

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

1. OCCURRED
 DATE: **15-AUG-2008** TIME: **1200** HOURS

2. OPERATOR: **Stone Energy Corporation**
 REPRESENTATIVE: **LeBouef, Corbett**
 TELEPHONE: **(337) 237-0410**
 CONTRACTOR:
 REPRESENTATIVE:
 TELEPHONE:

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

4. LEASE: **G03135**
 AREA: **VR** LATITUDE:
 BLOCK: **267** LONGITUDE:

5. PLATFORM: **I**
 RIG NAME:

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

7. TYPE:
 HISTORIC INJURY
 REQUIRED EVACUATION 1
 LTA (1-3 days)
 LTA (>3 days) 1
 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 **lubricator blew off well.**

6. OPERATION:

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

8. CAUSE:

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

9. WATER DEPTH: **173** FT.

10. DISTANCE FROM SHORE: **71** MI.

11. WIND DIRECTION: **WNW**
 SPEED: **10** M.P.H.

12. CURRENT DIRECTION: **W**
 SPEED: **3** M.P.H.

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

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On Friday August 15, 2008, a Production Operator, Wireline Operator (WLO) and Third Party Well Intervention Consultant (TPWIC) traveled by boat to VR-267-I platform. The crew was sent to the location to perform a well bore assessment for future temporary plug and abandonment of well I-1. An Application for Permit to Modify (APM) requesting approval to conduct these operations was filed in the Lake Charles District Office and approved on July 30, 2008. Once the crew arrived on location they rigged up (R/U) the wireline (W/L) Unit on well I-1 in preparation of running in the hole (RIH) and pulling the DX plug. As per 30 CFR 250.618(c) the W/L lubricator was to be tested prior to RIH. Statements from crew members indicate that the SITP was zero psi on the well when the SSV was opened. Standard operating procedure (SOP) is to pressure up on top of the plug in order to equalize the tubing above the plug with the pressure below the plug before attempting to pull a plug out of the hole. Our investigation revealed that the W/L lubricator was not pressure tested prior to RIH nor was pressure applied above the plug. Although the pressure was not equalized on both sides of the DX plug, the decision was made by the TPWIC to RIH with a standard W/L pulling tool and pull the DX plug out of the wellbore. Once the WLO reached the DX plug set at 505 feet, an unsuccessful attempt was made to equalize the pressure on both sides of the plug via the equalizing prong on the pulling tool. Two unsuccessful attempts to remove the plug were made and the WLO suspected that the plug was pressure locked in place. He then requested a pump to pressure up on the top of the DX plug. Testimony indicates that the request for the pump was denied by the TPWIC and the decision was made to continue pulling on the DX plug. It was during this process when the DX plug dislodged and traveled uncontrollably up the hole and became stuck approximately 455 feet from the surface. (A continuation of the Investigatory Findings appear in Item 20).

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

- * Failure to comply with regulatory requirement at 30 CFR 250.618(c), resulted in the W/L lubricator not being tested prior to RIH to pull the DX plug.
- * Failure to follow the approved procedures in the APM for testing the lubricator, failure to begin each day/tower with a Job Safety Analysis (JSA), and failure to review previous well bore activity by use of W/L tickets available in well records.
- * Failure to follow SOP for pulling down hole plug out of wellbore. The decision was made to pull the DX plug without first equalizing the plug.

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

- * Improper W/L tool used for pulling modified DX plug out of wellbore.
- * No written JSA for the task at hand.
- * Management of Change (MOC) procedures were not implemented when the operation deviated from the original plan.
- * Failure to exercise Stop work Authority (SWA) procedures allowed critical warning signs leading up to the accident to be overlooked. Requests from the WLO to the TPWIC were denied for a W/L Helper to assist the W/L Operator, in addition to acquiring a pump to test the W/L lubricator and pressure the production tubing above the DX plug prior to attempting to pull the plug.

20. LIST THE ADDITIONAL INFORMATION:

At the time of the plug lodging at 455 feet, 3100 psi was observed on the W/L lubricator gauge. Testimony indicates pressure was bled off of the well and approx. 5 gals of fluid was removed from the well bore. The decision was made by the TPWIC to continue trying to remove the DX plug and subsequent to two additional tugs on the W/L, the plug dislodged and an unexpected burst of pressure blew the W/L BOP and lubricator off the wellhead and into the Gulf of Mexico. W/L records were reviewed by the Lessee subsequent to the incident to determine that a modified DX plug had been set in well I-1 on May 25, 2006, thus requiring a W/L pulling tool specifically designed (with a longer equalizing prong) for pulling a modified plug. This incident resulted in severe facial injuries to the WLO as he fell trying to get out of harms way.

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

N/A

N/A

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The Lake Charles District recommends that MMS Office of Safety Management (OSM) issue a safety alert which includes the following:

- * W/L lubricators are required to be pressure tested prior to commencing W/L activities.
- * A complete analysis of historical well file data shall be conducted prior to commencing W/L activities.
- * All applicable personnel involved with well intervention activities shall review and adhere to approved applications.
- * Operators should remind all workers of the Lessee's philosophy with respect to Stop Work Authority.
- * Company Stop Work Authority (SWA) and Management of Change (MOC) procedures/policies should be exercised by all parties involved in the task at hand.
- * Site specific JSA meetings should always be conducted prior to performing the task at hand, but JSA meetings become even more critical when non-routine jobs are performed.
- * Operators are reminded that pre-job planning and communications are crucial tools for the successful outcome of all job tasks.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

- W-172 > When lubricator initially installed on well is it pressure tested?
Lubricator not tested as required.
- G-115> Are operations conducted in accordance with approved applications?
Failure to perform the JSA meeting.
- G-110 > Does lessee perform all operations in a safe workmanlike manner ?
Failure to utilize SWA in order to stop job when operations varied from approved procedure.

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:

Bill Olive /

29. ACCIDENT INVESTIGATION
PANEL FORMED:

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Williamson

APPROVED

DATE: 07-NOV-2008

INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER Third party W/L company

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE: 5 YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE: