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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **21-MAR-2020** TIME: **1200** HOURS

2. OPERATOR: **Cox Operating, L.L.C.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Parker Drilling Company**
   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: **00310**
   AREA: **SM**
   BLOCK: **223**

5. PLATFORM: **218**
   RIG NAME: **PARKER 77-B**

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		
[X] Other Injury	**0**	**1**

medical treatment

- [ ] POLLUTION
- [ ] FIRE
- [ ] EXPLOSION

LWC
- [ ] HISTORIC BLOWOUT
- [ ] UNDERGROUND
- [ ] SURFACE
- [ ] DEVERTER
- [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

8. OPERATION:
- [ ] PRODUCTION
- [ ] DRILLING
- [X] 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: **11** FT.
11. DISTANCE FROM SHORE: **8** MI.
12. WIND DIRECTION: **NE**
    SPEED: **10** M.P.H.
13. CURRENT DIRECTION:
14. SEA STATE: **2** FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

17. INVESTIGATION FINDINGS:

At approximately 12:00 hours on 21 March 2020, a Parker Drilling Company (PDC) Roustabout sustained a finger injury onboard the PDC 77B barge rig while conducting well operations for Cox Operating, L.L.C. (Cox) at South Marsh Island (SMI) Block 223. The incident occurred when a PDC Roustabout used incorrect hand placement while trying to place a three feet by six feet basket onto the keyway deck with the rig's crane. The severity of the PDC Roustabout's right finger required evacuation for medical treatment.

On 21 March 2020, the PDC crew decided to move equipment from the pipe rack to a derrick barge and to the lower deck (keyway). The PDC crew engaged in a pre-job safety meeting during which a Work Safe Procedure (WSP) and Job Safety Analysis (JSA) was reviewed. The PDC crew made several lifts, transferring equipment to the derrick barge.

The PDC crew then initiated the task of moving a three feet by six feet basket that contained a 13.625-inch double studded adapter (DSA) from the pipe rack onto the keyway deck. This lift was more complicated because it involved placing the basket in tight spot on the keyway deck. This task was not discussed during the safety meeting. The PDC Crane Operator lifted, transferred and landed the basket in the keyway. The PDC Motorman assisted in landing the basket by pulling in on the basket's lifting cables. The PDC Motorman unlatched the four-part lifting cables from the basket. The PDC crew then realized the basket needed to be repositioned to create room to place the wellhead on the keyway deck.

At this time, a PDC Roustabout came back from a break and assisted the PDC Motorman in repositioning the basket. The PDC Motorman latched the four-part lifting cables back on the basket. The PDC Crane Operator lifted the basket slightly. The PDC Motorman and the PDC Roustabout attempted to the push the basket out, allow the basket to swing back in and then hold the basket in place until the crane landed the load. However, when the basket swung back in and held by the PDC Motorman and PDC Roustabout, the DSA shifted inside the basket. The PDC Motorman held the sling connected to the basket while the PDC Roustabout held on the top rim of the basket when the DSA shifted. The DSA shifted in the basket causing it to roll over the PDC Roustabout's right hand pinching it between the DSA and basket's top rim. The PDC Roustabout sustained a cut to his right-hand middle finger and was treated on-site for his injury.

The PDC Roustabout was evacuated to Gulf Regional Occupational Medical Center (GROMC) located in Abbeville, Louisiana for a medical evaluation. A GROMC doctor diagnosed the PDC Roustabout with a laceration and fracture to his right-hand middle finger. The PDC Roustabout received stitches for the suture and was released to full duty. The PDC Roustabout was assigned to working on stack rigs for PDC.

On 23 March 2020, BSEE Inspectors conducted an incident investigation at the PDC 77B rig located at SMI-223 and gathered all available documentation. The post incident investigation revealed the following:

1) The pre-JSA did not cover landing the basket on the keyway deck. The approved procedure for landing the basket on the keyway deck involved the use of an air hoist. The PDC Crane Operator thought the rest of the PDC crew was using an air hoist to position the basket. The PDC Motorman and PDC Roustabout did not know using the air hoist was part of the procedure. The PDC crew did not use an air hoist while landing the basket in the keyway.
2) The JSA did not cover positioning the basket on the lower deck or using an air hoist.

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

The BSEE incident investigation team determined that the probable causes of the incident were due to:
1). Performed job task not covered in the pre-job safety meeting and not covered in approved work procedure;
2). Improper hand placement by the PDC Roustabout; and
3). Not following correct work procedure for job task.

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

BSEE's investigation into this incident revealed the following contributing causes:
1). Inadequate job briefing and preparations for setting the basket down on the keyway deck;
2). Poor communications between all parties involved in the transfer operations; and
3). The load in the basket was not secured properly during transfer operations.

20. LIST THE ADDITIONAL INFORMATION:

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

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District makes no recommendations to the Office of Incident Investigations 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 Cox Operating, L.L.C., (Cox) failed to oversee that operations were performed in a safe and workmanlike manner on the Parker Drilling Company (PDC) 77B barge rig during well operations at South Marsh Island Block 223. On 21 March 2020, a PDC Roustabout sustained an injury during crane operations. The injury occurred when a crane, with an assist from an air hoist, was lowering a three feet by six feet basket containing a 13.625-inch Double Studded Adapter (DSA) to the keyway deck. The PDC Roustabout had his hand on the top rim of the basket as it landed out on the keyway deck, when the DSA rolled in the basket over his right middle finger. The PDC Roustabout was evacuated to a medical facility as a result of the incident. A doctor diagnosed and treated the PDC Roustabout for a laceration and fracture to his right-hand middle finger.

25. DATE OF ONSITE INVESTIGATION:

23-MAR-2020

26. INVESTIGATION TEAM MEMBERS:

Troy Naquin (On-site and Report Author) / Roy Kuhn (On-site) / Jack Angelle (On-site) /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Robert Ranney

APPROVED DATE: **12-AUG-2020**