

UNITED STATES DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: 04-NOV-2007 TIME: 1615 HOURS

2. OPERATOR:

Hess Corporation

REPRESENTATIVE: Rachal, Erin

TELEPHONE: (281) 578-3388

CONTRACTOR: Performance Energy Service, LLC

REPRESENTATIVE: Landry, Mike

TELEPHONE: (985) 665-5965

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

4. LEASE:

AREA: GB LATITUDE:
BLOCK: 260 LONGITUDE:

5. PLATFORM:

A (BALDPATE)

RIG NAME:

6. ACTIVITY:

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

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

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 Air Hoist
 DAMAGED/DISABLED SAFETY SYS.
 INCIDENT >\$25K
 H2S/15MIN./20PPM
 REQUIRED MUSTER
 SHUTDOWN FROM GAS RELEASE
 OTHER

6. OPERATION:

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

8. CAUSE:

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

9. WATER DEPTH: 1648 FT.

10. DISTANCE FROM SHORE: 108 MI.

11. WIND DIRECTION: NE
SPEED: 10 M.P.H.

12. CURRENT DIRECTION: E
SPEED: 2 M.P.H.

13. SEA STATE: 3 FT.

17. INVESTIGATION FINDINGS:

On 4 November 2007 at approximately 1615 hours, a construction crew contracted by Hess Corporation was attempting to install an incoming flowline riser from the Walter Oil and Gas Garden Banks 302 subsea Well No.1, when an incident occurred injuring one of the contractors. A Performance Energy Services contract construction rigger (Injured Person - IP) was involved in lowering a section of flowline riser to a location below the platform cellar deck. The nylon sling used to make the lift parted when it became exposed to 800 degrees from the turbine generator exhaust. The flowline riser fell approximately 20-25 feet before trapping the IP. The IP was pinned between a section of handrailing and cable from an air hoist used to maneuver the riser into place. A Performance Energy Services Lead Foreman () was checking up on other job task assigned to personnel when the a construction crew employee () alerted him that an accident had occurred. Together the two men found a come-a-long, chain and nylon straps. They proceeded back to the area where the IP () and the construction crew employee () had been working. At this time a few more members from the work crew had arrived with an extra come-a-long. The work crew decided to hook the come-a-long to the crane's stinger and lift up on the flowline riser section to relieve the tension from the line pressing against the IP's () mid-section. The work crew lifted the load of the flowline riser using the come-a-long which removed the weight off the cable from the air hoist freeing the IP () from between the cable and handrail. The IP was then set on a stretcher and brought out to an open deck area where he could be lifted. A personnel basket was lowered to the open deck area where the IP () was placed into the personnel basket and lifted to the top deck. He was then transported into the TV room where his blood pressure and pulse was monitored by Hess first responders. Air Med was notified at 1630 hours and arrived at 1830 hours. The IP () was brought back outside and placed back into the personnel basket and lifted to the heliport where he was placed into the helicopter. The aircraft departed GB 260-A at 1907 hours.

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

The nylon sling exposure to the extreme heat of 800 degrees from the turbine generators exhaust caused melting of the sling to the point of sling failure.

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

The decision by platform personnel involved in the lift to use a nylon sling instead of using wire rope slings. As a result, the slings were place in an area of high temperature which exceeded their design use, causing the slings to fail.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

- 1) Section of handrailing
- 2) Nylon Sling

Bent
melted, burnt

ESTIMATED AMOUNT (TOTAL): \$300

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The Lafayette District recommends that the Office of Safety Management issue a Safety Alert(s) emphasizing that all nylon slings used in the Gulf of Mexico OCS be used with extreme caution and should only be used as per manufacturer specification.

As part of the finding in this investigation it has been identified and determined that the use of the nylon sling were used inappropriately during this lifting operation. These types of slings are being used in various crane operations throughout the Gulf of Mexico OCS. As indicated in an attached document to this report, a pre-use inspection was performed but due to the use and the area in which it was used, the sling failed due the exposure to the high temperatures present during the lifting operation.

To further add to these recommendations, it has been well documented by MMS through accident/incident reporting that several incidents have occurred in the OCS involving nylon slings over the pass year which has resulted in serious and fatal injuries. The only way to prevent reoccurrence and to prevent these types of injuries and/or fatality from occurring again is to ban their use. A study by the office of Safety Management should indicate the dangers associated when using nylon slings improperly.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

07-NOV-2007

26. ONSITE TEAM MEMBERS:

Maxie Lambert / Tom Basey / David
Suire / Pat Sarsfield /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S.Smith

APPROVED

DATE: 07-DEC-2007

INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER _____

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE:

Crane/Other Material-Handling Equipment Attachment

Equipment Information

Installation date: 17-DEC-1998

Manufacturer: TITAN INDUSTRIES SERIAL # 227-8189-140D

Manufacture date: 01-JUL-1998

Make/Model: TITAN / T12000AC

Any modifications since manufactured? Describe and include date(s).

01-JAN-1999

Changed out the lower heel boom section for additional length.

What was the maximum lifting capacity at the time of the lift?

Static: Dynamic:

Was a tag line utilized during the lift? N

Were there any known documented deficiencies prior to conducting the lift? If yes, what were the deficiencies?

List specific type of failure that occurred during this incident. (e.g. cable parted, sticking control valve, etc.)

Nylon slings used during the lifting operation came into contact with the hot surface of the platform generator exhaust system causing the sling to melt to the point of failure.

If sling/loose gear failure occurred does operator have a sling/loose gear inspection program in place? Y

Type of lift: DD

For crane only:

Type of crane: HYDRAULIC

Boom angle at time of incident: Degrees: 46 Radius: 100

What was load limit at that angle? 8650

Crane equipped with: B

Which line was in use at time of incident? F

If load line involved, what configuration is the load block: 1 part.

Load Information

What was being lifted?

Description of what was being lifted (e.g. 10 joints of 2 3/8-inch pipe, ten 500-lb. sacks of sand, 2 employees, etc.)

Approximate weight of load being lifted:

Was crane/lifting device equipped with an operable weight indicator? **N**

Was the load identified with the correct or approximate weight? **N**

Where was the lift started, where was it destined to finish, and at what point in the lift did the incident occur? Give specific details (e.g. pipe rack, riser cart, drill floor, etc.)

If personnel was being lifted at the time of this incident, give specific details of lifting device and riding apparatus in use (e.g. 1) crane-personnel basket, 2) air hoist-boatswain chair, other)

Were personnel wearing a safety harness?

Was a lifeline available and utilized?

List property lost overboard.

Rigger/Operator Information

Has rigger had rigger training?

If yes, date of last training:

How many years of rigger experience did rigger have?

How many hours was the operator on duty prior to the incident?

Was operator on medication when incident occurred? **N**

How many hours was the rigger on duty prior to the incident?

How much sleep did rigger have in the 24 hours preceding this incident?

Was rigger on medication when incident occurred?

Were all personnel involved in the lift drug tested immediately following this incident?

Operator: **N** Rigger: Other:

While conducting the lift, was line of sight between operator and load maintained?

N

Does operator wear glasses or contact lenses? **N**

If so, were glasses or contacts in use at time of the incident? **N**

Does operator wear a hearing aid? **N**

If so, was operator using hearing aid at time of the incident? **N**

What type of communication system was being utilized between operator and rigger at time of this incident?

For crane only:

What crane training institution did crane operator attend?

SOUTHERN CRANE & HYDRAULICS, LLC

Where was institution located? **HOUMA, LA**

Was operator qualified on this type of crane? **Y**

How much actual operational time did operator have on this particular crane involved in this incident?

Years: 0

Months: 1

List recent crane operator training dates.

4/17/07

For other material-handling equipment only:

Has operator been trained to operate the lifting device involved in the incident? **N**

How many years of experience did operator have operating the specific type of lifting device involved in the incident?

For other material-handling equipment only:

Was equipment visually inspected before the lift took place?

What is the manufacture's recommendation for performing periodic inspection on the equipment involved in this incident?

Safety Management Systems

Does the company have a safety management program in place?

Does the company's safety management program address crane/other material-handling equipment operations?

Provide any remarks you may have that applies to the company's safety management program and this incident?

Did operator have an operational or safety meeting prior to job being performed?

Did operator fill out a Job Safety Analysis (JSA) prior to job being performed?

What precautions were taken by operator before conducting lift resulting in incident?

Procedures in place for crane/other material-handling equipment activities:

Did operator have procedures written?

Did procedures cover the circumstances of this incident?

Was a copy available for review prior to incident?

Were procedures available to MMS upon request?

Is it documented that operator's representative reviewed procedures before conducting lift?

Additional observations or concerns: