

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-JUL-2013 TIME: 1200 HOURS

2. OPERATOR: **McMoRan Oil & Gas LLC**

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

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

6. OPERATION:

4. LEASE: **G02697**

AREA: **HI** LATITUDE:

BLOCK: **A 536** LONGITUDE:

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

5. PLATFORM: **C**

RIG NAME:

7. 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: 200 FT.
10. DISTANCE FROM SHORE: 79 MI.
11. WIND DIRECTION:  
SPEED: 8 M.P.H.
12. CURRENT DIRECTION:  
SPEED: M.P.H.
13. SEA STATE: FT.

17. INVESTIGATION FINDINGS:-

On July 18, 2013 a construction crew arrived at HI A536 'C' to replace a leaking flange gasket on the pipeline company's equipment. The platform was shut in at the time of the incident to perform the repair. A Behavioral Job Safety Analysis (BJSA) was held and secondary tasks were discussed but not specifically addressed in the BJSA. After the pipeline flange gasket was replaced, the construction crew continued to the secondary task of removing a sight glass from Blowdown Separator MBF-1350. The Blowdown Separator is a piece of pipeline equipment used during pipeline repairs to prevent excessive liquid flow to the Flare Scrubber. The Blowdown Separator was Out-Of-Service (OOS) at the time of the injury. The 65# sight glass was attached to the separator with an upper and lower pipe nipple. While attempting to remove the bottom nipple of the sight glass with a pipe wrench, the nipple broke off due to severe corrosion. The IP then grabbed the sight glass at the bottom and pulled it away from the separator in an attempt to break off the top nipple which was also severely corroded. When the IP pushed the site glass back toward the Blowdown Separator, the top nipple broke causing his left index finger to be driven into the corroded ASME code plate bracket causing the severe laceration.

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

The IP lost control of the 65# site glass after the upper pipe nipple broke. After the upper pipe nipple broke, the weight of the sight glass and momentum caused his left index finger to strike the corroded edge of the ASME code plate bracket.

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

The IP was not wearing gloves.-  
The BJSA did not include sight glass removal.-  
Improper technique was used to remove the site glass.-

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

**None**

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

**No recommendations.**

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

Two (2) Incidents of Non Compliance were issued to the lessee.

G-110 'C' At the time of the Accident Investigation, It was determined that the IP was not wearing gloves in accordance with BJSA stipulations. This violation was verified by witnesses.

P-430 'C' At the time of the Accident Investigation, Blowdown Separator MBF-1350 was not stamped in accordance with the ASME Boiler and Pressure Vessel code. The bracket that the ASME code stamp was supposed to be attached to had corroded and fallen off. This was the point of impact that caused the severe laceration to the IP's left index finger.

25. DATE OF ONSITE INVESTIGATION:

19-JUL-2013

26. ONSITE TEAM MEMBERS:

Mike Hankamer /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

John McCarroll

APPROVED

DATE: 17-SEP-2013