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: **15-JAN-2020** TIME: **0715** HOURS
2. OPERATOR: **Talos Petroleum 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

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

4. LEASE: **G06896**
   AREA: **VK** LATITUDE:
   BLOCK: **956** LONGITUDE:

5. PLATFORM: **A-Ram Powell**
   RIG NAME:

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

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

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

Received 7 stitches

- [ ] 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.
   - [X] OTHER **Construction**

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: **3216** FT.
11. DISTANCE FROM SHORE: **55** MI.
12. WIND DIRECTION:
    SPEED: **8** M.P.H.
13. CURRENT DIRECTION:
    SPEED: M.P.H.
14. SEA STATE: **6** FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

INCIDENT SUMMARY:

On 15 January 2020, at 0715 hours, at Viosca Knoll (VK) 956 A (Ram Powell) platform operated by Talos Petroleum, LLC, a construction supervisor used a portable bandsaw to cut a section of one inch steel tubing. The bandsaw required two hands to operate. However, the construction supervisor (IP) used one hand to hold the saw and used the other hand to hold the tubing. Consequently, the tubing moved, and the bandsaw blade slipped onto the IP's left hand. Although the IP was wearing cut resistant gloves at the time of the incident, the bandsaw blade made a deep laceration into the IP's left index finger just below the first knuckle. The IP was immediately provided first aid, while being escorted to Ram Powell's Onsite Clinic. Under the supervised MD assistance the IP received 7 stitches. It was later determined by the MD that the IP had a full range of motion and was released back to full duty. The IP later departed the facility as a part of his regular crew change.

SEQUENCE OF EVENTS:

The IP personnel went through the morning Simultaneous Operations (SIMOPS) and Pre-job Safety meetings with the Health Safety Environment (HSE) advisor, Production, Construction and Well Work operations personnel between 0545 and 0645. The task at hand was the completion of the tubing revisions on the Methanol Subsea Injection Skid #1. The tubing cutting began at 0710. The incident occurred at 0715 hours. The IP was given first aid while being escorted to the Onsite Clinic. Talos personnel secured the incident area and gathered relevant information. At 0800 hours, Talos made verbal communication with BSEE's New Orleans District Supervisory Inspector. Stop Work Authority was utilized, and all construction activities ceased on the facility. A safety stand-down was held with all crew members. At the end of the stand-down, the Ultimate Work Authority (UWA) authorized work activities to resume and completed a Job Safety Environmental Analysis (JSEA) Report.

BSEE INVESTIGATION:

The BSEE Investigator arrived on location on 14 February 2020. Copies of all JSEAs, Task Hazard Assessments, permits, and documents were requested and received. He received statements and follow-up Talos investigation reports. The BSEE Investigator performed a walk-through of the incident area located at the UB-900 Chemical Injection Skid No. 1 and took photos. The BSEE Investigator met with the Offshore Installation Manager (OIM) on duty as well as the on-site Medic. According to statements, the task of completing the tubing installation for the skid was completed and personnel involved in the project as well as the IP had departed during normal crew change on 15 January 2020.

The review of the documents received demonstrated several areas of concern. On the JSEAs, there was no indication for the use of the portable bandsaw. On the Task Hazard Assessment Form, under Equipment and Tools, the following was checked: Use the correct tools for task. During the interviews with the 3rd Party, HSE Advisor, and the Talos Supervisor, it was stated that prior to the incident, the tubing job was in its final completion stage. The section of tubing that needed to be refitted/re-cut was due to making a correction to its location. The tool normally used to cut steel tubing (manual tubing cutters) had been stored away in a toolbox in preparation for crew change. Even without the use of the tubing cutters, the use of a manual vise to secure the tubing while the cut was made could have prevented the injury.

CONCLUSIONS:

The IP's injury can be attributed to several factors. The IP did not use the safest

tool for the job. Also, the IP did not secure the tubing before cutting. The contributing causes were that the safest tool was not listed in the JSEA and the IP was in a hurry to complete the job.

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

Equipment Failure: Inadequate/improper tools or equipment used.

Human Performance Error: Not following proper procedures – IP used a 2-handed tool with one hand.

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

Human Performance Error: Rushing to get job completed.

Management Systems: Inadequate documentation or availability of hazard analyses, job procedures, or emergency procedures.

20. LIST THE ADDITIONAL INFORMATION:

VK 956 A has on-board medical services: (On-site Clinic). All medical procedures are recorded and visually monitored.

IP crew changed on normal crew change day. IP's schedule was over on the day of the incident. Workload changed. Went from 30 hands to 12 hands.

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: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 30 CFR 250.107 Failure to perform job task (tubing installation) is a safe manner.

25. DATE OF ONSITE INVESTIGATION:

14-FEB-2020

26. INVESTIGATION TEAM MEMBERS:

Gerald Taylor

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

David Trocquet

APPROVED DATE: **28-MAY-2020**