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

ACCIDENT INVESTIGATION REPORT

1.	OCCURRED DATE: 04-AUG-2006 TIME: 1200 HOURS	STRUCTURAL DAMAGE CRANE
2.	OPERATOR: Newfield Exploration Company REPRESENTATIVE: Larry Moerbe TELEPHONE: (281) 389-0734 CONTRACTOR: REPRESENTATIVE: TELEPHONE:	OTHER LIFTING DEVICE DAMAGED/DISABLED SAFETY SYS. INCIDENT >\$25K H2S/15MIN./20PPM REQUIRED MUSTER SHUTDOWN FROM GAS RELEASE X OTHER Choke stem, Gas Buster, Piping
3.	OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:	6. OPERATION:
4.	LEASE: G01898 AREA: ST LATITUDE: BLOCK: 148 LONGITUDE:	PRODUCTION DRILLING WORKOVER COMPLETION HELICOPTER MOTOR VESSEL
5.	PLATFORM: B RIG NAME: * COIL TUBING UNIT	PIPELINE SEGMENT NO. OTHER
	ACTIVITY: EXPLORATION (POE) DEVELOPMENT/PRODUCTION (DOCD/POD) TYPE: HISTORIC INJURY REQUIRED EVACUATION LTA (1-3 days) LTA (>3 days RW/JT (1-3 days)	8. CAUSE: EQUIPMENT FAILURE HUMAN ERROR EXTERNAL DAMAGE SLIP/TRIP/FALL WEATHER RELATED LEAK UPSET H20 TREATING OVERBOARD DRILLING FLUID
	RW/JT (>3 days) Other Injury FATALITY	OTHER 9. WATER DEPTH: 109 FT.
	POLLUTION FIRE	10. DISTANCE FROM SHORE: 38 MI.
	EXPLOSION LWC HISTORIC BLOWOUT UNDERGROUND	11. WIND DIRECTION: SE SPEED: 10 M.P.H.
	SURFACE DEVERTER SURFACE EQUIPMENT FAILURE OR PROCEDURES	12. CURRENT DIRECTION: SPEED: M.P.H.
	COLLISION HISTORIC >\$25K <=\$25K	13. SEA STATE: 3 FT.

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17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On Friday August 04, 2006, at approximately 1200 hours, an incident occurred during coiled tubing operations at Lease OCS-G 01898, South Timbalier Block 148, Platform "B", causing moderate damage to the gas buster and associated piping. Inspectors from the Houma District arrived on location to conduct an accident investigation on August 09, 2006.

While attempting to circulate a hydrate plug out with coiled tubing using a 50/50 fluid mixture of glycol and water, gas came through the gas buster due to the slow response of the hydraulic choke operator. He was cautioned about the importance of mainting control of the gas during the CT operation. After pulling out of the hole, a lead impression block was attached to the CT. On the next trip in the hole, the CT could not get deeper than 8 feet. While pulling out of the hole, the operator was told to close the choke. It could not be determined after Newfield's ivestigation into the accident, that the operator closed the choke before or after the incident. A large gas bubble went up the 2 inch return line, through the choke, then into the gas buster, shearing the bolts securing it to the top of the sand trap tank and falling approximately six feet to the deck. After the accident, the operator found both choke stems and beans damaged. These were replaced as well as the gas buster and the choke operator. The job was completed with no other occurrances. There was no pollution, injuries, or fatalities.

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

Slow response of the hydraulic choke operator.

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

Once it was realized during the operation by the supervisor that the choke operator was too slow to react to gas kicks, the job was not shut down.

20. LIST THE ADDITIONAL INFORMATION:

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21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

1. Gas Buster

2. Associated Piping

3. Hydraulic Choke Stems and Beans

1. Bent Piping, Broken Bolts

2. Broken Piping

3. Broken Choke Stems and Beans

ESTIMATED AMOUNT (TOTAL):

\$1,000

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Due to the specific nature of this incident, the Houma District has no recommendations at this time.

- 23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO
- 24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:
- 25. DATE OF ONSITE INVESTIGATION:

09-AUG-2006

26. ONSITE TEAM MEMBERS:

Lance Belanger / Terry Hollier /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

27. OPERATOR REPORT ON FILE: NO

30. DISTRICT SUPERVISOR:

Michael J. Saucier

APPROVED

DATE: 20-SEP-2006

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