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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **22-FEB-2020** TIME: **1530** HOURS
2. OPERATOR: **Magnum Hunter Production, Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Seatrax**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [X] CRANE
- [ ] OTHER LIFTING
- [ ] 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:

4. LEASE: **G19822**
   AREA: **SS** LATITUDE:
   BLOCK: **358** LONGITUDE:

5. PLATFORM:
   RIG NAME:

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

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[ ] REQUIRED EVACUATION		
[ ] LTA (1-3 days)		
[ ] LTA (>3 days)		
[ ] RW/JT (1-3 days)		
[ ] RW/JT (>3 days)		
[ ] FATALITY		
[ ] Other Injury		

   - [ ] POLLUTION
   - [ ] FIRE
   - [ ] EXPLOSION

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

   COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

8. OPERATION:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [X] OTHER **Abandonment**

9. CAUSE:
   - [ ] EQUIPMENT FAILURE
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER _____

10. WATER DEPTH: **419** FT.
11. DISTANCE FROM SHORE: **72** MI.
12. WIND DIRECTION:
    SPEED: **10** M.P.H.
13. CURRENT DIRECTION:
    SPEED: M.P.H.
14. SEA STATE: **2** FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

17. INVESTIGATION FINDINGS:

On February 22, 2020, a crane incident occurred during operations for the operator, Magnum Hunter Production, Inc, located at Ship Shoal Block 358 “A” OCS–G19822. The Crane Operator was lowering a Conex box from the platform to a supply vessel when a pendent line caught the boom connector section and caused significant damage to the heel section of the boom. There were no injuries reported at the time of the incident.

On the afternoon of February 22, 2020, at approximately 15:30 hours, the Seatrax Crane Operator was transferring a 6-by-6-by-6-foot Conex box from the supply vessel, John Harville, to the platform. The Conex box contained cases of drinking water and weighed approximately 3,000 pounds. Prior to commencing work, the crew which consisted of a crane operator and the rigger / signal person completed a Job Safety Analysis on the lift that was to be performed. All documents were reviewed and signed by the crew. A Seatrax S100P temporary crane was used to lift the Conex box from the supply vessel to the platform. During the lift, the Crane Operator boomed up to a high angle in order to place the Conex box close to the galley door. The Crane Operator and Rigger / Signal Person were unaware that the pendant line on the right side of the boom fell to the side of the boom frame. Once the Conex box was emptied, the Crane Operator proceeded to hoist and swing the container to load back onto the supply vessel. While the Crane Operator was booming down, the pendant line snagged on a bolt in the flange connecting the heel and mid-section of the boom. The more the Crane Operator boomed down, the tighter the pendant line became until it finally twisted the boom. The Crane Operator set the Conex box on the deck of the supply vessel then proceeded to boom up when he noticed the boom was twisted. He stopped the operation, then exited the crane cab to inspect the damage. No other equipment was damaged, and the crane was tagged out of service until a replacement boom could be delivered.

The Bureau of Safety and Environmental Enforcement (BSEE) investigation team conducted the initial onsite investigation on February 28, 2020. The team took photographs, interviewed personnel and collected documentation. The investigation team learned that the Seatrax S100 temporary crane was installed on November 24, 2019. All documents and certifications were on the facility once the initial install and rig up was complete. The Crane Operator stated in an interview that he was has been employed with Seatrax since July 2019 and is a certified crane operator with numerous years of experience operating various types of cranes. The Crane Operator also stated that he lifted the Conex box from the supply vessel onto the platform positioning it next to the galley using the fast line. Once unloaded, the Crane Operator hoisted up and swung the container over the handrail to place it back onto the supply vessel. After clearing the handrail, the Crane Operator proceeded to lower the container with the fast line and boom down simultaneously, unaware that the right pendant line had fallen to the side of the boom frame. He landed the container on the deck of the supply vessel safely and proceeded to boom up when he noticed the boom was bent. He stopped and shut down the crane and exited the cab to inspect the damage.

According to the Seatrax erection procedure for the S100P portable crane, the pendant lines were connected to the boom and crane gantry at the time of the crane installation. There are two sets of pendant lines consisting of 1-3/8” cables. The first set is approximately 44.5 feet long and connected to the second set which is approximately 38.5 feet long. The Seatrax erection procedure states that the pendant lines are to remain attached after rig-up to serve as a secondary retention when there is no boom rest. There are no safety devices in place to keep both pendant lines from falling on the outside of the boom perimeter while it is in use. This crane was in operation approximately 2 months making numerous lifts, without having any issues. Since this incident, Seatrax has revised their S100P Portable Crane erection procedure by eliminating the step of leaving the pendant lines attached after the installation is complete.

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

The right side pendant line fell outside the frame of the boom allowing it to snap on a bolt of the heel section, causing the boom to twist as the crane operator was lowering the boom.

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

Lack of Awareness: Crane operator and rigger / signal man failed to recognize that the pendant line on the right side was outside the border of the boom.

20. LIST THE ADDITIONAL INFORMATION:

None

21. PROPERTY DAMAGED:

Crane boom

NATURE OF DAMAGE:

Bent crane boom

ESTIMATED AMOUNT (TOTAL): **$25,000**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE Houma District has no recommendations at this time, for the Office of Incident Investigations.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

None

25. DATE OF ONSITE INVESTIGATION:

28-FEB-2020

26. INVESTIGATION TEAM MEMBERS:

Paul Reeves /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR: **Amy Pellegrin**

APPROVED DATE: **25-AUG-2020**