

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: 26-DEC-2011 TIME: 1540 HOURS

2. OPERATOR: **Flextrend Development Company, L.L**
REPRESENTATIVE:
TELEPHONE:
CONTRACTOR:
REPRESENTATIVE:
TELEPHONE:

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

4. LEASE: **G13363**
AREA: **GB** LATITUDE:
BLOCK: **72** LONGITUDE:

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

6. ACTIVITY: EXPLORATION (POE)
 DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
 HISTORIC INJURY
 REQUIRED EVACUATION
 LTA (1-3 days)
 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

6. OPERATION:
 PRODUCTION
 DRILLING
 WORKOVER
 COMPLETION
 HELICOPTER
 MOTOR VESSEL
 PIPELINE SEGMENT NO.
 OTHER **Construction**

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

9. WATER DEPTH: 541 FT.

10. DISTANCE FROM SHORE: 164 MI.

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

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

13. SEA STATE: FT.

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

17. INVESTIGATION FINDINGS:

On 26 December 2011 an employee injured his right index finger while decommissioning a portable crane (PC). The PC being decommissioned was affiliated with a construction project for a Newfield well that will be processed at the facility. Due to the projects completion, the PC was being dismantled and placed on a supply vessel. The platform crane was being used to load the PC to the supply vessel. Using a four part sling, the injured employee (IE) secured the loose gear fastened to the boom tip of the platform crane. Once tension was applied to the four part sling, the IE unbolted the boom tip from the remaining crane boom. The IE was standing on a walkway located between the boom sections. The walkways were constructed for safer access to assemble and disassemble the boom sections. A signalman was on location and was given the signal by all employees involved with the lift that it was safe to proceed. Using the platform crane, the crane operator began to lift the boom tip away from the PC to be loaded on the motor vessel. As the boom tip was lifted, it separated from the remaining boom section and caused the remaining section to move. The IE placed his right hand on the outer edge of the boom section as he was attempting to balance himself. The boom tip shifted in the opposite direction smashing the IE's right index finger as the boom tip came in contact with the remaining boom section. The Medic on board the platform treated the injury and transported the IE to Industrial Medical located in Broussard Louisiana for further treatment. No pollution or property damages resulted from this incident.

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

* The lessee and all personnel engaged in the disassembling operations failed to adhere to Enterprise's EH&S Management System Safety Policies Manual 3.6.3 Lift Guidelines:

Line 6. Check the area of lift and travel prior to the lift to ensure that personnel are notified, in safe positions and clear of obstructions.

Line 7. All persons remain at a safe distance away from the lifted load at all times.

* As per the Seatrax Accident Investigation Report, the recommended action to prevent future or similar occurrences: Sequence of job steps in JSA address personnel to move back away from the boom connection points before removing boom sections. This step should have been addressed as per Enterprise's EH&S Management System Safety Policy prior to decommissioning operations.

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

The IE was a short service employee (SSE) according to Seatrax policy. Seatrax Short Service Employee policy, Section 48.1 Key Practices defines a SSE as any personnel with less than six months experience in the same job type or with Seatrax, Inc... The policy also states that multiple mentors will be assigned to each SSE and will be onsite to supervise the SSE. In Section 48.2 Responsibility, the policy states that the mentor communicates the SSE policy and expectations at the pre-job meeting. Although Seatrax provided a mentor for the SSE, the mentor failed to ensure the safety of the SSE.

The mentor, crane operator and signalman should have ensured that the SSE remained at a safe distance away from the boom tip before giving the signal to make the lift.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

n/a

n/a

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The Lafayette District has no recommendations.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

INC G-110 is issued "After the Fact" to document that Flextrend Development Company, L.L.C. failed to protect health, safety and the environment by not performing operations in a safe and workmanlike manner as follows: Flextrend Development Company, L.L.C. failed to properly supervise the dismantling of a S230 rental crane in a safe manner to protect the equipment and employees. Flextrend employees failed to ensure that all persons remain at a safe distance away from the load at all times as per the Flextrend Safety Policies Manual. While removing the boom tip on the rental crane, an employee's finger was pinched between the boom tip and the remaining crane boom sections.

25. DATE OF ONSITE INVESTIGATION:

01-JAN-2012

26. ONSITE TEAM MEMBERS:

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

