

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: 01-NOV-2013 TIME: 1215 HOURS

2. OPERATOR: **Anadarko Petroleum Corporation**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR:

REPRESENTATIVE:

TELEPHONE:

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

4. LEASE: **G05612**

AREA: **ST** LATITUDE:

BLOCK: **205** LONGITUDE:

5. PLATFORM: **B**

RIG NAME: *** LIFT BOAT (HOUMA DIST)**

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 **Plug and abandon**

8. CAUSE:

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

9. WATER DEPTH: 165 FT.

10. DISTANCE FROM SHORE: 45 MI.

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

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

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS: -

On November 1, 2013, while in the process of performing abandonment operations to Anadarko's B007 well, an employee was injured when a joint of 2 3/8 inch tubing fell approximately 15 feet and struck the employee in the head.

The accident took place on Fieldwood's "B" platform located in ST. 205. Fieldwood had contracted Chet Morrison Well Services to perform abandonment operations on the B007 well, owned by Anadarko Petroleum Corporation. Prior to the accident, the crew had cut and pulled 2 7/8 inch tubing from the well and set a Cast Iron Bridge Plug (CIBP) in the 7 5/8 inch production casing. The crew then planned to run back into the hole with a 2 3/8 inch work string and place a cement plug on top of the CIBP that was previously set. Before starting the job, the crew held a safety meeting and filled out a Job Safety Analysis (JSA) in an attempt to identify potential hazards associated with the task. Although the proper measures were followed, the crew failed to discuss the proper size elevators to be installed before attempting to pick up the new pipe. The Injured Person (IP) was in charge of hooking up the elevators, which would allow the crane, located on the lift boat, to lift each joint of pipe and move it over the well. As the IP hooked up the first joint of 2 3/8 inch pipe to the elevators, he failed to notice that the elevators had not been changed to the proper size since the crew had pulled the 2 7/8 inch tubing. The pipe was hooked up and the IP gave the go ahead for the Signalman to instruct the Crane Operator to lift the pipe. As the Crane Operator lifted the joint of pipe, the elevators did not latch onto the pipe collars as they should have, causing the pipe to fall approximately 15 feet to the deck below. Because the IP failed to move away from the load as it was being lifted, the IP was struck in the head by the pipe as it fell to the deck.

The IP was immediately transported via helicopter to Terrebonne General Medical Center in Houma, LA. There he was diagnosed with compression fractures to his vertebrae and transferred to West Jefferson Medical Center in Marrero, LA. The IP underwent a surgery to repair two of the fractures and is anticipated to fully recover within approximately six months.

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

1. Unsafe Behavior / Lack of Focus: Failure of crew members to recognize that the elevators in use were the improper size for the pipe to be run.
2. Body Placement / Lack of Focus: Failure of crew members to recognize or address the hazards of the IP's position in relation to the load being lifted.

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

1. Lack of Communication: Although a JSA and Safety Meeting were held before the job began, there was no discussion on what size elevators were to be used for the task at hand.
2. Not Completing Task: Once the crew had successfully pulled the 2 7/8 inch tubing, personnel failed to remove the elevators from the crane as stated in the work procedures.

20. LIST THE ADDITIONAL INFORMATION:

N/A -

21. PROPERTY DAMAGED:

NA -

NATURE OF DAMAGE:

NA

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE 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:

On November 1, 2013, an employee was severely injured while performing abandonment operations on the B007 well located on Fieldwood's ST. 205 "B" platform. The accident occurred due to the crew failing to recognize that the elevators installed were the wrong size for the pipe that was being used. The mistake resulted in a joint of 2 3/8 inch pipe falling from the elevators and striking the employee in the head.

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS: -

James Richard / Jeramie Liner /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED

DATE: 16-JUL-2014