# UNITED STATES DEPARTMENT OF THE INTERIOR BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT PACIFIC OCS REGION

# **ACCIDENT INVESTIGATION REPORT**

1.	OCCURRED DATE: 27-JUL-2006 TIME: 1200 HOURS	STRUCTURAL DAMAGE  X CRANE OTHER LIFTING DEVICE
2.	OPERATOR: Dos Cuadras Offshore Resources, L:     REPRESENTATIVE:     TELEPHONE:     CONTRACTOR:     REPRESENTATIVE:     TELEPHONE:	1 1
3.	OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:	6. OPERATION:
4.	LEASE: P00241  AREA: LA LATITUDE: BLOCK: 6658 LONGITUDE:	X PRODUCTION DRILLING X WORKOVER COMPLETION HELICOPTER MOTOR VESSEL
5.	PLATFORM: A RIG NAME:	PIPELINE SEGMENT NO. OTHER
6.	ACTIVITY: EXPLORATION (POE)  DEVELOPMENT/PRODUCTION	8. CAUSE:    X   EQUIPMENT FAILURE
7.	(DOCD/POD)  TYPE:  HISTORIC INJURY  REQUIRED EVACUATION  LTA (1-3 days)  LTA (>3 days  RW/JT (1-3 days)  RW/JT (>3 days)	HUMAN ERROR EXTERNAL DAMAGE SLIP/TRIP/FALL WEATHER RELATED LEAK UPSET H2O TREATING OVERBOARD DRILLING FLUID OTHER
	Other Injury  FATALITY	9. WATER DEPTH: 188 FT.
•	POLLUTION FIRE EXPLOSION	10. DISTANCE FROM SHORE: 6 MI.
	LWC HISTORIC BLOWOUT UNDERGROUND	11. WIND DIRECTION:  SPEED: M.P.H.
	SURFACE DEVERTER SURFACE EQUIPMENT FAILURE OR PROCEDURES	12. CURRENT DIRECTION: SPEED: M.P.H.
	COLLISION   HISTORIC   >\$25K   <=\$25K	13. SEA STATE: FT.
		14. PICTURES TAKEN: YES
		15. STATEMENT TAKEN: NO

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#### 17. INVESTIGATION FINDINGS:

Describe in sequence how accident happened: A power outage had caused sanding in the progressive cavity pump on well A-24. The south (Unit) crane was employed to lift the rod string to allow the well to flush the settled sand out of the stator. The first pull proceeded until the weight indicator showed 19,000 pounds (max was 19,600 pounds for that boom angle), and brakes were allegedly applied. Operator communicated to the tool pusher that the weight limit had been reached. Upon reexamination, the load indicator showed a fairly rapid rise to 50,000 pounds, at which time the lift was terminated. At some point in this first pull the lifting rod was bent. A second rod was employed, and a second pull was attempted to test the load indicator, as per the tool pusher's direction. Allegedly all went 'normal'. On the third pull the crane operator was allegedly instructed by the tool pusher to 'watch me, not the weight indicator' which kept the crane operator's line of sight away from said load indicator. At some point in the pull, the rods parted at the liftrod-polished rod junction, and the boom rebounded significantly, causing the untethered whipline headache ball to swing around and impact the top of the boom tip section causing significant damage to the lattice and flat plate.

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

Improper use of crane.

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

No written procedures for flushing out a stuck rod pump. Failure to address maintenance issues with the weight indicator in a timely manner. Toolpusher's instructions to the crane operator to watch him rather than the weight indicator during the pull.

## 20. LIST THE ADDITIONAL INFORMATION:

June and July Monthly crane inspections had comments indicating that the load cell needed to be pumped up.

\*29JUN2006 Daily Pre-Use Inspection had a comment that the "weight indicator does not work".

No Service Reports indicating load cell maintenance.

Only recent mention of the load cell in Service Reports is '...will come back and...pump up load cell...' on 18July06.

### 21. PROPERTY DAMAGED:

\*Unit crane boom tip section. \_ \*Two joints of %" sucker rod.

#### NATURE OF DAMAGE:

\*Crane boom tip section lattice and plating must be repaired per RP2D 4.3.3.
--One lattice member end completely parted.

--Several lattice members bent and/or partially parted.

-- Tip plate bent/dished.

ESTIMATED AMOUNT (TOTAL):

\$30,000

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- 22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE: Recommendations to prevent recurrence narrative:
  - \*No more use of crane for pulling rods or any unknown/stuck weight.
  - \*Address crane maintenance items in a more timely manner, and Red Tag cranes until maintenance is done.
  - \*Have and strictly follow procedures for all crane operations.
  - \*Reemphasize crane operator's authority and responsibilities on all crane
- 23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES
- 24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

Specify violations directly or indirectly contributing narrative:

- \*G-110 Use of Unit Crane on 27JUL06 to PULL stuck progressive cavity pump rods and flush pump on well # A-24 constituted a danger to personnel.
- -No written procedure for said operation.
- \*W-102 No safety meeting prior to commencing rod-pulling/well flushing operation on well # A-24 on 27JAN06.
- \*I-105 Not taking Unit Crane out of service when deficiencies (load cell) that impair safe operation have been identified on current (18 July) and previous (16 June) Monthly Inspections. The deficiency was also noted on a previous Daily (29 June) Inspection.
- \*I-101 Operating Unit Crane on 27JUL06 after first attempt showed either problems w/the load indicator or badly stuck rods. Load indicator showed 50,000 pounds on a boom angle max of 19,600 pound "lift". Load cell problems had been documented in current and previous Monthly Inspections, and a previous Daily Inspection.
- \*I-153 Not making repairs on a critical component (load cell) on the Unit Crane in a timely manner. Records indicated load cell problems 6 weeks prior to the 27JUL06 incident. Load cell problems were documented on both the 16 June and the 18 July Monthly Inspections. Problem was also noted on the 29 June Daily Inspection. No record of load cell repair or maintenance on this issue prior to the 27JUL06 incident.
- 25. DATE OF ONSITE INVESTIGATION:

28-JUL-2006

26. ONSITE TEAM MEMBERS:

Paul Napoleone / Scott Drewry /

28. ACCIDENT CLASSIFICATION:

MINOR

29. ACCIDENT INVESTIGATION PANEL FORMED:

OCS REPORT:

30. DISTRICT SUPERVISOR:

Phil Schroeder

27. OPERATOR REPORT ON FILE:

APPROVED

DATE:

28-AUG-2006

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