

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

ACCIDENT INVESTIGATION REPORT

For Public Release

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

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.

LWC HISTORIC BLOWOUT
 UNDERGROUND
 SURFACE
 DEVERTER
 SURFACE EQUIPMENT FAILURE OR PROCEDURES

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 :

