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: **12-FEB-2021** TIME: **0900** HOURS

2. OPERATOR: **Cox Operating, L.L.C.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Quality Production Management**
   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: **G02323**
   AREA: **EI** LATITUDE:
   BLOCK: **360** LONGITUDE:

5. PLATFORM: **E**
   RIG NAME:

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

7. TYPE:
   INJURIES:
- [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	**0**	**1**
[ ] 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.
- [ ] 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: **307** FT.
11. DISTANCE FROM SHORE: **77** 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:

Investigation Findings: On 12 February 2021, at approximately 0900 hours, an injury occurred on Cox Operating (Cox) L.L.C.'s OCS-G02323 Eugene Island (EI) 360-E Facility.

Sequence of Events:

On 12 February 2021, a Quality Construction and Production (QCP) crew began work to remove a heater tube from a heat exchanger. The crew began removing a handrail to create enough space for removal of the heater tube from the heat exchanger, HBG-700. The crew successfully removed two of the three legs, but the third leg was unable to be removed due to it being stuck in the socket. The crew then utilized the crane to aid with the removal of the handrail's third leg. A nylon strap was positioned above the last vertical member of the third leg and attached to the fast line of the crane. The crane operator was directed to place tension on the fast line with the crane. After tension was applied by the crane, the crew tried to dislodge the handrail manually (by hand) and also by striking the handrail with a hammer but could not dislodge the handrail from the socket. A QCP employee, the Injured Personnel (IP), retrieved a 5' pry bar and positioned the pry bar under the kick plate to remove the handrail, but was unsuccessful. The IP, repositioned himself, stood up and used his foot to gain more leverage while another QCP crew employee pushed the handrail with his hands. The handrail broke free under tension from the crane and struck the standing IP in the face. The IP was attended by the Offshore First Aider and transported onshore for medical evaluation. The medical evaluations revealed the IP suffered lacerations, a fractured nose, and a fractured orbital socket.

On 16 February 2021, the IP was admitted to the hospital and surgery was performed on his orbital socket.

BSEE INVESTIGATION:
On 12 February 2021, a Bureau of Safety & Environmental Enforcement (BSEE) Lafayette District (LD) Accident Investigator (AI) received a phone call notification of an incident with injury occurring on Cox's EI 360-E Facility. The AI requested additional information pertaining to the incident such as JSAs, Operating Practices and other relevant documents from Cox and its contractor.

On 4 March 2021, the BSEE LD AI and a BSEE LD Production Inspector performed an on-site investigation of the event. During the on-site investigation, photographic documentation of the incident location was taken, procedures were requested, and witness statements of relevant personnel were taken.

The AI found that stop work should have been implemented and the JSA should have been revised as new potential hazards were introduced due to the handrail's third leg being stuck in the socket. The BSEE AI looked into Cox's Safety Environmental Management System Crane Operations Policy General Operating Practices l) and found the crane shall not be used in a manner that might result in shock loading (for example, pulling up grating that is still welded to the platform). The AI researched into API Recommended Practices 2D 3.1.5 and found "a. The Qualified Crane Operator (herein also called Crane Operator) is responsible for those operations under his or her direct control. Whenever there is any doubt as to safety, the Crane Operator should have the authority to stop and refuse to handle loads or continue operations as safety dictates."
CONCLUSION:

BSEE found that the probable cause of the injury was a failure to follow the JSA and implementing stop work.

BSEE found that the contributing cause of the injury was failure to follow Cox's Safety Environmental Management System Crane Operations Policy General Operating

Practices l, and API RD 2D 3.1.5 Operating Practices.

Inattention/ lack of awareness, in that a decision was made to use the crane to remove the handrail without proper job planning.

Improper use of tools or equipment, regarding use of a prybar and crane in an unsafe manner.

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

LIST THE PROBABLE CAUSE(S) OF ACCIDENT:

• Human Performance Error- Not following proper procedure: The construction crew attempted to dislodge the handrail by hand while tension was applied by the crane. As per the Job Safety Analysis (JSA), stop work should have been implemented and the JSA revised as the potential hazards changed from the original JSA.
• Human Performance Error: Inattention to task: Decision was made to use the crane to remove the handrail before creating a new JSA to identify hazards.

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

LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

• According to the Cox - Safety Environmental Management System Crane Operations Policy General Operating Practices l), the crane shall not be used in a manner that might result in shock loading (for example, pulling up grating that is still welded to the platform).
• Also, API RP 2D 3.1.5 Operating Practices a. The Qualified Crane Operator (herein also called Crane Operator) is responsible for those operations under his or her direct control.
• Equipment Failure: Inadequate/improper tools or equipment used: Using prybar in unsafe manner.

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:

On February 12, 2021, Cox Operating, LLC failed to perform operations in a safe and workmanlike manner as follows: An injury occurred while attempting to remove a handrail. Two legs of the handrail were removed but the third leg stayed in the socket. The crane was used to assist with the removal of the handrail. A nylon strap was positioned around the last vertical leg and attached to the fast line of the crane. The crane operator placed tension on the line. The construction crew attempted to dislodge the handrail by hand but could not. An employee retrieved a 5' pry bar and positioned the pry bar under the kick plate but the handrail would not move. The employee stood up and used his foot to gain more leverage while the other employee pushed with his hands. The handrail broke free striking the standing employee in the face.

First Aid was administered on the facility. The injured employee was transported by helicopter to a medical facility for additional treatment. The employee suffered lacerations, a fractured nose and fractured orbital socket. The employee was admitted to the hospital and surgery was performed on his orbital socket on 16th February 2021.

25. DATE OF ONSITE INVESTIGATION:

04-MAR-2021

26. INVESTIGATION TEAM MEMBERS:

M. Williams / W.Guillotte /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Robert Ranney

APPROVED DATE: **12-JUL-2021**