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: **04-SEP-2023** TIME: **0900** HOURS
2. OPERATOR: **W & T Offshore, Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Zealous Energy and Environmenta**
   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: **G13808**
   AREA: **HI** LATITUDE:
   BLOCK: **A 379** LONGITUDE:

5. PLATFORM: **B**
   RIG NAME:

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

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[ ] REQUIRED EVACUATION		
[ ] 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.
   - [ ] DECOMMISSIONING
     - [ ] PA [ ] PIPELINE [ ] SITE CLEARANCE
     - [ ] TA [ ] PLATFORM
   - [ ] 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: **390** FT.
11. DISTANCE FROM SHORE: **110** 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:

On September 4, 2023, at 12:15 hours, W&T Offshore (W&T) reported an injury incident occurred at approximately 09:15 hours on High Island (HI) A 379 B platform Lease G 13808. The W&T Safety Manager reported, “the Injured Person (IP) was found, in the NBK-1070 Heater Treater Vessel, unconscious, with shallow breathing, weak pulse, and currently was breathing normal and talking, waiting evacuation to shore base for medical evaluation.”

On September 7, 2023, at approximately 17:30 hours the Bureau of Safety and Environmental Enforcement (BSEE) Lake Jackson District Production Operations Supervisory Inspector, received a call from the Lead Operator at HIA 379 B platform. During the conversation, the Operator stated, “the IP was found in the Heater Treater submersed face down not breathing and no pulse. The Operator stated the Crews performed CPR on IP for approximately 20 minutes before he was revived.”

On September 8, 2023, BSEE Inspectors conducted an on-site investigation at HIA 379 B. The investigation revealed that on September 4, 2023, while pumping fluids from the NBK-1070 Heater Treater vessel, the IP entered the vessel without a Supplied Air Respirator (SAR), and only wearing an Air Purifying Respirator (APR). He was overcome by the fumes in the vessel and passed out face down in the fluids and sludge.

The Pump Operator stated prior to the incident, he noticed the IP with approximately 60 percent of his body inside the hatch opening of the vessel. He looked away to observe the pump. When he looked back in the direction of the vessel, he could not see the IP. After a few minutes of not seeing the IP, the Pump Operator went to vessel and could not locate the IP. He then went to find a flashlight to look inside the dark vessel. The Pump Operator informed the vessel cleaning Crew Supervisor in the Operators office, of the situation, he obtained a flashlight, and they went to the Heater Treater vessel. The cleaning Crew Supervisor looked for the IP inside the vessel after not observing him. He then entered the vessel without a respirator and found the IP face down in the fluid/sludge. While attempting to move the IP toward the hatch opening, the cleaning Crew Supervisor, was overcome by the fumes and had to exit vessel. The Construction Supervisor arrived at the vessel as the Cleaning Crew Supervisor was exiting. The Construction Supervisor made entry without respirator, moved the IP to the hatch opening and attached a rope to him for extraction. When the IP was removed from the vessel, the crew members found the IP not breathing, with no pulse, and began cardiopulmonary resuscitation (CPR) on the IP. After approximately 20 minutes of CPR, the IP began to breath on his own. The IP was flown to the hospital in Galveston, Texas by Medivac helicopter for treatment.

The Investigation revealed the Lessee and their subcontractor Zealous Energy Services, failed to follow their confined space entry plan. No Tri-gas survey was conducted when the Heater Treater vessel hatch was initially opened, and to continuous monitoring for Tri-gas readings. Additionally, the Lessee failed to designate an individual for Hole Watch at hatch opening, have rescue equipment set up at the location of the vessel before and during the cleaning operation. The IP made the vessel entry without the proper permit, and without proper respiratory protection. The two Supervisors made entry to rescue the IP without proper respiratory equipment, because of the equipment not being set up prior to the beginning of vessel cleaning operation as per Lessee’s plan.

Further investigation revealed the Lessee’s initial reporting at 12:15 hours on September 4, 2023, was misleading as to the seriousness of this incident. The Lessee initially reported the IP was found unconscious, with shallow breathing, and a weak pulse. It was relayed that the IP was currently breathing normal, talking, and is awaiting medivac aircraft to take him in for medical evaluation. It was discovered that the Lessee was informed at approximately 10:10 hours that the IP was found in the vessel face down in the fluid/sludge with no pulse, not breathing, and CPR was administered for approximately 20 minutes to revive the IP. On September 4, 2023, the lake Jackson District Accident Investigator contacted the Lessee at 19:00 hours for an update and was told the IP is fine and is being released to full duty. The Lessee never stated the seriousness of the IP’s condition, and failed to mention the IP was

in the Intensive Care Unit for a period of three (3) days. It wasn't until 17:30 hours on September 7, 2023, after Lake Jackson Accident Investigator contacted the Lessee, that he learned the IP was in Intense Care Unit for three (3) days before being released.

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

Lessee and Subcontractor failure to follow Confined Space Entry Plan.
- Failure to conduct Tri-Gas testing and continuous monitoring.
- Crew member making entry into vessel without permit.
- No Hole Watch identified and posted at hatch opening.
- Stop Work Authority not used.
- Improper Personal Protective Equipment.

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

Failed to have rescue equipment set up and at the location of the vessel before and during the cleaning operation.
PIC not trained in Confined Space Entry yet is responsible issuing the permit.
No vetting of personnel for specific job qualifications.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: **None**

NATURE OF DAMAGE: **None**

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

- Ensure all Subcontractors ahere to work plans.
- Ensure all Company and Subcontracted personnel are properly trained before prior to task/work is started.
- Ensure accurrate incident reporting is made, to include follow up reports.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 C 250.107
Lessee failed to perform all operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment. The investigation of the injury incident that occurred on 9-4-2023 revealed the Lessee and its Subcontractors failed to ensure their Vessel cleaning plan was executed safely by the following:
- No Tri-Gas (O2, H2S, LEL) initial and continuous monitoring conducted.
- No Hole watch individual identified as assigned at hatch opening.
- Personal Protective Equipment was not used properly or appropriate for task being conducted.
- Rescue equipment was not set up at location of vessel before and during the cleaning operation.
- Crew member making entry into vessel without proper entry permit.
- Stop work authority was not used.
- PIC responsible for issuing the work permit was not trained in confined space entry.
- Vetting of personnel for specific job qualifications was not conducted appropriately.

G-132 W 250.189

Lessee failed to verbally notify the Lake Jackson District immediately following incidents involving all injuries requiring evacuation connected with any operations or activities on a lease. Investigation of the injury incident that occurred on 9-4-2023 revealed Lessee's initial and update reporting on the day of the incident, failed to report the severity of the incident to Lake Jackson District in accurate and timely manner.

For Public Release

25. DATE OF ONSITE INVESTIGATION:

08-SEP-2023

26. Investigation Team Members/Panel Members:

Steven Cline /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Stephen Martinez

APPROVED DATE: **27-NOV-2023**