UNITED STATES DEPARTMENT OF THE INTERIOR BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT PACIFIC OCS REGION

ACCIDENT INVESTIGATION REPORT

	OCCURRED DATE: 11-APR-2003 TIME: 1100 HOURS OPERATOR: Exxon Mobil Corporation	STRUCTURAL DAMAGE CRANE OTHER LIFTING DEVICE
۷.	REPRESENTATIVE: TELEPHONE: CONTRACTOR: REPRESENTATIVE: TELEPHONE:	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: P00188 AREA: SM LATITUDE: BLOCK: 6636 LONGITUDE:	DRILLING WORKOVER COMPLETION HELICOPTER MOTOR VESSEL
5.	PLATFORM: HONDO RIG NAME:	PIPELINE SEGMENT NO. OTHER
6.	ACTIVITY: EXPLORATION (POE) X DEVELOPMENT/PRODUCTION (POCE (POE))	8. CAUSE:
7.	(DOCD/POD) TYPE: REQUIRED EVACUATION LTA (1-3 days) LTA (>3 days RW/JT (1-3 days) RW/JT (>3 days)	X HUMAN ERROR EXTERNAL DAMAGE SLIP/TRIP/FALL WEATHER RELATED LEAK UPSET H2O TREATING OVERBOARD DRILLING FLUID OTHER
	Other Injury FATALITY POLLUTION	9. WATER DEPTH: 842 FT. 10. DISTANCE FROM SHORE: 5 MI.
	FIRE EXPLOSION LWC HISTORIC BLOWOUT UNDERGROUND SURFACE DEVERTER SURFACE EQUIPMENT FAILURE OR PROCEDURES	11. WIND DIRECTION: SPEED: M.P.H. 12. CURRENT DIRECTION: SPEED: M.P.H.
	COLLISION HISTORIC >\$25K <=\$25K	13. SEA STATE: FT.
		14. PICTURES TAKEN: NO
		15. STATEMENT TAKEN: NO

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17. INVESTIGATION FINDINGS:

Contract worker was having difficulty removing threaded studs on flow safety valve on 4-inch flowline on Well #H-38, so he decided to use a pneumatic saw to cut through the studs. When he cut through the second to last stud, trapped pressure was released spraying oil/water emulsion on chest and under worker's face shield and safety glasses. Trapped pressure was not anticipated because prior to attempting to remove the flow safety valve, the existing flow line was cold cut upstream of the check valve without incident.

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

Pressurized fluids were trapped between the flow safety valve and a downstream header block valve. Once the flowline connection was partially opened, the trapped fluids were free to escape. Interviews with wellbay operators indicate that the system does not provide the means by which to bleed down trapped pressure downstream of the flow safety valve.

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

Worker may not have followed proper procedure or safe work practice in electing to remove threaded studs by cutting rather than unscrewing. Cutting of the studs may have resulted in a sudden separation at the connection flange rather than a gradual separation which may have been achieved by unscrewing. Worker may not have obtained prior approval from job foreman to cut threaded studs. Studs may have been in need of replacement if threads were galled or otherwise damaged to prevent proper unscrewing action.

20. LIST THE ADDITIONAL INFORMATION:

None.

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

None.

Not Applicable.

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Maintain threaded connections in servicable condition. Bleed pressure into known, monitorable system so that pressure can be verified before connection is broken. Install tap to accommodate pressure gauge or bleed off point in flowline sections where pressure can not otherwise be determined.

- 23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO
- 24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

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Not Applicable.

25. DATE OF ONSITE INVESTIGATION:

12-APR-2003

26. ONSITE TEAM MEMBERS:

Ralph Vasquez /

28. ACCIDENT CLASSIFICATION:

MINOR

29. ACCIDENT INVESTIGATION

PANEL FORMED: 1

OCS REPORT:

30. DISTRICT SUPERVISOR:

Thomas Dunaway

27. OPERATOR REPORT ON FILE: YES

APPROVED

DATE:

13-FEB-2004

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