

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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: 26-NOV-2017 TIME: 0405 HOURS

2. OPERATOR: Walter Oil & Gas Corporation

REPRESENTATIVE:  
TELEPHONE:

CONTRACTOR:  
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: 8. OPERATION:

4. LEASE: G27982

AREA: EW LATITUDE: 28.16033773  
BLOCK: 834 LONGITUDE: -89.94834344

5. PLATFORM: A  
RIG NAME: H&P 203

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

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

9. CAUSE:

7. TYPE:

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

- 10. WATER DEPTH: 1186 FT.
- 11. DISTANCE FROM SHORE: 70 MI.
- 12. WIND DIRECTION:  
SPEED: M.P.H.
- 13. CURRENT DIRECTION:  
SPEED: M.P.H.
- 14. SEA STATE: FT.

- LWC  HISTORIC BLOWOUT  
 UNDERGROUND  
 SURFACE  
 DEVERTER  
 SURFACE EQUIPMENT FAILURE OR PROCEDURES
- COLLISION  HISTORIC  >\$25K  <=\$25K

17. INVESTIGATION FINDINGS:

On November 26th, 2017 at 0405, an incident with injury occurred at a Walter Oil & Gas Corp. Ewing Banks 834-A OCS-G 27982 Platform. The Helmerich & Payne (H&P) International Drilling Co. (Rig P-203) platform drilling package was conducting flow back operations on the Walter Oil & Gas EW 790 Well #A3 Lease OCS-G 33140.

The H&P roustabouts and crane operator were preparing to transfer flow back materials/fluids through a 3" hose from Well A-3. The roustabouts placed the end of the hose into an Auxiliary Mud Tank (AMT) with a 3-4' hatch opening. The Roustabout closed the hatch to hold down the 3" hose in an attempt to secure the 3" hose. The Roustabout 1 (R1) asked Roustabout 2 (R2) if he was ready to start receiving fluids from the Marine Portable Tank (MPT). The R2 responded "yes" to send the fluid. R1 opened the valve and started sending fluids, R2 noticed that he was not receiving fluids. R2 told R1 that R2 was told by daytime production operators that when the Marine Portable Tank (MPT) is halfway, the hose will get clogged with an oil ball. R1 asked R2 to give him a minute to hook up an airline from the rig compressor to clear the hose. R1 hooked the airline up and asked R2 if he was ready to receive flowback fluids again. The R2 said "yes" at that time. R1 failed to communicate that the air was still hooked up to the hose to send the fluid.

R2 lifted the hatch up to verify he was receiving fluids. When the fluids came through the hose, approximately 125 psi discharged of air and fluids caused the hose to come out of the tank striking R2 (injured person) in the right upper collarbone causing an injury.

The job was immediately stopped to help the IP with his injury. The Medic on-board evaluated the IP and noted that the right upper collarbone of the IP was injured. The IP was evacuated by helicopter to a medical center in Houma, La. to treat his injuries. The IP did not miss work and was put on restrictive duty in the H&P yard to finish his hitch. The IP will be released on 1/15/2018 to full duty.

During the BSEE investigation on November 26, 2017, at approx. 0400 hrs leading up to the incident the H&P crane operator assisted the Walter Oil & Gas production operators. The production operators needed the assistance of the H&P crane operator to dispose of the produced water from the flowing wells during daytime hours. The job scope was to dispose the produced water from the MPT to the AMT.

The investigation revealed during night operations, the H & P roustabouts took over the actions of transferring the produced water into the AMT, emptying on an average of 7-8 MPTs during their shift.

The Investigation revealed the following while the roustabouts were transferring the flowback fluids :

- Supervisor gave insufficient delegation to the roustabouts.
- The roustabouts failed to secure the 3" hose to the AMT while introducing fluids and air to the hose.
- Improper placement of feet to secure the hose.
- The roustabouts failed to follow the operating procedures for transferring produced water from the MPT to the AMT.
- Inadequate horizontal communication between the roustabouts.
- Inadequate vertical communication between the supervisors and the roustabouts.
- The roustabouts failed to identify the hazards and risk associated with the job scope.

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

- Operators failed to update and include in the JSA using air pressure to clear the line of obstruction when job was stopped.
- Lack of clear communication between roustabouts during flowback operations.
- Failed to tie down transfer hose.
- Improper placement of feet to secure the hose.

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

- Inadequate horizontal communication between the roustabouts.
- Inadequate vertical communication between the supervisors and the roustabouts.
- The roustabouts failed to identify the hazards and risk associated with the job scope.
- Supervisor gave insufficient delegation to the roustabouts.

20. LIST THE ADDITIONAL INFORMATION:

- Walter Oil & Gas corrected the issue by installing bolt in the cover of the tank with a hose connection.
- The IP returned to restricted duties at the H & P shop. The IP was to be fully released to full duty as of 1/15/2018.
- The report is based on limited information given by the company and witnesses.

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

No Damage

N/A

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

- Update JSA for transferring "produced water" from production to include; potential hose restrictions & associated hazards, use of pressurized air & associated hazards and securing the "dump" end of the transfer hose with an engineered device.
- Develop procedures for ALL rigs for securing both ends of all transfer hoses when transferring fluids from one tank to another regardless if hoses are under pressure or not.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

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

OCS REPORT:

26. INVESTIGATION TEAM MEMBERS:

29. DISTRICT SUPERVISOR:  
**David Trocquet, Sr.**

**Pierre Lanoix ( Accident Investigation  
Specialist) /**

APPROVED

DATE: 27-Feb-2018

