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: **31-MAY-2016** TIME: **1445** HOURS

2. OPERATOR: **Tarpon Operating & Development, L**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Quality Energy Services, LLC**
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G12808**
   AREA: **WC** LATITUDE:
   BLOCK: **616** LONGITUDE:

5. PLATFORM:
   RIG NAME:

6. ACTIVITY:
- [ ] EXPLORATION(POE)
- [X] DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
- [ ] HISTORIC INJURY
- [X] REQUIRED EVACUATION **1**
- [ ] LTA (1-3 days)
- [ ] LTA (>3 days
- [X] RW/JT (1-3 days) **1**
- [ ] 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

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

6. OPERATION:
- [ ] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [X] OTHER **abandonment**

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

9. WATER DEPTH: FT.

10. DISTANCE FROM SHORE: MI.

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

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

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS:

On May-31-2016, at approximately 2:45pm, an incident occurred during crane lifting operations on West Cameron 616-A. The work crew was removing 381.66' of 13.375 casing weighing approximately 25,953 lbs. from the well bore when a worker injured his hands.
At the time of the incident, the operation being performed included the of use the crane to lift the casing through the casing jacks that were set up on the top deck of the platform, and then lay the casing down on the deck of the platform. The casing was attached to the crane load block with two separate lifting slings approximately 20' in length. The slings were connected to casing using shackles and the looped ends of the slings were connected to the load block. When the load was lifted approximately 15', the injured person (IP) instructed the crane operator "to boom up" in order to allow the casing to pass through the casing jacks. At the same time the boom was being raised, the IP put his hands on the slings to assist alignment of the lift through the casing jacks. The casing began to rotate and wrap the slings around each other, trapping the IPs left hand between the slings and momentarily catching the IPs right hand. In order to free the IPs left hand from the slings one of the sling had to be cut with a torch to remove the IPs hand from the sling assembly.

The IP received injuries to both hands as follows: 1) the left hand had bruising, and 2) the right hand had a fractured thumb. The IP was released for light duty work on June-1-2016.

On June-7-2016, BSEE Lake Charles District inspection team assembled onsite to conduct an investigation into the incident. Two of the three Job Safety Analysis (JSA) completed for the removal of the casing mentioned the need to use tag lines for controlling the load during lifting operations. Furthermore, API Recommended Practice 2D Sixth Edition, May 2007 section 3.2.3 "Moving the Load," states "Appropriate tag or restraining lines should be used where necessary to control the load". An inspection of the load block found that the hook would not rotate when a load was applied. The load block was sent to Seatrax for further analysis. During the analysis of the load block, the trunnion bearing was found to be unserviceable. Sand and other particles were found inside the bearing assembly. The sand and particles were found mixed with the grease in the bearing causing the bearing to seize and lock up with minimal force. The seizing of the bearing did not allow the hook to rotate on the load block, which in turn forced the slings to wrap around the IPs hands.

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

The IP put his hands on the slings to assist alignment of the lift through the casing jacks. The IP did not use the appropriate tag or restraining lines to control the load.

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

1) IP did not follow the JSA for pulling out of the hole and laying down casing (use a tag lines during crane lifts).
2) The seizing of the bearing on the load block did not allow the hook to rotate, which in turn forced the slings to wrap around the IPs hands.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

N/A

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110: The IP put his hands on the slings to assist alignment of the lift through the casing jacks. The IP did not use the appropriate tag or restraining lines to control the load.
§30 CFR 250.107: What must I do to protect health, safety, property, and the environment?
(a) You must protect health, safety, property, and the environment by:
(1) Performing all operations in a safe and workmanlike manner.

25. DATE OF ONSITE INVESTIGATION:

07-JUN-2016

26. ONSITE TEAM MEMBERS:

Mitchell Klumpp / Guy Bertrand / Larry Miller /

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Mark Osterman

APPROVED DATE: **06-JUL-2016**