

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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **22-AUG-2012** TIME: **0145** HOURS

2. OPERATOR: **Energy Resource Technology GOM, I**
REPRESENTATIVE:
TELEPHONE:
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 **Gas Pocket Ignition**

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

6. OPERATION:

4. LEASE: **00599**
AREA: **ST** LATITUDE:
BLOCK: **63** LONGITUDE:

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

5. PLATFORM: **21**
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

LWC HISTORIC BLOWOUT
 UNDERGROUND
 SURFACE
 DEVERTER
 SURFACE EQUIPMENT FAILURE OR PROCEDURES

9. WATER DEPTH: **86** FT.
10. DISTANCE FROM SHORE: **18** MI.
11. WIND DIRECTION: **N**
SPEED: **1** M.P.H.
12. CURRENT DIRECTION: **N**
SPEED: **1** M.P.H.
13. SEA STATE: **1** FT.

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

17. INVESTIGATION FINDINGS:

On 22 August 2012, Energy Resource Technology was conducting abandonment and platform removal operations at South Timbalier Block 63. As per the submitted wellbore schematic, the wellbore was abandoned and the annuli were isolated from the formation. The well was open to atmosphere and was checked with a gas detector and found to have no readings of hydrocarbons at the time of operation.

A welder was cutting a window out of the conductor casing. After finishing his cut, he leaned over to look to the inside of the casing to see a cut being made by another welder opposite him when a gas pocket of residual acetylene in the cutting operations was ignited. The welder lost consciousness momentarily and was evacuated for medical evaluation. He was diagnosed with a slight sprain to the left wrist and released to return to work.

All precautions listed in the Job Safety Analysis (JSA) were taken, but the incident still occurred due to human error. The JSA did not consider confined space as a potential hazard in this operation. Confined space should have been considered during the safety meeting.

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

There was human error as the welder in question should not have been leaning into the conductor as that would be a risk of a confined space.

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

An investigation found that residual acetylene in the cutting operations was likely ignited.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

NA

NA

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Houma District has no recommendations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:

Vikas Atmakuri /

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED

DATE: **08-NOV-2012**

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 :

