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: **26-APR-2017** TIME: **0830** HOURS

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

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

4. LEASE: **G01757**
   AREA: **BA** LATITUDE:
   BLOCK: **A 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

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

6. OPERATION:
- [X] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER

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

9. WATER DEPTH: **188** FT.

10. DISTANCE FROM SHORE: **39** MI.

11. WIND DIRECTION: **ESE**
    SPEED: **15** M.P.H.

12. CURRENT DIRECTION: **SE**
    SPEED: **1** M.P.H.

13. SEA STATE: **7** FT.

17. INVESTIGATION FINDINGS:

On 26 April 2017, Fieldwood Energy reported a crane incident that occurred at BAA 105A, Lease G01757, at approximately 0830 hours. It was reported that while offloading a 550 gallon diesel tote tank from the Motor Vessel (M/V) Miss Julie a Deckhand was injured.

The Deckhand attached the crane's stringer to a pre-slung, four part wire rope sling on the tote tank, stepped clear of the load, and then signaled to lift the load. The Deckhand then noticed that one leg of the four part wire rope sling was caught on a shackle. The Deckhand proceeded to move toward the tote tank without stopping the lifting action in an attempt to free the sling.

The tote tank was lifted while one leg of the sling was caught up on the shackle. As the tote tank came off the deck it was unbalanced, swinging briefly, while pinning the Deckhand between the tote tank and starboard gunwale. The Deckhand was injured, falling to his hands and knees with pain to his right leg and chest. The Deckhand, Injured Person (IP), was kept onboard the Miss Julie and transported to BAA 133 where he was treated by the Field Medic.

The Field Medic evaluated the IP, he was then littered to the helideck of BAA 133 and transported by a field helicopter to Christus Spohn Shoreline Hospital in Corpus Christi, Texas. IP was diagnosed with a fracture to his lower right leg and two fractured left ribs. IP underwent surgery to his right leg where a plate and screws were installed to set the fracture.

Investigation revealed the four part sling was fabricated with approximately eleven foot legs (11'), normally the slings are fabricated with four foot legs (4') It was surmised that this length of sling may have contributed to the leg of sling wrapping around the shackle. The Job Safety Analysis (JSA) that was conducted for crane operations that day onto the M/V Miss Julie failed to have cooresponding dates throughout the entire JSA.

IP approached the tote tank as it was ascending. After he gave the signal to begin the lift, he then placed his body in a pinch point between the tote tank and gunwale. IP entered the area after he had gave the signal to lift the load. IP failed to recognize the immediate hazard by not stopping the crane's actions before entering the hazardous area. Sea state at the time of the incident was reported at 7 feet.

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

IP entered the hazard area after he had gave the signal to lift the load. IP failed to recognize the immediate hazard by not stopping the crane's actions before entering the hazardous area.

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

Investigation revealed the four part sling was fabricated with approximately eleven foot legs (11'), normally the slings are fabricated with four foot legs (4'). It was surmised that this length of sling may have contributed to the leg of sling wrapping around the shackle. Sea state at the time of the incident was reported at 7 foot.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

None

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Jackson District makes no recommendation to the Office of Incident Investigations.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110(C) IP entered the area after he had gave the signal to lift the load, IP failed to recognize the immediate hazard by not stopping the crane's actions before entering the hazardous area.
G-110(W) Investigation revealed the four part sling was fabricated with approximately eleven (11') foot legs, normally the slings are fabricated with four (4') foot legs, it was surmised that this length of sling may have contributed to the leg of sling wrapping around the shackle.
G-110(W) The JSA that was completed for the Crane operations of off loading and back loading the M/V Julie failed to have corresponding dates through out the entire JSA.

25. DATE OF ONSITE INVESTIGATION:

26-APR-2017

26. ONSITE TEAM MEMBERS:

Edward Keown /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

John McCarroll

APPROVED DATE: **25-MAY-2017**