## 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:		STRUCTURAL DAMAGE	
	11-SEP-2017 TIME: 1138 HOURS		CRANE	
			OTHER LIFTING DEVICE	
2.	OPERATOR: Energy Resource Technology GOM, L	1	DAMAGED/DISABLED SAFETY SYS.	
	REPRESENTATIVE:		INCIDENT >\$25K	
	TELEPHONE:		H2S/15MIN./20PPM	
	CONTRACTOR:		REQUIRED MUSTER	
	REPRESENTATIVE:		SHUTDOWN FROM GAS RELEASE	
	TELEPHONE:		OTHER	
			L OTHER	
3.	OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR	c		
	ON SITE AT TIME OF INCIDENT:	ь.	OPERATION:	
			X PRODUCTION DRILLING	
4.	LEASE: G02280		WORKOVER	
	AREA: SM LATITUDE:		COMPLETION	
	BLOCK: 130 LONGITUDE:		HELICOPTER	
			MOTOR VESSEL	
5.	PLATFORM: A		PIPELINE SEGMENT NO.	
	RIG NAME:		OTHER	
б.	ACTIVITY: EXPLORATION(POE)	8.	CAUSE:	
	X DEVELOPMENT/PRODUCTION			
	(DOCD/POD)		EQUIPMENT FAILURE X HUMAN ERROR	
7.	TYPE:		EXTERNAL DAMAGE	
	HISTORIC INJURY		SLIP/TRIP/FALL	
	X REQUIRED EVACUATION 1		WEATHER RELATED	
	LTA (1-3 days)		LEAK	
	LTA (>3 days		UPSET H20 TREATING	
	RW/JT (1-3 days)		OVERBOARD DRILLING FLUID	
	RW/JT (>3 days)		OTHER	
	Other Injury		·····	
	T FATALITY	9.	. WATER DEPTH: 215 FT.	
	POLLUTION			
	FIRE	10.	. DISTANCE FROM SHORE: 78 MI.	
	EXPLOSION			
		11.	. WIND DIRECTION:	
	LWC HISTORIC BLOWOUT		SPEED: M.P.H.	
	UNDERGROUND SURFACE			
	DEVERTER	12.	. CURRENT DIRECTION:	
	SURFACE EQUIPMENT FAILURE OR PROCEDURES		SPEED: M.P.H.	
	COLLISION HISTORIC >\$25K <-\$25K	13.	. SEA STATE: FT.	

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On September 11, 2017 at approximately 1138 hours, an employee severed a fingertip while attempting to relocate a compressor head without the use of an overhead hoist. The Injured Employee (IE) was administered first aid then evacuated via helicopter to a medical facility. BSEE was notified of the incident on the same day (September 11, 2017).

On September 11, 2017, the (IE) was assisting the compressor mechanic in changing the heads on the compressor. The compressor heads were removed utilizing the overhead hoist and placed on the floor of the compressor building. Additional room was needed to place the remaining compressor heads in the compressor building. In an attempt to make space, the IE tilted a compressor head on its side using a piece of 1" pipe connected to the top of the compressor head and walked it to a different location. When the IE attempted to lower the compressor head, the weight of the compressor head fell, the IE's left index finger was caught between the 1" pipe and a compressor head located on the floor.

As the IE removed his impact resistant gloves, he discovered the tip of his left index finger had been severed. The IE was transported to a medical facility for treatment. Prior to the work being performed, a Job Safety Analysis (JSA) was completed which included the task steps, potential hazards and the hazard controls that were specific to the task being performed. If the IE would have followed the task steps and hazard controls as documented on the JSA by utilizing the overhead chain hoist to relocate the compressor heads the incident would have been avoided.

On September 12, 2017, The BSEE Lafayette District conducted an onsite investigation.

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

The probable cause of the accident is not using the proper tools for the task. The IE did not follow the task steps and hazard controls as documented on the JSA by utilizing the overhead chain hoist to relocate the compressor heads.

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

20. LIST THE ADDITIONAL INFORMATION:

EV2010R

none

NATURE OF DAMAGE:

NA

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ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

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

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23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G110 (W) Does the Lessee perform all operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment? The Lessee failed to protect an employee during a compressor repair by failing to adhere to the procedures on the Job Safety Analysis resulting in severe injuries to an employee.

As per the Task Steps located on the Job Safety Analysis form, the injured employee should have utilized the overhead chain hoist to relocate the compressor heads which could have alleviated the possibility of coming in contact with sharp edges or a pinch point.

25. DATE OF ONSITE INVESTIGATION: 28.

 12-SEP-2017
 29. ACCIDENT INVESTIGATION PANEL FORMED: NO

 26. ONSITE TEAM MEMBERS:
 OCS REPORT:

 / Toby Ware / John Mouton / Wade Guillotte /
 OCS REPORT:

 30. DISTRICT SUPERVISOR:

APPROVED DATE: 17-OCT-2017

Elliott Smith

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