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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **23-OCT-2008** TIME: **1730** HOURS

2. OPERATOR: **Energy Resource Technology GOM, In**
   REPRESENTATIVE: **Wendy Braddock**
   TELEPHONE: **(281) 618-0551**
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G02280**
   AREA: **SM** LATITUDE:
   BLOCK: **130** LONGITUDE:

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

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

7. TYPE:
- [ ] HISTORIC INJURY
- [X] REQUIRED EVACUATION **1**
- [ ] 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
- [X] OTHER **Injury to person**

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

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

9. WATER DEPTH: **215** FT.

10. DISTANCE FROM SHORE: **82** MI.

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

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

13. SEA STATE: FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On October 23, 2008, at approximately 1730 hrs, a Lead Operator (LO) sustained a break to his right arm just above his wrist during a pipeline pigging operation. All valves leading to the pig launcher were closed/isolated, and the pig launcher was depressurized in preparation for the pig's insertion. Subsequent to loading the pig into the launcher/receiver, the pig prematurely ejected backwards striking the LO on his right arm before he could remove his arm and securely close the trap door cover. The LO was evacuated by helicopter and flown to the Houma Terrebonne General Hospital for treatment. The LO was released to restricted work duty until November 10, 2008.

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

Pipeline system pressure slowly leaked through two closed main 8" manual isolation block valves located on the vertical run of the pig launcher. This allowed pressure to build up inside the launching/receiving trap behind the pig once it was placed in the launcher. The pig, being new, allowed for a complete seal with no blow-by. After initially bleeding down the pig launcher system, the LO failed to ensure the pig launcher remained depressurized while being isolated from all pressure sources.

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

Although a Job Safety Analysis (JSA) was conducted prior to the operation, the LO failed to follow the JSA guidelines secondary to the LO's upper body and right arm being exposed to pig loading operation. This bodily exposure violated the JSA recommended procedure, as well as the ERT pig launching procedure, of not standing in front of the launcher/receiver during pigging operations.

20. LIST THE ADDITIONAL INFORMATION:

MMS recommends the following:

***Pig launching Standards of Operating Procedures (SOPs) should be discussed during the JSA, and followed by all personnel during the pig launching operation.**

***All safety precautions and procedures should be followed while performing pig launching operations on the depressurized/pressurized piece of equipment. As per the ERT pig launching procedures, a wooden pig loading pole or rod should be used to safely insert the pig into the launcher to prevent unnecessary personnel exposure.**

***Contingency procedures, including Stop Work Authority (SWA), should be in place to deal with faulty or inadequate safety systems or devices; e.g., leaking block valves and/or insufficient venting.**

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

None

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The MMS Lafayette District has no recommendations to the MMS Region Office of Safety Management (OSM).

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

Incident of Noncompliance (INC) G-110 is issued "After the Fact" to document that Energy Resource Technology GOM (ERT) failed to protect health, safety, and the environment by not performing operations in a safe and workmanlike manner as follows:

ERT failed to ensure personnel follow all written procedures including the JSA and SOP recommendations. Specifically, the LO failed to ensure that the pig launcher sustained a zero pressure prior to loading the pig into the launcher. In addition, the LO failed to stay clear of the pig launcher while inserting the pig.

ERT is advised to submit a letter of explanation to the Lafayette District Manager addressing the above INC, and ERT's plans for eliminating future incidents of this nature.

25. DATE OF ONSITE INVESTIGATION:

27-OCT-2008

26. ONSITE TEAM MEMBERS:

Douglas Frerich / Mark Shuff / Jason Abshire /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S Smith

APPROVED

DATE: **22-DEC-2008**

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: