

UNITED STATES DEPARTMENT OF THE INTERIOR -  
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT -  
GULF OF MEXICO REGION -

ACCIDENT INVESTIGATION REPORT

**For Public Release**

1. OCCURRED

DATE: 17-MAY-2014 TIME: 0830 HOURS

2. OPERATOR: **Walter Oil & Gas Corporation**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: -

REPRESENTATIVE:

TELEPHONE:

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

4. LEASE: **G32224**

AREA: **ST** LATITUDE:  
BLOCK: **285** LONGITUDE: -

5. PLATFORM:

RIG NAME: **ROWAN GORILLA IV**

6. ACTIVITY:  EXPLORATION (POE)

DEVELOPMENT/PRODUCTION  
(DOCD/POD)

7. TYPE:

HISTORIC INJURY -

REQUIRED EVACUATION

LTA (1-3 days)

LTA (>3 days) 2

RW/JT (1-3 days) 1 -

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 **Flash of gas ignited**

6. OPERATION:

PRODUCTION  
 DRILLING  
 WORKOVER  
 COMPLETION  
 HELICOPTER  
 MOTOR VESSEL  
 PIPELINE SEGMENT NO.  
 OTHER **P&A**

8. CAUSE:

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

9. WATER DEPTH: 375 FT.

10. DISTANCE FROM SHORE: 55 MI.

11. WIND DIRECTION: **N**  
SPEED: 1 M.P.H.

12. CURRENT DIRECTION: **N**  
SPEED: 1 M.P.H.

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS:-

On May 17, 2014, while in the process of performing abandonment operations on Walter Oil and Gas's (Walter) #001 well, three employees onboard the Rowan Gorilla IV were burned by a flash fire when welding operations ignited gas that had migrated into the wellbore.

The rig crew had just finished cutting and pulling the 22 inch casing from the well and was preparing to move on to the 36 inch casing. A 'Hot Work Permit', along with a Job Safety Analysis (JSA), was filled out by the crew members before operations began. Although the documents were filled out as required, both failed to identify all of the hazards associated with the operation. Furthermore, Walter's approved welding plan calls for strict supervision of welding operations that take place outside of the 'Safe Welding Area'. More oversight on the part of the Supervisors may have helped prevent the accident.

In order to complete the task, the crew was going to need to weld pad eyes to the inside of the casing in order to latch onto the load and pull it from the well. The preferred way to accomplish this task would have been to weld the pad eyes to the outside of the casing. Because of the casing's large diameter (36 inches), the pad eyes needed to be welded to the inside walls to allow enough room for the casing to pass through the rotary on the drill floor. The JSA completed prior to the start of the job failed to identify any hazards associated with performing welding operations in a hazardous area or the risk of gas being ignited from inside the well. During the investigation, a Permit to Work was provided to the inspectors upon request but the form was incomplete. There are specific sections on the form that are provided to allow for the gas readings to be recorded and the certification dates of the equipment to be documented, but all were blank. In addition, several of the precautions stated in Walter's approved "Welding, Burning, and Hot-Tapping Plan" were ignored or overlooked, increasing the chances of an accident.

The crew cut the 36 inch casing and began getting ready to remove it. As the pad eyes were being welded to the inside of the pipe, burning slag was allowed to fall inside of the wellbore. The gas that was present inside the well was ignited, which caused flames to be shot out of the casing at the surface. Three employees near the casing at the time of the incident suffered first and second degree burns to their upper bodies. The job was stopped and all three of the injured employees were sent to the hospital for further evaluation.

The investigation following the accident showed that the gas readings near the surface, where the injured employees were burned, had no gas present. A gas detector was then sent down the inside of the casing, and at a depth of approximately 40 feet, the gas readings increased significantly. It was determined that the gas had entered the wellbore after the casing was cut, which allowed the gas to migrate from the reservoir into the well.

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

The employees failed to identify that the hazards and risk associated with the job changed when the operation had to be changed. The risk associated with the job should have been reevaluated when the crew realized they were going to have to weld the pad eyes to the inside of the casing, instead of being able to weld them to the outside of the casing as they had done previously.

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

- 1) JSA failed to properly identify all of the risk associated with the job to be performed.
- 2) Employees failed to properly complete a 'Hot Work Permit' and take gas readings as required.
- 3) Failure of the crew to follow Walter's approved 'Welding, Burning, and Hot-Tapping Plan'
- 4) Poor Supervision

20. LIST THE ADDITIONAL INFORMATION:

Prior to performing any welding operations on casing, the operator should take measures to ensure that not only the immediate area is clear of all hydrocarbons, but that there is no gas present inside the casing as well.

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Houma District has no recommendations to BSEE regarding this incident.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

The INC issued following the accident states:

G-110: On May 17, 2014, while in the process of performing Abandonment operations on Walter's #001 well, an accident occurred which injured three employees. The accident occurred at approximately 08:30 hours while the crew was attempting to weld pad eyes onto the 36 inch casing so that it could be pulled. During the operation, gas was ignited, resulting in a flash fire that burned three employees"

25. DATE OF ONSITE INVESTIGATION:

**20-MAY-2014**

26. ONSITE TEAM MEMBERS:

**James Richard /**

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

30. DISTRICT SUPERVISOR:

**Bryan A. Domangue**

APPROVED

DATE: **19-SEP-2014**