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: **18-OCT-2020** TIME: **0820** HOURS

2. OPERATOR: **W & T Energy VI, LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **Hand Dolly**
- [ ] 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: **G19931**
   AREA: **MC** LATITUDE:
   BLOCK: **243** LONGITUDE:

5. PLATFORM: **A(MATTERHORN SE**
   RIG NAME:

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

7. TYPE:
   INJURIES:
- [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	0	1
[ ] LTA (1-3 days)		
[ ] LTA (>3 days)		
[ ] RW/JT (1-3 days)		
[X] RW/JT (>3 days)	0	1
[ ] FATALITY		
[X] Other Injury	0	1

Amputated fingertip

- [ ] 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

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

10. WATER DEPTH: **2850** FT.
11. DISTANCE FROM SHORE: **30** 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:

17. INVESTIGATION FINDINGS:

INCIDENT SUMMARY:

On 18 October 2020, 0820 hours, at Mississippi Canyon (MC) 243 A (Matterhorn), operated by W&T Energy Offshore (W&T), a crane mechanic's (Injured Person - IP) finger was crushed while attempting to transport a 55-gallon drum. The injury required evacuation. The medical treatment required amputation of the fingertip which caused the IP to be placed on restricted work for greater than 3 days.

SEQUENCE OF EVENTS:

During the morning of 18 October 2020, at the 0600 hours safety meeting, the IP and an operator were asked to refill the crane's hydraulic oil reservoir.

At 0820 hours, personnel safely added one 55-gallon drum of hydraulic oil to the crane reservoir. The first 55 gallon drum of oil was already stored near the base of the crane. Once the drum was emptied, 2 personnel transported the empty drum across the deck to refill it. Once the drum was refilled, they began transporting it across the platform deck with the use of a hand dolly. In transport, they lifted the dolly and drum onto a 12-inch high I-beam which they were not able to pull the dolly and drum across. A W&T operator left to get additional assistance leaving the dolly and drum on the beam held in place by the IP. The IP attempted to secure the hand dolly and drum on the beam. However, the dolly slipped from the IP's grip and his righthand middle finger got caught between dolly handle and skid beam crushing the fingertip.

The field helicopter landed within 15 minutes and evacuated the IP to West Jefferson Hospital in New Orleans.

The incident was reported to BSEE New Orleans District at 0953 hours the same day.

The Emergency Room doctor amputated the fingertip, cleaned up the remaining bone and sewed the skin over the bone. The IP was scheduled for cosmetic hand surgery on 22 October 2020.

The IP was released to light duty at Sparrow's shop.

BSEE INVESTIGATION:

The BSEE Accident Investigator (AI) reviewed the incident in eWell on 19 October 2020. The AI requested and reviewed statements, JSA's, workpermits, POB, and photos. The AI received information from the W&T Office and Field Safety Coordinators.

BSEE found that an inattention to task may have been the probable cause of the incident. The operator did not secure the dolly and drum back on the deck before leaving to get assistance. BSEE also found that a contributing cause of the incident was that W&T did not identify the safest means to lift the drum across the beam.

CONCLUSIONS:

BSEE determined this root cause of this incident to be an inattention to task. The operator should have secured the dolly and drum back on the deck before leaving to get assistance. BSEE also determined that the personnel did not identify the safest means to lift the drum across the beam. Other mechanical aids should have been considered.

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

Supervision: Not providing adequate tools for equipment for tasks - Personnel did not identify the safest means to lift the drum across the beam. Other mechanical aids should have been considered.

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

Human Performance Error - inattention to task. The operator should have secured the dolly and drum back on the deck before leaving to get assistance.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans District makes no recommendations to the Office of Incident Investigation.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

19-OCT-2020

26. INVESTIGATION TEAM MEMBERS:

Gerald Taylor Accident Investigator /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

David Trocquet

APPROVED DATE: **31-DEC-2020**