1. OCCURRED
   DATE: 26-APR-2017  TIME: 0830  HOURS

2. OPERATOR: Fieldwood Energy LLC
   REPRESENTATIVE: 
   TELEPHONE: 
   CONTRACTOR: 
   REPRESENTATIVE: 
   TELEPHONE: 

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

4. LEASE: G01757
   AREA: BA  LATITUDE: 
   BLOCK: A 105  LONGITUDE: 

5. PLATFORM: A
   RIG NAME: 

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

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

   STRUCTURAL DAMAGE
   CRANE
   OTHER LIFTING DEVICE
   DAMAGED/DISABLED SAFETY SYS.
   INCIDENT >$25K
   H2S/15MIN./20PPM
   REQUIRED MUSTER
   SHUTDOWN FROM GAS RELEASE
   OTHER

8. CAUSE:
   EQUIPMENT FAILURE
   HUMAN ERROR
   EXTERNAL DAMAGE
   SLIP/TRIP/FALL
   WEATHER RELATED
   LEAK
   UPSET H2O TREATING
   OVERBOARD DRILLING FLUID
   OTHER

9. WATER DEPTH: 188 FT.

10. DISTANCE FROM SHORE: 39 MI.

11. WIND DIRECTION: ESE
   SPEED: 15 M.P.H.

12. CURRENT DIRECTION: SE
   SPEED: 1 M.P.H.

13. SEA STATE: 7 FT.
On 26 April 2017, Fieldwood Energy reported a crane incident that occurred at BAA 105A, Lease G01757, at approximately 0830 hours. It was reported that while offloading a 550 gallon diesel tote tank from the Motor Vessel (M/V) Miss Julie a Deckhand was injured.

The Deckhand attached the crane’s stringer to a pre-slung, four part wire rope sling on the tote tank, stepped clear of the load, and then signaled to lift the load. The Deckhand then noticed that one leg of the four part wire rope sling was caught on a shackle. The Deckhand proceeded to move toward the tote tank without stopping the lifting action in an attempt to free the sling.

The tote tank was lifted while one leg of the sling was caught up on the shackle. As the tote tank came off the deck it was unbalanced, swinging briefly, while pinning the Deckhand between the tote tank and starboard gunwale. The Deckhand was injured, falling to his hands and knees with pain to his right leg and chest. The Deckhand, Injured Person (IP), was kept onboard the Miss Julie and transported to BAA 133 where he was treated by the Field Medic.

The Field Medic evaluated the IP, he was then littered to the helideck of BAA 133 and transported by a field helicopter to Christus Spohn Shoreline Hospital in Corpus Christi, Texas. IP was diagnosed with a fracture to his lower right leg and two fractured left ribs. IP underwent surgery to his right leg where a plate and screws were installed to set the fracture.

Investigation revealed the four part sling was fabricated with approximately eleven foot legs (11'), normally the slings are fabricated with four foot legs (4'). It was surmised that this length of sling may have contributed to the leg of sling wrapping around the shackle. The Job Safety Analysis (JSA) that was conducted for crane operations that day onto the M/V Miss Julie failed to have cooresponding dates throughout the entire JSA.

IP approached the tote tank as it was ascending. After he gave the signal to begin the lift, he then placed his body in a pinch point between the tote tank and gunwale. IP entered the area after he had gave the signal to lift the load. IP failed to recognize the immediate hazard by not stopping the crane’s actions before entering the hazardous area. Sea state at the time of the incident was reported at 7 feet.

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

IP entered the hazard area after he had gave the signal to lift the load. IP failed to recognize the immediate hazard by not stopping the crane’s actions before entering the hazardous area.

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

Investigation revealed the four part sling was fabricated with approximately eleven foot legs (11'), normally the slings are fabricated with four foot legs (4'). It was surmised that this length of sling may have contributed to the leg of sling wrapping around the shackle. Sea state at the time of the incident was reported at 7 foot.

20. LIST THE ADDITIONAL INFORMATION:
21. PROPERTY DAMAGED: None
   NATURE OF DAMAGE: None

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:
   The Lake Jackson District makes no recommendation to the Office of Incident Investigations.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:
   G-110(C) IP entered the area after he had gave the signal to lift the load, IP failed to recognize the immediate hazard by not stopping the crane’s actions before entering the hazardous area.
   G-110(W) Investigation revealed the four part sling was fabricated with approximately eleven (11') foot legs, normally the slings are fabricated with four (4') foot legs, it was surmised that this length of sling may have contributed to the leg of sling wrapping around the shackle.
   G-110(W) The JSA that was completed for the Crane operations of off loading and back loading the M/V Julie failed to have corresponding dates through out the entire JSA.

25. DATE OF ONSITE INVESTIGATION:
   26-APR-2017

26. ONSITE TEAM MEMBERS:
   Edward Keown /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

30. DISTRICT SUPERVISOR:
    John McCarroll

APPROVED DATE: 25-MAY-2017