

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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: 05-JUL-2011 TIME: 1530 HOURS

2. OPERATOR:

Chevron U.S.A. Inc.

REPRESENTATIVE: Broussard, Cory

TELEPHONE: (337) 989-3472

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 Potable water tank rupture

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

6. OPERATION:

4. LEASE:

G02323

AREA: EI LATITUDE:

BLOCK: 360 LONGITUDE:

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

5. PLATFORM:

E

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 1
  - 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: 307 FT.

10. DISTANCE FROM SHORE: 102 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:

On 5 July 2011, at approximately 1630 hours, an employee was struck by piping and debris from a potable water tank that ruptured causing severe injuries to the employees face. The platform operators were experiencing low water pressure on the fresh water system and began to investigate to determine the cause. It was discovered by the employees that the water pressure tank (WPT) was empty which could possibly mean a plugged inlet line or a filter problem. A Job Safety Analysis (JSA) was completed for changing the filters on the fresh water system in an attempt to alleviate the problem. The fresh water pump switches were turned off and the system isolated to depressurize the lines. The automation specialist and the injured employee (IE) began to disconnect a flexible hose that connected the bottom of the WPT to the discharge piping. It was discovered that the flexible hose was plugged with scale and a screwdriver was utilized to dislodge the scale. The WPT tank was removed from the storage cradle and was placed on its side. The WPT contains a bladder that stores 60 pounds of pressure that is pre-charged by the manufacturer. The automation specialist and the IE began to remove a nozzle located at the bottom of the WPT. When the nozzle reached the final thread, the pressure from the bladder located inside the WPT forced the nozzle to detach causing the bladder to rupture. The pressure caused the WPT to launch and strike a storage building before landing on top of the fresh water skid. The nozzle fitting and the pedestal were ejected in the opposite direction of the WPT and is believed to have struck the IE. The IE was found approximately five feet from the potable water skid. The IE was conscious but suffered severe injuries to his face. The IE was initially transported to Lafayette General, but due to the severity of the facial injuries he was then transported to Houston Memorial Herman Hospital for additional treatment. Due to the severity of the employee's injuries, the lessee has postponed questioning until a later date.

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

The WPT bladder has a Schrader valve located on the top side of the tank. As per the manufacturer, "The WPT bladder should be depressurized by utilizing the Schrader valve prior to disassembling any piping or fittings." This incident could have been prevented if the WPT bladder were depressurized prior to disassembling the discharge piping.

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

\*There were no manuals from the manufacture located on the facility for the employees to access information needed to disassemble the WPT in a safe manner. The employees stated they were not familiar with the design of the WPT.

\*A JSA was prepared to change the filters on the fresh water system, but not on the removal of the WPT. If a JSA would have been completed on the removal of the WPT, the depressurizing of the bladder would have been discussed in order to eliminate the hazard.

20. LIST THE ADDITIONAL INFORMATION:



APPROVED  
DATE:

29-AUG-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:

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER \_\_\_\_\_

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

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# INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

INJURY

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FATALITY

OTHER \_\_\_\_\_

WITNESS

NAME :

HOME ADDRESS :

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TOTAL OFFSHORE EXPERIENCE :

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BUSINESS ADDRESS :

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