**ACCIDENT INVESTIGATION REPORT**

For Public Release

1. OCCURRED
   - DATE: 23-JAN-2022  TIME: 1545 HOURS

2. OPERATOR: Anadarko Petroleum Corporation
   REPRESENTATIVE: Blake International, Inc.
   TELEPHONE: 3675 FT.

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR
   ON SITE AT TIME OF INCIDENT:

4. LEASE: G14205
   AREA: EB  LATITUDE:
   BLOCK: 602  LONGITUDE:

5. PLATFORM: A(Nansen Spar)
   RIG NAME:

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

7. TYPE:
   - HISTORIC INJURY
   - REQUIRED EVACUATION OPERATOR CONTRACTOR
   - LTA (1-3 days) 0 1
   - LTA (>3 days) 0 1
   - RW/JT (1-3 days) 0 1
   - RW/JT (>3 days) 0 1
   - PATALITY 0 1
   - Other Injury 0 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

10. WATER DEPTH: 3675 FT.

11. DISTANCE FROM SHORE: 142 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:

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UNIVERSITY DEPARTMENT OF THE INTERIOR
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
GULF OF MEXICO REGION

MMS - FORM 2010
EV2010R

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Incident Summary:

On 23 January 2022, at approximately 1545 hours, an injury occurred on Blake International’s (Blake) Rig 1007 on Anadarko Petroleum Corporation’s Nansen SPAR at OCS-G14205 East Breaks 602.

Sequence of Events:

On 23 January 2022, while a Blake rig crew was completing the installation of a mast, a Blake floorhand, the injured party (IP), was instructed by the Driller to ascend the derrick to check if a light plug approximately 15 feet above the derrick was connected. The IP donned a dual lanyard safety harness for fall protection, ascended the derrick ladder and corrected the light plug connection. After verifying the connection, the IP began to ascend the derrick to retrieve the Self Retracting Line (SRL), that was currently at the top of the derrick. The Driller noticed the IP was ascending the derrick and told him to come down immediately to the rig floor. After no acknowledgement was given from the IP, the Driller radioed to the Derrickman to inform the IP to come down along with continued verbal orders to the IP. The IP acknowledged the Driller and made his descent down the derrick ladder to the access platform approximately 11 feet above the A-frame walkway. The IP then disconnected both fall protection lanyards, removing his 100 percent tie off, fell off the access platform (ladder landing for the derrick ladder), and struck his head on the top edge of the A-frame walkway wall before coming to rest on the A-frame walkway. The IP sustained moderate internal injuries to his body and lacerations to his head. The injuries from the fall required multiple back surgeries, and sutures for the head lacerations.

Investigation:

On 27 January 2022, one Bureau of Safety and Environmental Enforcement (BSEE) Accident Investigator (AI) performed an onsite investigation of the incident. The BSEE AI performed a site survey of the incident location, gathered the Job Safety and Environmental Analysis (JSEA), training certificates and other documents from Anadarko and Blake, conducted witness interviews, took photographs, and inspected the personal protective equipment in use during the incident.

The BSEE AI found that the IP had four years of oil field experience, two years land based and two years offshore as a roustabout and floor hand. The IP was on his second hitch as a floorhand with this rig. The IP took part in the morning Job Safety and Environmental Analysis (JSEA). The IP was wearing serviceable personal protective equipment including a two-lanyard safety harness (Fall Protection with Rescue Planning training completed on 14 September 2021). The IP disconnected both lanyards while standing on the derrick access platform. The IP stated during his telephonic interview with BSEE, “he felt dizzy and he did not feel right on the derrick access platform,” before he fell. During the time the IP disconnected his lanyard and attempted to tie off, the IP lost his balance and fell.

The BSEE investigation also found that the SRL the IP was attempting to retrieve was left in the fully retracted position at the top of the derrick without an easily accessible tag line and no alternative ladder system or safety cage was installed.

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

IP disconnected both lanyards from the derrick ladder while on the derrick access platform. IP failed to remain tied off 100% as he lost his balance causing him to fall to the A-frame walkway.

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:
SRL was left in the fully retracted position at the top of the derrick without an easily accessible tag line. If the SRL would have been available, it would have prevented the use of the loop back lanyard. This type of lanyard is slow and tedious to use, which may cause more physical and mental fatigue on the climber due to a slower pace while ascending and descending.

IP failed to follow documented safety procedures (Blake International Personnel Safety Manual SG-4 Working at Heights) and remain 100% tied off while ascending or descending derrick ladder.

There was no alternative ladder safety system, or a safety cage installed, which would have been a less fatiguing option than the personal fall protection used.

20. LIST THE ADDITIONAL INFORMATION:

The A-frame walkway kept the IP from falling an additional 30’ which would have caused further injury or death.

Emergency rescue plan worked as designed even though the emergency rescue plan was not identified (checked/marked) on the JSEA as being discussed prior to the job.

21. PROPERTY DAMAGED: NONE

NATURE OF DAMAGE: NA

ESTIMATED AMOUNT (TOTAL): NA

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

NONE

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

The Lessee failed to perform all operations in a safe and workmanlike manner. During derrick scoping operations, an employee fell and was seriously injured on 11 January, 2022, while descending the derrick. BSEE investigation revealed employee failed to follow documented safety procedures as stated in Blake International's Personnel Safety Manual, SG-04 Working at Heights, page 2: "All persons shall be 100% tied off at all times when working above the six-foot level and any time the potential for falling exists." Employee failed to remain 100% tied off while traversing the Derrick Access Platform and fell 11 feet 2 inches onto the A-frame walkway resulting in an injury requiring medical treatment and immediate evacuation.

25. DATE OF ONSITE INVESTIGATION: 27-JAN-2022

26. INVESTIGATION TEAM MEMBERS: Perry Brady /

27. OPERATOR REPORT ON FILE: NA

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR: Stephen Martinez