

UNITED STATES DEPARTMENT OF THE INTERIOR
Bureau of Ocean Energy Management, Regulation and Enforcement
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **28-MAY-2010** TIME: **1415** HOURS

2. OPERATOR: **Maritech Resources, Inc.**

REPRESENTATIVE: **Feik, Courtney**

TELEPHONE: **(281) 578-3388**

CONTRACTOR: **TETRA Technologies, Inc.**

REPRESENTATIVE: **Mike Walters**

TELEPHONE: **(281) 364-5353**

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER **Cutting torch fire**

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

6. OPERATION:

4. LEASE: **G02560**

AREA: **WC** LATITUDE:

BLOCK: **630** LONGITUDE:

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

5. PLATFORM: **A**

RIG NAME:

6. ACTIVITY: EXPLORATION (POE)
 DEVELOPMENT/PRODUCTION
(DOCD/POD)

8. CAUSE:

7. TYPE:

HISTORIC INJURY

- REQUIRED EVACUATION 1
- LTA (1-3 days)
- LTA (>3 days) 1
- RW/JT (1-3 days)
- RW/JT (>3 days)
- Other Injury

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

- FATALITY
- POLLUTION
- FIRE
- EXPLOSION

9. WATER DEPTH: **337** FT.

- LWC HISTORIC BLOWOUT
- UNDERGROUND
 - SURFACE
 - DEVERTER
 - SURFACE EQUIPMENT FAILURE OR PROCEDURES

10. DISTANCE FROM SHORE: **119** MI.

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

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

COLLISION HISTORIC >\$25K <=\$25K 13. SEA STATE: FT.

17. INVESTIGATION FINDINGS:

On 28 May 2010, a third party construction crew was in the process of preparing the platform for removal. The task conducted at the time of the incident involved the cutting away of pipe spools on the cellar deck of the platform as part of the preparatory phase of the decommissioning process. The piping systems would be dismantled by cutting them into sections for removal. During the week leading up to this incident, three crew changes occurred among the personnel conducting preparatory work.

The scope of work included the removal of interconnecting piping between decks to facilitate deck removal. A Job Safety Environmental Analysis (JSEA) which addressed "hydrocarbon in lines" was prepared and stated, "Before cutting on pipes, drill and check with gas meter, have pipe open ended, cold cut if necessary. Cut away from body". Although the JSEA states to "have pipe open-ended", it failed to specifically address draining and flushing lines before cutting.

At the time of the incident a welder was on the production cellar deck when he utilized a cutting torch to make a hole in a 2-inch pipe that extended overhead. As the welder cut through the pipe that had not been drained and rendered free of flammable materials, liquid hydrocarbons were released. The liquid contacted the welder and instantly ignited the welders clothing. The welder was at an elevated level working off of scaffolding at the time of the incident. He disconnected his fall arrest system then jumped down to the deck below and began rolling on the deck.

The firewatch extinguished the flames on the welder and surrounding area within a couple of minutes and the welder was immediately evacuated for medical attention. The welder received 2nd degree burns on the front of both thighs, back of his right hand and a 1.5-inch by 2.5-inch area on his face. He also had bruising on his right calf and complained of pain in his right ankle and foot. As of 16 June 16 2010, the welder was still in the hospital recovering from skin graft surgery.

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

The welder utilized a cutting torch to cut into process piping that had not been rendered free of flammable contents.

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

Human error by the welder as a result of the following:

1. Poor judgment in that the operation was performed without recognizing the hazard of the process piping not being rendered free of flammable contents.
2. Failure to follow recommendations to eliminate or reduce potential hazards specified in the JSEA (i.e. "Before cutting on pipes, drill and check with gas meter, have pipe open ended, cold cut if necessary, and cut away from body").

Furthermore, either of the following or a combination of these contributed to the incident:

- a) The company representative on board at the time of the incident failed to ensure that the construction crew adhered to company policy/procedures, specifically to control fluids and gases as stipulated on page 13 of the Lockout/Tagout procedures.
- b) The Job Safety Environmental Analysis (JSEA), signed by personnel on the date of the accident, failed to specifically address draining and flushing lines before

cutting.

c) The three crew changes in the week of preparatory work could have resulted in poor communication and the resulting incomplete hazard analysis and lack of corrective action taken prior to the incident.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

None

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Charles District does not have any recommendations for the Regional Office of Safety Management.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-310 The construction crew failed to properly isolate process piping and render the flammable contents inert prior to utilizing a cutting torch to perform the cut. Furthermore, the crew failed to follow recommendations in the JSEA which stipulated "Before cutting on pipes, drill and check with gas meter, have pipe open ended, cold cut if necessary, and cut away from body".

25. DATE OF ONSITE INVESTIGATION:

07-JUN-2010

26. ONSITE TEAM MEMBERS:

Wayne Meaux / Scott Mouton / Royce
Buford / Mike Jardell / Willard
Smith /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

williamson, larry

APPROVED

DATE:

17-NOV-2010

FIRE/EXPLOSION ATTACHMENT

1. SOURCE OF IGNITION: **Open flame torch cutting into pipe.**

2. TYPE OF FUEL:
- GAS
 - OIL
 - DIESEL
 - CONDENSATE
 - HYDRAULIC
 - OTHER

3. FUEL SOURCE: **Platform process piping.**

4. WERE PRECAUTIONS OR ACTIONS TAKEN TO ISOLATE
KNOWN SOURCES OF IGNITION PRIOR TO THE ACCIDENT ? **NO**

5. TYPE OF FIREFIGHTING EQUIPMENT UTILIZED:
- HANDHELD
 - WHEELED UNIT
 - FIXED CHEMICAL
 - FIXED WATER
 - NONE
 - OTHER **Water and rolled**

INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER Individual

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE:

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER Allison Marine Contractors In

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE:

INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER Allison Marine Contractors I:

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

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