UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
GULF OF AMERICA REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **03-MAY-2025** TIME: **0830** HOURS

2. OPERATOR: **GOM Shelf LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **ISLAND OPERATORS CO. INC.**
   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: **G01967**
   AREA: **MP** LATITUDE:
   BLOCK: **153** LONGITUDE:

5. PLATFORM: **B**
   RIG NAME:

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

7. TYPE:
   INJURIES:
- [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[ ] REQUIRED EVACUATION		
[ ] LTA (1-3 days)		
[ ] LTA (>3 days)		
[ ] 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
- [ ] TEMP ABAND
- [ ] PERM ABAND
- [ ] DECOM PIPELINE
- [ ] DECOM FACILITY
- [ ] SITE CLEARANCE

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

10. WATER DEPTH: **300** FT.

11. DISTANCE FROM SHORE: **10** 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:

INCIDENT SUMMARY:

On 03 May 2025, at 0830 hours, an incident occurred at Main Pass 153 B (MP 153 B) platform. MP 153 B is a Fixed Leg Platform located in the Gulf of America that is owned and operated by GOM Shelf LLC (GOM Shelf). During the incident, Island platform operators (operators) were in the process utilizing the platform crane on the top deck to install an Electric Submersible Fire Water Pump (ESFWP) in a caisson that was below the top deck. As the crane was on the deck above the caisson the ESFWP was being installed in, a blind lift was utilized. While performing this blind lift operation, a flange attached to a Fiberbond pipe contacted an I- Beam. This contact resulted in the separation of the piping at the flange, resulting in the ESFWP along with 25 feet of pipe still attached, falling 4 feet to the deck below. The incident resulted in minor damage to the deck grating, Fiberbond pipe, and to the ESFWP. There were no injuries or pollution associated with the incident.

SEQUENCE OF EVENTS:

On 03 May 2025, at approximately 0830 hours, operators were in the process of replacing the ESFWP when the Fiberbond piping separated between the upper and mid-section flanged connection point. When the piping separated, it caused the ESFWP to fall to the grating below, near the caisson where the ESFWP was being installed. When the ESFWP fell, it struck the steel grating and went through the grating approximately 1-2 feet. The ESFWP became lodged in the grating. Once the area was clear of any other safety concerns, the operators used the platform crane to remove the ESFWP from the grating. The operators immediately used wooden boards to cover the bent grating, preventing an open hole hazard in the working area. The crew then called an all stop of operations by utilizing Stop Work Authority (SWA). The operators and additional contractors on the platform relocated to the platform galley where they conducted a meeting with all individuals involved in the operation to discuss the incident that had just occurred.

Due to the Fiberbond piping separating and the ESFWP falling to the deck, there were minor damages observed to the ESFWP, the 20-foot section of 3-inch Fiberbond piping, and the section of grating that was bent from contact with the ESFWP. The platform had to have repair materials shipped to location and received the repair materials on 04 May 2025. Once the Fiberbond pipe section was replaced, the ESFWP was repaired, and the grating was repaired by installing a permanent steel covering, the crew was able to install the ESFWP without any further incidents on 04 May 2025.

BSEE INVESTIGATIONS:

On 06 May 2025, at 1049 hours, GOM Shelf submitted an incident report, notifying the Bureau of Safety and Environmental Enforcement (BSEE) of an incident that occurred at MP 153 B on 03 May 2025. The incident report provided a brief description of the incident that occurred, cost of damages due to the incident, photographs of the area where the incident occurred, the Job Safety Analysis (JSA) for the work being performed, witness statements, and other relevant information concerning the incident. After receiving the incident report, a BSEE Accident Investigator (AI) began collecting evidence and performing an office-based investigation of the incident.

On 08 May 2025, a BSEE (AI) began reviewing the incident and requesting additional information about the incident. The BSEE AI requested additional photographs of the surrounding area where the incident took place and further detailed information about the incident.

On 03 May 2025, the operators at for MP 153 B were performing a lift to replace the ESFWP. The new ESFWP was going to be installed in a caisson on the deck below. Due to

the caisson location being below the top deck where the crane was located, the lift was considered a blind lift as the Crane Operator was unable to see the area in which the load was being placed. The Crane Operator relied on a signalman to relay hand signals to the crane operator to direct him on any crane functions that needed to be made. The Crane Operator was also in radio communications with an operator on the deck below and was receiving verbal commands from that operator as well as the hand signals from the Signalman on the deck above.

While the lift was being lowered through the opening in the top deck to the lower deck where the caisson was located, the Signalman stated that the lift was centered in the opening. The ESFWP was near the location where personnel were required to handle the load on the lower deck when it was determined that the lift had to be raised for repositioning, so that a protective sleeve could be installed on the electric motor. While repositioning the lift, the Signalman on the top deck noticed that the load had become off-center. The Signalman noticed that the flange that was connecting the fiber bond piping was about 1 foot away from an I-beam under the top deck. The Signalman then looked down to the working area near the caisson to see the progress of the operators handling the sleeve and ESFWP. When the Signalman turned his attention back to the pipe flange, he noticed the flange had become hung up on the I-beam. The Signalman then tried to push on the lift to assist in centering the load, but he was unable to move it. Once he realized he couldn’t reposition the load, he tried to signal the Crane Operator to stop lifting the load. Before the lift was able to be stopped, the Fiberbond pipe sections separated at the flange. The Crane Operator stated that he noticed the load jerk as the piping parted. The Signalman then yelled to the personnel working on the lower deck to alert them of the pipe separation and potential falling objects.

While reviewing the evidence for the incident, it was stated that there was one operator on the deck below that had radio communications with the Crane Operator as well as the Signalman on the top deck that was giving hand signals to the Crane Operator. The Operator that had the radio on the lower deck was in radio communications with the Crane Operator at the time of the incident. This took the Crane Operator’s attention off the Signalman providing hand signals on the top deck during the lift. Both the Operator with the radio on lower deck, and the Signalman on the deck where the lift was being performed, were giving the Crane Operator instructions at the time of the incident, causing confusion that contributed the incident.

The investigation also identified that personnel did not utilize tag lines or any other means of stabilizing the load as it was being lowered into the caisson. Instead, personnel used their hands to attempt to control the load once it was in reach and attempted to guide the ESFWP in place. At the time of the piping separating, personnel were using their hands to guide the ESFWP into place and were in very close proximity to the falling equipment.

IN CONCLUSION:

The incident that occurred at MP 153 B on 03 May 2025 could have resulted in a far worse outcome. Due to the size and weight of the lift and the proximity of the personnel to the lift, serious injuries or fatalities could have occurred. Proper planning ahead of the work being performed could have prevented the incident from occurring. Personnel did not utilize tag lines to assist in lowering the lift or raising/stabilizing the lift. This allowed the lift to become off-centered and caused the pipe flange to contact the I-beam that was located under the top deck. With proper planning, a more thorough evaluation of the area could have been conducted. This evaluation could have identified the I-beam as a hazard that was near the lift as the load was being lowered and raised through the access hole in the top deck.

Consideration for the use of tag lines should have been addressed due to the size and shape of the lift being made. With proper tag line placement, personnel could have had better control of the load throughout the lift. Proper tag line use would have also prevented personnel from having to be so close to the ESFWP as it was being lowered, raised and repositioned. In the future, more attention should be given to providing methods of keeping personnel away from the lift being made. Personnel should keep a safe distance from the load until secured.

Personnel involved in the operation failed to identify a single source of communication from the Signalman to the Crane Operator. For all blind lifts being performed, there should be one designated source of communication to the Crane Operator. This single source of communication would prevent confusion or conflicting instructions during the lifts. While there was a signalman on the top deck in view of the Crane Operator, there was a failure to provide an additional signalman on the lower deck to identify any possible hazards or obstructions on the bottom side of the top deck where the I-beam was located. Instead, an operator on the lower deck radioed his directions to the Crane Operator, instead of to/through the designated signalman. Having a signalman on the lower deck could have prevented the incident, as the Crane Operator was receiving information from two different sources during the lift.

GOM Shelf has stated that in the future, they will provide and discuss a more thorough JSA to identify hazards while performing operations including blind lifts. GOM Shelf also stated that they will utilize extra personnel if needed and designate just one single source of communication with the Crane Operator. Better communication techniques will be implemented to provide more efficient and safe operations in the future. In addition, there will be two designated signalmen during any blind lifts to provide full coverage when identifying hazards. Only one of the two signalmen will be in direct contact with the crane operator to avoid confusion.

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

Human performance error: Not aware of hazards- Hazards were not properly identified before or during the blind lift and were not discussed with the personnel involved in the operations.

Communication: No or inadequate job instructions provided- Operators were not instructed to utilize tag lines failed to use tag lines or other means necessary to stabilize the lift that was being made.

Communication: No or inadequate job instructions provided- Failure to designate one single source of communication to the crane operator during the lift.

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

Supervision: No or inadequate pre-job safety and operation meeting- Supervision failed to account for all safety processes that should have been put in place and discussed with personnel during pre-job meetings such as the use of tag lines and establishing proper communication methods during the operation.

Supervision: Inattention to worker safety- As personnel were not instructed to use taglines to guide the ESFWP into place, personnel had to reposition the load by hand, putting themselves into harm’s way.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

Deck grating, 20-foot section of Fiber bon piping, Teflon sleeve on ESFWP

NATURE OF DAMAGE:

Bent, broken

ESTIMATED AMOUNT (TOTAL): **$1,792**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE New Orleans District recommends the Office of Incident Investigations should consider issuing a Safety Alert regarding the incident.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

26. Investigation Team Members/Panel Members:

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

27. OPERATOR REPORT ON FILE:

OCS REPORT:

30. DISTRICT SUPERVISOR:

Michael J. Saucier

APPROVED DATE: **30-JUN-2025**