UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: 05-MAR-2012   TIME: 1415 HOURS

2. OPERATOR: Rooster Petroleum, LLC
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: Chet Morrison Contractors Inc.
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: G14364
   AREA: EC   LATITUDE:
   BLOCK: 129   LONGITUDE:

5. PLATFORM: A (SEAHORSE)
   RIG NAME:

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

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

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

9. WATER DEPTH: 81 FT.

10. DISTANCE FROM SHORE: 33 MI.

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

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

13. SEA STATE: FT.

14. PICTURES TAKEN: YES

15. STATEMENT TAKEN: YES

For Public Release

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

PRODUCTION
DRILLING
WORKOVER
COMPLETION
HELICOPTER
MOTOR VESSEL
PIPELINE SEGMENT NO.
X OTHER P&A

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

MMS - FORM 2010
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31-MAY-2012
On 03-05-2012 at 1425 hours, during P&A operations on the EC-129 Well A-01 a well service assistant working for the contractor Chet Morrison Well Sevrvices (CMWS), was the Injured Person (IP) who suffered head and face injuries.

The IP was returning from the lower deck of the platform to assist two other well service assistants on the upper deck via a spiral stair case located next to well A-01. The two assistants on the upper deck were in the process of replacing a grating panel approximately three feet wide by six feet long weighing in excess of one hundred pounds over the barricaded open hole above well A-01. During the process of sliding the grating cover over the hole, the panel slid through the hole and fell to the deck below. The panel bounced off the stair case and struck the IP, who was ascending the stairs, on the top front of his hard hat impacting the nose and facial area.

The IP sustained lacerations to face, nose and lips, with a possibility of a broken nose, and was given immediate first aid and air transported at 1600 hours to University of Texas Medical Branch (UTMB) Surgery Hospital in Galveston, Texas for additional medical treatment.

After reviewing multiple Job Safety Analysis (JSA) for the day of the accident BSEE inspectors were unable to locate a JSA for the specific task of replacing grating in the barricaded open hole over well # A-1. None of the JSAs available mentioned open-hole awareness.

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

Human error: Two personnel attempting to replace a heavy piece of grating over an open hole without the aid of a crane, or securing the grating with a safety tie down. The IP was walking directly under an open hole with personnel working on the level above.

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

There was human error by the IP and, the lack of supervision at the job site. There was an attempt by two assistants to replace heavy grating over an open hole without the aid of proper slings, use of crane, or other safety securing devices for grating.

**20. LIST THE ADDITIONAL INFORMATION:**

**21. PROPERTY DAMAGED:**

**NATURE OF DAMAGE:**
22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Charles District has no recommendations to make to the Regional Office of Safety Management.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING NARRATIVE:

G-110 Authority: 107 (a) Safe Workmanlike Operations
1) Planning for the operation was inadequate.
2) The JSA meeting failed to identify or discuss the danger of the open hole.
3) Lack of proper supervision.

25. DATE OF ONSITE INVESTIGATION: 06-MAR-2012

26. ONSITE TEAM MEMBERS:
Wayne Meaux / Mitchell Klump / William Olive /

27. OPERATOR REPORT ON FILE: YES

28. ACCIDENT CLASSIFICATION: MAJOR

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

30. DISTRICT SUPERVISOR: Williamson, Larry

31. OCS REPORT:

APPROVED DATE: 05-MAY-2012
INJURY/FATALITY/WITNESS ATTACHMENT

☐ OPERATOR REPRESENTATIVE
☐ CONTRACTOR REPRESENTATIVE
X OTHER  Assistant

☐ INJURY
☐ FATALITY
X WITNESS

NAME:
HOME ADDRESS:
CITY: STATE:
WORK PHONE:
TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:
BUSINESS ADDRESS:
CITY: STATE:
ZIP CODE:

☐ OPERATOR REPRESENTATIVE
☐ CONTRACTOR REPRESENTATIVE
X OTHER  E Line Operator

☐ INJURY
☐ FATALITY
X WITNESS

NAME:
HOME ADDRESS:
CITY: STATE:
WORK PHONE:
TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:
BUSINESS ADDRESS:
CITY: STATE:
ZIP CODE:
INJURY/FATALITY/WITNESS ATTACHMENT

☐ OPERATOR REPRESENTATIVE ☐ INJURY
☐ CONTRACTOR REPRESENTATIVE ☐ FATALITY
☑ OTHER Pump Operator ☑ WITNESS

NAME:
HOME ADDRESS:
CITY: STATE:
WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:
BUSINESS ADDRESS:
CITY: STATE:
ZIP CODE: