

**UNITED STATES DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
GULF OF MEXICO REGION
ACCIDENT INVESTIGATION REPORT**

1. OCCURRED

DATE: **02-FEB-2008** TIME: **1545** HOURS

2. OPERATOR: **PetroQuest Energy, L.L.C.**
 REPRESENTATIVE: **Joey Veazey+**
 TELEPHONE: **(337) 232-7154**
 CONTRACTOR: **ISLAND OPERATORS CO. INC.**
 REPRESENTATIVE: **Burnell Roberson**
 TELEPHONE: **(337) 272-7440**

- 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: **G03137**
 AREA: **VR** LATITUDE:
 BLOCK: **287** LONGITUDE:

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

5. PLATFORM: **A**
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

9. WATER DEPTH: **184** FT.

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

10. DISTANCE FROM SHORE: **81** MI.

11. WIND DIRECTION: **SSE**
SPEED: **7** M.P.H.

12. CURRENT DIRECTION: **NW**
SPEED: **1** M.P.H.

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

13. SEA STATE: **5** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

MMS Investigators found that the heater treater (NBK 1107) had been improperly designed and installed. This unit was equipped with manually operated drains that were used to drain water and sand from the bottom of the vessel. The drains had individual 2" manual valves and were manifolded together. A single line from the drain manifold was piped directly to the skimmer's overboard line and it bypassed all upstream water treating equipment. This design / installation is not designed / installed correctly to prevent pollution and was in violation of 30 CFR 250.300 (b) (3). Manual drains used to drain the bottom of pressure vessels should be piped to water / sand treating equipment prior to discharge. Since the spill, the drains from the heater treater were blind flanged. This will correct the design / installation of the heater treater.

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

A cleaning crew inadvertently bumped one of the heater treater's drain valves open allowing approximately one bbl of oil to drain to the overboard line and into the GOM.

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

A contributing cause of the spill was that a water polishing unit had been recently taken out of service. The original design / installation had the heater treater manual drain line connected upstream of the water polishing unit so that fluids would be properly treated when draining the bottoms from the heater treater. After, the water polishing unit was taken out of service, the heater treater manual drain line was piped directly to the skimmer's overboard line.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

None

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The Lake Charles District recommends that OSM issue a safety alert which includes the following:

* - Manual drains used to drain the bottom of pressure vessels should be piped to water / sand treating equipment prior to discharge to an open ended sump or overboard. Discharge to an open ended sump, without prior treatment, is a violation of 30 CFR 250.300 (b) (4). Discharging directly overboard does not prevent pollution and is a violation of 30 CFR 250. 300 (b) (3).

* - The operator should review all possible process flow paths when making modifications to surface facilities on an offshore production platform. In this case, when the water polishing unit was taken out of service, the heater treater drain line was inadvertently piped directly overboard. A thorough review of the system would have caught this oversight.

* - A Management of Change (MOC) policy may have prevented this spill from occurring.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

E-100 - Personnel failed to recognize the hazards involved with a modification made to the process flow on this facility and a pollution incident occurred. The manual drain lines from the heater treater were redirected from the water polishing unit directly overboard.

25. DATE OF ONSITE INVESTIGATION:

06-FEB-2008

26. ONSITE TEAM MEMBERS:

Mark Osterman / Scott Mouton /

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Williamson

APPROVED

DATE: **17-MAR-2008**

