

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: 06-APR-2015 TIME: 0630 HOURS

2. OPERATOR: EPL Oil & Gas, Inc.

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR:

REPRESENTATIVE:

TELEPHONE:

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

4. LEASE: G00985

AREA: EI LATITUDE:

BLOCK: 259 LONGITUDE:

5. PLATFORM: C

RIG NAME:

6. ACTIVITY:  EXPLORATION (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 1 Failed to report  
to Lessee

FATALITY

POLLUTION

FIRE

EXPLOSION

LWC

HISTORIC BLOWOUT

UNDERGROUND

SURFACE

DEVERTER

SURFACE EQUIPMENT FAILURE OR PROCEDURES

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

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

6. OPERATION:

PRODUCTION  
 DRILLING  
 WORKOVER  
 COMPLETION  
 HELICOPTER  
 MOTOR VESSEL  
 PIPELINE SEGMENT NO.  
 OTHER Following Crane Inspection

8. CAUSE:

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

9. WATER DEPTH: 160 FT.

10. DISTANCE FROM SHORE: 49 MI.

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

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

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS:

On April 06, 2015 at approximately 0630 hours, a Wire Line Employee (WLE) stated he injured his left arm while attempting to prevent himself from falling into an open hole.

While attempting to complete a pull test on the crane, the crane mechanic removed a hatch to access a pad eye. The crane mechanic failed to barricade the area to prevent any employees from injury. Once the hatch was removed, the hole was 25" wide, 17" long and 17" deep. After completing the pull test, the crane mechanic failed to place the hatch back over the hole.

During the pull test, wire line operations were taking place in another area of the facility. After the crane mechanic completed the pull test, a WLE was walking up the stairway and noticed the open hole. The WLE grabbed the handrails prior to stepping in the open hole. The WLE advised the Lessee of the incident and stated he was not injured at the time of the incident.

Three days later, the WLE received a call from his employer informing him that he had to crew change due to the amount of time he was on the structure.

Ten days after the incident, the WLE entered a local hospital to receive treatment for an injury to his left arm he claimed happened while grabbing the handrails. The employee was referred to a company physician where there were no injuries found. The company physician recommended an MRI be performed to determine the cause of the WLE's discomfort. The WLE refused the MRI.

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

The crane mechanic failed to barricade the area to prevent any employees from injury. Also, after completing the pull test, the crane mechanic failed to place the hatch back over the hole.

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

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL): \$

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District office makes no recommendations to the Office of Safety Management (OSM).

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

INC G-110 is issued to document that EPL Oil & Gas, INC. failed to protect health, safety and the environment by not performing operations in a safe and workmanlike manner as follows: The Lessee failed to properly supervise crane operations after a crane mechanic removed a piece of grating to access a pad eye to perform a pull test. The crane mechanic failed to barricade the open hole allowing a wireline employee to nearly step in the hole. The wireline employee stated he injured his hand while preventing his fall. The hole was 25" wide, 17" long and 17" deep.

25. DATE OF ONSITE INVESTIGATION:

05-MAY-2015

26. ONSITE TEAM MEMBERS:

Raymond Johnson / Wade Guillotte /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED

DATE: 01-JUN-2015

### INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER \_\_\_\_\_

WITNESS

NAME:

HOME ADDRESS:

# INJURY/FATALITY/WITNESS ATTACHMENT

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE: