

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

1. OCCURRED

DATE: **23-MAY-2008** TIME: **0200** HOURS

2. OPERATOR:

Chevron U.S.A. Inc.

REPRESENTATIVE: **George, Noel**

TELEPHONE: **(985) 773-6542**

CONTRACTOR:

REPRESENTATIVE:

TELEPHONE:

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

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

6. OPERATION:

4. LEASE:

G02445

AREA:

VK

LATITUDE:

BLOCK:

900

LONGITUDE:

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

5. PLATFORM:

A

RIG NAME:

6. ACTIVITY:

EXPLORATION(POE)

DEVELOPMENT/PRODUCTION
(DOC/POD)

8. CAUSE:

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

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

LWC HISTORIC BLOWOUT

UNDERGROUND

SURFACE

DEVERTER

SURFACE EQUIPMENT FAILURE OR PROCEDURES

9. WATER DEPTH: **340** FT.

10. DISTANCE FROM SHORE: **21** MI.

11. WIND DIRECTION:
SPEED: M.P.H.

12. CURRENT DIRECTION:
SPEED: M.P.H.

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

13. SEA STATE: FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On May 23, 2008 at 0200 hours on Chevron U.S.A. Incs.'s Lease OCS-G-02445, Viosca Knoll (VK) Block 900, Platform A, production operations were suspended and all crews mustered subsequent to a gas alarm. While pumping fresh water down the tubing of a well, the regulator used on the water pump was leaking 50 psi, allowing gas to flow back into the platform's fresh water system. Well injection operations were immediately suspended, resulting in isolation of the gas, gas levels dissipated, and the check valve replaced in order to resume operations.

Sequence of Events:

Notes from investigation conducted 5/23/2008

0200 hours:

Alarm sounded.

Operator representative (OR) checked SCADA with no alarms showing.

OR went upstairs to check MCC room System 3 and gas detector; found nothing in alarm state.

OR went into production living quarters and mustered with day operators. Day and night Or's rechecked System 3 and production gas detector.

Or's checked alarm status on rig.

Approximately 0210 hours:

The drilling personnel informed the production personnel that gas was flowing from toilets of several buildings. It was surmised that the high pressure well pumping operation was communicating with the rig's fresh water system. Well injection operations were immediately suspended which confirmed isolation of the gas from entering the fresh water supply system.

Approximately 0220 hours:

Production personnel bleeding gas from the fresh water system living quarters when the gas alarm (only) sounded. By the time production purged and cleared their system, rig personnel cleared their alarm and water system.

Approximately 0230 hours:

The all clear was given, with both the production operators and drilling representatives checking the status of back flow gas in the system. The header manifold check valve was tested successfully to 900 psig, but was replaced as a precautionary measure. In addition, a second check valve was installed at the discharge of the wash-down pump, and a third check valve installed on the suction of the pump. The high pressure pump was then successfully functioned and tested by both production and drilling representatives.

Production personnel discussed the incident at the 0530 safety meeting with the drilling crew. The next morning the Operator ordered 6 new check valves to place throughout the system.

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

Human Error:

The high pressure water pump utilized for well operations was connected to the quarter's fresh water supply system

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

20. LIST THE ADDITIONAL INFORMATION:

Root Cause:

Gas migrated into the bunkhouse water supply system from the water-wash pump.

Corrective Actions:

Disconnected the pump from the fresh water supply system.

Installed an independent water source for the pump.

Ensured the building was gas-free.

Additional Information:

The alarms sounded in the rig living quarters simultaneous with well washing operations.

The OR's shutdown the pump and isolated it from the water system which corrected the gas flow back problem.

The pump's regulator was tested following the incident to determine that it was leaking at the lower pressure of 50 psig.

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

None

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The New Orleans District recommends to the Office of Safety Management, that a safety alert be issued to inform operators that they should never hook up the fresh water system to production or drilling operations unless it is isolated from the quarters.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:

No onsite investigation /

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Troy Troclair

APPROVED

DATE: **15-JUL-2008**