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:		STRUCTURAL DAMAGE
	31-JUL-2014 TIME: 1230 HOURS		CRANE
2	OPERATOR: McMoRan Oil & Gas LLC		OTHER LIFTING DEVICE
2.	REPRESENTATIVE:		INCIDENT >\$25K
	TELEPHONE:		H2S/15MIN./20PPM
	CONTRACTOR: -		REQUIRED MUSTER
	REPRESENTATIVE:		SHUTDOWN FROM GAS RELEASE
	TELEPHONE:		OTHER
3.	OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:	6.	OPERATION:
			X PRODUCTION
1	LEASE: G02697		DRILLING
4.	AREA: HI LATITUDE:		
	BLOCK: A 536 LONGITUDE: -		COMPLETION HELICOPTER
			MOTOR VESSEL
5.	PLATFORM: - C		PIPELINE SEGMENT NO.
	RIG NAME:		OTHER
6	ACTIVITY: EXPLORATION (POE)	8.	CAUSE:
0.	X DEVELOPMENT/PRODUCTION		_
	(DOCD/POD)		EQUIPMENT FAILURE
7.	TYPE:		EXTERNAL DAMAGE -
	HISTORIC INJURY -		SLIP/TRIP/FALL -
	X REQUIRED EVACUATION 1-		WEATHER RELATED
	LTA (1-3 days) LTA (>3 days		UPSET H20 TREATING
	RW/JT (1-3 days)		OVERBOARD DRILLING FLUID
	X RW/JT (>3 days) 1 -		OTHER
	Other Injury-	a	WATER DEPTH: 200 FT.
	FATALITY	٦.	WATER DEFIN. 200 FT.
	POLLUTION	10.	DISTANCE FROM SHORE: 79 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	12	SEA STATE: FT.
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EV2010R-

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On July 31, 2014, the crew of HI A536 platform C was preparing to move a Water Maker from its position on the top deck. The Water Maker was built into a cubic lifting frame with four pad eyes welded at the top corners, shackle bolts were attached at all four points and connected to a four-point wire sling, with each sling point terminating with a wire loop and thimble. The deck was crowded with other equipment and the crane operator had a full view of were the incident occurred.

There were three people observing the lift besides the crane operator. The Injured Party (IP) was closest to the load and gave the signal to begin the lift. As tension was applied one of the shackle bolts did not rotate upwards, with the sling loop stuck between the pad eye and shackle bolt base. The IP grabbed the wire rope above the loop (at the ferrule) with his left hand, presumably in an effort to free the shackle bolt, and trapped his ring finger between the wire loop thimble and head of the shackle bolt safety pin. The IP screamed and the crane operator reduced tension and shut down, the load had not left the ground.

Extent of the injury was not known until the glove was removed on the way to the quarters building to get first aid. The tip of the left ring finger had been crushed with bone exposed. Injury was treated with hydrogen peroxide and gauze bandages until IP could be evacuated, detached section of fingertip was put in a ziplock bag with ice. The hospital was unable to reattach fingertip and removed the remainder of the distal phalange.

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

The accident was caused by the Injured Party placing his hand on a tensioning wire sling and becoming trapped between the wire rope thimble and shackle bolt safety pin.

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

There was no solely designated signal man. Job Safety Analysis (JSA) did not include a procedure to safely handle a jammed shackle bolt. 20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

Ap

injury

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

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none

- 23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO
- 24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

none

25. DATE OF ONSITE INVESTIGATION:

08-AUG-2014

26. ONSITE TEAM MEMBERS: 29. ACCIDENT INVESTIGATION George Timoh / Aaron Campbell / PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Stephen P. Martinez

APPROVED DATE: 11-SEP-2014

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