

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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: 08-APR-2008 TIME: 1000 HOURS

2. OPERATOR: Anadarko Petroleum Corporation

REPRESENTATIVE: McDermott, Michael

TELEPHONE: (832) 636-8778

CONTRACTOR:

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER Shutdown from Glycol Release

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

6. OPERATION:

4. LEASE: G23338

AREA: GB LATITUDE:

BLOCK: 876 LONGITUDE:

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

5. PLATFORM:

RIG NAME:

6. ACTIVITY: EXPLORATION (POE)

DEVELOPMENT/PRODUCTION
(DOCD/POD)

8. CAUSE:

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

7. TYPE:

HISTORIC INJURY

REQUIRED EVACUATION

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

9. WATER DEPTH: 5300 FT.

10. DISTANCE FROM SHORE: 160 MI.

11. WIND DIRECTION: ENE
SPEED: 10 M.P.H.

12. CURRENT DIRECTION: N
SPEED: 2 M.P.H.

13. SEA STATE: FT.

COLLISION HISTORIC >\$25K <=\$25K

17. INVESTIGATION FINDINGS:

On 8 April 2008 at approximately 1000 hours, a Platform Operator (PO) was performing routine glycol sampling from the facility's glycol dehydration system when the PO encountered a sample catch valve plugged with internal sediment. The PO removed the flange from a two inch block valve where the sample point was located in order to clear the blockage with a water hose. Subsequent to removing the flange and flushing with water, he proceeded to open the two inch isolation block valve. Upon opening the isolation valve, glycol and salt solution was released at a temperature of 270 degrees Fahrenheit with approximately 40 to 60 psi on the system. The released heated glycol sprayed onto the PO's shoulder, arm, face and neck. Hot steam from the glycol contacted a TSE located on the vessel resulting in a facility shutdown. An alert employee in the area arrived on the scene and noticed hot glycol spraying through the opened sample flange. From a safe location he grabbed a stainless steel rod and reached through piping located next to the vessel and pushed the two inch isolation valve handle to the closed position stopping the flow of hot glycol. At that time other employees arrived on the scene to help move the injured PO to a safe area away from the release where he could be medically treated.

Anadarko Petroleum Corporation's safe work practice procedures included the proper use of company required Personal Protection Equipment (PPE).

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

Debris and sediment lodged in the sample catch valve did not allow glycol to be safely removed for sampling. The PO elected to remove the two inch flange where the sample catch valve was located in order to wash and clean the blockage with a water hose.

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

The PO's failure to follow Anadarko Petroleum Corporation's proper safe work practice procedures and not using the proper PPE established by Anadarko prior to performing this type of maintenance.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

No Physical property damage

N/A

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The Lafayette District has no recommendation to the Regional Office of Safety Management (OSM).

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

Incident of Noncompliance (INC) G-110 is issued "After the Fact" to document that Anadarko Petroleum Corporation failed to protect health, safety and the environment by performing operations in an unsafe and unworkmanlike manner. The incident that occurred on 8 April 2008 was the result of platform personnel not following company safe work practices and proper use of required PPE during the operation.

25. DATE OF ONSITE INVESTIGATION:

11-APR-2008

26. ONSITE TEAM MEMBERS:

Leo Dartez / Jason A. Abshire / Tom Basey /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED

DATE: 04-JUN-2008

INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER _____

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE:

