

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: **04-JUN-2021** TIME: **0930** HOURS

2. OPERATOR: **Talos Oil and Gas LLC**

REPRESENTATIVE:  
 TELEPHONE:  
 CONTRACTOR:  
 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: **G33242**

AREA: **GC** LATITUDE:  
 BLOCK: **281** LONGITUDE:

5. PLATFORM:

RIG NAME: **SEADRILL WEST NEPTUNE**

6. ACTIVITY:

- EXPLORATION(POE)
- DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:

INJURIES:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> HISTORIC INJURY<br><br><input type="checkbox"/> REQUIRED EVACUATION<br><input type="checkbox"/> LTA (1-3 days)<br><input type="checkbox"/> LTA (>3 days)<br><input type="checkbox"/> RW/JT (1-3 days)<br><input checked="" type="checkbox"/> RW/JT (>3 days)<br><input type="checkbox"/> FATALITY<br><input type="checkbox"/> Other Injury | OPERATOR<br><br><br><br><br><br><br><br>0 | CONTRACTOR<br><br><br><br><br><br><br><br>1 |
|---|---|---|

8. OPERATION:

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

9. CAUSE:

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

- POLLUTION
- FIRE
- EXPLOSION

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

- 10. WATER DEPTH: **2755** FT.
- 11. DISTANCE FROM SHORE: **80** 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:

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

On June 4, 2021, an incident occurred onboard the Seadrill West Neptune working for Talos Oil and Gas LLC. Completion operations were being conducted at Green Canyon Block 281, OCS-G 33242, Well #3. The Oceaneering Remotely Operated Vehicle (ROV) crew was in the process of launching the ROV when the ROV Technician inadvertently placed his left hand in an identified pinch point between the two cantilever support areas of the ROV lifting frame, as it extended over the side of the vessel. The ROV Technician informed the winch operator to lift the frame to release his hand from the pinch point. The ROV Technician reported to the medic on board, then was sent in on a medivac helicopter for further evaluation and an onsite investigation was initiated.

On the morning of June 4, 2021, the Oceaneering ROV team, consisting of one ROV Supervisor, one ROV Winch Operator, and one ROV Deckman, attended the pre-tour meeting with the day drilling crew to discuss ongoing operations. After the meeting, the ROV team convened in the ROV shack to complete additional paperwork and review and sign the Task Based Risk Assessment Form (TBRA) on the launch of the ROV. A pre-dive inspection was completed, with barriers in place, and the gates lowered in preparation for the ROV deployment. The ROV Supervisor was piloting the ROV while the Winch Operator and Deckman prepared to launch the ROV over the port side of the drillship. The ROV team always used open radio communications during the launch of the ROV. The Deckman's responsibility was to pull the rope to lower the gate on the ROV deck as it is being deployed and stand back out of the Red Zone. After the gate was lowered, the Deckman remained in an unidentified Red Zone as the Winch Operator lowered the A-Frame onto the lower pedestal. The Deckman placed his left hand between the two contact points where the A-Frame and lower pedestal met. The Deckman immediately contacted the Winch Operator by radio to stop the operation and retract the A-Frame to remove his hand. Upon removal, the Deckman informed the ROV Supervisor and reported to the Medic's office. It was decided to Medi-Vac the Deckman to shore for further evaluation.

Due to the Covid - 19 pandemic, the Bureau of Safety and Environmental Enforcement (BSEE) team was unable to conduct an initial onsite investigation at the time of this incident. However, the investigation team was able to collect documentation and pictures furnished by the operator at the team's request. The investigation team reviewed the documentation and noted that a Task Based Risk Assessment Form (TBRA) was reviewed and signed by the entire Oceaneering ROV team involved in the launching of the ROV for a routine inspection dive. It was noted that the TBRA did not identify the potential pinch point hazard between the upper A-Frame and lower pedestal on the ROV lifting unit. Also, each crew member involved in the task, read the TBRA themselves and signed the document without any open discussion as a team to identify additional hazards. The incident location was not identified as a potential red zone during the risk assessment of the task. The Deckman pulled the gate rope to lower the gate on the ROV deck and remained in an unidentified red zone instead of proceeding to the next task of observing the ROV being deployed over the side. The ROV team considered the launching of the ROV a routine operation which the Deckman had been involved in multiple times with no issues noted. The Deckman stated that he was not under any pressure to hurry up but just became complacent of where his hand was during the task.

Seadrill and Oceaneering will update the TBRA form on the launch and recovery of the ROV as well as identify red zones and safe observation zones which will be properly labeled for all ROV systems with this existing hazard. Also, a physical barrier will be designed and installed on the launch and recovery system to eliminate this pinch point.

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

Lack of situational awareness due to the IP's left hand placement in a clearly

identified pinch point.

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

IP was placed in an unnecessary position in a unidentified red zone.  
IP became complacent with the job.

20. LIST THE ADDITIONAL INFORMATION:

n/a

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

N/A

N/A

ESTIMATED AMOUNT (TOTAL): \$

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

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

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION

26. INVESTIGATION TEAM MEMBERS:

PANEL FORMED: NO

Paul Reeves /

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR: Amy

Pellegrin

APPROVED

DATE:

08-DEC-2021