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

1.	OCCURRED	8.	CAUSE: CAUSE: CAUSE EQUIPMENT FAILURE			
	DATE: 22-FEB-2006 TIME: 0825 HOURS		X HUMAN ERROR			
2.	OPERATOR: Marlin Energy Offshore,		EXTERNAL DAMAGE			
	L.L.C.		SLIP/TRIP/FALL			
			WEATHER RELATED			
	REPRESENTATIVE: Lee Lawson					
	TELEPHONE: (337) 769-4064		UPSET H20 TREATING			
3.	LEASE: 00263		OVERBOARD DRILLING FLUID			
	AREA: ST LATITUDE:		OTHER			
	BLOCK: 21 LONGITUDE:	9.	WATER DEPTH: 40 FT.			
4.	PLAIFORM. 116		DISTANCE FROM SHORE: 3 MI.			
			WIND DIRECTION:			
			SPEED: M.P.H.			
5.	ACTIVITY: C EXPLORATION(POE)	12.	CURRENT DIRECTION:			
	X DEVELOPMENT/PRODUCTION		SPEED: M.P.H.			
-		13.	SEA STATE: FT.			
6.	TYPE: X FIRE					
	BLOWOUT	16	OPERATOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:			
		10.				
	INJURY NO.		Mitch Saam			
	FATALITY NO.		CITY: Lafayette STATE: LA			
	POLLUTION					
	OTHER		TELEPHONE: (863) 833-2890			
7.	OPERATION: X PRODUCTION		CONTRACTOR: Fluid Crane and Construction			
	DRILLING					
	WORKOVER COMPLETION MOTOR VESSEL		CONTRACTOR REPRESENTATIVE/			
			SUPERVISOR ON SITE AT TIME OF INCIDENT:			
			William Clark			
			CITY: Lafayette STATE: LA			
			TELEPHONE: (337) 364-6191			
	OTHER					

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On February 2, 2006, work was being performed on Platform #116. A pre job safety meeting was held, JSA completed, the Hot-work permit was issued, and a gas detector was used, finding no traces of gas at flanges. The well had been shut in since the storm and the crew began there assigned task. Certain individuals were assigned to break the nuts and remove a 2 inch ball valve for the gas lift line that penetrated the cellar deck. The crew understood that the platform had been shut in since the storm and confirmed that the check valve and block valve behind the 2 inch valve were closed. The bolts had been broken and prior to having removed the valve, the crew was stopped so that they could allow for the welder to cut the damage grating on the production deck. This was above the two inch valve. A fire watch and a man with the gas detector were posted on the cellar deck. As the grating was being cut, escaping gas from the 2 inch valve ignited and was immediately extinguished with no injury or damage.

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

The probable cause of the fire were small gas leaks in the valve and checkvalve upstream of the unbolted flange.

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

NATURE OF DAMAGE:

None

None

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Due to the specific nature of this incident, The Houma District has no recommendations to the Regional Office.

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: Brad Hunter /
- 29. ACCIDENT INVESTIGATION PANEL FORMED: NO OCS REPORT:
- 30. DISTRICT SUPERVISOR:

Michael J. Saucier

APPROVED DATE: **12-APR-2006**

FIRE/EXPLOSION ATTACHMENT

1. SOURCE OF IGNITION: Cutting Torch

- 2. TYPE OF FUEL: X GAS OIL DIESEL CONDENSATE HYDRAULIC OTHER
- 3. FUEL SOURCE: Hydrocarbon in Line
- 4. WERE PRECAUTIONS OR ACTIONS TAKEN TO ISOLATE KNOWN SOURCES OF IGNITION PRIOR TO THE ACCIDENT ? YES

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