

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: 17-OCT-2016 TIME: 0100 HOURS

2. OPERATOR: W & T Offshore, Inc.

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: Quality Energy Services, LLC

REPRESENTATIVE:

TELEPHONE:

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

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

6. OPERATION:

4. LEASE: 00763

AREA: WC LATITUDE:

BLOCK: 180 LONGITUDE:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER Decommissioning

5. PLATFORM: G

RIG NAME:

6. ACTIVITY: EXPLORATION(POE)
 DEVELOPMENT/PRODUCTION
(DOCD/POD)

8. CAUSE:

7. TYPE:

- HISTORIC INJURY
- REQUIRED EVACUATION 1
- LTA (1-3 days)
- LTA (>3 days) 1
- RW/JT (1-3 days)
- RW/JT (>3 days)
- Other Injury

- EQUIPMENT FAILURE
- HUMAN ERROR
- EXTERNAL DAMAGE
- SLIP/TRIP/FALL
- WEATHER RELATED
- LEAK
- UPSET H2O TREATING
- OVERBOARD DRILLING FLUID
- OTHER _____

- FATALITY
- POLLUTION
- FIRE
- EXPLOSION

- LWC
- HISTORIC BLOWOUT
 - UNDERGROUND
 - SURFACE
 - DEVERTER
 - SURFACE EQUIPMENT FAILURE OR PROCEDURES

9. WATER DEPTH: 50 FT.
10. DISTANCE FROM SHORE: 26 MI.
11. WIND DIRECTION:
SPEED: 17 M.P.H.
12. CURRENT DIRECTION:
SPEED: M.P.H.
13. SEA STATE: FT.

COLLISION HISTORIC >\$25K <=\$25K

17. INVESTIGATION FINDINGS:

On 17-OCT-2016, at 1:00am, an incident occurred at West Cameron 180G platform (WC-180G) while tripping work string into the G9 well. A 30 foot tubing joint weighing 13.3 pounds per foot (ppf) struck the injured persons (IP) chest and ankle; the ankle was subsequently fractured requiring an evacuation. The incident occurred while a tubing joint was being lifted via a liftboat crane.

On the day of the incident, the liftboat Tobie Eymard owned by Offshore Marine Contractors, Inc. (OMC) was on location assisting in the abandonment operation of G9 well. The Quality Energy Services crew was running a 9.5 inch casing cutter with 15 inch sweep knives with tubing joints. The tubing joints were being assembled together with a power tong attached to a power tong arm. At the time of the incident, the liftboat crane was conducting blind lifts of the tubing joints. The out of service (OOS) platform box boom crane was obstructing the crane operator's view of the tubing joint. During the operation a designated flagman was using a radio to communicate with the crane operator with no other duties.

During the lift of the tubing joint, the box end (female) of the joint contacted the tong arm causing the pin end (male) of the joint to rise up striking the IP in the chest. The IP fell onto the platform decking and the tubing joint landed on his ankle. According to W&T, the IP was tasked with ensuring each joint on the pipe rack had thread protectors on the pin end of the joint. The protectors prevent the thread damage during the lifts while dragging the joints across the grating deck.

A Bureau of Safety and Environmental Enforcement (BSEE) onsite visit was performed on 17-OCT-2016. During a visit photographs were taken along with collecting statements, JSAs, daily reports, and safety meeting sheet provided by W&T.

According to W&T, there was a "safe zone" (danger zone) established during the safety meeting and during the operations. There were no findings of documentation of a safe zone (danger zone) by BSEE, which is verified by W&T in the incident report review conducted by W&T. BSEE also could not find any markings of a safe zone (danger zone) or barricades blocking danger zones for the night of the incident in the photographs collected from W&T. Furthermore, BSEE does not understand why the term "safe zone" is being used to describe "danger zone".

According to W&T, the "IP was witnessed putting his hands on the pipe and was directed not to touch the pipe". The W&T report provided to BSEE "Incident Reporting Review & Internal Routing" with a date of 17-OCT-2016 has the cause of the incident to be as follows; "IP was verbally instructed not to enter safe zone, IP was reprimanded just prior to the incident to not touch the pipe and to stay away from safe zone". BSEE could not find any documentation of a stop work authority used or a safety stand down to discuss the unsafe action. This unsafe action was not added to the existing JSA for the task of "Tripping In Hole (TIH) with Tubing Using Tongs" prior to the injury incident. The JSA for TIH and the report provided by W&T mentions "Swing tubing over well; Getting struck by swinging tubing; Keep hands on tubing as it is picked up; and, Keep load under control". There is no mention in the JSA as to which point the workers needed to enter the safe zone (danger zone) mentioned by W&T and put their hands on the tubing joint to keep the load under control. Furthermore, the JSA for crane operation during this incident contradicts the JSA for TIH by stating "use tag line to assist in controlling load, maybe two per lift".

W&T did not provide any information on why the designated flagman did not see the lift approaching the tong arm or radio all stop before the lift contacted the tong arm. Furthermore, the company representative/person in charge (PIC) for W&T and the supervisor for Quality Energy Services were both on the deck within 30 feet of the injury incident. Neither supervisor used stop work authority when the IP continued

the behavior of entering the danger zone of the lift that W&T stated was corrected prior to the injury incident.

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

During the lift of the tubing joint, the box end of the joint contacted the tong arm causing the pin end of the joint to rise up striking the IP in the chest. The IP fell on the platform decking and the joint landed on his ankle.

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

1. There were no markings or barricades blocking workers from entering danger zones during the lift.

2. Prior to the injury the IP was purportedly told not to touch the tubing joint and to stay away from the "safe zone" (danger zone). BSEE could not find any documentation of a stop work authority used or a safety stand down to discuss the unsafe action of touching the tubing joint during the lift or adding this unsafe action to the JSA.

3. The JSA for TIH mentions to keep hands on the tubing as it is being lifted to keep the load under control. There is no mention in the JSA at which point the workers need to enter the "safe zone" (danger zone) mentioned by W&T and put their hands on the tubing to keep the load under control.

4. The JSA for crane operation during this incident contradicts the JSA for TIH by stating "use tag line to assist in controlling load, maybe two per lift".

5. The designated flagman did not see the lift approaching the tong arm or he did not radio all stop before the lift contacted the tong arm.

6. Neither supervisor on the work deck used stop work authority when the IP continued the behavior of entering the danger zone of the lift that W&T stated was corrected prior to the incident.

7. W&T uses the term "safe zone" to describe "danger zones".

20. LIST THE ADDITIONAL INFORMATION:

After the injury incident W&T took the following actions;

1. Added a rigid barrier around the pin end of the tubing joints with red hazard tape around the danger zone.

2. Added a trough (tray) over the grating from the pipe rack to the rigid barrier around the pin end of the tubing joints.

3. Added a Safe Zone (danger zone) requirement to the JSA for future operations.

4. The OOS crane boom on the platform was swung to a different location eliminating blind lifts during future operations.

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

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N/A

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

N/A

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

On 17-OCT-2016, at 1:00am, an incident occurred at West Cameron 180G platform while tripping work string into the G9 well. The liftboat Tobie Eymard's crane was conducting blind lifts when the box end of the tubing joint contacted the tong arm causing the pin end of the joint to rise up striking the IP in the chest. The IP fell onto the platform deck and the tubing joint landed on his ankle. The IP ankle was subsequently fractured requiring an evacuation.

25. DATE OF ONSITE INVESTIGATION:

24-OCT-2016

26. ONSITE TEAM MEMBERS:

Mitchell Klumpp /

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Mark Osterman

APPROVED

DATE:

12-DEC-2016