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

### **ACCIDENT INVESTIGATION REPORT**

2. OPERAT RI TI CONTF RI	TE: 10-JUL-2008 TIME: 1015 HO	STRUCTURAL DAMAGE  CRANE  OTHER LIFTING DEVICE  DAMAGED/DISABLED SAFETY SYS.  INCIDENT >\$25K  H2S/15MIN./20PPM  REQUIRED MUSTER  SHUTDOWN FROM GAS RELEASE  OTHER
	FOR/CONTRACTOR REPRESENTATIVE/SUPSITE AT TIME OF INCIDENT:	ERVISOR 6. OPERATION:
ARE BLO 5. PLATFO	: 00247 AA: WC LATITUDE: OCK: 102 LONGITUDE: ORM: G-AUX NAME:	PRODUCTION DRILLING WORKOVER COMPLETION HELICOPTER MOTOR VESSEL PIPELINE SEGMENT NO. X OTHER Construction
6. ACTIVI		8. CAUSE:
X	DEVELOPMENT/PRODUCTION (DOCD/POD)  TORIC INJURY  REQUIRED EVACUATION 1  LTA (1-3 days)  LTA (>3 days 1  RW/JT (1-3 days)  RW/JT (>3 days)	EQUIPMENT FAILURE  X HUMAN ERROR EXTERNAL DAMAGE SLIP/TRIP/FALL WEATHER RELATED LEAK UPSET H20 TREATING OVERBOARD DRILLING FLUID OTHER
	Other Injury	9. WATER DEPTH: <b>42</b> FT.
POI X FIF	LLUTION RE	10. DISTANCE FROM SHORE: 14 MI.
TMC EXE	PLOSION  HISTORIC BLOWOUT  UNDERGROUND	11. WIND DIRECTION: <b>SE</b> SPEED: <b>15</b> M.P.H.
	SURFACE  DEVERTER  SURFACE EQUIPMENT FAILURE OR PR	12. CURRENT DIRECTION: SPEED: M.P.H.
COLLI	ISION   HISTORIC   >\$25K	<=\$25K 13. SEA STATE: <b>5</b> FT.

MMS - FORM 2010 PAGE: 1 OF 4

EV2010R

#### 17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On the morning of July 10, 2008, the welder/fitter utilized a cutting torch to cut a section of handrail located next to a pneumatic wash-down pump on the top deck of the G-Aux platform. The welder/fitter's helper noticed a section of synthetic (polyflow) tubing connected to the handrail, and held it away from the flame as the welder/fitter cut the handrail's lower post. After completing the cut, the welder/fitter turned off the torch and removed his gloves. At that moment, hot slag from the metal being cut burned through the polyflow tubing which contained process fuel gas to operate the pneumatic wash-down pump. A flame of approximately 8" in length emanated from the poly-flow resulting in a second degree burn to the back of the welder/fitter's right hand and fingers. The flame was extinguished with a hand held fire extinguisher, and the supply gas valve was closed to isolate the flow of fuel gas from the tubing.

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

- 1. Hot slag from the metal being cut burned through the synthetic tubing (poly-flow) and ignited the process fuel gas.
- 19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:
  - 1. No production personnel on the platform at the time of the incident
  - 2. Construction crew not familiar with equipment in the area they were working.
  - 3. Flammable material containing process fuel gas for the wash-down pump was not blocked off, bled down and removed from the area before hot work began.
  - 4. Construction crew was working in an area not permitted on the "hot work permit".

    The hot work permit was issued for hot work that would be conducted on the jacket walkway/boat landing level only (plus 10 level), not on the top deck where the incident occurred.
  - 5. The welder/fitter removed his PPE (gloves) before securing the area.
- 20. LIST THE ADDITIONAL INFORMATION:
  - 1. No production operators were onboard at the time of the incident since it was production's crew change day.
  - 2. The construction crew was directly supervised by an onsite construction superintendent and 3rd party construction consultant (PIC); both of which were not in the immediate area at the time of the incident.
  - 3. Personnel were reminded to adhere to the JSA and hot work permits, and issue new permits while conducting site specific JSA's as the scope and/or location of the work changes.
  - 4. Personnel were also reminded to utilize stop work authority should anyone recognize any hazards involved with the task at hand.
  - 5. The operator should ensure that onsite supervisors clearly communicate and properly document specific job duties assigned to each third party crew onboard the facility.

MMS - FORM 2010 PAGE: 2 OF 4

EV2010R 28-AUG-2008

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

None

ESTIMATED AMOUNT (TOTAL):

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N/A

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The district has no recommendations for MMS.

- 23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES
- 24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-112 (C) Failure to remove a fire hazard in a hot work area resulted in a Loss Time Accident (LTA) injury.

- \* Flammable synthetic material (poly-flow) containing process fuel gas to power the wash-down pump was not blocked off, bled down and removed from the area before hot work began.
- \* Construction crew was working in an area not permitted on the "hot work permit". The hot work permit was issued for hot work that would be conducted on the jacket walkway/boat landing level only (plus 10 level), not on the top deck where the incident occurred.
- 25. DATE OF ONSITE INVESTIGATION:

31-JUL-2008

26. ONSITE TEAM MEMBERS:

Scott Mouton / Wayne Webster /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Williamson

APPROVED

DATE: 25-AUG-2008

28-AUG-2008

MMS - FORM 2010 PAGE: 3 OF 4

EV2010R

## INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE CONTRACTOR REPRESENTATIVE  OTHER Construction	x injury  FATALITY  WITNESS	
NAME:		
HOME ADDRESS: CITY:	STATE:	
WORK PHONE:	TOTAL OFFSHORE EXPERIENCE:	YEARS
EMPLOYED BY:		
BUSINESS ADDRESS:		
CITY:	STATE:	
ZIP CODE:		

MMS - FORM 2010 PAGE: 4 OF 4