

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: **03-JUN-2013** TIME: **1000** HOURS

2. OPERATOR: **Cobalt International Energy, L.P.**
REPRESENTATIVE:
TELEPHONE:
CONTRACTOR:
REPRESENTATIVE:
TELEPHONE:

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

4. LEASE: **G31765**
AREA: **GC** LATITUDE:
BLOCK: **896** LONGITUDE:

5. PLATFORM:
RIG NAME: **ENSCO 8503**

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

7. TYPE:

HISTORIC INJURY

<input checked="" type="checkbox"/>	REQUIRED EVACUATION	1
<input type="checkbox"/>	LTA (1-3 days)	
<input type="checkbox"/>	LTA (>3 days)	
<input type="checkbox"/>	RW/JT (1-3 days)	
<input checked="" type="checkbox"/>	RW/JT (>3 days)	1
<input type="checkbox"/>	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

8. CAUSE:

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

9. WATER DEPTH: **5510** FT.

10. DISTANCE FROM SHORE: **150** MI.

11. WIND DIRECTION: **E**
SPEED: **1** M.P.H.

12. CURRENT DIRECTION: **E**
SPEED: **1** M.P.H.

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS: -

On June 3, 2013, a Floorhand working on the Ensco 8503 drilling rig suffered a fractured ankle after the man riding basket he occupied fell approximately 10 feet while being lifted above the rig floor.

On the day of the accident, the Ensco 8503 drilling rig was working for Cobalt International Energy and was located at Green Canyon Block 896. The accident occurred while the drill crew was preparing to pressure wash some of the I-beams of the derrick utilizing a man basket on the rig floor. The Hoist Operator was lifting the Injured Person (IP), in the man lift, up to the beams and was at a height of approximately 35 feet when the basket suddenly fell 8 to 10 feet before coming to a stop. After the fall, the Hoist Operator began to lower the man basket back toward the rig floor so that they could get the IP out of the basket to see how bad he was injured. When the man basket had been lowered to a height of approximately 15 feet the basket fell once again, this time an estimated 4 feet before coming to a stop. The Assistant Driller called for all operations to be stopped and the decision was made to use a ladder to get the IP back to the deck. After a ladder had been found, the IP was able to climb out of the basket and was able to safely get back down to the floor.

The IP was taken to the rig hospital and evaluated by the Medic before being sent to an onshore medical facility for further evaluation. It was determined that the IP had sustained a fractured ankle. IP was placed on restricted work duty at an onshore warehouse facility.

Further investigation into the accident showed that the winch being used at the time of the accident was not certified to lift personnel. The utility hoist used also had a label on the side warning operators not to use the hoist for personnel lifts. Prior to starting the operation a cold work permit was opened, Work Instructions (WI) were reviewed, and a Job Safety Analysis (JSA) was written and discussed for the job task. Although all steps were followed, not all hazards were identified in the WI and/or JSA. It was determined that the reason the basket fell was because the cable was improperly spooled, allowing for the cable to jump at different intervals. ENSCO's investigation report showed that the Hoist Operator was inexperienced and not qualified to make lifts with personnel. The Hoist Operator was unaware that the "Blue Hoist", the one used at the time of the accident, was not to be used to lift personnel or that when using the hoist you must use a line guide to spool the cable correctly onto the hoist drum.

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

The hoist used at the time of the accident was not certified to make personnel lifts and the cable for the hoist was improperly spooled allowing the cable to jump off of the drum during the lift.

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

1) All steps and hazards not identified in the Work Instructions and/or Job Safety Analysis.

2) Poor Supervision

3) Lack of Experience

4) Lack of Training

20. LIST THE ADDITIONAL INFORMATION:

Since the accident, corrective actions have been put into place. These corrective actions include:

- Larger signs posted on all hoists to identify if hoist is certified for personnel.
- Increased training and supervision-
- Workers are to be selected by the Person in Charge (PIC) during the JSA. -

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

N/A -

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

Houma District has no recommendations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

A G-110 was issued stating: "On June 03, 2013, an employee was injured after the man riding basket he occupied fell while being lifted. The operator did not perform operations in a safe and workmanlike manner. The operator did not use a hoist that was certified for personnel hoisting and the hoist cable was not properly spooled onto the drum causing it to come off the drum during the lift".

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS: -

James Richard / James Benetatos /

29. ACCIDENT INVESTIGATION

PANEL FORMED: - NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED
DATE:

14-JAN-2014