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: **19-JUN-2022** TIME: **0930** HOURS
2. OPERATOR: **Cox Operating, L.L.C.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **DANOS, L.L.C.**
   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: **G01083**
   AREA: **WD** LATITUDE:
   BLOCK: **73** LONGITUDE:

5. PLATFORM: **C**
   RIG NAME:

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

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	**0**	**1**
[ ] LTA (1-3 days)		
[X] LTA (>3 days)	**0**	**1**
[ ] 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:
   - [X] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] OTHER

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

10. WATER DEPTH: **172** FT.
11. DISTANCE FROM SHORE: **17** MI.
12. WIND DIRECTION: **NE**
    SPEED: **16** M.P.H.
13. CURRENT DIRECTION:
    SPEED: M.P.H.
14. SEA STATE: **3** FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

INCIDENT SUMMARY:

On 19 June 2022 at 0930 hours at West Delta (WD) 73 C, Lease number OCS-G 01083, during personnel transfers from the Motor Vessel (M/V) Sapphire to WD 73 C by personnel basket, the basket came in contact with a scrap iron basket. The impact caused 1 of the 8 individuals to fall 2-3 feet from the personnel basket to the deck of the M/V, injuring his right foot. The Injured Person (IP) was seen by a medic and then evacuated by helicopter for further medical evaluation by a physician onshore. Post medical evaluation revealed that the IP suffered a fractured right heel. There were no other injuries or damages to equipment. Cox Operating LLC (Cox) is listed as the operator of the platform.

SEQUENCE OF EVENTS:

At 0600 hours on 19 June 2022, the Ultima Work Authority (UWA) prepared and reviewed a Job Safety Analysis (JSA) report for the task of offloading construction crew personnel from the M/V Sapphire with the use of the 8-man personnel basket.

At 0930 hours, the personnel basket, with the JSA attached, was lowered and waited for the M/V to back into position under the basket. All personnel involved with the transfer were required to review then sign the JSA. As the personnel basket landed on deck, the JSA was removed then signed by the approaching riders as they began placing their baggage in the designated areas. As personnel, wearing their approved personnel floatation devices (PFD), began getting on the basket, the M/V began drifting away from the platform. The boat captain was having a difficult time keeping the boat centered under the crane boom tip. The crane operator could not boom any further down to keep the lifting block and hook centered over the personnel basket. He was concerned that the continuing drifting M/V would cause the basket to be dragged across the deck with personnel.

The crane operator made the decision to immediately lift or hoist up the basket, even though the deckhand had not given the lift-up signal or secured the tag line in hand. Communication methods used for the lift were: Between the crane operator and the captain – handheld radios; between the crane operator and the deckhand/rigger – hand signals; between the captain and deckhand – boat PA system. The basket began dragging across the deck of the boat with the 8 riders holding on. At approximately 2 feet off the deck, the basket made a sudden contact with a 4 in x 8 foot x 12 foot scrap iron basket stored on the deck. The IP was not able to hold on,lost his grip, and was reported to have fallen/jumped off the basket, landing on his right foot. His right foot became entangled in the trailing tagline, causing him to fall backwards. As the personnel basket continued dragging across the deck, carrying the 7 riders, the IP was dragged along towards the rear of the vessel. The quick action taken by the deckhand enabled him to untangle the tag line and free the IP's leg. Once freed, the personnel basket continued up and away from the M/V until it reached the top deck of the platform to safely offload the 7 remaining riders. The platform medic was lowered back down on to the M/V to provide medical assistance. The IP was then transported (by personnel basket) up to the platform where he was evacuated by helicopter to shore base and transported to the OMS clinic in Houma LA for further medical evaluation. Cox reported the incident to the Bureau of Safety and Environmental Enforcement New Orleans District (BSEE NOD).

BSEE INVESTIGATIONS:

The BSEE Accident Investigator (AI) received notification of WD 73 C's Lost Time Accident (LTA) on 24 Jun 2022. The AI requested, received, and reviewed the following documents: The JSA for the personnel lift operation; Cox's Crane Pre-Use Inspection Report for June; June's Personnel Basket Inspection Report; Crane Operator's Certificate; Cox's Safety Alert Bulletin dated June 20, 2022; Cox's Incident Analysis Summary Report of June 19, 2022; Cox's Lessons Learned Report; and 10 witness statements and photos. After reviewing the documents, the AI started an Incident Follow-Up Report (IF), began the BSEE 2010 Report, and submitted the incident into the eInspection Reporting System. The AI made an onsite visit to WD 73 C on 07 December 2022 and met with the 2 Person(s) In Charge/Ultimate Work Authority (PIC/UWA) on board.

The AI found several factors that possibly lead up to the incident. First, the JSA was not signed by any of the M/V Sapphire personnel. It was mentioned by the PIC that the M/V completed their own separate JSA. Second, prior to or during the lift, the boat had engine problems but did not communicate these issues with platform personnel. The M/V Sapphire was running only on one main engine per the witness statement submitted by the deckhand. Also, there were communication problems with the handheld radios used to communicate between the crane operator and M/V captain. The investigation findings also noted that several personnel basket riders had concerns prior to the lift but did not voice these concerns. In fact, several riders put in their statements that they could tell that "the crane boom tip was not centered" before the lift started.

The action taken by the crane operator was inappropriate for that situation. The lifting of the personnel basket while not centered under the boom tip created a pendulum swinging effect. The deckhand was attempting to tell the 8 riders "to get off the basket" just as the crane operator was starting to pick up. According to "Best Practices," the more appropriate action would have been to lower the fastline down, whereas the basket would have collapsed forcing the riders to step off and back away.

BSEE also determined that the condition of the back deck of the M/V Sapphire contributed to the incident. As shown by photos obtained by the investigator, the deck was crowded with equipment, tool boxes, baskets, a welding machine, and bottle racks, which left a small narrow area for landing and lifting the large 8-man personnel basket. It required the deckhand to guide and control the personnel basket with the tag line to safely land and when lifting the basket, to and from the M/V.

IN CONCLUSION:

BSEE has determined that all possible hazards associated with the transferring of personnel from the motor vessel to the platform were not identified and shared with personnel involved in the lift through the JSA process. The M/V being underpowered should have been listed on a shared JSA to be discussed and provide methods to prevent an undesirable event. BSEE agrees with Cox's assessment that there were several opportunities for multiple personnel to use Stop Work Authority.

BSEE also determined that the crowded back deck of the M/V Sapphire was a contributing factor.

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

Human Performance Error: Not aware of hazards. Not following proper procedure. Rushing to get job done. The 8 personnel should not have stepped onto the personnel basket without ensuring that the M/V was positioned stationary enough for them to board. Also, the crane operator should not have responded to the drifting M/V by lifting up the personnel basket, especially, since the deckhand had not secured the tagline in

hand. And the crane operator should not have lifted the basket without proper signaling from the deckhand/rigger.

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

Equipment Failure: Inoperable equipment: 1 Motor vessel engine failed. Crane operator handheld radio not functional.

Work Environment: Congested or hazardous workspace - The landing area for the personnel basket did not have sufficient space for the large 8-man personnel basket.

20. LIST THE ADDITIONAL INFORMATION:

BSEE also received the following data in the investigation.
The M/V Sapphire is not the regular field boat. It was contracted for the use by the construction crew.
The deckhand/rigger communicated with the crane operator through hand signals.
There was a +10 boat landing area available at WD 73 C in the event personnel could not transfer by personnel basket.

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Ensure that all personnel involved with the personnel transfers from the MV to the platform are familiar with/ and discussed all potential hazards that may affect the safe outcome of the transfers. Use the JSA, JSEA, Hazard Analysis, and pre-job safety meetings processes to communicate to everyone.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

07-DEC-2022

26. Investigation Team Members/Panel Members:

Gerald Taylor /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

David Trocquet

APPROVED DATE: **11-FEB-2023**