

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

1. OCCURRED

DATE: **18-JUL-2006** TIME: **2200** HOURS

2. OPERATOR:

**TOTAL E&P USA, INC.**

REPRESENTATIVE: **John Itlemen**

TELEPHONE: **(713) 647-3425**

CONTRACTOR:

REPRESENTATIVE:

TELEPHONE:

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

4. LEASE:

**G10942**

AREA: **VK** LATITUDE:

BLOCK: **823** LONGITUDE:

5. PLATFORM:

**A-Virgo**

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

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: **1100** FT.

10. DISTANCE FROM SHORE: **70** MI.

11. WIND DIRECTION: **S**  
 SPEED: **5** M.P.H.

12. CURRENT DIRECTION: **SE**  
 SPEED: **6** M.P.H.

13. SEA STATE: **3** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On July 18, 2006, a meter technician for Donovan Controls was proving the LACT meters. Unable to get the meters to prove, he removed the prover ball from the prover loop to inspect it. The prover ball needed to be resized due to a slightly larger ball being in place for a recent water draw calibration of the prover loop. The technician finished his work around 9:45 PM and retired to the living quarters.

At approximately 10:00 PM VK 823 shut in due to the gas detector (ASH) in the general area of the LACT pump skid. Investigation revealed oil discharging through two open ½" needle valves and a loose access door on the prover loop. Approximately 50% of the oil was captured by the containment system with the other half (2bbbls) discharging overboard.

Findings:

1. Work was suspended without securing the needle valves on the prover loop doors. The needle valves were left in the open position even though the loop was supposedly isolated. This may have occurred due to fatigue for working a long day.
2. Proving a meter was considered a routine operation. There was no work permit and no proper procedures.
3. Leaking isolation valve (4-way valve) on prover loop lact.
4. The access door to the prover was not properly sealed.
5. Lack of supervision and there was no JSA or work permit for this job.

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

The operator failed to secure the needle valves to the prover, which were left in the open position and the access door was not properly sealed, when the pumps kicked on the needle valve and access door started to leak which caused the pollution event.

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

Proving the meter was considered a routine operation. There were no work permit, no JSA, and no procedure to insure the proving was preformed and completed in a safe manner.

21. PROPERTY DAMAGED: NATURE OF DAMAGE:  
Loss 2 bbls of crude oil. Lost overboard

ESTIMATED AMOUNT (TOTAL): \$142

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

No recommendations to MMS

The New Orleans District concurs with the operators recommendations to prevent recurrence.

LACK meter proving was considered a routine operation thus falling outside of our permit to work program. It will now be considered a non-routine operation being covered by permit to work. The JSA used at our Matterhorn TLP will be reviewed and revised to meet Virgo's specific needs. This addresses the isolation and verification of isolation of the valves and proper communication with the platform operator.

The needle valves on the prover loop will be fitted with piping angled 90 degrees downward to the skid pan.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

E-100 - The operator did not prevent pollution of Gulf waters.

25. DATE OF ONSITE INVESTIGATION:

19-JUL-2006

26. ONSITE TEAM MEMBERS:

Perry Jennings /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Troy Trosclair

APPROVED

DATE: 14-SEP-2006

