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

# ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **14-JAN-2005** TIME: **1145** HOURS

2. OPERATOR: **SPN Resources, LLC**

REPRESENTATIVE: **James Brockmeyer**

TELEPHONE: **(281) 391-7424**

3. LEASE: **G00911**

AREA: **WC** LATITUDE:

BLOCK: **280** LONGITUDE:

4. PLATFORM: **B**

RIG NAME

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

6. TYPE:
- [ ] FIRE
- [ ] EXPLOSION
- [ ] BLOWOUT
- [ ] COLLISION
- [X] INJURY NO. 2
- [ ] FATALITY NO. ____
- [ ] POLLUTION
- [X] OTHER **Atmospheric release of gas.**

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

8. CAUSE:
- [X] EQUIPMENT FAILURE
- [X] HUMAN ERROR
- [ ] EXTERNAL DAMAGE
- [ ] SLIP/TRIP/FALL
- [ ] WEATHER RELATED
- [ ] LEAK
- [ ] UPSET H2O TREATING
- [ ] OVERBOARD DRILLING FLUID
- [ ] OTHER ____

9. WATER DEPTH: **94** FT.

10. DISTANCE FROM SHORE: **64** MI.

11. WIND DIRECTION: **E**

SPEED: **25** M.P.H.

12. CURRENT DIRECTION:

SPEED: M.P.H.

13. SEA STATE: **6** FT.

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

CITY: STATE:

TELEPHONE:

CONTRACTOR:

CONTRACTOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:

**Jim Lejeune**

CITY: STATE:

TELEPHONE: **(337) 761-8822**

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

Our investigation revealed the platform was shut-in and bled down the morning of 1-14-05. The pipeline company arrived at around 10:30 a.m. to perform maintenance on their valves. Before Duke departed the platform the 16" sales valves and 16" riser valves were closed. Operations personnel were having problems maintaining dry fuel gas to run the gas generator. Later in the day the decision was made to flow the platform in order to get rid of the condensate in the vessels, so the 16" sales valve, 16" riser valve and 2" condensate injection line were opened. Production personnel used well B-8 to pressurize the system and at 5:15 p.m. on 1-14-05 the pressure on the pipeline meter tube was 870 psi. Personnel reported condensate blowing out the flare boom and openended piping on the coalescer at around 9:15 p.m. on 1-14-05. The decision was made to shut back in and bleed the system down. It is evident that the system was not isolated and bled down the same way it was that morning because pressure remained on the pipeline meter tube. Once the pressure was bled off the production equipment, the 3rd party construction crew continued removing old valves from the coalescer. Gas was reported coming from the top of the coalescer at around 11:30 p.m. and the 1/2" ball valve and gauge valves were closed. The gas release began at around 11:45 p.m. on 1-14-05 and lasted until 8:45 a.m. on 1-16-05.

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

Personnel not properly isolating the energy source (gas pipeline) allowed gas to migrate from the gas sales pipeline back through the production train and escape through openended piping at the coalescer.

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

Personnel complained of being pushed to finish the job, which allowed for hasty decisions to be made. Multiple jobs being performed at the same time and the absence of an on site supervisor dedicated to oversee the safety aspect of each job being performed pevented personnel from focussing on specific job details. The failure to develop a detailed written procedure (JSA) for the work to be performed prevented personnel from identifying and properly isolating the energy source. The lack of communication between the production personnel and the failure to utilize the companies stop work authority policy allowed critical warning signs leading up to the incident to be overlooked.
Personnel were working with insufficient lighting at the time of the incident and the 16" pipeline check valve not performing it's designed function also contributed to the incident.

20. LIST THE ADDITIONAL INFORMATION:

This incident resulted in 26 miles of 30" pipeline being bled down and 35.4 million cubic feet of gas being vented to the atmosphere.

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

**The District recommends a safety alert be issued to include the PIC clearly communicating and properly documenting specific job duties assigned to each person. Personnel must utilize a stop work authority process especially when the scope of the job changes, then reevaluate the situation appropriately. Personnel must develop and follow site specific procedures when performing simultaneous operations. Proper lockout and tagout procedures must be utilized to properly isolate all energy sources before any pipe, valve, etc. is removed from the production train.**

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

**Issued G-110. The operator failed to perform operations in a safe and workmanlike manner. The operator's failure to provide adequate supervision during simultaneous operations resulted in a very unsafe work environment. The following either directly or indirectly contributed to the incident.**
*** Personnel were required to work in insufficient lighting**
*** Personnel failed to properly isolate production equipment and process piping**
*** Personnel failed to utilize lockout and tagout procedures**
*** Personnel failed to utilize company STOP work policy allowed critical warning signs to be overlooked or not reported to proper authority.**
*** The JSA provided to the MMS inspector was deficient in terms of detail.**
*** SPN failed to provide field personnel with detailed procedures for the scope of work**
*** Improper management of time and work scheduling led to exhausted and fatigued personnel**

25. DATE OF ONSITE INVESTIGATION:

**18-JAN-2005**

26. ONSITE TEAM MEMBERS:

**Milford Cole / Eric Fontenot / Scott Mouton /**

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

**Larry Williamson**

APPROVED

DATE: **10-MAR-2005**

# INJURY/FATALITY/WITNESS ATTACHMENT

[ ] OPERATOR REPRESENTATIVE
[ ] CONTRACTOR REPRESENTATIVE
[X] OTHER **2M Oilfield Services**

[X] INJURY
[ ] FATALITY
[ ] WITNESS

WORK PHONE: **(337) 577-7650**

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE:

[ ] OPERATOR REPRESENTATIVE
[ ] CONTRACTOR REPRESENTATIVE
[X] OTHER **Louisiana Safety System**

[X] INJURY
[ ] FATALITY
[ ] WITNESS

WORK PHONE: **(800) 333-6710**

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE: