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    UNITED STATES DEPARTMENT OF THE INTERIOR -
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT-
                    GULF OF MEXICO REGION -
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## ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED

DATE:
12-DEC-2014 TIME: 0900 HOURS
2. OPERATOR: ANKOR Energy LLC REPRESENTATIVE:
TELEPHONE: -
CONTRACTOR: -
REPRESENTATIVE: -
TELEPHONE:
3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:
4. LEASE: 00830

AREA: SS LATITUDE:
BLOCK: 229 LONGITUDE:-
5. PLATFORM: - A

RIG NAME: * COIL TUBING UNIT (HOUMA DIST
6. ACTIVITY:
7. TYPE:HISTORIC INJURY-

| X | REQUIRED EVACUATION |
| :---: | :---: |
|  | LTA (1-3 days) |
|  | LTA (>3 days |
|  | RW/JT (1-3 days) |
|  | RW/JT (>3 days) |
|  | Other Injury- |

FATALITY
POLLUTION
FIRE
EXPLOSION
LWC HISTORIC BLOWOUT UNDERGROUND
SURFACE
DEVERTER
SURFACE EQUIPMENT FAILURE OR PROCEDURES
COLLISION $\square$ HISTORIC $\square>\$ 25 \mathrm{~K} \quad \square<=\$ 25 \mathrm{~K}$

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STRUCTURAL DAMAGE
CRANE
OTHER LIFTING DEVICE nylon sling
DAMAGED/DISABLED SAFETY SYS.
INCIDENT >$25K
H2S/15MIN. / 20PPM
REQUIRED MUSTER
SHUTDOWN FROM GAS RELEASE
OTHER
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6. OPERATION:

PRODUCTION
DRILLING
X WORKOVER
COMPLETION
HELICOPTER
MOTOR VESSEL PIPELINE SEGMENT NO. OTHER
8. CAUSE:

X EQUIPMENT FAILURE
X HUMAN ERROR EXTERNAL DAMAGE SLIP/TRIP/FALL WEATHER RELATED LEAK UPSET H2O TREATING OVERBOARD DRILLING FLUID
OTHER $\qquad$
9. WATER DEPTH: 130 FT.
10. DISTANCE FROM SHORE: 62 MI.
11. WIND DIRECTION: N-

SPEED: 1 M.P.H.
12. CURRENT DIRECTION: N

SPEED: $\quad 1$ M.P.H.
13. SEA STATE: 3 FT.

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08-A P R-2015-
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On December 12, 2014, a CETCO Plug and Abandon (PA) crew was rigging up Coiled Tubing (CTU) equipment on Ankor's Ship Shoal (SS) 229 A facility. The PA crew members were using the lift boats crane to lift the riser section of the equipment in order to drain water out of the bottom of the riser. Nylon slings were held in place by two studded bolts threaded to a flange at the top of the riser in order to complete the lift, in place of a proper lifting device. Two PA employees held the slings in place in order to keep the slack out as they radioed the crane operator to begin lifting the riser. When all slack had be removed from the slings they gave the "all stop" command to the crane operator, and at this time one of the eyes on the nylon sling parted and struck one of the PA crew members who had been holding the sling in place on the right wrist. The PA crew called an "all stop" at this point and the Injured Person (IP) was evaluated at the facility by Ankor's contract safety representative. The IP's hand had already began to swell from the knuckles to his wrist, and he was sent by helicopter to Ankor's shore base in Patterson, Louisiana where he was met by CETCO's safety representative, and he was taken to Occupational Medicine Clinic (OMC) in New Iberia, Louisiana for further evaluation. The OMC doctor diagnosed the IP with a broken wrist, and CETCO placed him on restricted duty.

Multiple issues allowed this incident to occur. The CETCO PA supervisor was not overseeing the rigging up of the equipment and the post incident evaluation noted that the IP was inadequately trained in lifting and rigging. A pre-use inspection of the lifting equipment was not conducted, the slings that were used appeared old and dirty, and no certifications for the slings were on board the facility. It was noted that these were the wrong slings for this type of lift and they were incorrectly rigged to the riser. The JSA for the job was inadequately filled out and was missing job steps and failed to identify all hazards. CETCO procedures for correct rigging to the riser flange were also missing from the job site.
18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:

- Inadequate Training in lifting and rigging equipment
- Improper lifting equipment used during job.

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

- Inadequate JSA: The JSA that was done failed to identify all hazards involved with job
- Operator failed to conduct a proper pre-use inspection of the lifting equipment
- Procedures for rigging and lifting the riser were not available to the employees
- Lifting equipment was in poor condition
- Poor Supervision

20. LIST THE ADDITIONAL INFORMATION:

N/A

N/A -

ESTIMATED AMOUNT (TOTAL):
22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE Houma District has no recommendations for the Region at this time.
23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES
24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

A G-110 was issued as follows:
"On December 12, 2014, a CETCO Plug and Abandon (PA) crew was rigging up Coiled Tubing (CTU) equipment on Ankor's SS229A facility. After rigging nylon slings to studded bolts at the top of the riser, an eye of one of the slings parted and struck an employee on the right hand, breaking his right wrist. The investigation following this incident identified the following causes:
a) Poor supervision of employees.-
b) Inadequate training in lifting and rigging of employees.-
c) The wrong lifting equipment was used for the job.-
d) No pre-use inspection of the lifting equipment.-
e) Lifting equipment was in poor condition. -
f) Procedures for rigging up to the riser flange were inadequate." -
25. DATE OF ONSITE INVESTIGATION:
26. ONSITE TEAM MEMBERS:-

Josh Ladner / James Richard /
29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:
30. DISTRICT SUPERVISOR:

Bryan Domangue

APPROVED
DATE:
06-MAR-2015

