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: **07-JUL-2018** TIME: **1115** HOURS

2. OPERATOR: **Fieldwood Energy LLC**
REPRESENTATIVE:
TELEPHONE:

CONTRACTOR: **Gulf Crane Services**
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:

4. LEASE: **G17938**
AREA: **SM** LATITUDE:
BLOCK: **105** LONGITUDE:

5. PLATFORM: **A**
RIG NAME:

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

7. TYPE:
- [ ] HISTORIC INJURY
- [X] REQUIRED EVACUATION **1**
- [ ] LTA (1-3 days)
- [X] 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

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: **191** FT.

11. DISTANCE FROM SHORE: **73** 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:

On July 7, 2018 at approximately 1115 hours, a contract crane mechanic (CCM) fell approximately 81 feet into the water while repairing a crane at Fieldwood Energy's South Marsh Island 105 A platform resulting in two fractured vertebrae.

The day before the incident, the CCM boarded the platform to retrieve information on the anti-two block control valve. The CCM removed the hydraulic hoses on the anti-two block control valve but did not tighten the hoses when putting the valve back in place causing hydraulic oil to spill onto the crane skid.

The CCM arrived at the facility the following day to replace the anti-two block control valve. Two operators on board the facility assisted the CCM by placing a 10 foot ladder between the crane and the overboard handrail. The CCM climbed the ladder and placed both feet on the crane skid, located over 7 ft. above the deck to replace the valve.

The CCM realized he needed additional tools and attempted to place his foot on the ladder and subsequently fell backwards over the handrail plummeting 81 feet before reaching the water. The CCM does not recall if he lost his grip or his foot slipped possibly due to hydraulic oil.

The operators on board heard the CCM yell for help prior to coming in contact with the water. The operators attempted to drop the CCM a life vest, but due to high winds the CCM could not retrieve the life vest. The operators placed the life vest in a life ring allowing the CCM to grab it. As the CCM began to drift, the operators boarded a helicopter and attempted to drop bottled water and an additional life vest but the high winds and the main rotor blade made it difficult to retrieve the vest.

Approximately 45 minutes after the incident, a fishing vessel located at a nearby facility was contacted and rescued the CCM transporting him back to the main facility. The CCM was transported to a hospital for treatment. It was later determined the CCM had suffered a fracture to the C-7 and a lower lumbar vertebrae.

The BSEE Lafayette District conducted an onsite investigation on July 10, 2018.

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

There were several policy and procedure failures that should have been addressed prior to this incident. The following policies of both the lessee and the contract crane company that are listed would have possibly prevented this incident from occurring.

Lessee's Fall Protection – Section D, Chapter 6, Version 2
• Scope
This procedure establishes minimum requirements for working at unguarded elevated work locations that are 6 feet or greater above floor/grade level or that present a potential for fall and/or injury to personnel. This procedure applies to all employees and contract personnel.

• Responsibilities
The Person in Charge (PIC) or Lead Operator is responsible for:
Understanding and complying with this procedure.

Evaluating the potential elevated work hazards at the facilities/sites, qualifying the level of risk of each job, and establishing the required safeguards.

Evaluating the need for a rescue plan as an integral part of pre-planning a job which requires the use of fall protection.

Ensuring the Working from Heights Checklist (Section D, Chapter 6, Part A) is completed prior to beginning work from heights.

• Employee or Contract Personnel are responsible for:
Understanding and following the requirements of this Fall Protection Policy and Procedure.

• Requirements
This Policy provides for continuous or 100% tie off fall protection, when possibility of a fall from 6 feet or greater exists. This means the employee must be tied off 100% of the time while repositioning or moving into a work area at heights of 6 feet or greater.

• Hazard Analysis
When a job task will create the possibility or potential for a fall, the Person in Charge (PIC), Lead Operator or Consultant should consider methods in which to address fall hazards in the following order:
Fall Elimination
Fall Prevention
Fall Protection

• As per the Contract Crane Mechanics Fall Protection Policy:
Fall protection is required whenever employees are potentially exposed to falls from heights of six feet (OSHA General Industry) or greater to lower levels. This includes work near and around excavations. Use of guard rails, safety nets, or personal or fall arrest systems should be used. When the standard methods of protection are not feasible or a greater hazard would be created.

• The crane mechanic contract representative failed to utilize fall protection as per Fieldwood’s Fall Protection Policy.

• Contract representatives failed in evaluation the need for a rescue plan as an integral part of pre-planning a job which requires the use of fall protection as per Fieldwood’s Fall Protection Policy.

• The accumulation of hydraulic oil in the crane skid from the anti-two block hoses being removed and the skid not being cleaned increased the risk of falling from the working surface.

• Numerous contract representatives failed in using stop work authority (SWA) as per Fieldwood’s SWA Policy due to the potential fall hazard.

• Contract representatives failed to identify fall elimination, fall prevention and fall protection in their job safety analysis (JSA). This includes but does not limit hazard control for job step 19 in the JSA, changing out the anti-two block valve.

• As per Fieldwood representatives, the crane could have been swung over to a different location which would have mitigated the chance of a person falling overboard.

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

If the lessee would have reviewed the Working from Heights and/or Open Hole Checklist located in Section D Chapter 6 Part-A, this incident would have been avoided.

The Fall Rescue Plan was not discussed during the pre-job planning. This step could have allowed a quicker rescue response.
• Fall Rescue Plans

Ensure a plan is discussed, proper equipment and personnel are available and described during pre-job planning JSA (Job Safety Analysis).

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District office makes the recommendation to the Regional Office of Safety Management (OSM) that a Safety Alert be issued due to the severity of this incident.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 (C) Lessee failed to protect health, safety and the environment by not performing operations in a safe and workmanlike manner as follows: A contract crane mechanic failed to perform operations in a safe and workmanlike manner by attempting to relocate himself from a crane skid onto a ladder while replacing an anti-two block control valve. The contract crane mechanic had both feet on the crane skid that was located over 7 ft. above the deck when he attempted to place one foot on a 10 ft. ladder he used to access the crane. The contract crane mechanic lost his balance failing over the platform handrail and approximately 81 feet to the water. The employee suffered a fracture to the C-7 and a fracture to the lower lumbar vertebrae due to this event.

25. DATE OF ONSITE INVESTIGATION:

10-JUL-2018

26. INVESTIGATION TEAM MEMBERS:

W.Guillotte / R. Johnson / J. LeMieux / J. Mouton /

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

OCS REPORT:

29. DISTRICT SUPERVISOR:

Elliott Smith

APPROVED DATE: **11-SEP-2018**