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

### **ACCIDENT INVESTIGATION REPORT**

### For Public Release

L .	OCCURRED	
	DATE:	STRUCTURAL DAMAGE
	29-SEP-2012 TIME: 0455 HOURS	CRANE
		OTHER LIFTING DEVICE
2.	OPERATOR: Black Elk Energy Offshore Operation	DAMAGED/DISABLED SAFETY SYS.
	REPRESENTATIVE:	INCIDENT >\$25K
	TELEPHONE:	H2S/15MIN./20PPM
	CONTRACTOR:	REQUIRED MUSTER
	REPRESENTATIVE:	SHUTDOWN FROM GAS RELEASE
	TELEPHONE:	X OTHER Finger Injury
		A CINER Finger injury
3.	OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR	6. OPERATION:
	ON SITE AT TIME OF INCIDENT:	6. OPERATION:
		D PROPRIGHTON
		PRODUCTION DRILLING
1.	LEASE: 00495	WORKOVER
	AREA: VR LATITUDE:	COMPLETION
	BLOCK: 124 LONGITUDE:	HELICOPTER
	block. 121	H MOTOR VESSEL
3	PLATFORM: E	PIPELINE SEGMENT NO.
	RIG NAME:	X OTHER P&A
	RIG NAME:	
5	ACTIVITY: EXPLORATION (POE)	8. CAUSE:
	X DEVELOPMENT/PRODUCTION	SOURCE SPECIAL
	(DOCD/POD)	EQUIPMENT FAILURE
7.	TYPE:	X HUMAN ERROR
	Питопорта титипи	EXTERNAL DAMAGE
	HISTORIC INJURY	SLIP/TRIP/FALL WEATHER RELATED
	X REQUIRED EVACUATION 1	LEAK RELATED
	LTA (1-3 days)	UPSET H20 TREATING
	X LTA (>3 days 1	OVERBOARD DRILLING FLUID
	RW/JT (1-3 days)	OTHER
	RW/JT (>3 days)	
	Other Injury	9. WATER DEPTH: 70 FT.
	FATALITY	
	POLLUTION	10. DISTANCE FROM SHORE: 30 MI.
	FIRE	
	EXPLOSION	11. WIND DIRECTION: W
	LWC   HISTORIC BLOWOUT	SPEED: 10 M.P.H.
	UNDERGROUND	orabb. IV M.F.M.
	SURFACE	10 GUDDINE DIDEGLOU
	DEVERTER	12. CURRENT DIRECTION:
	SURFACE EQUIPMENT FAILURE OR PROCEDURES	SPEED: M.P.H.
	COLLISION HISTORIC >\$25K <=\$25K	13. SEA STATE: 4 FT.

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#### 17. INVESTIGATION FINDINGS:

On September 29, 2012, Freedom Well Services was on location at VR-124 for Black Elk Energy conducting Permanent Abandonment (PA) operations on the E-4 well. On September 28th at 18:00 hours, a safety meeting and Job Safety Analysis (JSA) was performed on rigging up casing jacks and pulling the 10%" and 24" casings. At 03:00 hours on September 29th, jacking of the casing began. At approximately 04:55hrs the casing reached the bottom set of split bowls in the jack. The bowls started to rise with the casing, jacking stopped and the Injured Person (IP) attempted to manually remove the bowls by hand. The split bowl (weighing ± 150 lbs.) slid off the jack stand crushing the IP's finger between the hand rail of the work basket and the split bowl. The IP's finger was cleaned, wrapped, and he was prepared for medical evacuation. Upon arrival at the Hospital the IP received sutures for a laceration and x-rays revealed that the tip of the finger was fractured.

On October 2, 2012, BSEE inspectors arrived for an onsite inspection. After reviewing statements, supporting documents and inspection of equipment involved, the following was found: On September 6, 2012, during casing removal when the last joint of casing passed through the bottom of the casing jacks, a half side of the split bowl was lifted up, and subsequently flipped on its side and fell through the opening under the jacks to the cellar deck below. Black Elk Energy filed an internal HSE incident Report. On September 23, 2012, while installing bowls into the casing jack, the Black Elk safety representative shut down operations to discuss concerns with the lifting eyes not being properly installed and to discuss proper lifting procedures to remove the bowls using the crane. Operations continued after the discussion with no changes to the lifting eyes.

Inspection of the casing slip bowls revealed that the threaded holes being used to install the lifting eyes were worn, corroded, and filled with debris that would not allow lifting eyes to be properly installed. Improperly installed lifting eyes prevented the crane from being used to remove the casing slip bowls and they would have to be removed manually by personnel. After reviewing statements, it was found that the normal practice for removal of the bowls is to install lifting eyes into the bowls and use the crane to remove bowls.

- 18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:
  - 1. The threaded holes used for the installation and removal of the lifting eyes were worn, corroded, and filled with debris that would not allow lifting eyes to be properly installed. Improperly installed lifting eyes would not allow crane to be used for removal of slip bowls.
  - 2. The IP attempted to manually remove the bowls by hand.
- 19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

No corrective action was taken when the Black Elk safety representative shut down operations to discuss concerns with the lifting eyes not threading completely into the casing slip bowls.

20. LIST THE ADDITIONAL INFORMATION:

Black Elk and Freedom Well Service could not provide any written procedures for removing the casing slip bowls from the jack stand.

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ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Charles District has no recommendations to the Regional Office of Safety Management.

- 23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES
- 24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:
  - G-111 The threaded holes used for the installation and removal of the lifting eyes were worn, corroded, and filled with debris that would not allow lifting eyes to be properly installed.
  - G-110 Injured Person (IP) attempted to manually remove the bowls without the aid of a lifting device.
- 25. DATE OF ONSITE INVESTIGATION:

02-OCT-2012

26. ONSITE TEAM MEMBERS:

Larry Miller / Mitchell Klumpp /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Williamson

APPROVED

DATE: 13-DEC-2012

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## INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE  X CONTRACTOR REPRESENTATIVE  OTHER	INJURY FATALITY  WITNESS	
NAME: HOME ADDRESS: CITY:	STATE:	
WORK PHONE:	TOTAL OFFSHORE EXPERIENCE:	ZEARS
EMPLOYED BY: BUSINESS ADDRESS:		
CITY: ZIP CODE:	STATE:	

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