### UNITED STATES DEPARTMENT OF THE INTERIOR

# MINERALS MANAGEMENT SERVICE GULF OF MEXICO REGION

## ACCIDENT INVESTIGATION REPORT

1.	OCCURRED	8.	CAUSE: X EQUIPMENT FAILURE	
	DATE: <b>05-FEB-2006</b> TIME: <b>1100</b> HOURS		HUMAN ERROR	
2	OPERATOR: Pogo Producing Company		EXTERNAL DAMAGE	
۷.			SLIP/TRIP/FALL WEATHER RELATED	
	REPRESENTATIVE: Wilton Duplantis		LEAK	
	TELEPHONE: (832) 615-8961		UPSET H2O TREATING	
3.	LEASE: <b>G16493</b>		OVERBOARD DRILLING FLUID	
	AREA: MP LATITUDE:		OTHER	
	BLOCK: 61 LONGITUDE:	9.	WATER DEPTH: 91 FT.	
4.	PLATFORM: A	10.	DISTANCE FROM SHORE: 20 MI.	
	RIG NAME		WIND DIRECTION: W	
	RIG NAME		SPEED: 10 M.P.H.	
5.	ACTIVITY: EXPLORATION (POE)	12.	CURRENT DIRECTION:	
	DEVELOPMENT/PRODUCTION		SPEED: M.P.H.	
_		13.	SEA STATE: 4 FT.	
6.	TYPE: X FIRE  EXPLOSION			
	닏			
	INJURY NO		OPERATOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:	
			Wilton Duplantis	
			CITY: Houma STATE: LA	
	POLLUTION		THE HOUSE. (020) 615 0061	
	OPERATION: X PRODUCTION		TELEPHONE: (832) 615-8961	
7.			CONTRACTOR:	
	DRILLING			
	WORKOVER  COMPLETION  MOTOR VESSEL  PIPELINE SEGMENT NO.  OTHER		CONTRACTOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:	
			CITY: STATE:	
			TELEPHONE:	

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#### 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.
- 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.

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

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21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

Glycol system

Fire Damage

ESTIMATED AMOUNT (TOTAL):

\$50,000

22. RECOMMENDATIONS TO PREVENT RECURRANCE 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

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### **FIRE/EXPLOSION ATTACHMENT**

1.	1. SOURCE OF IGNITION: Glycol Unit Stack							
2.	TYPE OF FUEL:		GAS					
			OIL					
			DIESEL					
		x	CONDENSATE					
			HYDRAULIC					
			OTHER					
3.	FUEL SOURCE: G1	ycol :	Separator					
4.	4. WERE PRECAUTIONS OR ACTIONS TAKEN TO ISOLATE KNOWN SOURCES OF IGNITION PRIOR TO THE ACCIDENT ? NO							
5.	TYPE OF FIREFIGHT	'ING E	QUIPMENT UTILIZED:	HANDHELD				
				WHEELED UNIT				
			x	FIXED CHEMICAL				
				FIXED WATER				
				NONE				
			П	OTHER				

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