

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

1. OCCURRED

DATE: **13-OCT-2008** TIME: **1620** HOURS

2. OPERATOR: **Walter Oil & Gas Corporation**

REPRESENTATIVE: **Rodriguez, Paul**

TELEPHONE: **(713) 659-1222**

CONTRACTOR: **Diamond Offshore**

REPRESENTATIVE: **Wills, Donald**

TELEPHONE: **(985) 839-4185**

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

4. LEASE: **G21738**

AREA: **EW** LATITUDE:

BLOCK: **871** LONGITUDE:

5. PLATFORM:

RIG NAME: **DIAMOND OCEAN SARATOGA**

6. ACTIVITY:

- EXPLORATION(POE)
 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

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER

6. 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: **868** FT.

10. DISTANCE FROM SHORE: **66** MI.

11. WIND DIRECTION: **E**
SPEED: **20** M.P.H.

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

13. SEA STATE: **6** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

The crane operator was in the process of raising the crane boom in order to set the upper limits for the starboard crane after the rig mechanic had completed changing out the High Angle Kick-Out control valve for the crane. The boom was hoisted to the upper limit stops to set and test the high angle kick out assembly. Once the boom reached the desired angle and didn't kick out, the mechanic voiced to the crane operator an "all stop" command. The crane operator released the boom control joystick and the boom continued to rise. The crane operator then pulled the hydraulic shut down but the boom still continued to rise. The crane operator then announced over the intercom for personnel to clear the area. The mechanic and crane operator then vacated the crane and the boom toppled over the back of the gantry. No injuries or pollution resulted from this incident.

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

The replacement valve was a new design type and was not installed correctly. The circuit flow for the hydraulic fluid was opposite from the original designed boom kick out valve. The boom kick out valve was installed per the original crane drawings which proved to be backwards. Hydraulic fluid was trapped in the valve causing the boom controls to lock-up (i.e. pressure could not be released). This hydraulic lock effect also rendered the cranes hydraulic shut down ineffective.

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

The Original Equipment Manufacturer (OEM) provided the replacement valve without drawings or documentation to show the circuit flow had changed on the newly designed valve.

20. LIST THE ADDITIONAL INFORMATION:

The crane manufacturer is SeaTrax. All parts supplied by the OEM will have detailed installation procedures and drawings prior to installation.

The rig contractor will make the following crane operating changes: (1) Prior to lifting the crane boom after any repairs to the mechanical or electrical components, the controls shall be function tested with the boom in the boom rest. Manually function both the lower and upper hydraulic limit switches while the boom is inside the cradle. (2) The crane operator did not pull the Engine Emergency Stop for the crane engine before the boom had started buckling over the gantry. In all situations where the crane controls have been lost, the first response will be to activate the engine Emergency Shut-Down.

21. PROPERTY DAMAGED:

Crane boom, smokers building, and work shed.

NATURE OF DAMAGE:

Failed crane boom, builings damaged from debris.

ESTIMATED AMOUNT (TOTAL):

\$340,000

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The Houma District has no recommendations to the Regional Office.

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:

Ben Coco /

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED

DATE: **05-JAN-2008**