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
   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

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

3. LEASE: G03137
   AREA: VR  LATITUDE: 
   BLOCK: 287  LONGITUDE: 

4. PLATFORM: A
   RIG NAME: 

5. ACTIVITY:
   EXPLORATION(POE)
   DEVELOPMENT/PRODUCTION (DOCD/POD)

6. TYPE:
   HISTORIC INJURY
   REQUIRED EVACUATION
   LTA (1-3 days)
   LTA (>3 days)
   RW/JT (1-3 days)
   RW/JT (>3 days)
   Other Injury
   POLLUTION
   FIRE
   EXPLOSION

7. OPERATION:
   PRODUCTION
   DRILLING
   WORKOVER
   COMPLETION
   HELICOPTER
   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: 184 FT.

10. DISTANCE FROM SHORE: 81 MI.

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

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

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: None

22. RECOMMENDATIONS TO PREVENT RECURRANCE 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 facilites 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
1. VOLUME: GAL 1 BBL

333 YARDS LONG X 40 YARDS WIDE

APPEARANCE: LIGHT BROWN

2. TYPE OF HYDROCARBON RELEASED: □ OIL
□ DIESEL
□ CONDENSATE
□ HYDRAULIC
□ NATURAL GAS
□ OTHER

3. SOURCE OF HYDROCARBON RELEASED: Heater Treater at Petroquest's VR 287 A platform

4. WERE SAMPLES TAKEN? NO

5. WAS CLEANUP EQUIPMENT ACTIVATED? NO

IF SO, TYPE: □ SKIMMER
□ CONTAINMENT BOOM
□ ABSORPTION EQUIPMENT
□ DISPERSTANTS
□ OTHER

6. ESTIMATED RECOVERY: GAL BBL

7. RESPONSE TIME: HOURS

8. IS THE POLLUTION IN THE PROXIMITY OF AN ENVIRONMENTALLY SENSITIVE AREA (CLASS I)? NO

9. HAS REGION OIL SPILL TASK FORCE BEEN NOTIFIED? NO

10. CONTACTED SHORE: NO IF YES, WHERE:

11. WERE ANY LIVE ANIMALS OBSERVED NEAR: NO

12. WERE ANY OILED OR DEAD ANIMALS OBSERVED NEAR SPILL: NO