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

ACCIDENT INVESTIGATION REPORT

1.	OCCURRED DATE: 12-NOV-2006 TIME: 0700 HOURS	STRUCTURAL DAMAGE CRANE OTHER LIFTING DEVICE
2.	OPERATOR: Newfield Exploration Company REPRESENTATIVE: Gary Harrington TELEPHONE: (281) 847-6090 CONTRACTOR: ISLAND OPERATORS CO. INC. REPRESENTATIVE: Jason Veillion TELEPHONE: (337) 232-2416	DAMAGED/DISABLED SAFETY SYS. INCIDENT >\$25K pipeline and structural H2S/15MIN./20PPM damage REQUIRED MUSTER SHUTDOWN FROM GAS RELEASE OTHER
3.	OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:	6. OPERATION:
	LEASE: G04090 AREA: WC LATITUDE: BLOCK: 294 LONGITUDE:	PRODUCTION DRILLING WORKOVER COMPLETION HELICOPTER MOTOR VESSEL
σ.	PLATFORM: C RIG NAME:	X PIPELINE SEGMENT NO. 13162 OTHER
	ACTIVITY: EXPLORATION(POE) DEVELOPMENT/PRODUCTION (DOCD/POD) TYPE: HISTORIC INJURY	8. CAUSE: EQUIPMENT FAILURE HUMAN ERROR X EXTERNAL DAMAGE SLIP/TRIP/FALL
	REQUIRED EVACUATION LTA (1-3 days) LTA (>3 days RW/JT (1-3 days) RW/JT (>3 days) Other Injury	WEATHER RELATED LEAK UPSET H2O TREATING OVERBOARD DRILLING FLUID OTHER
	FATALITY POLLUTION FIRE	9. WATER DEPTH: 44 FT. 10. DISTANCE FROM SHORE: 30 MI.
	LWC HISTORIC BLOWOUT	11. WIND DIRECTION:
	UNDERGROUND SURFACE DEVERTER	SPEED: M.P.H.
	SURFACE EQUIPMENT FAILURE OR PROCEDURES	12. CURRENT DIRECTION: SPEED: M.P.H.
	COLLISION HISTORIC >\$25K <=\$25K	13. SEA STATE: FT.

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17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

Operator stated they were preparing to shut-in the WC294 A structure for hot work and they went to Scada onboard 294A and remotely shut-in well C-2 on 294C prior to shutting in the SDV on WC294A host facility. Operator states they were unaware that the 294C2 well did not shut. Stated the PSH 1 and 2 failed. They also heard then observed a large amount of gas vapors escaping to the atmosphere from what they believed to be the PSV on the fuel gas system. Upon arrival at WC-294-C it was discovered that the departing pipeline had parted. The investigation revealed that fragments from the rupture of the pipeline riser damaged the pneumatic boat loop ESD, which shut-in the C-2 well. This ESD system is separate from that of the remote ESD system.

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

Operators failed to follow proper steps for total shut-in of entire field and host facility. Operator failed to recognize critical warning signs indicated on the Scada log, PSH1 AND PSH2 tripped and operator acknowledged but no mitigating action was taken to prevent the pipeline from overpressure. The panel at WC-294-C was not properly designed and prevented the safety devices from performing their design function. (PSH-1&2 S/D signals were not connected to independent solenoids, so if this single solenoid failed then neither PSH would perform its function).

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

Operator failed to verify closure of well C2 at WC294C before initiating closure of the incoming pipeline SDV at WC294A. Operator not being familiar with all aspects of the Scada system allowed critical warning signs to be overlooked. The operators had no detailed written procedure to follow for shutting in the entire field including the host facility. Operations personnel relied on the cascading affect to initiate shut-in action of the satellite wells.

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21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

Pipeline segment 13162, Navaids Equipment, small materials, pipeline braces.

Pipeline parted in two. Braces broken off. Navaids equipment missing or damaged.

ESTIMATED AMOUNT (TOTAL):

\$100,000

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Charles District recommends that a Safety Alert be issued with the following recommendations. For pipelines that deliver production to a host facility and you are subject to pressure greater than the MAOP encourage operators that have Scada systems installed on both the satellite and host facility to install a valve position indicator on the incoming SDV, which sends a shut-down signal to close all affected wells when the incoming SDV on the host facility closes. Furthermore, for a scheduled shut in, verify that all production from satellite structures is shut in at the wellhead prior to closure of the incoming SDV at the host platform.

- 23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES
- 24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 Operator failed to perform annual function test on production safety system as per 14C appendix D.

p-405 Well C-2 has a SITP greater than the flowline/pipeline MAOP and does not have an independent PSH or PSV.

- G-110 The operator failed to perform operations in a safe and workmanlike manner.
 - * The JSA which was provided to MMS was deficient in terms of detail.
- * The failure to utilize Apache's "STOP" work authority policy allowed critical warning signs to be over looked.
- * A written detailed procedure for shutting in the entire field including WC-294-A was not followed.
- 25. DATE OF ONSITE INVESTIGATION:

14-NOV-2006

26. ONSITE TEAM MEMBERS:

Wayne Meaux / Guy Thibodeaux / Scott Mouton / Ricky Deville /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

FPausina for LWilliamson

APPROVED

DATE: 31-JAN-2007

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