

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: **18-OCT-2012** TIME: **0825** HOURS

2. OPERATOR: **W & T Offshore, Inc.**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR:

REPRESENTATIVE:

TELEPHONE:

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

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

6. OPERATION:

4. LEASE: **G03316**

AREA: **HI** LATITUDE:

BLOCK: **A 384** LONGITUDE:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

5. PLATFORM: **A**

RIG NAME:

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

8. CAUSE:

7. TYPE:

- HISTORIC INJURY
- REQUIRED EVACUATION 1
- LTA (1-3 days)
- LTA (>3 days) 1
- RW/JT (1-3 days)
- RW/JT (>3 days)
- Other Injury

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

- FATALITY
- POLLUTION
- FIRE
- EXPLOSION

- LWC HISTORIC BLOWOUT
- UNDERGROUND
 - SURFACE
 - DEVERTER
 - SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION HISTORIC >\$25K <=\$25K

9. WATER DEPTH: **358** FT.
10. DISTANCE FROM SHORE: **111** MI.
11. WIND DIRECTION:
SPEED: **15** M.P.H.
12. CURRENT DIRECTION:
SPEED: M.P.H.
13. SEA STATE: **4** FT.

17. INVESTIGATION FINDINGS:

On 18 October 2012, an injury occurred while crane operations were being conducted at HI A 384A. On the previous day (17 October 2012), painting and blasting operations were being conducted and at 1700 hours the paint and blast crew covered the crane's fast line with plastic and secured it with duct tape along the length of wire rope in the 70' boom. After the wire rope was covered in plastic, the Crane Operator (CO) made two lifts without removing the plastic before shutting the crane down for the day. Witness statements of the paint crew say Stop Work Authority was used to point out plastic in crane mechanisms on 10-17 but that the CO resumed operations regardless.

The next day (18 October 2012), the same CO resumed crane operations at 0800 with the wire rope still covered in plastic. A total of 4 lifts were made without incident including 2 personnel transfer lifts to a workboat. The CO then positioned the boom over his next load and was signaled to winch down. The 210 pound cylindrical crane ball descended 30' and jammed up-stopping unexpectedly. The CO continued to work the crane controls causing the wire rope to unspool and "ball up" before the jib section. Once an estimated 50' of slack wire rope winched out, the wire rope jam freed, causing the ball to free-fall 40', striking the Injured Person (IP) in his left foot. The IP was evacuated by field aircraft to a Lafayette medical facility where he was treated for injuries to his left foot, including two fractures and lacerations to the bottom of his foot.

Investigation revealed that the CO was not certified in accordance with API RP 2D. The Crane pre-use inspection did not identify foreign objects in the wire rope spool. Work was not stopped at the first sign of crane failure.

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

The injury was caused by the free-fall of the fast line crane ball, which struck the IP directly on his left steel toe boot.

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

1. The plastic and duct tape used to protect the wire rope while blast work was performed on the crane boom was never removed and was still present in the wire works at the time of investigation.
2. The CO failed to comply with Stop Work Authority.
3. Crane operator was not certified in accordance with API RP 2D.
4. Crane pre-use inspection did not identify foreign objects in the wire rope spool.
5. Work was not stopped at the first sign of crane failure.

20. LIST THE ADDITIONAL INFORMATION:

The crane is a pedestal crane with 70' boom and 3'6" jib. BSEE Investigator believes the wire rope and crane were in good repair and their condition did not contribute to this event. The workboat deck was 70' below the crane deck. The crane ball was in free-fall 40' before striking IP. 12' to 30' of slack was on the workboat deck. The crane ball was raised when the workboat left to take IP to HI A379 B (~300 yards away)

for helicopter evacuation. The workboat was not present during the accident investigation.

The CO had a card for a crane safety course, and no record of certification to be a qualified crane operator in accordance with industry standards. The district recommends operators review crane related certifications to ensure crane operators are specifically API RP 2D qualified crane operators.

21. PROPERTY DAMAGED:

Wire rope

NATURE OF DAMAGE:

Wire rope needs to be replaced following incident

ESTIMATED AMOUNT (TOTAL): \$2,000

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Jackson District makes no recommendations to the Agency at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 Unsafe and unworkmanlike practices

I-101 Crane was operated under known adverse/unsafe conditions and resulted in an accident

I-105 Crane not taken out of service with known deficiencies

I-143 Pre-Use inspection not in accordance with API RP 2D

25. DATE OF ONSITE INVESTIGATION:

19-OCT-2012

26. ONSITE TEAM MEMBERS:

Edward Keown /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Stephen Martinez

APPROVED

DATE: 08-JUL-2013