

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

1. OCCURRED
 DATE: **27-FEB-2009** TIME: **1120** HOURS

2. OPERATOR: **McMoRan Oil & Gas LLC**
 REPRESENTATIVE: **Spencer, Blair**
 TELEPHONE: **(504) 582-4241**
 CONTRACTOR:
 REPRESENTATIVE:
 TELEPHONE:

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

4. LEASE: **G02027**
 AREA: **WC** LATITUDE:
 BLOCK: **639** LONGITUDE:

5. PLATFORM: **A**
 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
 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 **crane maintenance**

8. CAUSE:

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

9. WATER DEPTH: **362** FT.

10. DISTANCE FROM SHORE: **123** MI.

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

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

13. SEA STATE: FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On February 2, 2009, a third party Crane Inspector performed a quarterly inspection on the platform crane which revealed pitting on the boom. The Crane Inspector noted the pitting as an area of concern and recommended to the company representative that the boom section be removed and either repaired or replaced. The decision was made to remove the crane boom at a later date and send it in for necessary repairs. The Crane Inspector returned to platform on February 25, 2009, and assessed the scope of the job and his tools arrived on February 26, 2009.

On the morning of February 27, 2009, the production crew participated in a Job Safety Analysis (JSA) with the Crane Inspector. The designated Crane Operator conducted a crane pre-use while another Production Operator assisted the Crane Inspector with preparations for removal of the defective section of crane boom. The auxiliary headache ball was removed from the auxiliary cable and a snatch block was attached to the gantry with a nylon strap. The auxiliary cable was then reeved through the snatch block and attached to the heel section of the boom with another nylon strap. Once tension was applied to the auxiliary cable the crew evaluated the rigging. The Crane Inspector instructed the Crane Operator to begin lowering the boom to deck and once the boom tip was on the deck the Production Operator was instructed to begin removing the bottom pins with a sledge hammer. The first pin was removed without any friction. The Production Operator attempted to remove the second pin and after striking the pin 4 or 5 times the Crane Inspector took his place. After the Crane Inspector struck the pin several more times forcing the second bottom pin out, the boom fell striking the Crane Inspector in the shoulder before trapping his leg under a section of boom. The Crane Operator stated that he heard the crane engine bog down under the strain of the load as he made an unsuccessful attempt to lift the boom off of the Crane Inspector's leg utilizing the auxiliary (fast line) cable which was attached to the heel section of the boom. It appeared the angle at which the auxiliary cable was attached to the heel section was insufficient and the auxiliary winch could not lift the boom. The Crane Operator and the Production Operator who was assisting the Crane Inspector made an unsuccessful attempt to manually remove the section of boom with a pry bar. Meanwhile the Crane Operator managed to get assistance from the Production Foreman who was about to depart the platform via helicopter and they were able to free the Crane Inspector's leg from under the boom. The Crane Inspector was transported by Air-Med to shore and diagnosed with a broken leg, pelvis and collar bone.

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

The boom was not properly supported ("securely blocked to prevent dropping of the boom") while attempting to remove the middle boom section and the boom fell to the deck after the bottom pins which connect the mid section to the heel were removed.

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

1. No site specific Job Hazard Analysis (JHA) was performed prior to removing the boom pins.
2. The JSA presented to the MMS representative was deficient in terms of detail.

Although body positioning and pinch points were mentioned it was specific to back strains and hand placement. No attention was given to the possibility of the boom falling.

3. Improper rigging of the boom through the use of an auxiliary winch that was unable to support the weight of the boom prior to removing the boom pins (the angle at which the auxiliary cable was attached to the heel section was insufficient). The crane company indicated that chain is normally used when rigging an alternate boom harness for support, but the Crane Inspector utilized nylon straps which have a tendency to stretch and slip out of position.

4. Failure to recognize warning signs leading up to the incident (i.e. 2nd boom pin was under tension and hard to remove (sledge hammer was used), handrail had to be removed to allow the lowering of the boom to the deck). Personnel did not re-evaluate job scope.

5. Personnel had to position themselves in harms way to remove boom pins. No safe alternate plan was in place to mitigate the risk of injury to personnel.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The Lake Charles District recommends that the MMS Regional Office of Safety Management (OSM) issue a Safety Alert to heighten industry's awareness of the hazards involved with insufficient rigging during the assemble and disassemble of crane booms.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 An unsafe unworkmanlike decision which led to the serious injury was made when personnel failed to fully analyze the task of disassembling the crane boom.

* Personnel failed to follow recommendations in API RP 2D Appendix F for disassembling the crane boom. API RP 2D C.4.3.3 (a) states "Booms which are being assembled or disassembled on the deck, with or without support of the boom harness, shall be securely blocked to prevent dropping of the boom and/or boom section".

* Personnel utilized an insufficient rigging practice to support the boom.

* Personnel failed to utilize any boom stand to "securely block" the boom prior to removing the pins.

* The failure to recognize critical warning signs and then implement Stop Work Authority allowed the incident to occur.

25. DATE OF ONSITE INVESTIGATION:

03-MAR-2009

26. ONSITE TEAM MEMBERS:

Scott Mouton / Wayne Meaux / Cody
LeBlanc /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Williamson

APPROVED

DATE: 11-MAY-2009

INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER Third Party Crane Company

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE: (337) 706-7900 TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE: