

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

For Public Release

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **13-MAR-2024** TIME: **2010** HOURS

2. OPERATOR: **Walter Oil & Gas Corporation**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **Enterprise Offshore Drilling**

REPRESENTATIVE: TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING
- 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:

4. LEASE: **G04232**

AREA: **SS** LATITUDE:

BLOCK: **189** LONGITUDE:

5. PLATFORM: **B**

RIG NAME: **ENTERPRISE 264**

6. ACTIVITY:

- EXPLORATION(POE)
- DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:

INJURIES:

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

- POLLUTION
- FIRE
- EXPLOSION

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

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

8. OPERATION:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- DECOMMISSIONING
- PA PIPELINE SITE CLEARANCE
- TA PLATFORM
- OTHER

9. CAUSE:

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

10. WATER DEPTH: **68** FT.

11. DISTANCE FROM SHORE: **31** MI.

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

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

14. SEA STATE: FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

On March 13, 2024, an incident occurred on the jack-up Enterprise 264, which was working under contract for Walter Oil & Gas (WOG). Plug & abandon (P&A) operations were being conducted at Ship Shoal Block 189, OCS-G04232. The Enterprise Crane Operator was offloading a 4 x 40' basket of tools, weighing 13,000 pounds, from the M/V GOL Cowboy (workboat) to the upper cantilever using the port side crane's main block and stinger. The stinger, which is rated for 9.80 tons in vertical pull, was connected to the basket, located on the workboat. The basket was hoisted to the required height to clear the living quarters on the Enterprise 264. The crane operator began to swing the basket over the living quarters when the stinger parted, dropping the basket, resulting in damage to the top of the control room, P-tanks, and platform on top of the living quarters. All operations were shut down and the affected areas were barricaded off. A plan was made to secure the tools and retrieve the basket. The basket was collected without further incident. No injuries are associated with this incident.

On the night of March 13, 2024, offloading of the workboat was scheduled to take place. A 4'x 40' basket of P&A tools was being moved from the workboat to the upper cantilever of the Enterprise 264. A cold work permit was utilized along with a Job Safety Analysis (JSA). The Preventive Maintenance Daily checklist was performed by the day crew and again by the night crew on the evening of the incident.

At approximately 20:10 hours, the crane operator, using the port crane with stinger, lifted a 4'x40' basket from the workboat. After hoisting up to a height to clear the living quarters of the Enterprise 264, the crane operator swung the basket toward the upper cantilever, the stinger failed, due to corrosion built up from moisture inside the socket over time, causing the basket to fall upside down damaging the top of the control room, P-tanks, and platform on top of the living quarters. Although the basket flipped, the tools remained inside. The weather details on the night of the incident were as follows: wind speed 10-15 MPH, wind direction SE, sea state 2-4', and general weather conditions were clear and calm.

The basket landed on the on top of the control room, P-tanks, and platform on top of the living quarters resulting in damage less than \$7,500. Initial actions taken after the incident was to shut down all operations and prevent access to the area. A safety stand down was performed with all crews. Next, a plan to retrieve the basket was put into place. The basket was recovered safely. All tools in the basket were inspected and found in good working order. A P-tank was swapped out instead of being repaired to not delay the project. Also, damaged sections of handrails were repaired. All slings and lifting gear to be inspected and damaged or degraded slings taken out of service. Replacement frequency of slings is being revised by Enterprise.

The Bureau of Safety and Environmental Enforcement (BSEE) Houma District office was notified orally and a written report was submitted in eWell within 15 days. The BSEE Houma District Inspectors (inspectors) were able to perform an onsite investigation on March 14, 2024, additional documents were obtained. Although a Preventive Maintenance Daily checklist was performed by the day and the night crew, the checklist did not clearly identify inspecting the stinger as a step in the checklist. A cold work permit was put in place along with a JSA. Neither of these documents specified inspecting the stinger. The stinger associated with this incident was ordered on December 4, 2018, put into service on April 28, 2022, and last annual inspection conducted on November 1, 2023. The stinger was left on the crane whether in use or not. The stinger failed due to corrosion build up from moisture build up in the socket over time.

Conclusion

Upon reviewing pictures, documents, WOG and Enterprise's investigation reports, BSEE concluded that failure to inspect the stinger contributed significantly to the

accident. Failure to inspect the stinger led to the crane operator using a faulty sling and caused the basket to fall. If the stinger was inspected prior to use, it could have been taken out of service and replaced with a new one.

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

Human Performance error - failure to identify degraded wire rope on stinger.

Equipment failure - Stinger was degraded inside the crimp on the wire rope making it difficult to identify.

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

Management systems - the Preventive Maintenance Daily checklist, Permit to Work, and JSA all failed to specifically list inspecting the stinger.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

Top of Control Room, P-Tank, and platform on top of living quarters

damage from impact

ESTIMATED AMOUNT (TOTAL): \$7,500

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE Houma District has no recommendations for the Office of Incident Investigations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

14-MAR-2024

26. Investigation Team Members/Panel Members:

29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR:

Amy Pellegrin

APPROVED

DATE: 29-MAY-2024