UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF OCEAN ENERGY MANAGEMENT, REGULATION AND ENFORCEMENT
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **22-MAY-2011** TIME: **2315** HOURS

2. OPERATOR: **Maritech Resources, Inc.**
   REPRESENTATIVE: **Pisciola, Kelley**
   TELEPHONE: **(281) 698-8519**
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **00054**
   AREA: **EI** LATITUDE:
   BLOCK: **129** LONGITUDE:

5. PLATFORM: **CF-QTR**
   RIG NAME:

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

7. TYPE:
- [ ] HISTORIC INJURY
- [X] REQUIRED EVACUATION **8**
- [ ] LTA (1-3 days)
- [X] LTA (>3 days **5**
- [ ] 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 [ ] HISTORIC [ ] >$25K [ ] <=$25K

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

6. OPERATION:
- [X] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [X] OTHER **Platform Abandonment**

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

9. WATER DEPTH: **45** FT.

10. DISTANCE FROM SHORE: **38** MI.

11. WIND DIRECTION: **SE**
    SPEED: **23** M.P.H.

12. CURRENT DIRECTION: **SE**
    SPEED: **2** M.P.H.

13. SEA STATE: **7** FT.

17. INVESTIGATION FINDINGS:

On 22 May 2011 at approximately 2315 hours, a bridge section connecting two independent structures (the production deck and the fire house deck) became dislodged while attempts were being made to remove it during decommissioning operations (DO). As a result, eight (8) personnel who were standing on the bridge section fell overboard into the Gulf waters. The Seacrane 600 crane, located on a 16,000 square feet derrick barge, was used to make the lift. Prior to attempting to lift the 36 ton bridge, employees were performing DO on a jacket that once produced hydrocarbons to the main structure. They were cutting piping and clamps that held the bridge in place. Due to complications, DO on the jacket were temporarily put on hold until additional tools could be sent to the location. While waiting on the additional tools and prior to starting DO, Job Safety Analysis's (JSA's) were completed and reviewed on all the bridge removal preparations. The bridge was connected to the crane with a four part D-ring sling, and four nylon straps connected the sling to the bridge. Due to the angle of the slings, each individual nylon strap was rated for approximately 25,200 lbs. The nylon straps were assembled in the v-basket positioned around the angle-iron supporting the sides of the bridge. The crane operator lifted the four-part sling alleviating the slack while the last cuts on the bridge were made to prepare for the lift. While making the final cuts, the middle support beam on the production side of the bridge was cut leaving a support beam on each corner. After the final cut, an attempt was made to lift the bridge. After applying 40 tons of tension on the lift, the crane operator and two other employees stated the bridge lifted four to five inches on the south side and started to buckle. It is not clear whether additional cuts were necessary or if the nylon straps were not positioned correctly to make the lift. The (stop work) command was authorized by the barge foreman to reassess what steps needed to be addressed. The barge foreman and the welding foreman boarded the bridge to verify all cuts were properly made. The crane operator lowered the slings six to eight feet to release the tension from the lift. Insufficient crane lighting required personnel using flash lights to check for possible uncut piping. Within several minutes, six other employees boarded the bridge to assist the barge foreman and the welding foreman. While assessing the production side of the bridge (north side), the bridge detached from the two remaining beams on the production side causing a shock load on the nylon straps. The two nylon straps supporting the production side of the bridge were severed causing the bridge on the production side to enter the Gulf waters, leaving the south side to remain suspended by the two remaining straps. The 8 employees descended approximately 60 to 70 feet before entering the water. Piping and other objects not secured, or that became detached during impact, struck employees while in the water. Employees were assisted out of the water onto a tug boat and brought back to the barge. The injured employees were then evacuated by helicopter and flown to three different hospitals: Terrebonne General, Thibodeaux General and Lafayette General where they received treatment. Two employees were allowed to return to work and one employee received light duty for three days. Other employees sustained more severe injuries including a fractured nose, torn muscle, two fractured ribs and an employee underwent surgery to repair a cut muscle in his arm.

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

***Once the (stop work) command was given, the barge foreman and the welding foreman should have assessed the hazards before boarding the bridge. The bridge was never disconnected from the nylon straps; therefore, the bridge would still be considered a load. Personnel should not have boarded the bridge until all safety concerns were addressed. As per Section 7.3.2 of the ( ) Lifting Operations manual, "The PIC shall ensure that lifting operations are conducted in strict accordance with the approved lift plan. Any variation from the agreed lift plan shall**

result in the job being made unsafe, stopped and reassessed to ensure continued safe operation."

***All non-essential personnel and third parties should have been kept out of any area where they might be struck or crushed by a load or lifting equipment if it swings, shifts or falls. No one should stand or work directly below a load, and visible barriers may be required.**

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

***As per the manufacturer representitive ( ) of the nylon straps that were severed, "The nylon straps should not have been utilized for this particular lift and the straps were cut due to being shock loaded on the edges of the angle iron supporting the bridge."**

***Loose piping and other unsecured objects were not removed to prevent injury to personnel or damage to equipment.**

***Personnel utilized flashlights due to lack of lighting in the load area. The DO should have been postponed until daylight hours or until sufficient lighting could have been obtained.**

***As per Section 7.2 of the ( ) Lifting Operations manual, the load shall possess sufficient integrity to withstand the forces applied during lifting. The method of rigging the load shall ensure that it remains stable and cannot tip, slip swing or fall unintentionally. The crane operator should not have lowered six to eight feet of slack on the slings. A shock load to the nylon straps could have been prevented if the slings would have had a foot or less of slack.**

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL): **$800**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lafayette District office makes no recommendations to the Agency.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

The following Incidents of Noncompliance (INCs) were issued "After the Fact" to document that Maritech Resources, Inc failed to protect health, safety and the environment by not performing operations in a safe and workmanlike manner as follows:

G-110 C 107 (a) 401(e)

Incident of Noncompliance (INC) G-110 is issued to document that on May 22, 2011, Maritech Resources, Inc. failed to properly supervise decommissioning operations while attempting to remove a bridge that connected two platforms in a safe manner to protect the equipment and employees. Eight employees were involved in decommissioning operations and were injured due to lack of supervision. The accident was the result of failing to address all hazards before allowing employees to board the bridge.

I-190 C 108 (f)

Incident of Noncompliance (INC) I-190 is issued to document that on May 22, 2011, Maritech Resources, Inc. failed to utilize the proper sling for lifting a bridge during decommissioning operations. Two nylon straps were severed and two were damaged due to the bridge collapsing causing a shock load to the nylon straps. Eight employees were involved in the decommissioning operations and were injured due to this incident.

Maritech Resources, Inc is advised to submit a letter of explanation addressing the aforementioned INC., and its plans for eliminating future incidents of this nature to the BOEMRE Lafayette District.

25. DATE OF ONSITE INVESTIGATION:

23-MAY-2011

26. ONSITE TEAM MEMBERS:

Wade Guillotte / Tom Basey / Raymond Johnson / Gerald Gonzales /

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

INJURY/FATALITY/WITNESS ATTACHMENT

[ ] OPERATOR REPRESENTATIVE
[X] CONTRACTOR REPRESENTATIVE
[ ] OTHER _____

[X] INJURY
[ ] FATALITY
[ ] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE:

[ ] OPERATOR REPRESENTATIVE
[X] CONTRACTOR REPRESENTATIVE
[ ] OTHER _____

[ ] INJURY
[ ] FATALITY
[X] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

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CITY: STATE:

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INJURY/FATALITY/WITNESS ATTACHMENT

☐ ☐
☐ ☐
☐ _____ ☐

NAME:

HOME ADDRESS:

CITY: STATE:

RIENCE: YEARS

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE: