UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
PACIFIC OCS REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE:
   18-JUL-2006 TIME: **0840** HOURS

2. OPERATOR: **Plains Exploration & Production C**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **P00441**
   AREA: **SM** LATITUDE:
   BLOCK: **6374** LONGITUDE:

5. PLATFORM: **IRENE**
   RIG NAME:

6. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [X] DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
   - [ ] HISTORIC INJURY
     - [ ] REQUIRED EVACUATION
     - [ ] LTA (1-3 days)
     - [ ] LTA (>3 days
     - [ ] RW/JT (1-3 days)
     - [ ] RW/JT (>3 days)
     - [X] Other Injury 1 **Flash burns**
   - [ ] FATALITY
   - [ ] POLLUTION
   - [X] FIRE
   - [X] EXPLOSION

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

   COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

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

6. OPERATION:
   - [X] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [X] OTHER **Maintenance**

8. CAUSE:
   - [ ] EQUIPMENT FAILURE
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER ______

9. WATER DEPTH: **242** FT.

10. DISTANCE FROM SHORE: **5** MI.

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

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

13. SEA STATE: FT.

14. PICTURES TAKEN: **NO**

15. STATEMENT TAKEN: **NO**

17. INVESTIGATION FINDINGS:

On July 18, 2006 Platform Irene was shut in for several maintenance items, one of which was to inspect the internal configuration of the flare scrubber vessel (V-200). The personnel working on the job had removed the 18 inch- man way hatch in preparation for the inspection. Approximately 30 minutes later they heard a whooshing sound, then a loud noise occurred with a flash and pressure wave exiting the man-way.The lead operator was positioned behind the hatch when this occurred. He received minor flash burns similar to sunburn to his face and hand, and some debris/particles from inside the vessel imbedded in his left hand due to the flash fire exiting the man-way. He was evacuated for medical evaluation shortly after the incident and was released to work that day. The lead operator may have also been exposed to H2S and SO2 due the gas in the vessel and the burning of the gas. Minor damage to the H2S detection equipment in the area was also reported.

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

PXP identified numerous causes that contributed to the incident. Documented pre-planning was not formally conducted prior to facility shutdown. PXP¿s existing safe work permit policy (includes safe work, hot work, energy isolation, confined space entry, air monitoring and job safety analysis) was not followed on the V-200 isolation and inspection prior to the flash fire. Proper vessel isolation was not performed. Proper lockout/tagout procedures were not followed. Supervision of the projected was handed off after initiation of the work and proper communication did not occur.

The direct causes for the incident are as follows: The V-200 vessel was not purged so there was a fuel source inside the vessel and effluent pipe, the flare pilot fuel source was not isolated, and the flare pilot igniter was not disabled prior to opening the man-way so there was an ignition source. Once the air mixed with the fuel after opening the man-way, the flare pilot ignited the air/fuel mixture inside the effluent pipe which runs from V-200 to the flare. The fire burned inside the stack pipeline back from the flare to V-200 where the flash occurred.

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

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:	NATURE OF DAMAGE:
H2S detectors in the area. Plxiglass covering	Cracked plexiglass, minor pitting of h2s detectors.

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:
On the day of the incident, the Platform Irene Production Superintendent halted all additional maintenance work, reviewed paperwork, and verified that all procedures were being followed. Later that week, the Superintendent stayed on the platform for 3 days observing and training to immediately ensure that all safety policies and procedures were being effectively applied and followed. Additionally, we have been spot checking safe work permits for routine maintenance items. Through these activities, production personnel on Platform Irene have been counseled that PXP's safety policies and procedure requirements must be followed and practiced at all times to prevent such incidents until the review and training described below can be fully implemented.

This incident occurred because PXP's existing safe work permit policies were not followed and as a result, disciplinary action is being administered to those employees who were directly responsible for this failure. Employee understanding of the existing policies will be reviewed at all PXP offshore facilities and "re-training" will be conducted as needed, to ensure consistent application of these policies. PXP is committed to operating all of it's facilities in a safe, compliant and environmentally-sound manner and we will stop at nothing to prevent incidents of this nature from reoccurring.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

- PINC Number G-110, in violation of 30 CFR 250.803 (b)(1), for failure to adhere with their existing Safety and Health Policy, Procedures and Practices Manual for planned work on Glycol Skid (not involved in the incident)

- PINC Number G-110, in violation of 30 CFR 250.803 (b)(1), for failure to adhere with their existing Safety and Health Policy, Procedures and Practices Manual for planned work on Flare Scrubber Vessel (V-200)

- PINC Number G-112, in violation of 30 CFR 250.803 (b)(1), for failure to comply with the standards set forth in part 5.1 of American Petroleum Institute¿s (API) document API 510, entitled ¿ Pressure Vessel Inspection Code: Maintenance, Inspection, Rating Repair, and Alteration¿ which is incorporated by reference in the subject regulation. The operator did not take all precautions necessary to provide for the safety of all personnel, resulting in the injury of one employee at the facility.

25. DATE OF ONSITE INVESTIGATION:

18-JUL-2006

26. ONSITE TEAM MEMBERS:

Scott Drewery / Louis Fernandez / Paul Napoleone /

27. OPERATOR REPORT ON FILE: **YES**

28. ACCIDENT CLASSIFICATION:

MINOR

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Phillip R Schroeder

APPROVED DATE: **15-AUG-2006**