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: 25-AUG-2018 TIME: 0345 HOURS

2. OPERATOR: W & T Offshore, Inc.
REPRESENTATIVE:
TELEPHONE:

CONTRACTOR: Helmerich & Payne
REPRESENTATIVE:
TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] 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: G12008
AREA: SS LATITUDE:
BLOCK: 349 LONGITUDE:

5. PLATFORM: A(MAHOGANY)
RIG NAME: H&P 107

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

7. TYPE:

- [ ] HISTORIC INJURY
- [x] REQUIRED EVACUATION 1
- [ ] LTA (1-3 days)
- [x] 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

8. OPERATION:

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

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: 375 FT.

11. DISTANCE FROM SHORE: 77 MI.

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

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

14. SEA STATE: FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

17. INVESTIGATION FINDINGS:

On August 25, 2018, an incident occurred on the rig Helmerich and Payne (H&P) rig 107 which was working under contract for W&T Offshore. The H&P 107 was located at Ship Shoal Block 349 OCS-G-12008 at the time of the incident. The incident involved an injury to an H&P employee who was working as a Floorhand. The resulting injury to the Floorhand was severe enough that he needed to be immediately evacuated from the rig via helicopter. The injured person (IP) was flown to a hospital in order to receive emergency medical treatment.

During the evening of Friday August 24, 2018, at approximately 1730 hours the rig was in the process of attempting to free a 5 inch drill pipe that was stuck in the wellbore. At 1800 hours the night drilling crew would report to work but before reporting the crew would hold a 30 minute pre-tour safety meeting. In the pre-tour meeting, it was decided that drilling jars would be needed to free the pipe. The evening crew successfully fired the drilling jars which allowed the pipe to come free and the Driller to hoist the pipe up, and to circulate/condition the drilling fluid. It is standard practice to perform a post jarring inspection of the derrick and top drive assembly in order to look for any abnormalities. The post jarring inspection was carried out by the evening drill crew which consisted of a Toolpusher, Driller, Assistant Driller, Derrickhand, and two Floorhands. Prior to commencing work, the following documents were reviewed and signed by the crew: Permit to Work/Safe Work Permit, Pre-Job Checklist for Personnel Hoisting, and two Job Safety Analysis (JSA) (one for Hoisting Personnel with a Man Riding Winch and the second for Servicing Top Drive and Block Inspection).

The post jarring operations first began as the Driller positioned the top drive assembly roughly sixty-seven feet above the rig floor so that it could be inspected. With the drill pipe being suspended, this would allow it to be off bottom so that the drilling fluid could be circulated throughout the wellbore and prevent future sticking of the pipe. The top drive assembly was now at its inspection height for the Floorhand to visually and physically assess. The Floorhand prepared himself to be hoisted into the derrick by putting on a Duncan and Buck Industries (DBI) Sala Bosun harness and securing it to the man rider cable. He also connected a three eighths inch secondary safety static line with a three foot lanyard and DBI Sala lifeline static cable grab to his set up. The Toolpusher was ready to hoist the Floorhand up to the top drive now that he was properly secured in his DBI harness and attached to the man rider cable. The hoisting of the Floorhand was under way with the Toolpusher operating the man rider winch. While the Toolpusher was operating the winch, he needed to reposition himself to the side of the winch due to the racked stands of drill pipe obstructing his line of sight. In the process of the Toolpusher repositioning himself, the Floorhand was still being hoisted upwards and the three-eighths inch safety static line became snagged on one of the fingers located on the monkey board.

With the hoist line still moving upwards and the safety line snagged, there were forces created in opposite directions. The forces in opposite directions resulted in the Floorhand being pulled in both directions. The Toolpusher did not have a visual line of sight as the Floorhand was being pulled but he immediately stopped the winch once he heard the Floorhand screaming to stop. After the pulling event ceased, the Floorhand was still suspended in pain. A second Floorhand along with a Derrickhand immediately proceeded into the derrick to aid him. Once they made it to the monkey board, they detached the lifeline static cable grab and the decision was made to lower the Floorhand to the drill floor. After the Floorhand was lowered, a safety stand down was called. The Floorhand was secured to a backboard and carried to await the medivac helicopter. The medevac helicopter was called at approximately 0430 arrived at 0550, and transported the IP to a hospital for further medical treatment.

During the safety stand down, W&T Offshore proposed that when another JSA meeting takes place that all personnel should speak up to address any issues with lines of sight. If lines of sight are an issue due to an obstacle, then a second person should be given the responsibility of constantly monitoring the individual who is out of sight. BSEE Houma District granted W&T approval to resume operations on August 25, 2018 at 0450 with the stipulation that any personnel lift using air hoists must have at least one spotter depending on the need of the operation, and this (these) spotter(s) had to be in direct communication with the hoist operator at all times while personnel were elevated.

The Bureau of Safety and Environmental Enforcement (BSEE) investigation team conducted the initial onsite investigation on August 26, 2018. The team collected evidence, took photographs, interviewed personnel, and wrote down statements from all involved witnesses. Documentation indicated that it was a clear night with light winds and sufficient illumination. The investigation team visually inspected the drill floor and man riding winch, and noted that there was nine stands of drill pipe, each ninety feet long, racked in the derrick which was directly in front of the man riding winch at the time of the incident. After performing the outside inspection, the team interviewed the Toolpusher who operated the winch. He stated that he had to stand to the side of the drill pipe while operating the hoist in order to keep visual contact of the Floorhand due to the multiple stands of drill pipe obstructing the hoist. It was discovered in the JSA and Pre-Job Checklist for Personnel Hoisting that if the line of sight is obstructed a flagger is to be used. The BSEE team concluded that the Toolpusher's line of sight on the hoisted Floorhand was restricted and a flagger was not used. The team confirmed that obstruction existed during the operation and a flagger should have been implemented as stated in the JSA and Pre-Job Checklist.

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

Line of sight by the Toolpusher, who was operating the man riding winch at the time of the incident, was obstructed by drill pipe racked back in the derrick.

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

A flagger was not used to mitigate the line of sight hazard.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

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

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110: On August 25, 2018, an incident occurred when a Floorhand was hoisted from the rig floor to inspect the Top Drive after a jarring operation. The floorhand's secondary line became hung up in a collar finger, causing him to be injured.

25. DATE OF ONSITE INVESTIGATION:

26-AUG-2018

26. INVESTIGATION TEAM MEMBERS:

Paul Reeves / Clint Campo /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

30. DISTRICT SUPERVISOR: OCS REPORT:
Bryan A. Domangue

APPROVED DATE: **14-JAN-2019**