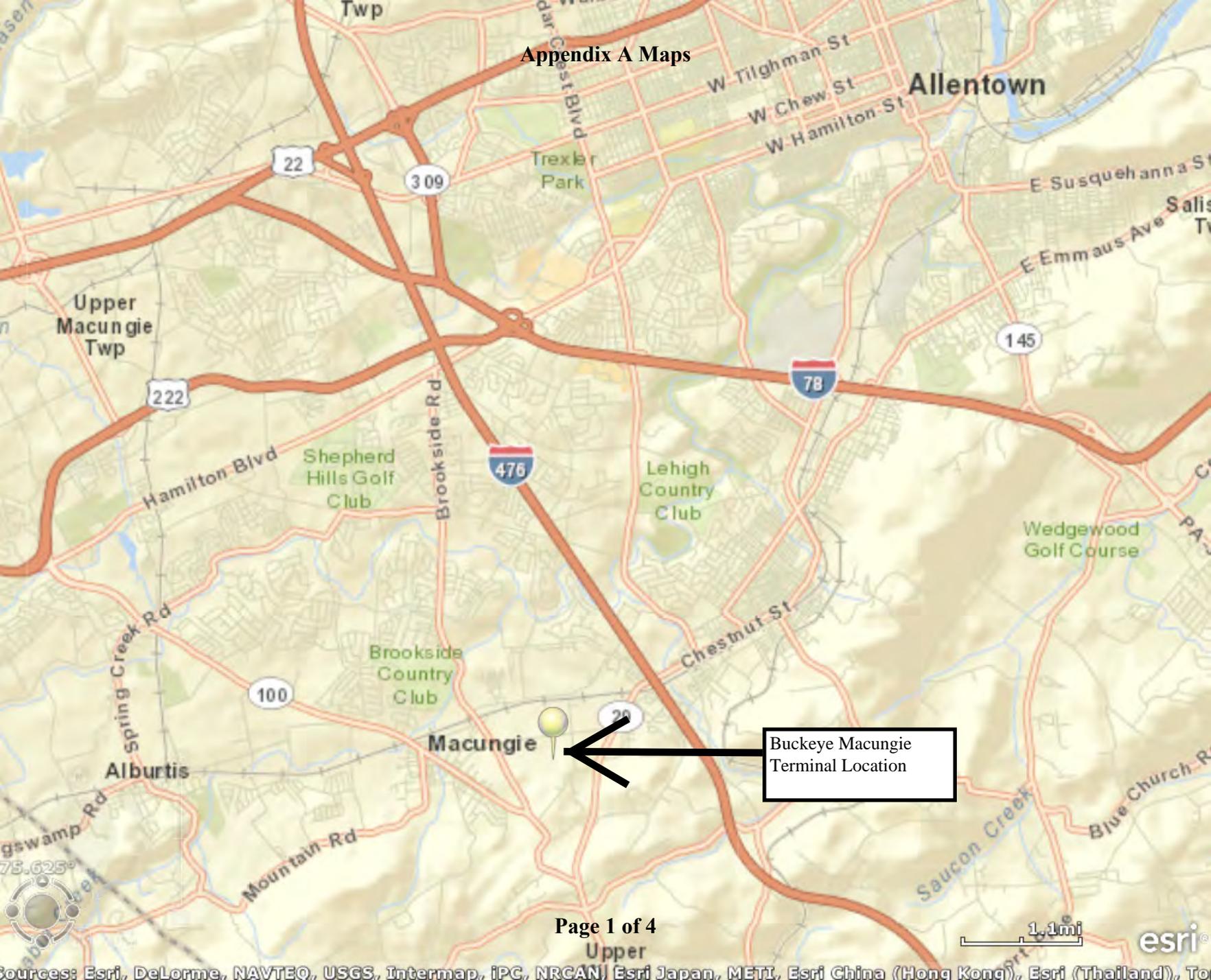
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Appendix	Description
A	140297 Appendix A Maps
B	140297 Appendix B NRC Report #1014928 6-18-12
C	140297 Appendix C 7000-1 Accident report 20120215-16856 - Final
D	140297 Appendix D Tank 228 Incident Investigation Report 08202012
E	140297 Appendix E_Buckeye Partners, LP H-09 – Tank Alarms and Gauging Equipment, Issued 910
F	140297 Appendix F_ Buckeye Partners, LP F-35 Tank Alarms and Gauging Equipment Issued 1211
G	140297 Appendix G_Measurement Manual, A-01 – Measurement Issued 1111

Appendix D through G Removed

File Available at PHMSA

Appendix A Maps



Buckeye Macungie Terminal Location

Appendix A Maps

Buckeye Macungie Tank Farm:
Macungie, PA

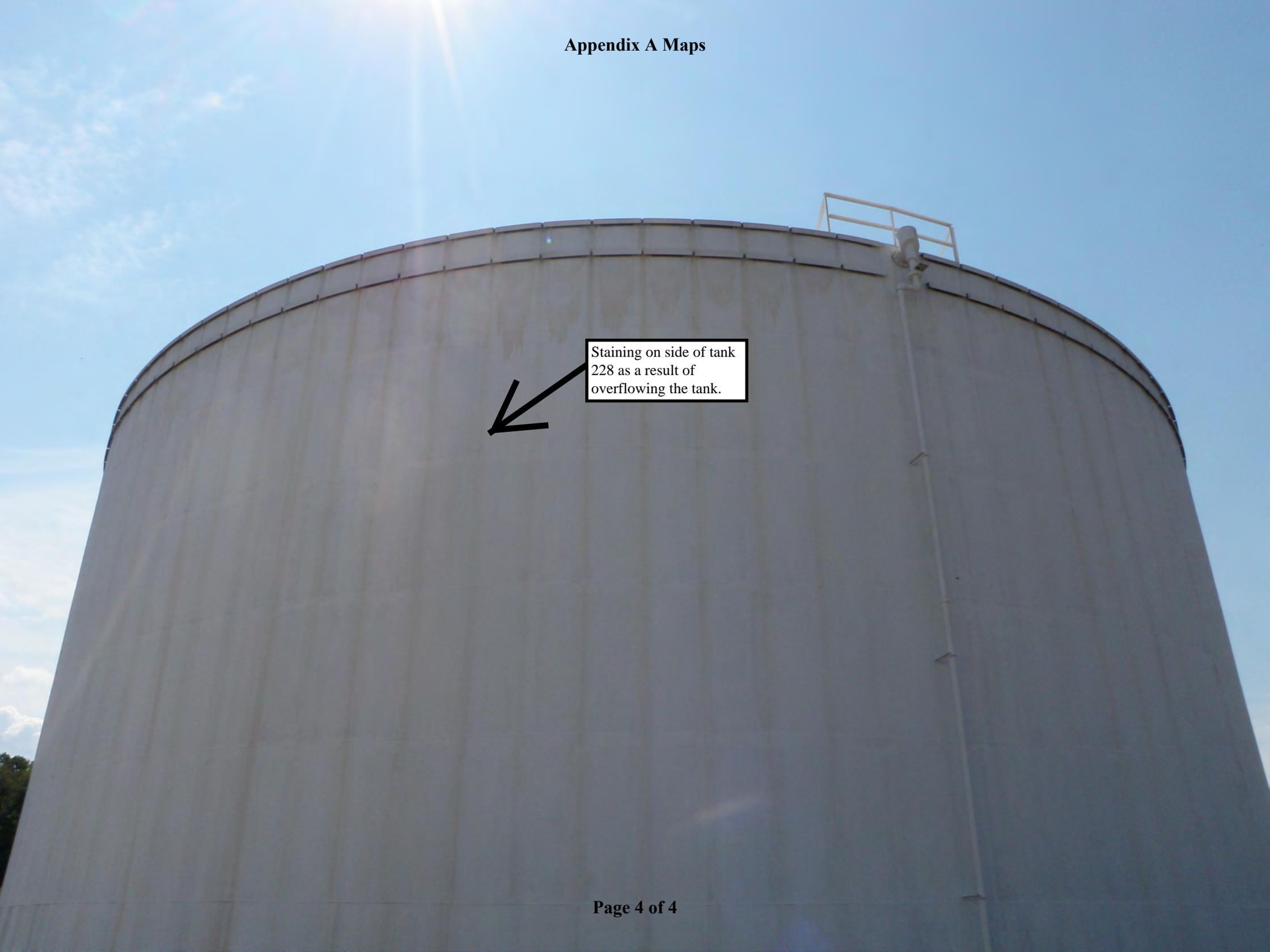
Tank #228



Buckeye Macungie
Terminal
Breakout Tank 228



Appendix A Maps



Staining on side of tank
228 as a result of
overflowing the tank.

NATIONAL RESPONSE CENTER 1-800-424-8802

*** For Public Use ***

Information released to a third party shall comply with any applicable federal and/or state Freedom of Information and Privacy Laws

Incident Report # 1014928

INCIDENT DESCRIPTION

*Report taken at 14:18 on 18-JUN-12

Incident Type: STORAGE TANK

Incident Cause: UNKNOWN

Affected Area:

The incident was discovered on 18-JUN-12 at 11:00 local time.

Affected Medium: OTHER SECONDARY CONTAINMENT

SUSPECTED RESPONSIBLE PARTY

Organization: BUCKEYE PARTNERS LP
EMMAUS, PA 18049

Type of Organization: PRIVATE ENTERPRISE

INCIDENT LOCATION

51231 BUCKEYE RD. County: LEHIGH
City: EMMAUS State: PA Zip: 18049
Latitude: 40° 31' 04" N

Longitude: 075° 32' 03" W

RELEASED MATERIAL(S)

CHRIS Code: GAS Official Material Name: GASOLINE: AUTOMOTIVE (UNLEADED)

Also Known As:

Qty Released: 300 BARREL(S)

DESCRIPTION OF INCIDENT

CALLER IS REPORTING A DISCHARGE OF GASOLINE ONTO THE SOIL. CALLER STATED THAT THERE WAS AN OVERFLOW FROM A TANK.

INCIDENT DETAILS

Description of Tank:

Tank Above/Below Ground: ABOVE

Transportable Container: NO

Tank Regulated: YES

Tank Regulated By: DOT

Tank ID: 228

Capacity of Tank:

Actual Amount:

DAMAGES

Fire Involved: NO Fire Extinguished: UNKNOWN

INJURIES: NO Hospitalized: Empl/Crew: Passenger:

FATALITIES: NO Empl/Crew: Passenger: Occupant:

EVACUATIONS: NO Who Evacuated: Radius/Area:

Damages: NO

<u>Closure Type</u>	<u>Description of Closure</u>	<u>Length of Closure</u>	<u>Direction of Closure</u>
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Air: N

Road: N

Waterway: N

Major Artery: N

Track: N

Passengers Transferred: NO
Environmental Impact: UNKNOWN
Media Interest: NONE Community Impact due to Material:

REMEDIAL ACTIONS

CLEAN UP CREW ON-SITE, CLEAN UP UNDERWAY, CONTRACTOR HAS BEEN HIRED, MATERIAL SPILLED INTO SECOND CONTAINMENT.

Release Secured: YES
Release Rate:
Estimated Release Duration:

WEATHER

Weather: OVERCAST, °F

ADDITIONAL AGENCIES NOTIFIED

Federal:
State/Local:
State/Local On Scene:
State Agency Number:

NOTIFICATIONS BY NRC

ATLANTIC STRIKE TEAM (MAIN OFFICE)
18-JUN-12 14:28
DHS PROTECTIVE SECURITY ADVISOR (PSA DESK)
18-JUN-12 14:28
DOT CRISIS MANAGEMENT CENTER (MAIN OFFICE)
18-JUN-12 14:28
U.S. EPA III (MAIN OFFICE)
18-JUN-12 14:30
FLD INTEL SUPPORT TEAM PHILADELPHIA (MAIN OFFICE)
18-JUN-12 14:28
NATIONAL INFRASTRUCTURE COORD CTR (MAIN OFFICE)
18-JUN-12 14:28
NJ STATE POLICE (MARINE SERVICES BUREAU)
18-JUN-12 14:28
NOAA RPTS FOR PA (MAIN OFFICE)
18-JUN-12 14:28
PA STATE POLICE (BUREAU OF CRIMINAL INVESTIGATION)
18-JUN-12 14:28
PA EMERG MGMT AGCY (MAIN OFFICE)
18-JUN-12 14:28

ADDITIONAL INFORMATION

CALLER HAD LIMITED INFORMATION AT THIS TIME.

*** END INCIDENT REPORT # 1014928 ***

Appendix C 7000-1 Accident report 20120215-16856 - Final

NOTICE: This report is required by 49 CFR Part 195. Failure to report can result in a civil penalty not to exceed \$100,000 for each violation for each day that such violation persists except that the maximum civil penalty shall not exceed \$1,000,000 as provided in 49 USC 60122.		OMB NO: 2137-0047 EXPIRATION DATE: 01/31/2014	
 U.S Department of Transportation Pipeline and Hazardous Materials Safety Administration	Original Report Date:	07/16/2012	
	No.	20120215 - 16856 ----- (DOT Use Only)	
ACCIDENT REPORT - HAZARDOUS LIQUID PIPELINE SYSTEMS			
A federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2137-0047. Public reporting for this collection of information is estimated to be approximately 10 hours per response (5 hours for a small release), including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, PHMSA, Office of Pipeline Safety (PHP-30) 1200 New Jersey Avenue, SE, Washington, D.C. 20590.			
INSTRUCTIONS			
Important: Please read the separate instructions for completing this form before you begin. They clarify the information requested and provide specific examples. If you do not have a copy of the instructions, you can obtain one from the PHMSA Pipeline Safety Community Web Page at http://www.phmsa.dot.gov/pipeline .			
PART A - KEY REPORT INFORMATION			
Report Type: (select all that apply)	Original:	Supplemental:	Final:
		Yes	Yes
Last Revision Date:	08/24/2012		
1. Operator's OPS-issued Operator Identification Number (OPID):	1845		
2. Name of Operator	BUCKEYE PARTNERS, LP		
3. Address of Operator:			
3a. Street Address	FIVE TEK PARK		
3b. City	BREINIGSVILLE		
3c. State	Pennsylvania		
3d. Zip Code	18031		
4. Local time (24-hr clock) and date of the Accident:	06/17/2012 05:52		
5. Location of Accident:			
Latitude:	40.514382		
Longitude:	-75.532567		
6. National Response Center Report Number (if applicable):	1014928		
7. Local time (24-hr clock) and date of initial telephonic report to the National Response Center (if applicable):	06/18/2012 14:18		
8. Commodity released: (select only one, based on predominant volume released)	Refined and/or Petroleum Product (non-HVL) which is a Liquid at Ambient Conditions		
- Specify Commodity Subtype:	Gasoline (non-Ethanol)		
- If "Other" Subtype, Describe:			
- If Biofuel/Alternative Fuel and Commodity Subtype is Ethanol Blend, then % Ethanol Blend:			
- If Biofuel/Alternative Fuel and Commodity Subtype is Biodiesel, then Biodiesel Blend (e.g. B2, B20, B100):	B		
9. Estimated volume of commodity released unintentionally (Barrels):	100.00		
10. Estimated volume of intentional and/or controlled release/blowdown (Barrels):			
11. Estimated volume of commodity recovered (Barrels):	26.50		
12. Were there fatalities?	No		
- If Yes, specify the number in each category:			
12a. Operator employees			
12b. Contractor employees working for the Operator			
12c. Non-Operator emergency responders			
12d. Workers working on the right-of-way, but NOT associated with this Operator			
12e. General public			
12f. Total fatalities (sum of above)			
13. Were there injuries requiring inpatient hospitalization?	No		
- If Yes, specify the number in each category:			
13a. Operator employees			
13b. Contractor employees working for the Operator			
13c. Non-Operator emergency responders			

13d. Workers working on the right-of-way, but NOT associated with this Operator	
13e. General public	
13f. Total injuries (sum of above)	
14. Was the pipeline/facility shut down due to the Accident?	No
- If No, Explain:	Product stream was swung to another tank
- If Yes, complete Questions 14a and 14b: (use local time, 24-hr clock)	
14a. Local time and date of shutdown:	
14b. Local time pipeline/facility restarted:	
- Still shut down? (* Supplemental Report Required)	
15. Did the commodity ignite?	No
16. Did the commodity explode?	No
17. Number of general public evacuated:	0
18. Time sequence (use local time, 24-hour clock):	
18a. Local time Operator identified Accident:	06/18/2012 09:00
18b. Local time Operator resources arrived on site:	06/18/2012 09:00
PART B - ADDITIONAL LOCATION INFORMATION	
1. Was the origin of Accident onshore?	Yes
<i>If Yes, Complete Questions (2-12)</i>	
<i>If No, Complete Questions (13-15)</i>	
- If Onshore:	
2. State:	Pennsylvania
3. Zip Code:	18049
4. City:	Emmaus
5. County or Parish:	Lehigh
6. Operator-designated location:	
Specify:	
7. Pipeline/Facility name:	Macungie Station
8. Segment name/ID:	
9. Was Accident on Federal land, other than the Outer Continental Shelf (OCS)?	No
10. Location of Accident:	Totally contained on Operator-controlled property
11. Area of Accident (as found):	Tank, including attached appurtenances
Specify:	
- If Other, Describe:	
Depth-of-Cover (in):	
12. Did Accident occur in a crossing?	No
- If Yes, specify below:	
- If Bridge crossing –	
Cased/ Uncased:	
- If Railroad crossing –	
Cased/ Uncased/ Bored/drilled	
- If Road crossing –	
Cased/ Uncased/ Bored/drilled	
- If Water crossing –	
Cased/ Uncased	
- Name of body of water, if commonly known:	
- Approx. water depth (ft) at the point of the Accident:	
- Select:	
- If Offshore:	
13. Approximate water depth (ft) at the point of the Accident:	
14. Origin of Accident:	
- In State waters - Specify:	
- State:	
- Area:	
- Block/Tract #:	
- Nearest County/Parish:	
- On the Outer Continental Shelf (OCS) - Specify:	
- Area:	
- Block #:	
15. Area of Accident:	
PART C - ADDITIONAL FACILITY INFORMATION	
1. Is the pipeline or facility:	Interstate
2. Part of system involved in Accident:	Onshore Breakout Tank or Storage Vessel, including Attached Appurtenances
- If Onshore Breakout Tank or Storage Vessel, Including Attached Appurtenances, specify:	Atmospheric or Low Pressure

Was this HCA identified in the "could affect" determination for this Accident site in the Operator's Integrity Management Program?	
- High Population Area:	Yes
Was this HCA identified in the "could affect" determination for this Accident site in the Operator's Integrity Management Program?	Yes
- Other Populated Area	
Was this HCA identified in the "could affect" determination for this Accident site in the Operator's Integrity Management Program?	
- Unusually Sensitive Area (USA) - Drinking Water	
Was this HCA identified in the "could affect" determination for this Accident site in the Operator's Integrity Management Program?	
- Unusually Sensitive Area (USA) - Ecological	
Was this HCA identified in the "could affect" determination for this Accident site in the Operator's Integrity Management Program?	
8. Estimated Property Damage:	
8a. Estimated cost of public and non-Operator private property damage	\$ 0
8b. Estimated cost of commodity lost	\$ 0
8c. Estimated cost of Operator's property damage & repairs	\$ 0
8d. Estimated cost of Operator's emergency response	\$ 0
8e. Estimated cost of Operator's environmental remediation	\$ 60,000
8f. Estimated other costs	\$ 27,000
	Describe: Tank cleaning and refurbishment
8g. Total estimated property damage (sum of above)	\$ 87,000
PART E - ADDITIONAL OPERATING INFORMATION	
1. Estimated pressure at the point and time of the Accident (psig):	.00
2. Maximum Operating Pressure (MOP) at the point and time of the Accident (psig):	.00
3. Describe the pressure on the system or facility relating to the Accident (psig):	Pressure did not exceed MOP
4. Not including pressure reductions required by PHMSA regulations (such as for repairs and pipe movement), was the system or facility relating to the Accident operating under an established pressure restriction with pressure limits below those normally allowed by the MOP?	No
- If Yes, Complete 4.a and 4.b below:	
4a. Did the pressure exceed this established pressure restriction?	
4b. Was this pressure restriction mandated by PHMSA or the State?	
5. Was "Onshore Pipeline, Including Valve Sites" OR "Offshore Pipeline, Including Riser and Riser Bend" selected in PART C, Question 2?	No
- If Yes - (Complete 5a. - 5e. below)	
5a. Type of upstream valve used to initially isolate release source:	
5b. Type of downstream valve used to initially isolate release source:	
5c. Length of segment isolated between valves (ft):	
5d. Is the pipeline configured to accommodate internal inspection tools?	
- If No, Which physical features limit tool accommodation? (select all that apply)	
- Changes in line pipe diameter	
- Presence of unsuitable mainline valves	
- Tight or mitered pipe bends	
- Other passage restrictions (i.e. unbarred tee's, projecting instrumentation, etc.)	
- Extra thick pipe wall (applicable only for magnetic flux leakage internal inspection tools)	
- Other -	
- If Other, Describe:	
5e. For this pipeline, are there operational factors which significantly complicate the execution of an internal inspection tool run?	
- If Yes, Which operational factors complicate execution? (select all that apply)	

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- Excessive debris or scale, wax, or other wall buildup	
- Low operating pressure(s)	
- Low flow or absence of flow	
- Incompatible commodity	
- Other -	
- If Other, Describe:	
5f. Function of pipeline system:	
6. Was a Supervisory Control and Data Acquisition (SCADA)-based system in place on the pipeline or facility involved in the Accident?	Yes
If Yes -	
6a. Was it operating at the time of the Accident?	Yes
6b. Was it fully functional at the time of the Accident?	Yes
6c. Did SCADA-based information (such as alarm(s), alert(s), event(s), and/or volume calculations) assist with the detection of the Accident?	No
6d. Did SCADA-based information (such as alarm(s), alert(s), event(s), and/or volume calculations) assist with the confirmation of the Accident?	No
7. Was a CPM leak detection system in place on the pipeline or facility involved in the Accident?	Yes
- If Yes:	
7a. Was it operating at the time of the Accident?	Yes
7b. Was it fully functional at the time of the Accident?	Yes
7c. Did CPM leak detection system information (such as alarm(s), alert(s), event(s), and/or volume calculations) assist with the detection of the Accident?	No
7d. Did CPM leak detection system information (such as alarm(s), alert(s), event(s), and/or volume calculations) assist with the confirmation of the Accident?	No
8. How was the Accident initially identified for the Operator?	Local Operating Personnel, including contractors
- If Other, Specify:	
8a. If "Controller", "Local Operating Personnel", including contractors", "Air Patrol", or "Guard Patrol by Operator or its contractor" is selected in Question 8, specify the following:	Operator employee
9. Was an investigation initiated into whether or not the controller(s) or control room issues were the cause of or a contributing factor to the Accident?	Yes, specify investigation result(s): (select all that apply)
- If No, the Operator did not find that an investigation of the controller(s) actions or control room issues was necessary due to: (provide an explanation for why the operator did not investigate)	
- If Yes, specify investigation result(s): (select all that apply)	
- Investigation reviewed work schedule rotations, continuous hours of service (while working for the Operator), and other factors associated with fatigue	Yes
- Investigation did NOT review work schedule rotations, continuous hours of service (while working for the Operator), and other factors associated with fatigue	
Provide an explanation for why not:	
- Investigation identified no control room issues	Yes
- Investigation identified no controller issues	Yes
- Investigation identified incorrect controller action or controller error	
- Investigation identified that fatigue may have affected the controller(s) involved or impacted the involved controller(s) response	
- Investigation identified incorrect procedures	
- Investigation identified incorrect control room equipment operation	
- Investigation identified maintenance activities that affected control room operations, procedures, and/or controller response	
- Investigation identified areas other than those above:	
Describe:	
PART F - DRUG & ALCOHOL TESTING INFORMATION	

1. As a result of this Accident, were any Operator employees tested under the post-accident drug and alcohol testing requirements of DOT's Drug & Alcohol Testing regulations? - If Yes:	Yes
1a. Specify how many were tested:	4
1b. Specify how many failed:	0
2. As a result of this Accident, were any Operator contractor employees tested under the post-accident drug and alcohol testing requirements of DOT's Drug & Alcohol Testing regulations? - If Yes:	No
2a. Specify how many were tested:	
2b. Specify how many failed:	
PART G – APPARENT CAUSE	
<i>Select only one box from PART G in shaded column on left representing the APPARENT Cause of the Accident, and answer the questions on the right. Describe secondary, contributing or root causes of the Accident in the narrative (PART H).</i>	
Apparent Cause:	G7 - Incorrect Operation
G1 - Corrosion Failure - only one sub-cause can be picked from shaded left-hand column	
External Corrosion:	
Internal Corrosion:	
- If External Corrosion:	
1. Results of visual examination: - If Other, Describe:	
2. Type of corrosion: <i>(select all that apply)</i>	
- Galvanic	
- Atmospheric	
- Stray Current	
- Microbiological	
- Selective Seam	
- Other: - If Other, Describe:	
3. The type(s) of corrosion selected in Question 2 is based on the following: <i>(select all that apply)</i>	
- Field examination	
- Determined by metallurgical analysis	
- Other: - If Other, Describe:	
4. Was the failed item buried under the ground? - If Yes :	
<input type="checkbox"/> 4a. Was failed item considered to be under cathodic protection at the time of the Accident? If Yes - Year protection started:	
4b. Was shielding, tenting, or disbonding of coating evident at the point of the Accident?	
4c. Has one or more Cathodic Protection Survey been conducted at the point of the Accident? If "Yes, CP Annual Survey" – Most recent year conducted: If "Yes, Close Interval Survey" – Most recent year conducted: If "Yes, Other CP Survey" – Most recent year conducted:	
- If No:	
4d. Was the failed item externally coated or painted?	
5. Was there observable damage to the coating or paint in the vicinity of the corrosion?	
- If Internal Corrosion:	
6. Results of visual examination: - Other:	
7. Type of corrosion <i>(select all that apply):</i> -	
- Corrosive Commodity	
- Water drop-out/Acid	
- Microbiological	
- Erosion	
- Other: - If Other, Describe:	
8. The cause(s) of corrosion selected in Question 7 is based on the following <i>(select all that apply):</i> -	
- Field examination	
- Determined by metallurgical analysis	

- Other:	
- If Other, Describe:	
9. Location of corrosion (select all that apply): -	
- Low point in pipe	
- Elbow	
- Other:	
- If Other, Describe:	
10. Was the commodity treated with corrosion inhibitors or biocides?	
11. Was the interior coated or lined with protective coating?	
12. Were cleaning/dewatering pigs (or other operations) routinely utilized?	
13. Were corrosion coupons routinely utilized?	
Complete the following if any Corrosion Failure sub-cause is selected AND the "Item Involved in Accident" (from PART C, Question 3) is Tank/Vessel.	
14. List the year of the most recent inspections:	
14a. API Std 653 Out-of-Service Inspection	
- No Out-of-Service Inspection completed	
14b. API Std 653 In-Service Inspection	
- No In-Service Inspection completed	
Complete the following if any Corrosion Failure sub-cause is selected AND the "Item Involved in Accident" (from PART C, Question 3) is Pipe or Weld.	
15. Has one or more internal inspection tool collected data at the point of the Accident?	
15a. If Yes, for each tool used, select type of internal inspection tool and indicate most recent year run: -	
- Magnetic Flux Leakage Tool	Most recent year:
- Ultrasonic	Most recent year:
- Geometry	Most recent year:
- Caliper	Most recent year:
- Crack	Most recent year:
- Hard Spot	Most recent year:
- Combination Tool	Most recent year:
- Transverse Field/Triaxial	Most recent year:
- Other	Most recent year:
Describe:	
16. Has one or more hydrotest or other pressure test been conducted since original construction at the point of the Accident?	
If Yes -	
	Most recent year tested:
	Test pressure:
17. Has one or more Direct Assessment been conducted on this segment?	
- If Yes, and an investigative dig was conducted at the point of the Accident::	
	Most recent year conducted:
- If Yes, but the point of the Accident was not identified as a dig site:	
	Most recent year conducted:
18. Has one or more non-destructive examination been conducted at the point of the Accident since January 1, 2002?	
18a. If Yes, for each examination conducted since January 1, 2002, select type of non-destructive examination and indicate most recent year the examination was conducted:	
- Radiography	Most recent year conducted:
- Guided Wave Ultrasonic	Most recent year conducted:
- Handheld Ultrasonic Tool	Most recent year conducted:
- Wet Magnetic Particle Test	Most recent year conducted:
- Dry Magnetic Particle Test	Most recent year conducted:
- Other	Most recent year conducted:
Describe:	

G2 - Natural Force Damage - only one sub-cause can be picked from shaded left-handed column	
Natural Force Damage – Sub-Cause:	
- If Earth Movement, NOT due to Heavy Rains/Floods:	
1. Specify:	
	- If Other, Describe:
- If Heavy Rains/Floods:	
2. Specify:	
	- If Other, Describe:
- If Lightning:	
3. Specify:	
- If Temperature:	
4. Specify:	
	- If Other, Describe:
- If High Winds:	
- If Other Natural Force Damage:	
5. Describe:	
Complete the following if any Natural Force Damage sub-cause is selected.	
6. Were the natural forces causing the Accident generated in conjunction with an extreme weather event?	
6a. If Yes, specify: <i>(select all that apply)</i>	
- Hurricane	
- Tropical Storm	
- Tornado	
- Other	
	- If Other, Describe:
G3 - Excavation Damage - only one sub-cause can be picked from shaded left-hand column	
Excavation Damage – Sub-Cause:	
- If Excavation Damage by Operator (First Party):	
- If Excavation Damage by Operator's Contractor (Second Party):	
- If Excavation Damage by Third Party:	
- If Previous Damage due to Excavation Activity:	
Complete Questions 1-5 ONLY IF the "Item Involved in Accident" (from PART C, Question 3) is Pipe or Weld.	
1. Has one or more internal inspection tool collected data at the point of the Accident?	
1a. If Yes, for each tool used, select type of internal inspection tool and indicate most recent year run: -	
- Magnetic Flux Leakage	Most recent year conducted:
- Ultrasonic	Most recent year conducted:
- Geometry	Most recent year conducted:
- Caliper	Most recent year conducted:
- Crack	Most recent year conducted:
- Hard Spot	Most recent year conducted:
- Combination Tool	Most recent year conducted:
- Transverse Field/Triaxial	Most recent year conducted:
- Other	Most recent year conducted:
	Describe:
2. Do you have reason to believe that the internal inspection was completed BEFORE the damage was sustained?	
3. Has one or more hydrotest or other pressure test been conducted since original construction at the point of the Accident?	
- If Yes:	
	Most recent year tested:
	Test pressure (psig):

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4. Has one or more Direct Assessment been conducted on the pipeline segment?	
- If Yes, and an investigative dig was conducted at the point of the Accident:	
Most recent year conducted:	
- If Yes, but the point of the Accident was not identified as a dig site:	
Most recent year conducted:	
5. Has one or more non-destructive examination been conducted at the point of the Accident since January 1, 2002?	
5a. If Yes, for each examination, conducted since January 1, 2002, select type of non-destructive examination and indicate most recent year the examination was conducted:	
- Radiography	
Most recent year conducted:	
- Guided Wave Ultrasonic	
Most recent year conducted:	
- Handheld Ultrasonic Tool	
Most recent year conducted:	
- Wet Magnetic Particle Test	
Most recent year conducted:	
- Dry Magnetic Particle Test	
Most recent year conducted:	
- Other	
Most recent year conducted:	
Describe:	
Complete the following if Excavation Damage by Third Party is selected as the sub-cause.	
6. Did the operator get prior notification of the excavation activity?	
6a. If Yes, Notification received from: <i>(select all that apply)</i> -	
- One-Call System	
- Excavator	
- Contractor	
- Landowner	
Complete the following mandatory CGA-DIRT Program questions if any Excavation Damage sub-cause is selected.	
7. Do you want PHMSA to upload the following information to CGA-DIRT (www.cga-dirt.com)?	
8. Right-of-Way where event occurred: <i>(select all that apply)</i> -	
- Public	
- If "Public", Specify:	
- Private	
- If "Private", Specify:	
- Pipeline Property/Easement	
- Power/Transmission Line	
- Railroad	
- Dedicated Public Utility Easement	
- Federal Land	
- Data not collected	
- Unknown/Other	
9. Type of excavator:	
10. Type of excavation equipment:	
11. Type of work performed:	
12. Was the One-Call Center notified?	
12a. If Yes, specify ticket number:	
12b. If this is a State where more than a single One-Call Center exists, list the name of the One-Call Center notified:	
13. Type of Locator:	
14. Were facility locate marks visible in the area of excavation?	
15. Were facilities marked correctly?	
16. Did the damage cause an interruption in service?	
16a. If Yes, specify duration of the interruption (hours)	
17. Description of the CGA-DIRT Root Cause <i>(select only the one predominant first level CGA-DIRT Root Cause and then, where available as a choice, the one predominant second level CGA-DIRT Root Cause as well):</i>	
Root Cause:	
- If One-Call Notification Practices Not Sufficient, specify:	
- If Locating Practices Not Sufficient, specify:	
- If Excavation Practices Not Sufficient, specify:	
- If Other/None of the Above, explain:	
G4 - Other Outside Force Damage - only one sub-cause can be selected from the shaded left-hand column	
Other Outside Force Damage – Sub-Cause:	

- If Nearby Industrial, Man-made, or Other Fire/Explosion as Primary Cause of Incident:	
- If Damage by Car, Truck, or Other Motorized Vehicle/Equipment NOT Engaged in Excavation:	
1. Vehicle/Equipment operated by:	
- If Damage by Boats, Barges, Drilling Rigs, or Other Maritime Equipment or Vessels Set Adrift or Which Have Otherwise Lost Their Mooring:	
2. Select one or more of the following IF an extreme weather event was a factor:	
- Hurricane	
- Tropical Storm	
- Tornado	
- Heavy Rains/Flood	
- Other	
- If Other, Describe:	
- If Routine or Normal Fishing or Other Maritime Activity NOT Engaged in Excavation:	
- If Electrical Arcing from Other Equipment or Facility:	
- If Previous Mechanical Damage NOT Related to Excavation:	
Complete Questions 3-7 ONLY IF the "Item Involved in Accident" (from PART C, Question 3) is Pipe or Weld.	
3. Has one or more internal inspection tool collected data at the point of the Accident?	
3a. If Yes, for each tool used, select type of internal inspection tool and indicate most recent year run:	
- Magnetic Flux Leakage	Most recent year conducted:
- Ultrasonic	Most recent year conducted:
- Geometry	Most recent year conducted:
- Caliper	Most recent year conducted:
- Crack	Most recent year conducted:
- Hard Spot	Most recent year conducted:
- Combination Tool	Most recent year conducted:
- Transverse Field/Triaxial	Most recent year conducted:
- Other	Most recent year conducted:
Describe:	
4. Do you have reason to believe that the internal inspection was completed BEFORE the damage was sustained?	
5. Has one or more hydrotest or other pressure test been conducted since original construction at the point of the Accident?	
- If Yes:	
	Most recent year tested:
	Test pressure (psig):
6. Has one or more Direct Assessment been conducted on the pipeline segment?	
- If Yes, and an investigative dig was conducted at the point of the Accident:	
	Most recent year conducted:
- If Yes, but the point of the Accident was not identified as a dig site:	
	Most recent year conducted:
7. Has one or more non-destructive examination been conducted at the point of the Accident since January 1, 2002?	
7a. If Yes, for each examination conducted since January 1, 2002, select type of non-destructive examination and indicate most recent year the examination was conducted:	
- Radiography	Most recent year conducted:
- Guided Wave Ultrasonic	Most recent year conducted:
- Handheld Ultrasonic Tool	Most recent year conducted:
- Wet Magnetic Particle Test	Most recent year conducted:
- Dry Magnetic Particle Test	Most recent year conducted:
- Other	Most recent year conducted:

	Describe:
- If Intentional Damage:	
8. Specify:	- If Other, Describe:
- If Other Outside Force Damage:	
9. Describe:	
G5 - Material Failure of Pipe or Weld - only one sub-cause can be selected from the shaded left-hand column	
Use this section to report material failures ONLY IF the "Item Involved in Accident" (from PART C, Question 3) is "Pipe" or "Weld."	
Material Failure of Pipe or Weld – Sub-Cause:	
1. The sub-cause selected below is based on the following: <i>(select all that apply)</i>	
- Field Examination	
- Determined by Metallurgical Analysis	
- Other Analysis	
	- If "Other Analysis", Describe:
- Sub-cause is Tentative or Suspected; Still Under Investigation (Supplemental Report required)	
- If Construction, Installation, or Fabrication-related:	
2. List contributing factors: <i>(select all that apply)</i>	
- Fatigue or Vibration-related	
	Specify:
	- If Other, Describe:
- Mechanical Stress:	
- Other	
	- If Other, Describe:
- If Original Manufacturing-related (NOT girth weld or other welds formed in the field):	
2. List contributing factors: <i>(select all that apply)</i>	
- Fatigue or Vibration-related:	
	Specify:
	- If Other, Describe:
- Mechanical Stress:	
- Other	
	- If Other, Describe:
- If Environmental Cracking-related:	
3. Specify:	
- Other - Describe:	
Complete the following if any Material Failure of Pipe or Weld sub-cause is selected.	
4. Additional factors: <i>(select all that apply)</i> :	
- Dent	
- Gouge	
- Pipe Bend	
- Arc Burn	
- Crack	
- Lack of Fusion	
- Lamination	
- Buckle	
- Wrinkle	
- Misalignment	
- Burnt Steel	
- Other:	
	- If Other, Describe:
5. Has one or more internal inspection tool collected data at the point of the Accident?	
5a. If Yes, for each tool used, select type of internal inspection tool and indicate most recent year run:	
- Magnetic Flux Leakage	Most recent year run:
- Ultrasonic	Most recent year run:
- Geometry	Most recent year run:
- Caliper	Most recent year run:
- Crack	Most recent year run:
- Hard Spot	Most recent year run:

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- Combination Tool	
Most recent year run:	
- Transverse Field/Triaxial	
Most recent year run:	
- Other	
Most recent year run:	
Describe:	
6. Has one or more hydrotest or other pressure test been conducted since original construction at the point of the Accident?	
- If Yes:	
Most recent year tested:	
Test pressure (psig):	
7. Has one or more Direct Assessment been conducted on the pipeline segment?	
- If Yes, and an investigative dig was conducted at the point of the Accident -	
Most recent year conducted:	
- If Yes, but the point of the Accident was not identified as a dig site -	
Most recent year conducted:	
8. Has one or more non-destructive examination(s) been conducted at the point of the Accident since January 1, 2002?	
8a. If Yes, for each examination conducted since January 1, 2002, select type of non-destructive examination and indicate most recent year the examination was conducted: -	
- Radiography	
Most recent year conducted:	
- Guided Wave Ultrasonic	
Most recent year conducted:	
- Handheld Ultrasonic Tool	
Most recent year conducted:	
- Wet Magnetic Particle Test	
Most recent year conducted:	
- Dry Magnetic Particle Test	
Most recent year conducted:	
- Other	
Most recent year conducted:	
Describe:	
G6 – Equipment Failure - only one sub-cause can be selected from the shaded left-hand column	
Equipment Failure – Sub-Cause:	
- If Malfunction of Control/Relief Equipment:	
1. Specify: <i>(select all that apply)</i> -	
- Control Valve	
- Instrumentation	
- SCADA	
- Communications	
- Block Valve	
- Check Valve	
- Relief Valve	
- Power Failure	
- Stopple/Control Fitting	
- ESD System Failure	
- Other	
- If Other – Describe:	
- If Pump or Pump-related Equipment:	
2. Specify:	
- If Other – Describe:	
- If Threaded Connection/Coupling Failure:	
3. Specify:	
- If Other – Describe:	
- If Non-threaded Connection Failure:	
4. Specify:	
- If Other – Describe:	
- If Defective or Loose Tubing or Fitting:	
- If Failure of Equipment Body (except Pump), Tank Plate, or other Material:	
- If Other Equipment Failure:	
5. Describe:	

Complete the following if any Equipment Failure sub-cause is selected.	
6. Additional factors that contributed to the equipment failure: <i>(select all that apply)</i>	
- Excessive vibration	
- Overpressurization	
- No support or loss of support	
- Manufacturing defect	
- Loss of electricity	
- Improper installation	
- Mismatched items (different manufacturer for tubing and tubing fittings)	
- Dissimilar metals	
- Breakdown of soft goods due to compatibility issues with transported commodity	
- Valve vault or valve can contributed to the release	
- Alarm/status failure	
- Misalignment	
- Thermal stress	
- Other	
- If Other, Describe:	
G7 - Incorrect Operation - only one sub-cause can be selected from the shaded left-hand column	
Incorrect Operation – Sub-Cause:	
Damage by Operator or Operator’s Contractor NOT Related to Excavation and NOT due to Motorized Vehicle/Equipment Damage	No
Tank, Vessel, or Sump/Separator Allowed or Caused to Overfill or Overflow	Yes
1. Specify:	
- If Other, Describe:	
Valve Left or Placed in Wrong Position, but NOT Resulting in a Tank, Vessel, or Sump/Separator Overflow or Facility Overpressure	No
Pipeline or Equipment Overpressured	No
Equipment Not Installed Properly	No
Wrong Equipment Specified or Installed	No
Other Incorrect Operation	No
2. Describe:	
Complete the following if any Incorrect Operation sub-cause is selected.	
3. Was this Accident related to <i>(select all that apply)</i> : -	
- Inadequate procedure	
- No procedure established	
- Failure to follow procedure	Yes
- Other:	
- If Other, Describe:	
4. What category type was the activity that caused the Accident?	Non-routine operating conditions (abnormal operations or emergencies)
5. Was the task(s) that led to the Accident identified as a covered task in your Operator Qualification Program?	Yes
5a. If Yes, were the individuals performing the task(s) qualified for the task(s)?	No, but they were performing the task(s) under the direction and observation of a qualified individual
G8 - Other Accident Cause - only one sub-cause can be selected from the shaded left-hand column	
Other Accident Cause – Sub-Cause:	
- If Miscellaneous:	
1. Describe:	

- If Unknown:

2. Specify:

PART H - NARRATIVE DESCRIPTION OF THE ACCIDENT

A SAFE FILL AND INDEPENDENT TANK HI-HI ALARM WERE RECEIVED FOR TANK 228 AT 05:52 A.M. ON THE MORNING OF 6/17/2012 AT BUCKEYE'S MACUNGIE, PA TANK FARM. PRODUCT FLOW TO THE TANK WAS IMMEDIATELY SHUT DOWN. VOLUME LEVELS AND CALCULATIONS INDICATED THE TANK TO BE AT SAFE-FILL HEIGHT SO THE TANK WAS NOT IMMEDIATELY INSPECTED. AT 11:00 A.M. ON 6/17/2012 AN ODOR COMPLAINT FROM A NEIGHBOR WAS RECEIVED BY THE BREINIGSVILLE CONTROL CENTER. THE BREINIGSVILLE CONTROL CENTER SHUT DOWN THE INBOUND PIPELINE AND CONTACTED MACUNGIE OPERATIONS. MACUNGIE OPERATIONS PERFORMED A FACILITY CHECK AND REPORTED NO PRODUCT ODOR OR SOIL STAINING WAS FOUND. THE INBOUND PIPELINE WAS RESTARTED AND NORMAL OPERATIONS RESUMED.

AT 09:00 A.M. ON THE MORNING OF 6/18/2012 A MACUNGIE PIPELINER WAS PREPARING MACUNGIE TANK 228 FOR AN OUTBOUND PRODUCT MOVEMENT. HE SMELLED GASOLINE AT THE BASE OF THE TANK AND NOTICED FREE PRODUCT IN THE TANK SHELL VALVE PIT. THE MACUNGIE PIPELINER THEN CALLED MACUNGIE STATION TO REPORT A POTENTIAL RELEASE. WHEN ADDITIONAL PERSONNEL ARRIVED ON SITE, PRODUCT STAINING WAS NOTICED AT THE TANK VENTS. EMERGENCY RESPONSE WAS BEGUN AND INTERNAL NOTIFICATIONS WERE PERFORMED. THE NRC WAS NOTIFIED AT 14:18 P.M. AFTER IT WAS DETERMINED THAT THE COSTS MAY REACH THE REPORTING CRITERIA.

THE INCIDENT INVESTIGATION IS STILL IN PROGRESS. PRELIMINARY FINDINGS SUGGEST MECHANICAL FAILURE MAY HAVE CONTRIBUTED TO THE INCIDENT. A SUPPLEMENTAL REPORT WILL BE FILED UPON THE COMPLETION OF THE INVESTIGATION.

REMEDICATION AND REPAIRS ARE ONGOING.

UPDATE: 8/24/2012

THE INCIDENT INVESTIGATION FOUND THAT TANK 228'S GAUGE SYSTEM WAS READING APPROXIMATELY 18 INCHES LOWER THAN THE ACTUAL LEVEL IN THE TANK. ADDITIONALLY, THE INVESTIGATION FOUND THE INDEPENDENT HI-HI MAGNETROL ALARM LEVEL WAS 7 INCHES TOO HIGH. AS A RESULT, THE TANK GAUGE WAS SHOWING THE TANK LEVEL TO BE AT MAX SAFE FILL AT THE SAME TIME THE HI-HI ALARM WAS RECEIVED AND THE TANK WAS IN AN OVERFILL CONDITION.

THE TANK GAUGE LEVEL AND ALARM LEVELS FOR TANK 228 WERE RECALCULATED AND ADJUSTED TO THE APPROPRIATE LEVELS. ALL OTHER TANKS AT THE MACUNGIE TANK FARM WERE ALSO CHECKED TO ENSURE GAUGE AND ALARM LEVEL ACCURACY.

THE TANK HAS BEEN PUT BACK IN SERVICE. MONITORING WELLS HAVE BEEN INSTALLED IN THE TANK DIKE. NO OTHER REMEDIATION ACTIVITIES ARE PLANNED.

File Full Name

PART I - PREPARER AND AUTHORIZED SIGNATURE

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Date	08/24/2012