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: **13-OCT-2023** TIME: **1745** HOURS
2. OPERATOR: **Cox Operating, L.L.C.**
   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: **G00985**
   AREA: **EI** LATITUDE:
   BLOCK: **259** LONGITUDE:

5. PLATFORM: **C**
   RIG NAME:

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

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

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

- [ ] 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.
   - [ ] DECOMMISSIONING
     - [ ] PA [ ] PIPELINE [ ] SITE CLEARANCE
     - [ ] TA [ ] PLATFORM
   - [ ] 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: **160** FT.
11. DISTANCE FROM SHORE: **49** 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 October 13, 2023, at approximately 1745 hours, a crane mechanic (CM) fell approximately 96 ft. from the gantry of the crane. The incident occurred on the Cox Operating L.L.C. (Cox) OCS-G00985 Eugene Island (EI) 259 C Facility. While attempting to replace the auxiliary winch, a brace the CM was attempting to remove broke free. The CM stated when the brace detached from the beam, the brace contacted the CM causing him to fall over the handrails and into the water. The CM suffered severe injuries due to this incident.

Sequence of Events:

On October 13, 2023, a CM and a helper arrived at EI 259 C to replace the auxiliary winch on the platform crane. The old winch had been removed and placed on the deck. The CM and a helper connected the winch to a chain hoist and was attempting to insert the winch through the side of the gantry. Once the winch was raised high enough, a brace that once supported the exhaust for the muffler piping needed to be removed in order to insert the winch. Without a harness or life vest, the CM positioned himself over the handrail on the gantry of the crane in order to reach the bolts holding the bracket. Utilizing a grinder, the CM attempted to remove the bolts. When the second bolt broke, the CM stated he heard a loud noise and was knocked off the crane falling approximately 96 ft to the water. It is unknown as to what struck the CM causing him to fall. The CM was retrieved from the water and complained of soreness in his hip and shoulder. An aircraft transported the CM to a medical facility where it was determined he suffered a fractured rib, a dislocated shoulder, and internal bleeding.

BSEE INVESTIGATION:

On October 13, 2023, the Bureau of Safety & Environmental Enforcement (BSEE) Lafayette District (LD) Accident Investigator (AI) received a notification by phone of a man overboard incident that occurred on Cox's EI 259 C Facility. The AI requested additional information pertaining to the incident such as: the Job Safety Analysis (JSA), Hot Work Permit, statements, and other relevant documents from Cox.

The BSEE LD AI and a LD Inspector conducted an onsite investigation at EI 259 C on October 16, 2023. BSEE conducted interviews with the personnel that were onboard the facility during the time of the incident. Following the onsite investigation, there were additional interviews with the crane company supervisor, HS&E manager, and the helper that was assisting the CM. BSEE was unable to interview the CM.

CONCLUSION:

As per 33 CFR 142.42, "Except when moving from one location to another, personnel engaged in an activity where there is a hazard of falling 10 or more feet shall wear a safety belt or harness secured by a lanyard to a lifeline, drop line or fixed anchorage". Even though the Job Safety Analysis discusses the use of a safety harness, the CM failed to wear the safety harness when reaching over the handrail or climbing onto the gantry to remove the brace. As per 33 CFR 143. 110(a), "The guard rail or fence shall be at least 42 inches high". The guard rail on the gantry was 38 inches high.

During the duration that the CM and helper were replacing the winch, the person in charge of the platform did not monitor or visit the site where the incident occurred.

Also, the CM failed to conduct a stop work authority and readdress the Job Safety Analysis when the decision was made to remove the brace.

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

Human Performance Error: Even though the Job Safety Analysis discusses the use of a safety harness, the CM failed to wear the safety harness when reaching over the handrail or climbing on the gantry to remove the brace.

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

No Supervision: During the duration when the CM and the helper were replacing the winch, platform operators did not monitor or visit the site where the incident occurred.

Management Systems: Inadequate hazard analysis - Also, the CM failed to conduct a stop work authority and readdress the Job Safety Analysis when the decision was made to remove the brace.

Work Environment: The guard rail onto the gantry was 38 inches high.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: **None**

NATURE OF DAMAGE: **NA**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District office makes no recommendations to the Regional Office of Incident Investigations (OII).

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. **110 C and Z-106 W - On October 13, 2023, Cox Operating, L.L.C. failed to perform operations in a safe and workmanlike manner as follows: A crane mechanic and a helper were in the process of replacing an auxiliary winch on the platform crane at EI-259-C. The crane mechanic was attempting to remove a bracket that was blocking the opening to install the auxiliary winch. Without a harness or life vest, the crane mechanic positioned himself over the handrail on the gantry of the crane in order to reach the bolts holding the bracket. Utilizing a grinder, the crane mechanic attempted to remove the bolts. When the second bolt broke, the crane mechanic stated he heard a loud noise and was knocked off the crane falling approximately 96 ft to the water. The crane mechanic was retrieved from the water and complained of soreness in his hip and shoulder. An aircraft transported the crane mechanic to a medical facility where it was determined he suffered a fractured rib, a dislocated shoulder and internal bleeding.**

25. DATE OF ONSITE INVESTIGATION:

16-OCT-2024

26. Investigation Team Members/Panel Members:

M. Gary / W. Guillotte /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Mark Malbrue

APPROVED DATE: **04-APR-2024**