

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF OCEAN ENERGY MANAGEMENT, REGULATION AND ENFORCEMENT
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: 26-JUN-2010 TIME: 0015 HOURS

2. OPERATOR: Exxon Mobil Corporation

REPRESENTATIVE: Porche, Will

TELEPHONE: (281) 654-1004

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

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

6. OPERATION:

4. LEASE: G03818

AREA: MC LATITUDE:

BLOCK: 280 LONGITUDE:

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

5. PLATFORM: A-Lena CT

RIG NAME:

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

8. CAUSE:

7. TYPE:

- HISTORIC INJURY
 - REQUIRED EVACUATION
 - LTA (1-3 days)
 - LTA (>3 days)
 - 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

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

9. WATER DEPTH: 1000 FT.
10. DISTANCE FROM SHORE: 22 MI.
11. WIND DIRECTION:
SPEED: M.P.H.
12. CURRENT DIRECTION:
SPEED: M.P.H.
13. SEA STATE: FT.

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

17. INVESTIGATION FINDINGS:

At approximately 0015 hours on 26 June 2010, the platform Operator shut-in the MC 280 A Platform by the platform's Emergency Shutdown System (ESD) due to a gas release. Although the platform was shut down and isolated, the venting continued. It was determined that the gas release was located in the wellbay, resulting in activation of the wellbay deluge system. The initial investigation revealed that the release was a result of a ruptured braided steel hose on the relief side of a pressure safety valve (PSV) protecting the gas lift injection line to the well. The PSV had an apparent malfunction which caused the valve to open but not reset. At approximately 0330 hours, the venting had subsided enough to allow personnel to safely enter the wellbay and close the A-35 well production casing valve which stopped the release. All personnel on board reported to the primary muster station where the situation was monitored. There were no injuries or damage as a result of the incident.

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

The malfunctioned PSV allowed the pressure to relieve and rupture the braided steel hose, resulting in ESD by the platform Operator.

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

Unknown malfunctioning of the PSV.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

1" High pressure braided hose used as a discharge line for PSV on well A-35 to bleed down header. Ruptured/Blew-out

ESTIMATED AMOUNT (TOTAL): \$450

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The New Orleans District has no recommendations for the Regional Office of Safety Management.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

27-JUN-2010

26. ONSITE TEAM MEMBERS:

Phil McLean /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

DAVID TROCQUET

APPROVED

DATE: 09-FEB-2011

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 :

