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

ACCIDENT INVESTIGATION REPORT

For Public Release

	IRED MUSTER DOWN FROM GAS RELEASE R
 3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR 8 ON SITE AT TIME OF INCIDENT: 4. LEASE: G31362 AREA: EI LATITUDE: BLOCK: 11 LONGITUDE: 5. PLATFORM: H DIG NAME: 	 OPERATION: X PRODUCTION DRILLING WORKOVER COMPLETION HELICOPTER MOTOR VESSEL PIPELINE SEGMENT NO. OTHER
Image: State of the state o	EQUIPMENT FAILURE EQUIPMENT FAILURE HUMAN ERROR EXTERNAL DAMAGE SLIP/TRIP/FALL WEATHER RELATED LEAK UPSET H20 TREATING OVERBOARD DRILLING FLUID OTHER
FATALITY 1 POLLUTION 1	0. WATER DEPTH: 13 FT. 1. DISTANCE FROM SHORE: 7 MI. 2. WIND DIRECTION:
LWC HISTORIC BLOWOUT UNDERGROUND 1 SURFACE DEVERTER SURFACE EQUIPMENT FAILURE OR PROCEDURES 1 COLLISION HISTORIC >\$25K < <=\$25K 1	SPEED: M.P.H. 3. CURRENT DIRECTION: SPEED: M.P.H. 4. SEA STATE: FT. 5. PICTURES TAKEN: 6. STATEMENT TAKEN:

EV2010R

For Public Release

On October 19, 2017 at approximately 1911 hours, a construction employee (CE) severely injured his left foot while attempting to remove a manway hatch from a skimmer. While attempting to clean the MBM-7110 Water Skimmer, the 24" manway hatch was being opened utilizing the davit pole to access the skimmer. The manway hatch was initially moved approximately one quarter of the way open to allow the skimmer to vent. The crew took a break and returned to reposition the manway hatch to allow additional access to the inside of the skimmer. As the CE was pulling the manway hatch, the piping supporting the rod failed causing the manway hatch to drop. The manway hatch struck a dump valve before coming in contact with the CEs left foot. The CE suffered a laceration to the top and bottom of the foot. The CE was transported to a medical facility for additional treatment where it was discovered the CE had suffered multiple fractures as well.

The manway cover is normally held in place by a rod assembly; a threaded rod passing through a hole in a davit pole where a washer and bolt are placed on the rod above the davit. After further investigation it was revealed that the washer that supports the rod assembly was either placed below the davit, or detached due to severe corrosion. Also, severe corrosion around the davit hole increased the size of the hole compared to its size when installed.

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

There was no inspection of the condition of the davit and rod assembly prior to placing the weight of the manway hatch on the davit and rod assembly.

The severe corrosion and location of the washer on the davit, and the corrosion of the davit was not detected.

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

The Job Safety & Environmental Analysis (JSEA) failed to capture the hazards associated with removing the skimmer manway hatch. The JSEA contained limited details specific to the operations being performed.

20. LIST THE ADDITIONAL INFORMATION:

As per Contango Operators Safe Work Practices-General Safety Topics 6.2 Hazard Assessment Policy: A hazard assessment in the form of a Job Safety Analysis (JSA) must be completed prior to entry into a confined space. The JSA must identify the sequence of work to be performed in the confined space, the specific hazards known or anticipated and the control measures to be implemented to eliminate or reduce each of the hazards to an acceptable level.

Also during the investigation, photos of the incident scene were sent from the lessee to the BSEE Lafayette District. It was observed in the photos that the lessee failed to follow Lock Out/Tag Out procedures. Failure to follow this procedure could have resulted in hydrocarbons entering an open vessel during confined space entry operations creating a high threat for injuries as well as property damage. An additional Incident of Noncompliance was written due to this failure. 21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

None

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:

G110 (C) Does the Lessee perform all operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment? During cleaning operations of MBM-7110 State Skimmer Vessel a 24 inch man-way cover broke off of the man-way cover davit pole fracturing a contract representative's (cleaning crew foreman) foot in two areas along with numerous stitches on the top and bottom of his foot. This incident occurred due to metal integrity issues on the man-way cover davit pole, along with improper installation of a fastening device (washer).

	Elliott S. Smith
Wade Guillotte / John Mouton /	29. DISTRICT SUPERVISOR:
26. INVESTIGATION TEAM MEMBERS:	
10-001-2017	OCS REPORT:
10-OCT-2017	PANEL FORMED: NO
25. DATE OF ONSITE INVESTIGATION:	28. ACCIDENT INVESTIGATION

APPROVED DATE: 10-JAN-2017

 MMS - FORM 2010
 PAGE: 3 OF 3

 EV2010R
 * * * * * * * * * * * * * * * * 22-JAN-2018