UNITED STATES DEPARTMENT OF THE INTERIOR
Bureau of Safety and Environmental Enforcement
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED
DATE: **01-NOV-2011** TIME: **1513** HOURS

2. OPERATOR: **W & T Offshore, Inc.**
REPRESENTATIVE: **Salter, Jeff**
TELEPHONE: **(504) 210-8167**
CONTRACTOR: **Dynamic Production Services**
REPRESENTATIVE: **Lewis Ashbey**
TELEPHONE: **(337) 981-9484**

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

4. LEASE: **G12808**
AREA: **WC** LATITUDE:
BLOCK: **616** 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)
  - [X] LTA (>3 days **1**
  - [ ] 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 **Troubleshooting Gen. Starter**

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

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: **300** FT.

10. DISTANCE FROM SHORE: **117** MI.

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

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

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS:

On November 1, 2011, the contract lead operator (CLO) was injured while troubleshooting what he believed to be a problem with the starter gas supply pressure on the No.1 gas generator. While troubleshooting the problem, the CLO disconnected the union on the upstream side of the starter and then manually activated the start switch in order to open the Amot valve and verify there was gas pressure getting to the starter. The CLO returned to the generator and waited for the starter Amot valve to open. Once the Amot valve opened, 150 psi of uncontrolled gas pressure caused the piping to swivel in a pinwheel motion and struck the CLO in his back; fracturing his ribs.

The BSEE investigation revealed that the day before the incident, the starter on the No.1 gas generator was replaced. The CLO was working alone at the time of the incident and did not perform a Job Safety Analysis (JSA) or follow the Lessees "Hazardous Energy Policy" prior to beginning the job. An evaluation of the gas supply piping revealed that the line was equipped with a ball valve and location to mount a gauge in order to check for pressure, but this was not utilized during the troubleshooting process.

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

The CLO disconnected a 2-inch union on the gas line and then manually activated the starter switch to open the Amot valve. Once the Amot valve opened, 150 psi of uncontrolled gas pressure caused the piping to swivel in a pinwheel motion and struck the CLO fracturing his ribs.

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

The following oversights contributed to the incident:
a) The Company's policy to control hazardous energy was not followed as mandated on pages 2, 18, 19, 33, 34, and 35 of W&T's Health and Safety Manual.
b) The JSA was not performed as indicated on page 15 of W&T's Health and Safety Manual.
c) Without a task-specific JSA prior to troubleshooting, the starter gas supply pressure, the associated hazards and mitigating measures were not identified.
d) Failure to thoroughly diagnose the possibility of a malfunctioning starter and/or Amot valve by first installing a pressure gauge to observe the pressure on the line between the Amot valve and the starter, prevented the CLO from safely ruling out the theory of insufficient supply pressure applied to the starter.

20. LIST THE ADDITIONAL INFORMATION:

A similar incident is referenced in the Agency's Safety Alert No. 285, where a worker's hand and face were burned. The possible ignition source was a spark generated from the engagement of the starter bendix and the engine flywheel while the exhaust piping was disconnected from the starter during troubleshooting measures. (See VR-38-E 2010 report dated Oct 14, 2009).

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

None **None**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Charles District has no recommendations for the Agency.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 An unsafe and unworkmanlike operation existed as a result of the Operator failing to follow the Company's policy of Lock and Tag Out in addition to a Job Safety and Evironmental Analysis prior to performing maintenance on the Gas Generator #1.

25. DATE OF ONSITE INVESTIGATION:

04-NOV-2011

26. ONSITE TEAM MEMBERS:

Darron Miller / Scott Mouton / Mitchell Klumpp / Willard Smith /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Williamson

APPROVED DATE: **07-DEC-2011**

INJURY/FATALITY/WITNESS ATTACHMENT

[ ] OPERATOR REPRESENTATIVE	[x] INJURY
[x] CONTRACTOR REPRESENTATIVE	[ ] FATALITY
[ ] OTHER _____	[ ] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE: