

UNITED STATES DEPARTMENT OF THE INTERIOR
 MINERALS MANAGEMENT SERVICE
 GULF OF MEXICO REGION
ACCIDENT INVESTIGATION REPORT

1. OCCURRED
 DATE: **01-AUG-2006** TIME: **0730** HOURS

2. OPERATOR: **Chevron U.S.A. Inc.**
 REPRESENTATIVE: **Bobby Wattley**
 TELEPHONE: **(504) 592-7360**
 CONTRACTOR:
 REPRESENTATIVE:
 TELEPHONE:

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR
 ON SITE AT TIME OF INCIDENT:

4. LEASE: **G04481**
 AREA: **MP** LATITUDE:
 BLOCK: **77** LONGITUDE:

5. PLATFORM: **A**
 RIG NAME:

6. ACTIVITY: EXPLORATION(POE)
 DEVELOPMENT/PRODUCTION
 (DOCD/POD)

7. TYPE:

- HISTORIC INJURY
- REQUIRED EVACUATION
 - LTA (1-3 days)
 - LTA (>3 days)
 - RW/JT (1-3 days)
 - RW/JT (>3 days)
 - Other Injury

- FATALITY
- POLLUTION
- FIRE
- EXPLOSION

- LWC HISTORIC BLOWOUT
- UNDERGROUND
 - SURFACE
 - DEVERTER
 - SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION HISTORIC >\$25K <=\$25K

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER **Pollution**

6. OPERATION:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

8. CAUSE:

- EQUIPMENT FAILURE
- HUMAN ERROR
- EXTERNAL DAMAGE
- SLIP/TRIP/FALL
- WEATHER RELATED
- LEAK
- UPSET H2O TREATING
- OVERBOARD DRILLING FLUID
- OTHER _____

9. WATER DEPTH: **225** FT.

10. DISTANCE FROM SHORE: **15** MI.

11. WIND DIRECTION: **NE**
 SPEED: **2** M.P.H.

12. CURRENT DIRECTION: **E**
 SPEED: **2** M.P.H.

13. SEA STATE: **2** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

When the LACT unit diverted on high BS&W to the Chem. Electric vessel, the pipeline pumps shut down. The Chem. Electric vessel continued to feed the Run Tank which supplies the pipeline pumps.

At approximately 4:30 AM of August 1, 2006 the operator noticed that the upper sight glass on the Run Tank was leaking. Fearing an oil spill on the deck, he undertook the task of repairing the sight glass. He attempted to close the isolation valves on the sight glass but was unable to do so. He then closed the valves that isolated the LSH and the sight glass from the vessel, thereby bypassing the safety function of the LSH.

At about 5:45 AM, the contract operator assisted the operator with cleaning the oil as well as assisting in the removal of the ball cock valves and installation of the of replacement valve and plugs.

Sometime between 7:00 - 8:00 AM, the operator opened the isolation valves on the Run tank LSH and the LSH immediately actuated a platform shut-in. As the platform was blowing down, the Secondary vent Scrubber malfunctioned and discharged oil overboard through its 4" vent line. Manual drain valves on the Primary and Secondary Vent Scrubber Vent Booms had been left open, and had been draining oil into the sump via the Vent Scrubber skid drain.

The Sump malfunctioned and oil sheen was observed in the vicinity of the Sump Skimmer overboard discharge line.

As a result of these events, approximately two barrels of oil entered offshore waters.

Findings:

The level on the Run Tank is isolated from the suction line on the Run Tank Circulation Pump by a valve. The valve was opened when the pump was running. The pump suction lowered the level in the bridle several feet below the actual level in the tank. This is what is believed to have prevented the LSH from actuating the high level alarm.

The Flow Control Valve (FCV) that pressures up the Secondary Vent Scrubber Blowcase was determined to be leaking when closed. This allowed pressure on the Blowcase preventing the Secondary Vent Scrubber (SVS) from draining and allowing oil to accumulate in the scrubber and flow out of the Vent Boom when the platform blew down.

The drain lines on the SVS and Primary Vent Boom were left open to the Vent Scrubber skid which allowed oil to go into the Sump System.

Residual oil was drained from the spill over line. The oil spill over line between the two Sump Scrubber Tanks and the Sump was plugged allowing oil to build-up in the sump, carrying under the oil bucket and discharged out of the water line.

The operator exercised poor judgment by not immediately shutting in the platform during an upset event.

18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:

The operator exercised poor judgment by not immediately shutting in the platform during this event.

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

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21. PROPERTY DAMAGED:

Produced Oil

NATURE OF DAMAGE:

Lost Overboard

ESTIMATED AMOUNT (TOTAL):

\$140

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

No Recommendations to MMS.

The New Orleans District concurs with Chevron's recommendations to prevent recurrence.

A skilnet was installed to isolate the LSH bridle from the pump suction. The LSH bridle was separated from the sight glass bridle.

The FCV and level controller were serviced by a valve technician to ensure proper valve functionality.

The drain lines on the Vent Booms will be re-routed directly to the sump tank and drained manually.

A tank cleaning crew verified all sumps and associated piping were cleaned.

The operator has been counseled on the impact of this event and will undergo additional production surface safety system training.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

30 CFR 250.300(a) The lessee shall take measures to prevent unauthorized discharge of pollutants into offshore waters.

E-100 - The lessee did not take appropriate measures to prevent approximately two barrels of oil from being discharged in to offshore waters.

P-103 - By-passed (LSH) on run tank (MBJ-1027) during maintenance of the sight glass.

25. DATE OF ONSITE INVESTIGATION:

01-AUG-2006

26. ONSITE TEAM MEMBERS:

Stephen Lucky /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

FPausina for TTrosclair

APPROVED

DATE: 18-OCT-2006

