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: **09-DEC-2021** TIME: **1030** HOURS
2. OPERATOR: **Cox Operating, L.L.C.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   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: **G02323**
   AREA: **EI** LATITUDE:
   BLOCK: **360** LONGITUDE:

5. PLATFORM: **E**
   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.
- [ ] 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: **307** FT.
11. DISTANCE FROM SHORE: **77** 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 9 December 2021, at approximately 1030 hours, an injury occurred on Cox Operating (Cox) L.L.C.'s OCS-G02323 Eugene Island (EI) 360-E Facility. A Danos rigger was injured (IE Injured Employee) while attempting to assist a Quality Construction and Production (QCP) rigger with laying down a large pulley with the platform crane. A Danos Crane Operator (DCO) was attempting to move a pulley weighing approximately 1,000 pounds, to another area of the facility. This incident was a Lost Time Accident (LTA) greater than three days, and the employee was evacuated to an onshore medical facility. An Incident of Noncompliance was issued due to this incident.

Sequence of Events:

On 9 December 2021, a DCO was attempting to move a pulley weighing approximately 1,000 pounds, to another area of the facility. The DCO, a QCP rigger, and the IE were all involved during the lift and filled out a Job Safety Analyses (JSA) but did not discuss how the pulley would be placed on the deck. The DCO intended to lay the pulley down horizontally on the deck with the crane. As the DCO lowered the pulley to the deck, the QCP rigger unhooked the strap from the pulley while the pulley was in the vertical position. The DCO had a clear view of the pulley and left the crane cab to discuss placing the pulley horizontally on the deck with the crane. As the QCP rigger unstrapped the pulley, he pushed the top of the pulley so it would drop horizontally to the deck. The IE moved forward placing his left foot in the path of the pulley as it fell. The pulley contacted the IE's left foot above the steel tip of the boot injuring three of the IE's toes.

The IE was transported by helicopter to an onshore medical facility for additional treatment. The employee suffered a fractured big toe and two dislocated toes. Surgery was required to repair the big toe. Part of the big toe was amputated.

BSEE INVESTIGATION:
On 9 December 2021, a Bureau of Safety & Environmental Enforcement (BSEE) Lafayette District (LD) Accident Investigator (AI) received a phone call notification of an incident with injury occurring on Cox's EI 360-E Facility. The AI requested additional information pertaining to the incident such as JSAs, Operating Practices, and other relevant documents from Cox and its contractor.

On 15 December 2021, the BSEE LD AI and a BSEE LD Production Inspector performed an on-site investigation of the event. During the on-site investigation, photographic documentation of the incident location was taken, procedures were requested, and witness statements of relevant personnel were taken.

The AI found that stop work should have been implemented as a potential hazard was introduced when the QCP rigger unhooked the strap before laying the pulley horizontally with the crane. The AI researched into API Recommended Practices 2D 3.1.5 and found "a. The Qualified Crane Operator (herein also called Crane Operator) is responsible for those operations under his or her direct control. Whenever there is any doubt as to safety, the Crane Operator should have the authority to stop and refuse to handle loads or continue operations as safety dictates."

The IE had a total of 7 months total rigging experience but less than 6 months' work experience at EI 360-E.

CONCLUSION:

BSEE found that the probable cause of the injury was a failure to discuss how the pulley would be lowered to the deck during the pre-job safety meeting and implementing stop work.

BSEE found that the contributing cause of the injury was failure to follow Cox's Safety Environmental Management System Crane Operations Policy General Operating Practices – The Crane Operator Responsibilities sections e and i, and API RD 2D 3.1.5 Operating Practices.

The following itemized bullets include, but do not limit, contributing/causal factors of the incident:

- **The DCO failed to stop operations due to safety concerns as the riggers unhooked the pulley before the DCO could lower the pulley horizontally to the deck as per API RP 2D 3.1.5 Operating Practices**
- **The employees failed to discuss how the load would be placed on the deck during the pre-job safety meeting.**
- **The employees failed to utilize stop work authority as per the Cox's JSA dated December 9, 2021.**

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

- **Human Performance Error- Not following proper procedure: As per the Job Safety Analysis (JSA), stop work should have been implemented and the JSA revised as the Crane Operator considered potential hazards when the rigger unhooked the pulley while in the vertical position.**
- **Human Performance Error: Inattention to task: The QCP rigger unstrapped the 1,000 lbs. pulley that was standing vertically and pushed it from the top to lay it down without communicating his intent to the IE prior to the incident.**

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

- **Management Systems- Inadequate Hazard Analysis: Personnel failed to follow the Safety Environmental Management System Crane Operations Policy General Operating Practices:**

1. The crane operator shall review the JSA as a pre-lift discussion with all personnel involved in the upcoming lifting operation.
2. The crane operator shall have the authority to stop the operation if unsafe conditions develop.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: **None** NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL): **$** **NA**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District office makes no recommendations to the Regional Office of Incident Investigations (OII).

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 C 107(a)
On December 9, 2021, Cox Operating, LLC failed to perform operations in a safe and workmanlike manner as follows: An employee was injured (IE) while attempting to lay down a large pulley with the platform crane. A crane operator was attempting to move a pulley weighing approximately 1000 pounds, to another area of the facility. The crane operator and the employees involved during the lift filled out a Job Safety Analyses (JSA) but did not discuss how the pulley would be placed on the deck. The crane operator intended to lay the pulley down horizontally on the deck with the crane. As the crane operator lowered the pulley to the deck, one of the two riggers unhooked the strap from the pulley while the pulley was in the vertical position. The crane operator had a clear view of the pulley and left the crane cab to discuss placing the pulley horizontally on the deck with the crane. As the rigger unstrapped the pulley, he pushed the top of the pulley so it would drop horizontally to the deck. The IE moved to avoid the falling pulley, but the pulley rolled slightly toward the IE before falling. The IE failed to realize his left foot was in the path of the pulley as it fell. The pulley contacted the IE's left foot above the steel tip of the boot injuring three of the IE's

The injured employee was transported by helicopter to a medical facility for additional treatment. The employee suffered a fractured big toe and two dislocated toes. Surgery was required to repair the big toe. Due to complications following the surgery, part of the big toe was amputated.

25. DATE OF ONSITE INVESTIGATION:

15-DEC-2021

26. INVESTIGATION TEAM MEMBERS:

Toby Ware / Wade Guillotte /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR: **Mark Malbrue**

APPROVED DATE: **16-MAR-2022**