MINERALS MAN	IAGE	ENT OF THE INTERIOR EMENT SERVICE ECO REGION
		GATION REPORT
OCCURRED	8.	CAUSE: X EQUIPMENT FAILURE
DATE: 18-JUN-2005 TIME: 2315 HOURS		HUMAN ERROR
OPERATOR: Chevron U.S.A. Inc.		SLIP/TRIP/FALL
		WEATHER RELATED
REPRESENTATIVE: Tim Guidry		
TELEPHONE: (337) 989-3829		UPSET H20 TREATING
LEASE: G02047		OVERBOARD DRILLING FLUID
AREA: EC LATITUDE:		OTHER
BLOCK: 272 LONGITUDE:	9.	WATER DEPTH: 182 FT.
PLATFORM: D	10.	DISTANCE FROM SHORE: 79 MI.
	11.	WIND DIRECTION: ESE
RIG NAME		SPEED: 3 M.P.H.
ACTIVITY: EXPLORATION(POE)	12.	CURRENT DIRECTION:
DEVELOPMENT/PRODUCTION (DOCD/POD)		SPEED: M.P.H.
TYPE: X FIRE	13.	SEA STATE: FT.
	14.	PICTURES TAKEN: YES
	15.	STATEMENT TAKEN: YES
BLOWOUT COLLISION	16.	OPERATOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:
INJURY NO. 0		Kenneth Strange
FATALITY NO. 0		CITY: Lafayette STATE: LA
□ □ other		TELEPHONE: (337) 989-3829
OPERATION: X PRODUCTION		CONTRACTOR: Danos & Curole Marine
DRILLING		Contractors, Inc.
WORKOVER		
COMPLETION		CONTRACTOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:
MOTOR VESSEL		AT my
PIPELINE SEGMENT NO.		CITY: STATE:
OTHER		

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*** *** 04-JAN-2006

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17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

Gas blow-by occurred from the H.P. separator water dump, which in turn dumps to the produced water skimmer. The skimmer operates in atmospheric service and the vent gas off the skimmer relieves to the oil stock tank which has two primary VPSV's and two secondary VPSV's. When the primary vents could not keep up with the amount of gas being relieved to the oil stock tank, the secondary vents which are local vents relieved causing a large accumulation of gas next to the gas compressor and generator building and the fire occurred.

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

1. Liquid level dump controller on the H.P. separator malfunctioned allowing gas blowby to the oil stock tank.

2. Secondary VPSV's on the oil stock tank relieved a large volume of gas which accumulated in a hazardous area.

3. Generator building not being properly isolated allowed a high concentration of gas to migrate inside the building.

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

1. Operators were not very familiar with the entire process flow and panel logic on the platform.

2. Operator failed to address critical warning signs which occurred early during the day.

- a. Several gas alarms in the gas generator building. (doors to building open)
- b. LSL liquid level switch on the H.P. separator malfunction.
- c. Liquid level dump controller on the H.P. separator malfunction.
- d. Increase fluid production in the H.P. separator.
- e. H.P. separator panel logic problems not allowing both H.P. wells to shut-in.

20. LIST THE ADDITIONAL INFORMATION:

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21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

Electrical components

Minor

ESTIMATED AMOUNT (TOTAL): \$150,000

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 Operator failed to perform operations in a safe manner.

* Inadequate supervision and operator oversight led to a unsafe work environment.

* The lessee failed to ensure that the personnel assigned to the facility were fully capable of operating the facility in a safe manner.

* Personnel onboard the facility failed to utilize company STOP work authority

policy which allowed critical warning signs to be overlooked.

* Improper isolation of the gas generator building allowed a high concentration of gas to migrate inside the building resulting in a flash fire.

25. DATE OF ONSITE INVESTIGATION: 28. ACCIDENT CLASSIFICATION:

20-JUN-2005

MAJOR

26. ONSITE TEAM MEMBERS: 29. ACCIDENT INVESTIGATION PANEL FORMED: Royce Buford / Milford Cole / Eric Fontenot / Wayne Meaux / Scott OCS REPORT: Mouton /

27. OPERATOR REPORT ON FILE: YES

30. DISTRICT SUPERVISOR:

Larry Williamson

NO

APPROVED

DATE: 23-AUG-2005

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