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

ACCIDENT INVESTIGATION REPORT

	OCCURRED	For Public Release
•	DATE: 28-SEP-2012 TIME: 0915 HOURS	STRUCTURAL DAMAGE CRANE OTHER LIFTING DEVICE
2.	OPERATOR: McMoRan Oil & Gas LLC REPRESENTATIVE: TELEPHONE: CONTRACTOR: REPRESENTATIVE: TELEPHONE:	DAMAGED/DISABLED SAFETY SYS. INCIDENT >\$25K H2S/15MIN./20PPM REQUIRED MUSTER SHUTDOWN FROM GAS RELEASE X OTHER Hand Injury
	OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:	6. OPERATION:
	LEASE: G02027 AREA: WC LATITUDE: BLOCK: 639 LONGITUDE:	PRODUCTION DRILLING WORKOVER COMPLETION HELICOPTER MOTOR VESSEL
· .	PLATFORM: A RIG NAME:	PIPELINE SEGMENT NO. X OTHER Decommissioning
	ACTIVITY: EXPLORATION (POE) DEVELOPMENT/PRODUCTION (DOCD/POD) TYPE: HISTORIC INJURY REQUIRED EVACUATION 1 LTA (1-3 days) LTA (>3 days RW/JT (1-3 days) X RW/JT (>3 days) 1	8. CAUSE: EQUIPMENT FAILURE HUMAN ERROR EXTERNAL DAMAGE SLIP/TRIP/FALL WEATHER RELATED LEAK UPSET H20 TREATING OVERBOARD DRILLING FLUID OTHER
	Other Injury	9. WATER DEPTH: 362 FT.
	FATALITY POLLUTION FIRE EXPLOSION	10. DISTANCE FROM SHORE: 116 MI.
	LWC HISTORIC BLOWOUT UNDERGROUND SURFACE DEVERTER	11. WIND DIRECTION: SPEED: M.P.H. 12. CURRENT DIRECTION: SPEED: M.P.H.
	SURFACE EQUIPMENT FAILURE OR PROCEDURES	
	COLLISION HISTORIC >\$25K <=\$25K	13. SEA STATE: FT.

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17. INVESTIGATION FINDINGS:

On September 28, 2012, at 0915 hours an incident occurred at the McMoRan Oil and Gas West Cameron 639A decommissioning project. The injured person (IP) is an employee of Cal Dive International (CDI). All proper personal protective equipment was being used by the IP at the time of the accident. The IP was making a torch cut on one of the well casings to be removed from the jacket. The two casings being removed were a 26 inch and a 16 inch and were not grouted together, leaving the 16 inch casing to move freely inside the 26 inch casing. The IP had already cut sections out of the 26 inch casing in order to access the 16 inch casing. While making a cut on the 16 inch casing, the IP placed his left hand between the 26 inch casing and the 16 inch casing (pinch point). The 16 inch casing swayed and pinched the IP's hand against the 26 inch casing cutting his hand. An all stop was called and the injury was reported to the safety advisor. The IP was given first aid and then transported to a clinic where he was treated but not released to return to work until after a follow-up appointment.

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

The IP placed his hand in a pinch point between the 26 inch and 16 inch casings.

- 19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:
 - 1) Job Safety Analysis did not specifically identify the pinch point between the 26 inch and 16 inch casings.
- 20. LIST THE ADDITIONAL INFORMATION:
- 1) The pinch point could have been eliminated before the job started by welding steel plates between the 16 inch and 26 inch casings.
- 21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Charles District Office has no recommendations to the Regional Office of Safety Management.

- 23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO
- 24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

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25. DATE OF ONSITE INVESTIGATION:

03-OCT-2012

26. ONSITE TEAM MEMBERS:

Matte, Carl / Miller, Larry /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Williamson

APPROVED DATE: 17-DEC-2012

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INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATE CONTRACTOR REPRESENTATE X OTHER Welder Perfor	ATIVE	INJURY FATALITY WITNESS	
NAME: HOME ADDRESS:	C.T.	ATTE •	
CITY: WORK PHONE:	-	ATE: HORE EXPERIENCE:	YEARS
EMPLOYED BY: BUSINESS ADDRESS:			
CITY:		STATE:	
ZIP CODE:			

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