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: **17-FEB-2020** TIME: **0800** HOURS

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

- [ ] STRUCTURAL DAMAGE
- [X] 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: **G02592**
   AREA: **SM**
   BLOCK: **149**

5. PLATFORM: **D**
   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)		
[ ] LTA (>3 days)		
[ ] 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:
- [ ] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [X] OTHER **Conductor Repair**

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: **234** FT.
11. DISTANCE FROM SHORE: **87** MI.
12. WIND DIRECTION:
13. CURRENT DIRECTION:
    SPEED:
14. SEA STATE:
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

At 07:55 hours on 17 February 2020, a Warrior Energy Service (WES) Electric Line (E/L) Helper sustained a foot injury during plug and abandonment (P&A) operations on a Fieldwood Energy LLC (Fieldwood) platform at the surface location of South Marsh Island (SM) Block 149D. The incident involved a 1.25-inch tubular falling through the single joint elevators while being hoisted by a platform crane. The tubular struck the E/L Helper on the right foot. The E/L Helper was evacuated from the facility for a medical evaluation. During the medical evaluation, the physician identified bruising on the right foot and released the WES employee to regular work duty. At 10:48 hours on 17 February 2020, Fieldwood verbally reported the incident to the Bureau of Safety and Environmental Enforcement (BSEE) Lafayette District.

On 17 February 2020, a WES E/L Operator latched a joint of 1.25-inch pipe, that was horizontally positioned in the pipe rack, to a set of single joint pipe elevators. The platform crane lifted the 1.25-inch pipe and a WES E/L Helper tailed the tubular with a piece of rope. As one end of the tubular lifted vertically, the tubular slipped through the closed elevators and fell back bouncing off the pipe rack and landing on the top of the E/L Helper's right foot. The incident caused swelling on the victim's right foot.

At 08:00 hours on 18 February 2020, the WES E/L Helper evacuated from the platform to Pelican State Outpatient (PSO) in Harahan, Louisiana for medical evaluation. A physician found no fractures, just bruising to the right foot. A PSO physician released the WES employee to regular work duty.

WES's post incident Root Cause Analysis Report revealed the tubular elevators arrived at the wellsite pre-dressed from the provider with the wrong sized elevator dies and with the elevator "C" plate installed upside down.

The on-site P&A crew was unaware the elevators were dressed incorrectly for 1.5-inch pipe operations as opposed to the required 1.25-inch pipe operations. Typically, crew members can quickly check the intended size by observing the size stamp on the "C" plate. However, with the elevator "C" plate installed upside down, the elevator die size stamp was not viewable as assembled. The on-site P&A crew did not effectively verify the elevators were compatible with the tubular prior to use.

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

The BSEE incident investigation team determined that the probable cause of the incident was using improper equipment for the job. The crew used tubular elevators dressed for 1.5-inch tubular instead of being dressed for 1.25-inch tubular.

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

BSEE's post investigation into this incident revealed the following contributing causes: 1) the elevators were pre-equipped for the wrong size pipe scheduled for the job; 2) inadequate pre-job planning for the determination of the correct elevator dies; 3) the "C" plate was incorrectly installed that masked the 1.5-inch size stamp on the "C" plate that is used visually to identify the size of the elevator dies installed and; 4) the elevators were not inspected prior to deployment in the field nor were the elevators inspected in the field.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: **No property was damaged during this incident.**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District recommendations to the Office of Incident Investigations to issue a Safety Alert for this incident.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

Based on the incident investigation findings, a G-110 Incident of Noncompliance (INC) is issued to document that Fieldwood Energy LLC., (Fieldwood) failed to oversee that operations were performed in a safe and workmanlike manner on Fieldwood's platform located at South Marsh Island Block 149D. On 17 February 2020, a Warrior Energy Services (WES) employee sustained an injury during lifting operations when a 1.25-inch pipe slipped through the elevators, bounced off the pipe rack and fell on the deck striking his right foot. It was determined that the incident occurred because the elevators had the wrong sized dies for handling the 1.25-inch pipe. The WES employee was evacuated from the platform and was diagnosed by a physician to have sustained bruising to his right foot.

25. DATE OF ONSITE INVESTIGATION:

26. INVESTIGATION TEAM MEMBERS:

Troy Naquin (Report Author) /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Robert Ranney

APPROVED DATE: **08-SEP-2020**