UNITED STATES DEPARTMENT OF THE INTERIOR BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

For Public Release

Ι.	OCCURRED			
	DATE: 12-APR-2013 TIME: 1325 HOURS	STRUCTURAL DAMAGE		
	12-APK-2013 TIME: 1325 HOURS	CRANE		
2.	OPERATOR: Mariner Energy Resources, Inc.	OTHER LIFTING DEVICE DAMAGED/DISABLED SAFETY SYS.		
	REPRESENTATIVE:	INCIDENT >\$25K H2S/15MIN./20PPM		
	TELEPHONE:			
	CONTRACTOR:	REQUIRED MUSTER		
	REPRESENTATIVE:	SHUTDOWN FROM GAS RELEASE		
	TELEPHONE:	X OTHER RW/JT Arm Injury		
3.	OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:	6. OPERATION:		
		☐ PRODUCTION		
		DRILLING		
4.	LEASE: G01198	WORKOVER		
	AREA: SM LATITUDE:	COMPLETION		
	BLOCK: 66 LONGITUDE:	HELICOPTER		
	DI AUEODM G	MOTOR VESSEL PIPELINE SEGMENT NO.		
ο.	PLATFORM: C RIG NAME:	X OTHER Construction		
	KIO NAMI.			
6.	ACTIVITY: X EXPLORATION (POE)	8. CAUSE:		
	X DEVELOPMENT/PRODUCTION	☐ EQUIPMENT FAILURE		
7	(DOCD/POD) TYPE:	X HUMAN ERROR		
		EXTERNAL DAMAGE		
	HISTORIC INJURY	SLIP/TRIP/FALL		
	REQUIRED EVACUATION 1	1 WEATHER RELATED		
	LTA (>3 days)	(>3 days) UPSET H20 TREATING		
	RW/JT (1-3 days)	OVERBOARD DRILLING FLUID		
	X RW/JT (>3 days)	OTHER		
	Other Injury	9. WATER DEPTH: 129 FT.		
	FATALITY			
	POLLUTION	10. DISTANCE FROM SHORE: 57 MI.		
	FIRE EXPLOSION			
		11. WIND DIRECTION:		
	LWC HISTORIC BLOWOUT	SPEED: M.P.H.		
	UNDERGROUND SURFACE			
	DEVERTER	12. CURRENT DIRECTION:		
	SURFACE EQUIPMENT FAILURE OR PROCEDURES	SPEED: M.P.H.		
	COLLISION HISTORIC >\$25K <=\$25K	13. SEA STATE: FT.		

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17. INVESTIGATION FINDINGS:

On April 12, 2013, at approximately 1325 hours, a contract welder (CW) fractured his right arm while conducting cutting operations on a 2-in line. Prior to cutting operations beginning, all personnel including the CW reviewed the Job Safety Analysis (JSA) that detailed recommended hazard controls such as, using good body positioning, wearing gloves, keeping hands and body clear of work (saw blade, wrenches and potential pinch points), do not get under loads and use proper rigging when lowering piping.

The CW entered the cellar deck and began cutting the 2-in pipe in approximately 7-ft long pieces utilizing a torch. Prior to the CW cutting the pipe, an employee would deliver a piece of rope through the grating and attach to the pipe to prevent the pipe from falling. During cutting operations, the CW approached a U-bolt that supported a section of pipe that was to be cut. The rope was dropped to the CW to attach to the pipe, but according to the employee dropping the rope, the CW failed to do so. The employee was still waiting for instructions from the CW when the incident occurred.

The CW cut the U-bolt closest to him first which forced the CW to place his arm under the pipe to reach the final cut on the U-bolt. As the final cut was made, the pipe fell coming in contact with the CW's arm and pinning the arm between a hand rail located below the pipe.

First aid was administered prior to the CW being evacuated. The CW was transported to a medical facility where it was determined he suffered a fractured arm. The CW was released to restricted duty.

The BSEE Lafayette District conducted an onsite investigation April 15, 2013.

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

The CW failed to ensure the piping was properly supported prior to cutting the U-bolt assuming there was additional support downstream.

The CW should have assessed the potential hazards prior to placing his arm under the piping.

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

The CW failed to communicate with the employee dropping the rope that he had failed to secure it to the pipe.

20. LIST THE ADDITIONAL INFORMATION:

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NATURE OF DAMAGE:

None NA

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District office makes no recommendations to the Regional Office of Safety Management (OSM).

- 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 Mariner Energy, Inc. failed to protect health, safety and the environment by not performing operations in a safe and workmanlike manner as follows: An employee failed to perform operations in a safe and workmanlike manner while attempting to remove a section of 2-in pipe utilizing a cutting torch, the employee cut a U-bolt that was supporting the entire section of pipe. The employee failed to secure the pipe prior to cutting the U-bolt which allowed the pipe to make contact with the employee's wrist as it fell. The employee suffered a fracture to his right wrist due to this injury.

25. DATE OF ONSITE INVESTIGATION:

15-APR-2013

26. ONSITE TEAM MEMBERS:

Gonzales / Guillotte /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

MICHAEL HEBERT

APPROVED

DATE: 03-JUN-2013

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INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPR			INJURY FATALITY WITNESS	
NAME: HOME ADDRESS:				
CITY:	WORK PHONE:	STAT	STATE:	
		TOTAL OFFSHOR	RE EXPERIENCE:	YEARS
EMPLOYED BY:				
BUSINESS ADDRESS	3:			
CITY:	CITY:		STATE:	
ZIP CODE:				

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