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

For Public Release

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **22-NOV-2023** TIME: **1130** HOURS

2. OPERATOR: **Cox Operating, L.L.C.**
   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: **G05753**
   AREA: **MO** LATITUDE:
   BLOCK: **916** LONGITUDE:

5. PLATFORM: **AP**
   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.
- [ ] DECOMMISSIONING
  - [ ] PA [ ] PIPELINE [ ] SITE CLEARANCE
  - [ ] TA [ ] PLATFORM
- [X] OTHER **Construction**

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: **61** FT.

11. DISTANCE FROM SHORE: **9** 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 22 November 2023, an incident occurred on a production platform owned and operating by Cox Operating, L.L.C. (Cox). Mobile 916 Platform "AP" is located approximately nine miles offshore in the Gulf of Mexico (GoM) in a water depth of 61 feet. The incident occurred when a contract construction worker with Burner Fire Control (Burner) was guiding a section of piping from an elevated pipe rack to the lower deck via rope. As the piping was being lowered, the Injured Person's (IP) hand was pinched between the pipe and a support beam. The job was immediately stopped, and platform personnel administered basic first aid to the IP. However, it was determined that treatment beyond first aid was needed, and the IP was evacuated from the facility.

SEQUENCE OF EVENTS:

On 22 November 2023 at approximately 0630 hours, construction crewmembers with Burner began their day with a Job Safety Analysis meeting to identify all potential hazards associated with the removal of two-inch airline piping located on the cellar deck. The crew then inspected all tools and equipment to be used for the job. The area on the cellar deck where the demolition work was being performed was flagged off to prevent all non-essential personnel from entering the work area. Once it was verified that the piping was isolated, bled down, and safe to remove, construction crewmembers began dismantling sections of piping for removal.

At approximately 1125 hours, as crewmembers were lowering an eight-foot section of the two-inch piping from the elevated pipe rack, the pipe shifted causing the IP's finger to be caught between the piping and an I-beam. A "Stop Work" was immediately called, and the IP reported to the supervisor and Person-In-Charge (PIC). The IP's finger was assessed by the PIC and placed in a taped splint. Arrangements were made to have the IP flown from the facility via helicopter and transported to an onshore medical facility for further evaluation. The IP was evaluated by medical personnel and diagnosed with a fractured right index finger. A follow-up appointment was scheduled for 1 December 2023, and the IP was sent home to rest and recover and not released to return to work until cleared by the physician.

BSEE INVESTIGATION:

On 22 November 2023 at 1213 hours, the BSEE Accident Investigator (AI) with the New Orleans District (NOD) received a phone call from a Cox Safety Manager informing the AI of a construction worker that was being sent in due to a finger injury sustained while working offshore. Details of the incident were vague at the time; however, the AI was informed that the IP may have broken his finger and needed to be sent to an onshore medical facility for further evaluation. The IP was wearing leather impact gloves at the time of the incident.

On 28 November 2023, Cox submitted an incident report to BSEE of the incident that occurred on 22 November 2023. The report stated that construction crews were in the process of removing and lowering an eight-foot section of two-inch diameter airline piping from an elevated pipe rack when the IP's finger was pinched between the pipe and a nearby beam. The job was stopped, and the IP was sent in for evaluation at an onshore medical facility where he was diagnosed with a fractured right index finger.

On 29 November 2023 at 0835 hours, the BSEE AI sent an email to Cox's safety manager with a list of documents and other pertinent information being requested. Cox responded with an email at 1351 hours containing photographs, Personnel on Board (POB), Job Safety Environmental Analysis, Safety Environmental Management System :

Safety Meeting Form and Fall Protection Policy, Internal Incident Report, and Witness Incident Statements. The IP had a follow-up appointment with medical providers on 1 December 2023 where it was determined that surgery was not required. However, it would be approximately four to six weeks before the IP would be released back to work duty, categorizing this incident as a Loss Time Accident (LTA) of greater than three days.

CONCLUSIONS:

After thoroughly reviewing the associated documents that Cox provided, the BSEE AI determined that lack of communication was a key factor in this incident. As the eight-foot section of the two-inch diameter piping was being lowered, the IP and the construction crewmembers involved did not communicate properly. This led to the shifting of the pipe while being lowered, which subsequently caused the IP's finger to become trapped between the piping and beam. Had all crewmembers adequately communicated hand placement and operational intent, the section of piping could have been safely lowered without incident. It was also determined that inadequate supervision was a contributing factor to the incident.

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

• Communication – Inadequate communication between personnel: While lowering the section of piping, crewmembers involved did not communicate properly resulting in an individual being injured.

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

• Supervision – No or inadequate supervision: Lack of supervision was found to be a contributing factor to the incident. This resulted in the piping shifting as it was being lowered, causing the IP's finger to become pinched between the piping and an adjacent beam.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

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:

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

26. Investigation Team Members/Panel Members:
Nathan Bradley /

29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

27. OPERATOR REPORT ON FILE:

OCS REPORT:

30. DISTRICT SUPERVISOR:
David Trocquet

APPROVED DATE: **29-JAN-2024**