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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **12-JUL-2009** TIME: **2030** HOURS

2. OPERATOR: **Fairways Offshore Exploration, In**
   REPRESENTATIVE: **Feik, Courtney**
   TELEPHONE: **(281) 578-3388**
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G05625**
   AREA: **ST** LATITUDE:
   BLOCK: **245** LONGITUDE:

5. PLATFORM: **A**
   RIG NAME:

6. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [X] DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
   - [ ] HISTORIC INJURY
     - [ ] REQUIRED EVACUATION
     - [ ] LTA (1-3 days)
     - [ ] LTA (>3 days
     - [ ] RW/JT (1-3 days)
     - [ ] RW/JT (>3 days)
     - [ ] Other Injury
   - [ ] FATALITY
   - [ ] POLLUTION
   - [ ] FIRE
   - [ ] EXPLOSION
   - LWC
     - [ ] HISTORIC BLOWOUT
     - [ ] UNDERGROUND
     - [ ] SURFACE
     - [ ] DEVERTER
     - [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES
   - COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K
   - [X] STRUCTURAL DAMAGE
   - [X] CRANE
   - [ ] OTHER LIFTING DEVICE
   - [ ] DAMAGED/DISABLED SAFETY SYS.
   - [X] INCIDENT >$25K **Platform crane & exit**
   - [ ] H2S/15MIN./20PPM **stairway**
   - [ ]
   - [ ] REQUIRED MUSTER
   - [ ] SHUTDOWN FROM GAS RELEASE
   - OTHER

6. OPERATION:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [X] OTHER **Permanent Abandonment**

8. CAUSE:
   - [ ] EQUIPMENT FAILURE
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER _____

9. WATER DEPTH: **185** FT.

10. DISTANCE FROM SHORE: **59** MI.

11. WIND DIRECTION: **SW**
    SPEED: **5** M.P.H.

12. CURRENT DIRECTION: **SW**
    SPEED: **5** M.P.H.

13. SEA STATE: **1** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

During Plug and Abandonment (P&A) operations the crane operator was instructed to position the Manitex ML 1200 platform crane over the number five wellbay, check the angle and make the lift to the maximum allowable pull at that angle. While attempting to pull 570 feet of 7-5/8"casing with the platform crane, the bolts holding the ring bearing to the pedestal broke causing the crane to fall. When the crane fell it struck the helipad and landed on top of a pump skid and a displacement tank. Subsequent to the incident the P&A work was shut-down. There were no injuries or pollution associated with the incident.

The Root Cause Analysis (RCA) performed by the Operator indicated that the ring bearing connection was not inspected during the crane annuals. The RCA indicated that eighteen swing gear bolts,however, were indicated to have been loose with three broken. The last crane maintenance inspection was performed on 12 July 2009 and the last annual inspection on 22 April 2009.

The crane operator was qualified for the type of crane, but had no actual operational time on this crane type, there was no weight indicator in the crane cab, but a dynamometer was installed on the main block hoist. A signalman was utilized for the lift operation using standard hand signals.

No Job Safety Analysis (JSA) documentation could be located to determine that a JSA was performed prior to the incident.

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

The probable cause of this incident was possible mechanical swing gear bolt failure as a result of exceeding the crane's load capacity for the specific angle and distance. The load limit at an angle of 47.1 degrees was 11,971 pounds and the approximate weight of the 7-5/8" casing being lifted was 22,230 pounds.

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

***Although the crane operator was qualified, he lacked actual operational time on this crane type and the boom angle was not considered during the lift.**
***The crane operator did not have full view of the whole operation while pulling on the casing and the lift was performed without a weight indicator in the crane cab. Although a dynamometer was installed on the main block hoist, the crane operator could not see the dynamometer since it was positioned by the wellbay which was below deck.**
***There was no weight indicator in the crane cab for the crane operator's use.**

20. LIST THE ADDITIONAL INFORMATION:

When the on-site investigation was conducted a replacement leap-frog crane was installed and the prior P&A work was continued.

21. PROPERTY DAMAGED:

The platform crane was completely destroyed and a pump skid was damaged. Also, when the crane hit the helicopter landing deck, the exit stairways were damaged and a dent was left in the helipad.

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL): **$600,000**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Due to the specific nature of this incident, the MMS Houma District has no recommendations to report to the MMS Regional Office.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

The following Incidents of Noncompliance (INC's) were written at the on-site investigation:

G-110: Crane operations that occurred during P&A work on 12 July 2009 were not performed in a safe and workmanlike manner to prevent property damages.

G-110: No Job Safety Analysis (JSA) documentation could be located to determine that a JSA was performed prior to the incident.

Z-140: The helicopter landing deck is damaged at the exit stairways and was continued to be used during the P&A; thereby posing a safety hazard. The perimeter protection is also corroded.

25. DATE OF ONSITE INVESTIGATION:

25-AUG-2009

26. ONSITE TEAM MEMBERS:

Freddie Mosely / Casey Bisso /

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED

DATE: **10-SEP-2009**