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

ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED
   DATE: **15-JAN-2016** TIME: **1530** HOURS

2. OPERATOR: **GOM Shelf LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **ISLAND OPERATORS CO. INC.**
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **00133**
   AREA: **GI** LATITUDE: **28.945539**
   BLOCK: **47** LONGITUDE: **-90.031099**

5. PLATFORM: **AP**
   RIG NAME:

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

7. TYPE:
- [ ] HISTORIC INJURY
- [X] REQUIRED EVACUATION **1**
- [ ] LTA (1-3 days)
- [X] 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
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

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

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: **89** FT.

10. DISTANCE FROM SHORE: **14** MI.

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

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

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

On 15-January-2016 at GOM Shelf LLC's Grand Isle (GI) 47-AP Platform, an incident with injury occurred during a crane lifting operation while moving three Marine Portable Tanks (MPT) from one area of the production deck to another. This operation was being performed to empty hydrocarbons into the platform's production system.

At approximately 1530 hrs, the field paramedic was called to attend an injury of a Production Operator (PO) who was assigned as the Certified Crane Rigger (CCR) at the time of the incident. During this operation, the CCR used improper hand signals to signal the Certified Crane Operator (CCO) to lift the load. During the lift, the MPT shifted towards the permanent chemical tote tank a few feet away. The CCR grabbed the MPT trying to control it when the CCR's left pinky finger was caught between the MPT and the chemical tote tank. The CCO stopped the job and attended to the injured CCR and notified the Person In Charge (PIC) of the facility to report the incident.

The Paramedic was contacted by the PIC at approximately 1530 hrs to attend to the injured employee. The Paramedic described the injury of the CCR to investigators that the left pinky fingernail was detached from the nail bed. The left pinky was cut from the nail bed to the inside of the lower knuckle. The paramedic cleaned the injury with sterile water and dressed it. As the paramedic of the Injured Person (IP), he made the decision to have the injured CCR flown in for treatment. The glove the IP was wearing showed no signs of tears or punctures. The paramedic also noted that the gloves worn by the CCR were Mechanic type gloves but not impact type gloves.

BSEE Investigators arrived on 20-January 2016 to conduct an Investigation of this incident. Statements, Job Safety Analysis (JSA), pictures of the crane at the scene of incident and initial reports obtained.

1. Based on interviews conducted and documents reviewed of the incident investigation, it was discovered that during a lifting operation, the CCO and CCR failed to incorporate familiarization with rigging hardware, taglines, slings, and safety issues associated with rigging and lifting loads. The safety factors and lift planning resulted in unsafe crane and rigging procedures. This type of operation caused an injury to working personnel. The CCR used improper positioning, inattention to footing, and improper hand signals to the CCO. The CCO also failed to follow procedures written in the JSA at the time of the incident.

2. Lessee failed to perform crane operating practices for attaching and moving the load being utilized in accordance with API RP 2D, paragraphs 3.2.1, 3.2.2 and 3.2.3

3. The Qualified Crane Operator and the designated signal person directing the lift, if utilized, should determine that:

A. The load is secured and properly balanced in the appropriate sling or lifting device before it is lifted.
B. The lift and swing paths are clear of obstructions and personnel.
C. The hook is brought over the load in such a manner as to minimize swinging.

4. During lifting operations, the designated tag lines were not utilized to control the load of approximately 6 Tons posing immediate danger to the equipment and the facility.

5. The probable cause of this incident was the lessee and the personnel engaged in this lifting operation failed to follow and adhere to all safe rigging practices. Also, the personnel failed to recognize all hazards which could have prevented this from occurring.

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

1. Lessee failed to perform crane operating practices for attaching and moving the load being utilize in accordance with API RP 2D, paragraphs 3.2.1, 3.2.2 and 3.2.3
2. During lifting operations the designated tag lines were not utilized to control the load of approximately 6 tons thus posing immediate danger to the equipment and the facility.
3. The probable cause of this incident is the lessee and personnel engaged in the lifting operation failed to follow and adhere to all safe rigging practices. In the addition, personnel also failed to recognize all hazards which could have prevented this incident, resulting with a serious injury.

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

1. CCO and CCR failed to incorporate familiarization with rigging hardware, taglines, slings and safety issues associated with rigging, lifting loads and lift planning which resulted in an unsafe crane and rigging operation that caused an injury to personnel.

20. LIST THE ADDITIONAL INFORMATION:

25-January-2016 UPDATE: Island Operating informed Fieldwood Energy that the injured contractor would be out 6 weeks from the date of the incident. Therefore, they expect he will be released to return to work by the end of February.

2. The incident occurred during the third and final lift of MPT tanks. At the time of the lift, the crane operator's load weight indicator noted that the load was approximately 6 tons. At the time of the lift, the crane operators noted the angle of the boom to be approximately 45 Degrees. The tag lines being used for this operation were 1/4 inch diameter and 15 to 20 feet in length. The tanks involved in the lifting operation were round MPT type tanks and a chemical tank UN 3266 corrosive liquid identified as Water Clarifier that was permanently installed to the treatment system.

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

No damage to equipment

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The New Orleans Disrtict makes no recommendation to the Office of Incident Investigation.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

1. G-110 Lessee failed to perform crane and rigging operations in a safe and workmanlike manner.
• Crane operator and rigger failed to incorporate familiarization with rigging hardware, taglines, slings and safety issues associated with rigging, lifting loads and lift planning resulting in unsafe crane and rigging practices, procedures and operations that caused an injury to personnel.

2. I-102 Lessee failed to perform crane operating practices for attaching and moving the load being utilize in accordance with API RP 2D, paragraphs 3.2.1,3.2.2 and 3.2.3
• During a lifting operation the appropriated taglines was not utilized at the time of the incident to control the load of approximately 6 tons posing immediate danger to equipment and the facility.

25. DATE OF ONSITE INVESTIGATION:

20-JAN-2016

26. ONSITE TEAM MEMBERS:

Pierre Lanoix / Jonathan Fraser /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

David Trocquet

APPROVED DATE: **25-MAY-2016**

INJURY/FATALITY/WITNESS ATTACHMENT

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

[ ] INJURY
[ ] FATALITY
[X] WITNESS

NAME:
HOME ADDRESS:
CITY: WORK STATE:
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: **ISLAND OPERATORS CO. INC. / 20324**
BUSINESS ADDRESS:
CITY: STATE:
ZIP CODE: