

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: 02-FEB-2018 TIME: 0750 HOURS

2. OPERATOR: Cox Operating, L.L.C.

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: 8. OPERATION:

4. LEASE: G02324

AREA: EI LATITUDE:  
BLOCK: 361 LONGITUDE:

5. PLATFORM: A  
RIG NAME:

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

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

7. TYPE:

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

- FATALITY
- POLLUTION
- FIRE
- EXPLOSION

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

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

9. CAUSE:

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

10. WATER DEPTH: FT.  
11. DISTANCE FROM SHORE: MI.  
12. WIND DIRECTION:  
SPEED: M.P.H.  
13. CURRENT DIRECTION:  
SPEED: M.P.H.  
14. SEA STATE: FT.

17. INVESTIGATION FINDINGS:

**For Public Release**

On February 02, 2018 at approximately 0750, a compressor mechanic (CM) was injured while attempting to reposition from the top of a compressor to the compressor walkway.

The CM was attempting to install new water jumpers on the cylinders. As the CM removed the old water jumpers, he stepped out of the space between the compressor cylinders while holding the old jumpers in each hand. The CM's boot came in contact with the toe-rail causing him to fall forward.

The middle section of the handrail was removed and replaced with yellow plastic chain that was secured with tie wraps. While falling forward, the CM grabbed the yellow chain. The subject chain broke causing the CM to fall approximately 9 feet to the deck below. The CM was able to land on his feet but later complained of constant back pain.

The CM was transported to a medical facility where x-rays were taken. The physician is treating the injury as a lumbar strain and will re-evaluate.

The BSEE Lafayette District conducted an onsite investigation February 20, 2018.

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

During compressor maintenance, the handrail should have not been removed and replaced with yellow plastic chain. The lessee failed to meet the requirements as per 33 CFR 143.110, (b) of this section, and areas not normally occupied, unprotected perimeter of all floor or deck areas and openings shall be rimmed with guards and rails or wire mesh fence. The guard rail or fence shall be at least 42 inches high. The two intermediate rails shall be so placed that the rails are approximately evenly spaced between the guard rail and the floor or deck area: Provided, that if a toe board is installed then one of the intermediate rails may be omitted and the other rail placed approximately half way between the top of the toe board and the top guard rail.

(c) Each catwalk and each stairway shall be provided with a suitable guard rail or rails, as necessary.

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

Lessee failed to follow the Fall Protection Policy which states Guardrails are erected to prevent workers from falling to lower levels. Guardrails may be constructed with steel-welded materials such as steel pipe, angle iron, and channel-iron, supported by steel barriers, 3/8- inch wire rope, or safety chains used as a barrier between guard posts, and must be capable of withstanding without failure a force of 250 pounds. Guardrails must have a top edge barrier of 42 inches above the walking/working surface and a middle barrier approximately 21 inches between the top rail and the floor. Guardrails must be secured when installed to prevent accidental displacement by inclement weather conditions, equipment, or workers.

Lessee failed to follow the Job Safety Analysis (JSA) which states under the Recommendations to Eliminate or Reduce Potential Hazards, risk of injury or illness, and/or environmental impacts: (1) The JSA mandated the following: to use 3 points of contact and to practice good housekeeping. The following rules were not followed. The skid was full of cluttered piping and had poor footing at best. At the time of the incident, the CM was not using 3 points of contact when holding a water jumper in both hands. (2) The CM should not have been walking and climbing on the skid.

21. PROPERTY DAMAGED: NATURE OF DAMAGE:  
**None** **NA**

ESTIMATED AMOUNT (TOTAL): \$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

**The BSEE Lafayette District office makes no recommendations to the Regional Office of Incident Investigations (OII).**

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

**G110 (C) Does the Lessee perform all operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment? A mechanic was injured after falling from the Cooper Compressor CAE-0301 walkway deck approximately 9 feet, to the solid deck below. The compressor deck had inadequate hand-rail coverage which failed to meet the intent of the regulation and allowed for an unsafe working environment.**

25. DATE OF ONSITE INVESTIGATION:

**20-FEB-2018**

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

OCS REPORT:

26. INVESTIGATION TEAM MEMBERS:

**John Mouton / Wade Guillotte /**

29. DISTRICT SUPERVISOR:

**Elliott S. Smith**

APPROVED

DATE: **29-MAR-2018**