

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

1. OCCURRED

DATE: **05-FEB-2006** TIME: **1100** HOURS

2. OPERATOR: **Pogo Producing Company**

REPRESENTATIVE: **Wilton Duplantis**

TELEPHONE: **(832) 615-8961**

3. LEASE: **G16493**

AREA: **MP** LATITUDE:

BLOCK: **61** LONGITUDE:

4. PLATFORM: **A**

RIG NAME

5. ACTIVITY: EXPLORATION(POE)

DEVELOPMENT/PRODUCTION
(DOCD/POD)

6. TYPE: FIRE

EXPLOSION

BLOWOUT

COLLISION

INJURY NO. _____

FATALITY NO. _____

POLLUTION

OTHER _____

7. OPERATION: PRODUCTION

DRILLING

WORKOVER

COMPLETION

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: **91** FT.

10. DISTANCE FROM SHORE: **20** MI.

11. WIND DIRECTION: **W**

SPEED: **10** M.P.H.

12. CURRENT DIRECTION:

SPEED: _____ M.P.H.

13. SEA STATE: **4** FT.

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

Wilton Duplantis

CITY: **Houma**

STATE: **LA**

TELEPHONE: **(832) 615-8961**

CONTRACTOR:

CONTRACTOR REPRESENTATIVE/
SUPERVISOR ON SITE AT TIME OF INCIDENT:

CITY:

STATE:

TELEPHONE:

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On February 5, 2006, at Main Pass 61-A a "Fire" incident causing a total shut-in of production occurred at 10:58 a.m.

On the morning of the fire an alarm sounded at 10:43 a.m., Level Safety High "LSH" glycol separator. The second alarm sounded with a Burner Safety Low "BSL" at 10:58 followed by a fire alarm.

At 10:58 the platform production process shut down by means of a Temperature Safety Element "TSE" caused by the fusible safety system. Also an Emergency Shut Down "ESD" was activated at 10:59 a.m.

The fire alarm was sounded by one of the construction foreman working in close proximity to the Glycol unit that was on fire. At this point he and other personnel extinguished the fire with dry chemical and then started cooling the system with water.

During this state other peripheral flames migrated via water pushing enflamed liquid into the open drain system. The personnel that extinguished the fire also prevented the possibility of a secondary ignition. No other physical damage was observed concerning the drainage system.

After the fire was extinguished all non-essential personnel mustered and were evacuated safely from the facility. No pollution or injury are known or reported.

Investigation Findings:

1. The LSH on the glycol separator tripped shut-in an alarm sounded.
2. BSL on glycol reboiler tripped shut-in an alarm sounded.
3. Production shut down by means of TSE on glycol system.
4. Separator was drained and restarted, there was no indication of condensate, and the pumps were restarted.
5. The glycol separator was not completely drained of condensate before the pumps were restarted, allowing condensate to migrate out of the top of the still column, where it ignited the stack.
6. Condensate migrated from separator to still column where it blew out at the top.
7. Condensate ignited the stack which caused the fire.
8. The stack was not insulated.
9. There was no sight glass on the glycol separator.
10. There was a west wind blowing across glycol system.

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

The separator was not completely drained of condensate before the pumps were restarted, allowing condensate associated flash gas via saturation of glycol combined with steam causing expansion, then migrated out the top of the still column, where it ignited the stack.

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

The stack was not insulated.

There was no sight glass to indicate the level of condensate in the glycol separator.

There was a west wind blowing across the glycol system which blew the condensate on the stack.

21. PROPERTY DAMAGED:

Glycol system

NATURE OF DAMAGE:

Fire Damage

ESTIMATED AMOUNT (TOTAL): **\$50,000**

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

No recommendations to MMS.

MMS New Orleans District concurs with the operator's recurrence narrative. Pogo personnel will receive additional training on the glycol dehydration system and equipment operation.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

28-FEB-2006

26. ONSITE TEAM MEMBERS:

**Jarvis Outlaw / Robert Neal /
David Emelien /**

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

FPausina for TTrosclair

APPROVED

DATE: **04-APR-2006**

FIRE/EXPLOSION ATTACHMENT

1. SOURCE OF IGNITION: **Glycol Unit Stack**

2. TYPE OF FUEL:
- GAS
 - OIL
 - DIESEL
 - CONDENSATE
 - HYDRAULIC
 - OTHER

3. FUEL SOURCE: **Glycol Separator**

4. WERE PRECAUTIONS OR ACTIONS TAKEN TO ISOLATE
KNOWN SOURCES OF IGNITION PRIOR TO THE ACCIDENT ? **NO**

5. TYPE OF FIREFIGHTING EQUIPMENT UTILIZED:
- HANDHELD
 - WHEELED UNIT
 - FIXED CHEMICAL
 - FIXED WATER
 - NONE
 - OTHER