

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

**ACCIDENT INVESTIGATION REPORT**

1. OCCURRED

DATE: **31-AUG-2009** TIME: **1624** HOURS

2. OPERATOR: **BP Exploration & Production Inc.**

REPRESENTATIVE: **Sustala, Dennis**

TELEPHONE: **(713) 865-6824**

CONTRACTOR:

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- 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:

AREA: **GC** LATITUDE:  
BLOCK: **787** LONGITUDE:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

5. PLATFORM: **A (Atlantis)**

RIG NAME:

6. ACTIVITY:  EXPLORATION (POE)  
 DEVELOPMENT/PRODUCTION  
(DOCD/POD)

8. CAUSE:

- EQUIPMENT FAILURE
- HUMAN ERROR
- EXTERNAL DAMAGE
- SLIP/TRIP/FALL
- WEATHER RELATED
- LEAK
- UPSET H2O TREATING
- OVERBOARD DRILLING FLUID
- OTHER \_\_\_\_\_

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

9. WATER DEPTH: **7050** FT.

10. DISTANCE FROM SHORE: **124** MI.

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

12. CURRENT DIRECTION: **SSE**  
SPEED: **0** M.P.H.

13. SEA STATE: **2** FT.

17. INVESTIGATION FINDINGS:

On 31 August 2009 a smoke detector was activated due to smoke detection in the instrument air compressor room. Once the alarm sounded, all personnel mustered and the facility was automatically shut-in. An appearance of smoke residue was observed near the compressor room door by the investigation fire team, but there was no sign of fire. Power to the affected area was isolated and the fire team members accessed the room while being prepared for fire suppression. The affected area was thoroughly checked with no signs of any hot spots or fire. Inspection of the equipment revealed compressor 7513 had an open 3 / 4 inch ball valve from the compressor lube oil system. This ball valve is the designed testing valve for the system's PSV. The open ball valve allowed pressurized lube oil and air to escape through the open port and spray an oily smoky mist. The released mist activated the smoke detection. The 7513 lag2 compressor started because the 7511 lag1 compressor had shut down when it reached its 225 degrees Fahrenheit high temperature setting. The 7512 lead compressor stayed online, but does not handle normal system usage by itself; thus, the 7513 compressor self-started and immediately set off smoke detection. The total quantity of lube oil released from the compressor into the skid was estimated to be 3 gallons. The 7513 compressor was last run on August 22nd, just prior to a Parts Maintenance being conducted on it. During the Parts Maintenance, the Technician had to bleed off all pressure from the unit prior to adding lube oil. The Technician opened the 3 / 4 inch ball valve in order to bleed off the pressure from the unit, but the investigation determined that the valve had been left in the open position. No injuries or environmental impact resulted from this incident.

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

The probable cause of this incident was the test valve for the PSV on the air compressor discharge line was left open. Because this valve was left open, a mist of oil/air mixture was released into the instrument air compressor room due to the 7513 compressor's self-start.

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

The contributing cause of this incident was human error.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

No property was damaged.

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL) :

\$

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

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

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

**N/A**

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:

**Casey Bisso /**

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

**Bryan A. Domangue**

APPROVED

DATE: **07-OCT-2009**