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: **07-JUN-2021** TIME: **1415** HOURS

2. OPERATOR: **BP Exploration & Production Inc.**
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:
AREA: **MC** LATITUDE:
BLOCK: **474** LONGITUDE:

5. PLATFORM: **A(NA KIKA FPDS)**
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 | **1** | |

**Finger laceration**

- [ ] 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: **6340** FT.
11. DISTANCE FROM SHORE: **59** 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:

**INCIDENT SUMMARY:**

**On June 7, 2021, an injury occurred on Mississippi Canyon (MC) 474 A (Na Kika), a platform operated by BP Exploration & Production Inc (BP). The injured person (IP), who is employed by BP suffered a laceration to the right ring finger that required sutures and a tetanus shot. After receiving treatment, the IP was released back to regular work duty.**

**SEQUENCE OF EVENTS:**

**On June 7, 2021, at approximately 1415 hours, the IP was loosening a TMC Connector on a transmitter with a pair of channel lock pliers when the IP's right ring finger suffered a laceration from a sharp edge. The sharp edge was located on a metal band that is used to secure metal identification tags in place. The band was located approximately 3-4 inches away from the TMC Connector attached to the transmitter. The IP reported to the platform's medic and was administered four sutures and a tetanus shot. After receiving treatment, the IP was then released back to regular work duty.**

**BSEE INVESTIGATION:**

**On June 9, 2021, an Accident Investigator (AI) with the Bureau of Safety and Environmental Enforcement (BSEE) received an email notification of the incident that occurred on June 7, 2021, at MC 474 A (Na Kika). A request was sent to BP by the AI to provide more details, photos, and the Job Safety Analysis (JSA) used for the work being done.**

**On June 11, 2021, the BSEE AI received photos and the The JSA used from BP.**

**BSEE AI found that the IP was wearing gloves at the time of the incident and determined that the JSA did identify possible hazards related to the job task and implemented control measures despite incident.**

**The excess slack from the metal band was cut off creating a sharp edge. Although the IP was wearing gloves at the time of the incident, the type of gloves worn did not provide adequate protection in preventing the laceration.**

**CONCLUSIONS:**

**The probable cause of the incident was inadequate PPE. The gloves worn by the worker should have provided adequate protection for the task. The metal band should have been installed in such a way to eliminate sharp edges.**

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

**Work Environment:**
- **Improper PPE - Gloves worn by IP did not provide adequate protection against cuts and abrasions.**
- **Equipment failure: Flawed equipment design or construction - Metal band should have been installed to reduce sharp edges.**

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:
**None.**

20. LIST THE ADDITIONAL INFORMATION:

**None.**

21. PROPERTY DAMAGED:

**None.**

NATURE OF DAMAGE:

**None.**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

**The BSEE New Orleans District has no recommendations for the Office of Incident Investigations at this time.**

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

**None.**

25. DATE OF ONSITE INVESTIGATION:

26. INVESTIGATION TEAM MEMBERS:

**Nathan Bradley /**

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

**David Trocquet**

APPROVED DATE: **14-SEP-2021**