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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **16-FEB-2004** TIME: **0748** HOURS

2. OPERATOR: **Nuevo Energy Company**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **P00240**
   AREA: **LA** LATITUDE:
   BLOCK: **6659** LONGITUDE:

5. PLATFORM: **HENRY**
   RIG NAME:

6. ACTIVITY:
- [ ] EXPLORATION(POE)
- [X] DEVELOPMENT/PRODUCTION (DOCD/POD)

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 0
- [ ] POLLUTION
- [X] 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
- [X] OTHER **Electrical Incident**

6. OPERATION:
- [X] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER

8. CAUSE:
- [X] 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: **4** MI.

11. WIND DIRECTION:
    SPEED: M.P.H.

12. CURRENT DIRECTION:
    SPEED: M.P.H.

13. SEA STATE: FT.

14. PICTURES TAKEN: **YES**

15. STATEMENT TAKEN: **YES**

17. INVESTIGATION FINDINGS:

On Well #B-12, 50 HP ESP began pulling high amperage. Circuit breakers did not trip. 480 vAC transformer on the pump's VSD unit overheated and caught fire. Platform operator noticed smoke issuing from lower MCC room and manually shut down platform. Upon further investigation, heavy smoke was witnessed emanating from upper MCC room. Platform personnel extinguished fire at transformer panel in upper MCC room. See photographs (provided by operator) to see extent of damage.

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

Operator believes root cause of incident to be that the well's relatively new ESP may have grounded-out downhole, which sent an over-amperage signal to the VSD and transformer. The VSD, in turn, sent a power spike to the pump causing the over-amperage to occur. Circuit breaker(s) did not trip, which allowed amperage spike to travel to and overheat the transformer/VSD unit and subsequently start an electrical fire.

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

-Circuit breaker(s) did not operate properly which allowed over-amperage to flow to transformer component of VSD and result in overheating and subsequent electrical fire.
-Smoke and/or fire was not readily detected by fire detection devices. Consequently, no alarm sounded to alert operator nor was automatic shut in of platform initiated.

20. LIST THE ADDITIONAL INFORMATION:

None.

21. PROPERTY DAMAGED:	NATURE OF DAMAGE:
480 vAC Transformer panel including VSD unit. Adjacent electrical equipment was also damaged by fire to such an extent that it may also need to be replaced.	Melted electrical wiring and insulation comprising transformer/VSD unit for Well B-12 and adjacent electrical equipment housed in electrcal panel, as well as the steel elctrical panel itself.

ESTIMATED AMOUNT (TOTAL): $5,000

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

-New circuit breakers may need to be installed because the units currently in place did not operate properly.
-Operator needs to review entire electrical and fire detection system in this process to better understand the exact causes of the over-amperage and the failure of the circuit breakers, and failure of the automatic fire detection/shut down system .
-Operator needs to certify that the devices that should have detected the fire/smoke associated with the incident are working properly or are providing adequate coverage.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

On March 9, 2004, PINCs F-108, F-141, and G-112 were issued. After meetings with operator that established that INC F-108 should be rescinded because LOTO procedures were followed, MMS rescinded the INC and on March 31, 2004 replaced it with PINC P-103 for VSD over protection being placed in a non-functional mode without being logged, flagged, and monitored by platform personnel.

25. DATE OF ONSITE INVESTIGATION:

16-FEB-2004

26. ONSITE TEAM MEMBERS:

Bob Hime /

28. ACCIDENT CLASSIFICATION:

MINOR

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Thomas Dunaway

27. OPERATOR REPORT ON FILE: **YES**

APPROVED DATE: **01-MAR-2004**