

UNITED STATES DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: 15-NOV-2009 TIME: 0530 HOURS

2. OPERATOR: BP Exploration & Production Inc.
REPRESENTATIVE: Douglas, Scherie
TELEPHONE: (281) 366-6843
CONTRACTOR: Transocean Offshore
REPRESENTATIVE: Sannon, Bill
TELEPHONE: (713) 422-4553

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- 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:

6. OPERATION:

4. LEASE: G32306
AREA: MC LATITUDE: 28.73814021
BLOCK: 252 LONGITUDE: -88.36594502

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

5. PLATFORM:
RIG NAME: T.O. MARIANAS

6. ACTIVITY: EXPLORATION (POE)
 DEVELOPMENT/PRODUCTION
(DOCD/POD)

8. CAUSE:

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

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

- FATALITY
- POLLUTION
- FIRE
- EXPLOSION

9. WATER DEPTH: 4992 FT.

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

10. DISTANCE FROM SHORE: 60 MI.

11. WIND DIRECTION:
SPEED: 3 M.P.H.

12. CURRENT DIRECTION:
SPEED: 26 M.P.H.

COLLISION HISTORIC >\$25K <=\$25K

13. SEA STATE: 2 FT.

17. INVESTIGATION FINDINGS:

Sequence of Events:

A Roustabout (now referred to as the Injured Person-IP) was in the process of moving risers stacked eight high by five risers wide from the port riser bay to the starboard riser bay. The IP climbed to the top of the riser stack while the crew members facilitated movement of the first set of riser pipe without incident. The IP was atop the riser pipe stack walking freely (without being secured) along the width and length of the riser pipe. He positioned himself at the ends of the riser pipe so he could fasten lifting straps to the ends of the risers for lifting. During the process the IP fell approximately 30' to the deck below, through a gap approximately 2' x 5' that existed between the stack of riser pipe and a bulkhead. The IP was evacuated for medical treatment where he was treated for chest, back and shoulder injuries.

Findings:

* The work crew conducted a pre-job safety meeting which included Transocean's Task Specific Think Procedure (TSTP) and a written THINK plan that crew members acknowledged by their signatures. Work procedures, material, equipment, company policies and individual crew member responsibilities were identified and/or considered to include: 100% tie off, getting caught between loads, working at heights of four feet or more, utilizing too few personnel, hand and body positioning, Permit to Work for using straps, inspection of straps, safety belts, work area and additional Health, Safety & Environmental (H&SE) manual requirements.

* SALA blocks were considered but determined to be ineffective because the risers were stacked too high (above the existing fall protection system). A harness with 6 feet of lanyard was used for personal fall protection, but there was no specific mention of alternate anchoring points in the written THINK plan. With the exception of an eye on the end of the riser, evidence does not support possible and proper usage of harness securing points in the vicinity from which IP fell. The lifting strap was put in place and the IP positioned himself between the riser and the handrail pinch point with no means of escape without secure feet placement.

* The only locations the IP could have stood while the riser was being moved were: (a) on a length of riser, (b) a ventilation hood or (c) holding onto the outside of a handrail next to the riser bay while standing on the toe board. As a result of not being properly secured and a slippery/wet surface where the IP was standing, the IP fell as described above.

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

Although all indications point to the IP wearing a harness, MMS was unable to confirm that the IP was properly secured to specific anchoring points to prevent falling.

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

Unsafe conditions were created by:

1. Stacking the riser pipe higher than the riser bay design resulted in being unable to properly secure the existing fall protection equipment.
2. Slippery/wet surface conditions may have contributed to the IP's fall.
3. The IP used poor situational awareness and/or task complacency while fastening the straps to the risers for lifting.
4. The IP was standing/stepping on unsafe areas (ventilation hoods, toe boards, etc.) while using only the outside handrail for support.
5. The work crew was not abiding by the company's written "THINK" plan to include: (a) 100% tie off, (b) getting caught between loads, (c) not utilizing enough personnel and (d) safety while working at heights.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The MMS New Orleans District makes no recommendations to the MMS Regional Office of Safety Management (OSM).

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

INC: G-110 - 30 CFR 107 (a) - Improper procedures used for working aloft allowed an employee to sustain personal injury from falling approximately 30 feet. In addition, the work crew was not abiding by the company's written "THINK" plan; specifically: (a) 100% tie off, (b) getting caught between loads, (c) not utilizing enough personnel and (d) working safely while at heights. The IP was walking freely between each end of the riser stack without properly tying off as a result of the riser stack's height preventing proper anchoring of the fall protection equipment.

25. DATE OF ONSITE INVESTIGATION:

17-NOV-2009

26. ONSITE TEAM MEMBERS:

Justin Josey / Joel Moore /

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

David J. Trocquet

APPROVED

DATE: **01-APR-2010**

INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

CONTRACTOR REPRESENTATIVE

OTHER _____

INJURY

FATALITY

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE:

OPERATOR REPRESENTATIVE

CONTRACTOR REPRESENTATIVE

OTHER _____

INJURY

FATALITY

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE:

INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

CONTRACTOR REPRESENTATIVE

OTHER _____

INJURY

FATALITY

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE:

OPERATOR REPRESENTATIVE

CONTRACTOR REPRESENTATIVE

OTHER _____

INJURY

FATALITY

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE: