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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **31-MAY-2024** TIME: **0100** HOURS

2. OPERATOR: **MC Offshore Petroleum, LLC**
   REPRESENTATIVE:
   TELEPHONE: CONTRACTOR: **Infinity Operators, LLC** REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [X] CRANE
- [ ] OTHER LIFTING
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [X] INCIDENT >$25K **70,000**
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

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

4. LEASE: **G05884**
   AREA: **GC** LATITUDE:
   BLOCK: **52** LONGITUDE:

5. PLATFORM: **A**
   RIG NAME:

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

7. TYPE:
   INJURIES:
- [ ] HISTORIC INJURY

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

- [ ] 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.
- [X] DECOMMISSIONING
  - [X] PA [ ] PIPELINE [ ] SITE CLEARANCE
  - [ ] TA [ ] PLATFORM
- [X] OTHER **Abandonment**

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

10. WATER DEPTH: **604** FT.

11. DISTANCE FROM SHORE: **86** 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 May 31, 2024, a lifting incident occurred at Green Canyon Block 52 A Platform , at OCS-G05884, owned by MC Offshore Petroleum, LLC. At the time of incident, abandonment operations were being conducted on Well A008. The crane operator (CO-1) was using the crane's fast line to offload and backload a boat. Crane operator 2 (CO-2), who was working on deck as a rigger, noticed a stinger hooked to the main block latched to a lace of the crane boom. The operation was stopped and the Person In Charge (PIC) was notified.

On the night of May 30, 2024, offloading and backloading of a boat was scheduled to take place. A pre-use crane inspection and a Job Safety Analysis (JSA) was conducted. Offloading and backloading operations took place without incident until 01:00 hrs on May 31, 2024. CO-2 observed a stinger attached to the main block had latched into a lace of the crane boom. The decision was made by CO-2 to stop operations, notify the PIC, and unhook the stinger from the boom lacing.

While offloading and backloading a boat on May 31, 2024, at 01:00 hrs, CO-1 was lifting a load from the boat using the crane's fast line to place it on the top deck of GC 52 A. CO-2 noticed that a stinger connected to the crane's main block was latched to a lace on the boom. When he saw this, he stopped the job and notified the PIC. The PIC signaled for CO-1 to lower the boom without slacking off the main block. CO-2 advised the PIC to lower the boom and main block at the same time. The PIC ignored the warning continued to signal CO-1 to only lower the boom. While booming down, the stinger pulled free from the lace. The boom was visually inspected for damage by CO-1. No damage was found at this time.

Offloading and backloading operations were completed. The following day the damaged lace was found on a crane pre-use inspection. CO-2 informed the PIC about the broken lace and he was instructed to keep using the crane. The crane was taken out of service by the Bureau of Safety and Environmental Enforcement (BSEE) Houma District inspectors on June 6, 2024. An independent crane inspector derated the crane's lifting capacity to 50% on June 10, 2024. The crane boom tip was replaced ($70,000.00), load tested, and placed back in service on June 16, 2024.

BSEE Houma District was not orally notified of this incident. This incident was uncovered on an inspection conducted by BSEE Houma District inspectors (inspectors) on June 6, 2024. Inspectors were able to obtain documents, pictures, and statements from witnesses. The operator was informed to input this incident into eWell within 15 days and they complied. Inspectors performed a follow up investigation on June 11, 2024, to gather additional documentation, pictures, and witness statements. Although a pre-use crane inspection was performed, the stinger attached to the main block was not identified as loose gear. After the stinger accidentally latched into a lace of the crane boom, the operation was stopped and the PIC was notified. The PIC instructed CO-1 to lower the boom. The PIC was informed by CO-2 that he should be flagging to lower the boom and the big block simultaneously to relieve the tension on the stinger. The PIC failed to listen and the stinger continued to tighten up until it snapped a weld of the lace freeing itself. The PIC, CO-1, and CO-2 assumed the stinger freed itself and did not observe any damage to the boom. The operation was completed without further incident. The next morning CO-2 was performing a pre-use inspection of the crane and observed the broken lace. The PIC was notified of the damage to the boom by CO-2. The PIC told the CO-2 to keep using the crane. Next, CO-2 asked about the diminished capacity of the crane and the PIC again told him to keep using the crane as is. The damaged crane stayed in operation from May 31, 2024, until June 6, 2024, when the Inspectors took the crane out of service.

Upon reviewing pictures, documents, the operator's incident report, and witness statements, BSEE concluded that failing to remove the stinger when not in use contributed significantly to this incident. Step 6 of the pre-use crane inspection is

to visually check for loose gear such as slings, hooks, and shackles. The JSA did not cover the possibility of the stinger hanging up on the boom. Also, stop work authority (SWA) was not used when the PIC failed to listen to CO-2 recommendation of lowering the boom and main block at the same time. SWA was not used after the lace on the crane boom was found to be damaged. Instead, CO-1 and CO-2 continued to run the crane with a damaged boom.

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

Human error performance – Failed to identify the hazard of leaving the stinger on the big block when not in use.

Supervision – The PIC failed to address the concerns of CO-2 when lowering the boom without lowering the main block.

Communication – Stop Work Authority (SWA) was not used when the boom was lowered without lowering the big block at the same time. SWA was not used after the damaged boom was identified.

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

Management systems – The JSA was inadequate. It did not specify the stinger possibly hanging up on boom.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

damaged the boom tip **Broken weld on lace on the boom tip**

ESTIMATED AMOUNT (TOTAL): **$70,000**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

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At the time of the inspection, while conducting a crane inspection, structural damage was discovered on the crane's boom lacing. Described damage occurred on May 31st, 2024, and the operator continued to use until the time of this inspection June 6th, 2024. Operator is instructed to take crane out of service and have inspected by qualified crane inspector. Operator is required to send corrected deficiencies to the Houma District, prior to placing crane back in service.
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At the time of inspection, it was discovered that a crane incident occurred on May 31st, 2024, BSEE was not immediately notified following the incident.
See NTL No. 2019-N05.
Note: Incident was not reported until the time of this inspection (May 31st, 2024 – June 6th, 2024)

25. DATE OF ONSITE INVESTIGATION:

11-JUN-2024

26. Investigation Team Members/Panel Members:

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Amy Pellegrin

APPROVED DATE: **08-AUG-2024**