

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: 17-JUN-2014 TIME: 2230 HOURS

2. OPERATOR: W & T Offshore, Inc.

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: -

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- 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:

6. OPERATION:

4. LEASE: G02061

AREA: EC LATITUDE:
BLOCK: 321 LONGITUDE: -

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

5. PLATFORM: - A

RIG NAME:

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

8. CAUSE:

7. TYPE:

HISTORIC INJURY -

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

- LWC - HISTORIC BLOWOUT
- UNDERGROUND
 - SURFACE
 - DEVERTER
 - SURFACE EQUIPMENT FAILURE OR PROCEDURES

9. WATER DEPTH: 220 FT.

10. DISTANCE FROM SHORE: 94 MI.

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

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

13. SEA STATE: FT.

COLLISION HISTORIC >\$25K <=\$25K

On 17-June-2014, the Nabors Super Sundowner XIX was drilling a new well for W&T Offshore on East Cameron 321A platform (EC-321A) when an incident resulted in a required evacuation for an injury.

At the time of the incident, the drill crew was tripping drill collars into the well. The tripping process requires installing a lifting sub on the drill collar and placing it in the mouse hole with the air tugger. The blocks are lowered and the elevators are latched onto the lifting sub. The drill collar is lifted from the mouse hole, stabbed into the drill string, and tightened up with the power tongs.

Prior to the incident, the power tongs had slipped while tightening up the collar. An employee with Timco, the Injured Person (IP) was called to the rig floor to make adjustments on the dies. After adjusting the dies, the tripping operation resumed. The IP remained on the drill floor to insure the adjustments fixed the slippage of the dies on the drill collars. As the elevators were being latched up to the drill collar in the mouse hole the IP placed his left hand on the lifting sub attempting to tighten the lifting sub because it had appeared to be loose. The drill collar rotated in the mouse hole dropping six inches further into the mouse hole pinching the IP's finger between the lifting sub and the elevators. The IP was able to pull his finger free from between the lifting nubbin and elevators while sustaining a laceration to his left index finger. The IP was given first aid and transported to Acadiana Center for Orthopedic and Occupational Medicine for further medical treatment. The IP received sutures and a full medical release from the attending physician to return to work.

The BSEE Inspectors, after reviewing documentation provided by W&T, found the IP should only have been on the drill floor for maintenance of the power tongs. The IP was not part of the drill crew or included on the JSA for tripping operations. Task sixteen in the drill crews JSA addressed the potential hazards of working with the elevators, including the mitigation of the known hazards.

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

The IP was allowed to participate in tasks he was not assigned to complete and used poor judgment on hand placement on moving equipment.

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

The IP was not part of the drill crew or included on the JSA for tripping operations.

20. LIST THE ADDITIONAL INFORMATION:

None

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL): \$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

Lake Charles district has no recommendations.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 Lessee failed to prevent the IP from participating in tasks he was not assigned to complete, this action contributed to the incident.

25. DATE OF ONSITE INVESTIGATION:

07-JUL-2014

26. ONSITE TEAM MEMBERS:

Mitchell Klumpp /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Dave Moore/Well Ops Chief

APPROVED

DATE: 04-SEP-2014

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: -

INJURY/FATALITY/WITNESS ATTACHMENT *For Public Release*

BUSINESS ADDRESS:

CITY:

STATE: -

ZIP CODE: