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: **26-JUN-2018** TIME: **1515** HOURS

2. OPERATOR: **W & T Energy VI, LLC**
REPRESENTATIVE:
TELEPHONE:

CONTRACTOR: **Nabors Offshore Corporation**
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: **G10942**
AREA: **VK** LATITUDE: **29.18192218**
BLOCK: **823** LONGITUDE: **-88.16774376**

5. PLATFORM: **A (VIRGO)**
RIG NAME: **NABORS MODS 201**

6. ACTIVITY:
- [ ] EXPLORATION(POE)
- [X] 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: **1132** FT.

11. DISTANCE FROM SHORE: **60** MI.

12. WIND DIRECTION: **NE**
SPEED: **6** M.P.H.

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

14. SEA STATE: **0** FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

17. INVESTIGATION FINDINGS:

On 26-June-2018 at approximately 03:15 p.m. after tripping pipe out of the hole, the drill crew was in the process of moving the mud bucket into a storage area on the rig floor. This task was being performed in order to make room on the rig floor for cleaning, scrubbing, housekeeping.

At this time, the mud bucket was tethered by an air hoist. Two Floorhands were pushing the mud bucket and the Injured Person (I.P.), who is also a Floorhand, was pulling the mud bucket back to the storage area. (The storage area for this component is behind the racked-back drill pipe).

It is stated that the I.P. was grasping the mud bucket by the handles when the incident occurred. While in the process of pulling and positioning the mud bucket to the designated area, the air hoist operator unexpectedly set the mud bucket on the deck (rig floor). Prior to this event occurring, there was no communication between any of the involved parties. The crew failed to identify a designated Flagger or Signaler in the JSA for the moving of the mud bucket with an air hoist.

As the mud bucket was set down, the I.P.'s right ring finger was caught between the handle of the mud bucket and the snubbing post (stanchion post) on the rig floor. Once free, the I.P. removed his glove which revealed a severe laceration to the right ring finger. The I.P. reported to the medic who then contacted the Rig Manager and Company Man. Arrangements were immediately made to send the I.P. to shore on 26-June-2018. The onshore surgeon attempted to save the fingertip by applying loose sutures in order to regenerate blood flow to the fingertip.

On 27-June-2018, with no blood flow to the fingertip, the surgeon amputated the distal flanges (fingertip just above the first knuckle).

The crew failed to follow the Contractor's Hoisting and Rigging Guildlines for Routine and Critical Lifts policy and the Operator's Hands-Free Procedures policy during the lifting operation as outlined below:

"Nabors Health, Safety and Environment Manuel"

Title: "Hoisting and Rigging Guidelines for Routine and Critical Lifts".

Section 3.0 Definitions and Acronyms

3.3. Designated leader - an individual assigned responsibility for safe handling of Routine lifts.

Section 5.0 Work Instruction

5.1 Planning

5.1.8 Ensure that tagline(s) are used to adequately control the load from a distance so no one can put their hands on the actual load being lifted.

5.1.9 Establish communication means (hand signals or radios) and designate who will be responsible to give directions to the Crane/Hoist operator.

W&T Offshore "Hands Free Procedure"

Procedure: Once a load is connected to a mechanical lifting device, personnel should not handle or touch a load with any part of their body as the load is being lifted or before the load is properly set down and all potential energy is released.

*** Identify hands free details during the JSEA discussion, record hands free tools to be used and communication method within the work crew.**

*** Identify the locations of potential pinch points and crush zones before the job starts.**

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

1.) Poor hand placement by the I.P.

2.) Crew failed to identify designated flagger in the JSA before moving the mud bucket with the air hoist.

3.) When the Mud Bucket was set down by the air hoist operator, the handle of the mud bucket impacted the snubbing post pinning and cutting the I.P.'s right ring finger in the process.

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

1.) Lifting and moving the Mud Bucket utilizing the air hoist was never referenced in the Housekeeping JSA.

2.) Nabors: "Hoisting and Rigging Guidelines for Routine and Critical Lifts" policy was not followed.

3.) W&T Offshore: "Hands Free Procedures" policy was not followed.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: **None**

NATURE OF DAMAGE: **None**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans District makes no recommendations to the Office of Incident Investigation.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 (c) 30 CFR 250.107.
After reviewing documentation in regards to the incident that occurred in 26-Jun-2018, BSEE investigator determined that the Lessee did not perform all operations in a safe and workmanlike manner. This resulted in a severe finger injury.

25. DATE OF ONSITE INVESTIGATION:

12-JUL-2018

26. INVESTIGATION TEAM MEMBERS:

Eary Roy /

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

David Trocquet

27. OPERATOR REPORT ON FILE:

APPROVED DATE: **08-FEB-2019**