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: **07-FEB-2024** TIME: **0855** HOURS
2. OPERATOR: **Williams Oil Gathering, L.L.C.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Danos & Curole Marine 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:
   AREA: **GA** LATITUDE:
   BLOCK: **A 244** LONGITUDE:

5. PLATFORM: **JP**
   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:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] DECOMMISSIONING
     - [ ] PA [ ] PIPELINE [ ] SITE CLEARANCE
     - [ ] TA [ ] PLATFORM
   - [X] OTHER

9. CAUSE:
   - [X] EQUIPMENT FAILURE
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [X] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER _____

10. WATER DEPTH: **363** FT.
11. DISTANCE FROM SHORE: **74** 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:

17. INVESTIGATION FINDINGS:

Incident Summary:
On February 7, 2024, at approximately 09:30 am, a loss time injury occurred during construction operations on the Galveston (GA) A 244 JP, Right of Way, operated by Williams Oil Gathering, the injury was a result of an inadequately built scaffolding ladder attached to the ExxonMobil Pipeline Company (EMPCO) Motor Control Center (MCC)/Control Building (ZZZ-006).

Sequence of Key Events:

The Danos personnel were contracted by EMPCO to replace an air conditioning (A/C) stack/unit on the EMPCO MCC/Control Building (ZZZ-006). A scaffolding ladder with a Self-Retracting Lanyard (SRL) was erected by Danos on the southwest corner of the EMPCO MCC Building so personnel could access the A/C stack. The ladder was not being used and Danos construction personnel needed the SRL in another area on the platform. After confirmation from EMPCO personnel the ladder was not in use a Danos scaffold builder removed the SRL and the scaffold tag from the scaffolding ladder, placing it out of service (OOS) on January 1, 2024, and it remained OOS up until the incident occurrence. No identifying tags or red tape was used to "mark/identify" the scaffolding ladder being placed OOS. On February 7, 2024, at 06:30 am two Danos Job Safety Analysis (JSA's)Crane & Demo with power tools, an Exxon Work Permit, and Job Loss Analysis(JLA) were created. Each of the permits created did not mention working from heights. Each JSA was signed only by their respective personnel i.e., Danos personnel on Danos with Danos personnel not on Williams or ExxonMobil other contractor JSA's.

On February 7, 2024,the Danos crane operator observed the Injured Person (IP) talking to personnel bolting the new A/C stack/unit to the EMPCO building. He also observed the IP going to an equipment tool room and get a Fall Arrest Harness(harness)and attempt to climb the OOS scaffolding ladder. He stated the IP climbed to the 3rd rung of the ladder when the ladder shifted, witnessing the IP jumping to the deck. The crane operator witnessed the IP raising his hands, noticing he couldn't get up. The crane operator locked the crane down to check on the IP. It was then noticed the IP had sustained injuries to the lower half of both legs. The platform personnel started to arrive where the injury took place, helping the IP across the deck to an area where he could be sat upright leaning against a deck box. The IP attempted to walk but was unsuccessful. After approximately two hours the Search and Rescue (SAR) helicopter arrived. The IP was secured in the stokes litter and lifted to the helideck using the crane. The IP was transported to University of Texas Medical Branch (UTMB)Galveston.

BSEE Investigation:

During the BSEE investigation, there were several equipment-related issues that contributed to the injury. Firstly, there was a harness being used with a tag that stated it was only to be used within a certain weight capacity range. Next, the fall arrest equipment that was being used with the harness was rated for a higher weight capacity than the harness and was not attached correctly. Additionally, there was no inspection records available for the harness and associated fall arrest equipment being used. Secondly, the scaffolding ladder being used had several issues as well. It was built and attached to the building with only one attachment point at the top and bottom, and there were no tags indicating the load rating or status of the ladder. Furthermore, the ladder was not being used for a few days and the inspection/ approval tag was removed, rendering it OOS. Finally, the SRL was removed from the top of the scaffold ladder/work area to be used in another area of the platform, which further exacerbated the ladder's unsafe condition.

The Platform Right of Way is operated by Williams Oil Gathering (Person in Charge (PIC) is a Williams representative) with Exxon personnel onboard the platform. Interestingly, the PIC for the platform was not involved with either Exxon's or Danos's JSA process, nor were they involved in the inspection process of the scaffolding ladder. It was later discovered that no discussion of working at heights or the requirement for a job hazard analysis was performed because there was not supposed to be any working at heights to be done on the day of the injury. Additionally, there is no bridging document between Exxon and Williams companies.

During the investigation, requested Exxon work permits for working at heights, & the response given was, "Please note that the work being performed at the time of the incident did not require the use of a ladder, or access to scaffolding, & working at heights." It is also worth noting that comments made by platform personnel was that no working at heights was discussed during any meetings or work permit approvals. Without a statement from the IP, it is unknown as to why he decided to climb the ladder. Although, witness statements say, "As he was climbing up to look where they can hook up on top of the building the scaffold ladder clamps released at the top causing the ladder to fall back."

In a typical scaffolding building process tags are usually accompanied with each item constructed, no tags associated with this scaffolding could be presented to investigators showing this ladder was inspected and maintained. During the BSEE investigation, one statement made is that the scaffold builder removed the SRL and tag at the same time. Not having these maintenance records/tags indicate the ladder was not being properly maintained or inspected. Once the tag and SRL was removed there were no other visual identifiers letting platform personnel know this scaffolding ladder was placed OOS.

The BSEE Investigation team also found that when platform personnel realized the IP had a broken leg and ankle he was stabilized then search and rescue (SAR) operators were contacted to assist.
The SAR times are of serious concern. One individual included in his statement that "The helicopter arrived two hours after being called." All SAR assets come from Louisiana and the incident occurred off the coast of Texas.

BSEE Investigation team also found during the investigation that depending upon subscriber level will depend on the appropriate SAR helicopter and crew (Medic or Hoist capability).Regarding the evacuation of the IP from the platform, it took over two hours for the IP to be evacuated. The IP had broken his leg and ankle and was unable to walk, so he was assisted to the helideck and placed in the platform stokes litter. It should be noted that the IP was not stabilized on a backboard, neck brace or splint prior to his evacuation from the platform. Research conducted by BSEE Investigation team found that one SAR company who provides a subscription service stated, "Depending on the platform subscribers tier level with SAR companies, the allowed SAR asset varies. If a Sikorsky S76 has been dispatched, a medic is onboard, and they can only land on a 12-kip deck and larger helideck but are not capable of hoist recoveries. Alternatively, if the AgustaWestland AW139 has been dispatched, it is hoist capable, can only land on 15-kip decks, and has a medic and swimmer onboard.

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

Equipment failure:
Inadequate preventative maintenance has been identified in the maintenance and inspection of built scaffolding on this facility.
Inadequate equipment inspection operators were not involved in the inspection process of the scaffolding ladder.

Flawed equipment construction the scaffold ladder anchor points were unconventional & not best practices. The scaffolding ladder had only two attached anchor points which contributed to its instability.
The legs of the ladder were not on the same plane as the platform deck, allowing some means to stabilize the ladder from unequal deflection which contributed to its instability.
Inadequate out of service tags for equipment there was no other visual identifiers letting platform personnel know this scaffolding ladder was placed OOS.
Human Performance Error:
Inadequate knowledge of equipment status
Not aware of hazards
Not following proper procedures been identified in the building procedures for scaffolding ladders.
Work Environment:
Poor layout or design of work area.
Prior to job equipment was not inspected.
Prior to job improper selection of safety equipment

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

Communication:
Inadequate communication between operator and platform personnel/contractors.
Management Systems:
No bridging documents between operators and contractors.
Supervision :
Inadequate approval of work permits from platform lease operators not having any input into other JSA's created by other contractors.
No pre-job safety meeting between all parties were four separate work permits created. One for Williams Pipeline (Work Permit), two for Danos (JSA), and one for EMPCO (JLA). Each contractor did not sign the other contractors JSA or were part of their respective toolbox/safety meeting on the platform.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

No damage to property or equipment was observed at the time of the investigation.

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lake Jackson District and the Office of Incident Investigations recommend that all operators review or revisit Safety Alert No. 469 (BSEE Identifies Medical Evacuation and Emergency Hazards During Risk-Based Inspections).

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

26. Investigation Team Members/Panel Members:

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

MINOR

29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Stephen Martinez

APPROVED DATE: **22-JUL-2024**