

UNITED STATES DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: 22-FEB-2004 TIME: 1445 HOURS

2. OPERATOR: BP Exploration Inc.

REPRESENTATIVE:

TELEPHONE:

3. LEASE: G05800

AREA: EW LATITUDE:

BLOCK: 826 LONGITUDE:

4. PLATFORM: A

RIG NAME

5. ACTIVITY: EXPLORATION (POE)

DEVELOPMENT/PRODUCTION
(DOCD/POD)

6. TYPE: FIRE

EXPLOSION

BLOWOUT

COLLISION

INJURY NO. 0

FATALITY NO. 0

POLLUTION

OTHER

7. OPERATION: PRODUCTION

DRILLING

WORKOVER

COMPLETION

MOTOR VESSEL

PIPELINE SEGMENT NO. _____

OTHER _____

8. CAUSE: EQUIPMENT FAILURE

HUMAN ERROR

EXTERNAL DAMAGE

SLIP/TRIP/FALL

WEATHER RELATED

LEAK

UPSET H2O TREATING

OVERBOARD DRILLING FLUID

OTHER _____

9. WATER DEPTH: 495 FT.

10. DISTANCE FROM SHORE: 66 MI.

11. WIND DIRECTION:

SPEED: M.P.H.

12. CURRENT DIRECTION:

SPEED: M.P.H.

13. SEA STATE: FT.

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

CITY: STATE:

TELEPHONE: (

CONTRACTOR:

CONTRACTOR REPRESENTATIVE/
SUPERVISOR ON SITE AT TIME OF INCIDENT:

CITY: STATE:

TELEPHONE:

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On February 22, 2004, at approximately 1445 hours, one of the platform operators was performing casing pressure diagnostic test operations when a flash fire occurred. The sequence of events is as follows: The operator was bleeding down the casing fluids from Well A-9, through a 1/2 inch needle valve, and then into a 3/8 inch stainless steel line. The fluid then flowed into a plastic 55 gallon Department of Transportation (DOT) Drum. During this bleed off period the operator noticed flames coming out of the drum. The operator then immediately went to the deluge button and pulled, however only a trickle of water came out of the nozzles. The operators then tried to shut off the flow by closing the 1/2 inch needle valve, however the flames were too intense. Thereafter the operator sounded the general alarm and soon after he pushed the fire alarm button. Another operator then arrived at the fire location. This newly arrived operator went to a 350lb dry chemical fire boss wheel unit, and attempted to charge the unit. But was unable to pull the handle, which charges the unit, he actually broke the handle, pulling on it. Soon after the operators found a 30lb. dry chemical hand held fire extinguisher and used that unit in the fire. The other operator found a fire hose to help extinguish the fire. Once the fire was out, one of the operators shut off the 1/2 inch needle valve. Water was later sprayed on the site so as to cool off the area.

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

It is believed that the cause of this accident is the buildup of static electricity which produced a spark in the drum. This is believed to be the ignition source.

There were no procedures and/or Job Safety Analysis (JSA) for this operation. British Petroleum (BP) stated in their report that the operator may not have had a sufficient understanding of static electricity. If this is the case, then a lack of education would have also been a factor in this incident.

Also BP has a policy relating to the usage of non-metal drums. The following is BP's General Safety Rule #28, taken from their Safe Practices Manual. "Use only metal containers that are grounded by metal-to-metal contact or ground straps while drawing hydrocarbons samples from pressurized vessels or lines. Transfer of depressurized sample from metal container to glass or plastic container is permitted after isolation from supply source."

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

20. LIST THE ADDITIONAL INFORMATION:

In reference to the Fire system failures, the BP accident investigation team visited the platform and looked into those failures. The failure of the deluge system was due to a bad Butterfly valve that failed to fully open, thus allowing only a limited amount of water to fill the deluge lines. This valve has been replaced. In reference to the 350lb dry chemical fire boss wheel unit, it is believed that rust and the excited state of the personnel, at the time, may have caused the failure of the personnel to properly operate the unit. Both systems have been checked and are now working.

21. PROPERTY DAMAGED:

none

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The Regional Office may want to consider a Safety Alert, emphasizing the hazards of using plastic containers and static electricity, near a hydrocarbon source.

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:

Brad Hunter / Amy Williamson /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Pausina for Saucier

APPROVED

DATE: 27-APR-2004

FIRE/EXPLOSION ATTACHMENT

1. SOURCE OF IGNITION: **Static Electricity**

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

3. FUEL SOURCE: **Well Fluids**

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