ATLANTA GAS LIGHT COMPANY – WAYCROSS SVC CNTR / INCIDENT INVESTIGATION INSPECTION NUMBER DL19-004 / DOCKET NUMBER 42166

(b) Where necessary, call the Service Center Support Team (SCST) for a section shutdown as described in Division II, Section 22.3.9 of this OPM if the leakage is creating a hazardous condition and cannot be located and/or immediately brought under control.

When there is a delay in venting or stopping the gas flow, it may be necessary to check surrounding buildings or other confined areas for the presence of gas more than once. Rechecking shall be as frequent as necessary. It is possible for gas to find a way into nearby buildings or confined areas while the crew is bringing the gas under control. Company crews or a designated contractor, properly equipped fire department personnel, etc. may be utilized to recheck, but the AGLC IC should be sure that rechecking is being done if appropriate."

During this investigation Staff found that the Operators initial responder/IC arrived at the scene of the incident at approximately 10:54 AM, and according to records provided by the Operator made the area safe at 11:48 AM. The explosion occurred at approximately 12:15 PM. Staff found no evidence which indicated that AGLC ever considered the use of an emergency valve to stop the flow of gas to the damaged facility. AGLC advised Staff that there was an identified emergency valve, and had it been used to stop the leak they would have lost service to an estimated 122 customers. Staff also found no evidence which demonstrated that any AGLC responder ever performed any monitoring in the surrounding buildings or other confined areas for the presence of gas with a combustible gas indicator prior to the explosion.

PROBABLE VIOLATION: AGLC failed to consider the use of a valve to stop the flow of gas, or to check the surrounding buildings and confined areas, during the response to this incident, as required by their procedures.

2. 49CFR §192.617 - Each operator shall establish procedures for analyzing accidents and failures, including the selection of samples of the failed facility or equipment for laboratory examination, where appropriate, for the purpose of determining the causes of the failure and minimizing the possibility of a recurrence.

INVESTIGATION FINDINGS: Staff determined that the Operator failed to follow their investigation procedures found in OPM Division II, Section 3.14.1 (Investigating and Documenting Third Party Damages) which states:

"At a minimum, an investigation shall be performed to determine the cause of each third party damage on Company facilities. A report should be completed as soon as possible indicating the results of the investigation. If the locating was performed by an independent contractor and the accuracy or availability of locate marks are in question, the person performing the investigation shall immediately notify the locating contractor to request a representative be present. Once the investigation has been performed and the cause has been identified, corrective actions shall be taken to work with all parties involved to try and eliminate the chance of a future occurrence."

Staff found that the Operator did not perform an independent investigation into this third party damage, but allowed their locate contractor, USIC, who performed the locate request to perform their investigation. Staff determined that the failure investigation performed by USIC was fundamentally flawed. The USIC investigators claim that the excavator "was boring outside the scope of all locate