

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: **23-MAR-2020** TIME: **1130** HOURS

2. OPERATOR: **Fieldwood Energy LLC**

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 **Cut wrist with knife**

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

8. OPERATION:

4. LEASE: **G07827**

AREA: **MP** LATITUDE:

BLOCK: **259** LONGITUDE:

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

5. PLATFORM: **A**

RIG NAME:

6. ACTIVITY:

- EXPLORATION(POE)
- DEVELOPMENT/PRODUCTION (DOCD/POD)

9. CAUSE:

7. TYPE:

INJURIES:

HISTORIC INJURY

REQUIRED EVACUATION

LTA (1-3 days)

LTA (>3 days)

RW/JT (1-3 days)

RW/JT (>3 days)

FATALITY

Other Injury

OPERATOR

CONTRACTOR

0

1

0

1

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

POLLUTION

FIRE

EXPLOSION

LWC HISTORIC BLOWOUT

UNDERGROUND

SURFACE

DEVERTER

SURFACE EQUIPMENT FAILURE OR PROCEDURES

10. WATER DEPTH: **390** FT.

11. DISTANCE FROM SHORE: **58** 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:

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

On 23 March 2020 at 11:30 hours, an injury occurred on Main Pass 259 A Fieldwood Energy LCC, OCS-G 07827 platform.

Sequence of Events:

On the day of the incident, while the contractors were working on the production deck, one contractor was "hot bolting" or replacing bolts on various flanges on process equipment. The flange the contractor was working on was heavily wrapped with electrical tape. The contractor used a cutting device to cut away the tape. As the contractor utilized his box cutter and started cutting the tape from bottom to top, he cut through his glove and into his wrist.

The Injured Person (IP) stopped to alert personnel on the platform. The platform personnel performed first aid until he could be evacuated for further evaluation. The IP was transported to the offshore medic by helicopter. The medic cleaned the wound and bandaged the IP wrist. The medic determined the IP needed further treatment to his wound. The IP was sent to a Clinic. The medical staff determined the need for five stitches to close the wound appropriately.

After the medical staff stitched the IP's wound, the clinic requested that the IP return the next day for reevaluation to determine bleeding control, motor/sensory function, and infection prevention.

On 24 March 2020, the medical staff reevaluated the IP and placed him on restricted/light duty work. The IP is expected to be placed back to full duty in an estimated fourteen days. The IP's next crew change to report to work will be in 22 days from 24 March 2020. The IP could be assigned to a different location for Fieldwood Energy LLC or another operator.

BSEE Investigation:

On 26 March 2020, one Bureau of Safety and Environmental Enforcement (BSEE) Accident Investigator performed an investigation. The BSEE Investigator collected witness statements, the Job Safety Analysis (JSA), and other documents from Fieldwood Energy LLC. The JSA, dated 23 March 2020, line 11, stated sharp cutting devices and body placement can cause serious injury to personnel. The witnesses indicated that the IP used an improper technique of cutting towards his body. The interviews also revealed that the IP was not wearing cut resistant gloves. However, Fieldwood Energy LLC emphasized in their report that before a cutting device can be used, a JSA must be completed that includes proper cutting techniques, the hazards involved, and the Personal Protective Equipment (PPE) necessary.

Conclusion:

BSEE found that the probable cause of the injury was a failure to use proper PPE and cutting techniques.

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

- Human Performance Error-Not following proper procedures: Injured person used improper techniques and poor body placement.
- Supervision-Not ensuring the use of proper PPE: Supervisor failed to ensure the IP was using cut resistant gloves.

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

None

20. LIST THE ADDITIONAL INFORMATION:

At the time of the incident, the IP discovered an improperly oversized flange ring keeper that was put in place by a prior worker and needed to be taped into place. The keeper was used due to a lack of properly sized keepers, and a failure to use stop work authority to prevent the use of improperly sized equipment.

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

N/A

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:

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION
PANEL FORMED: NO

26. INVESTIGATION TEAM MEMBERS:

Pierre Lanoix AI Specialist

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR:

David Trocquet

APPROVED

DATE:

28-MAY-2020