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: **20-MAR-2024** TIME: **0700** HOURS

2. OPERATOR: **Talos ERT LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **SCHLUMBERGER**
   REPRESENTATIVE:
   TELEPHONE:

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:

4. LEASE: **G26664**
   AREA: **GB** LATITUDE:
   BLOCK: **506** LONGITUDE:

5. PLATFORM:
   RIG NAME: **HELIX Q-4000**

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)		
[ ] LTA (>3 days)		
[ ] RW/JT (1-3 days)		
[X] RW/JT (>3 days)	**0**	**1**
[ ] FATALITY		
[ ] Other Injury		

   - [ ] POLLUTION
   - [ ] FIRE
   - [ ] EXPLOSION

   LWC
   - [ ] HISTORIC BLOWOUT
   - [ ] UNDERGROUND
   - [ ] SURFACE
   - [ ] DEVERTER
   - [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES

   COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **Coil Tubing**
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

8. OPERATION:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [X] 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: **2249** FT.
11. DISTANCE FROM SHORE: **131** MI.
12. WIND DIRECTION: **ESE**
    SPEED: **12** M.P.H.
13. CURRENT DIRECTION:
    SPEED: M.P.H.
14. SEA STATE: **3** FT.
15. PICTURES TAKEN: **YES**
16. STATEMENT TAKEN: **YES**

Incident Summary:
On 20 March 2024, at approximately 0705 hours, a shoulder injury occurred on the Helix Energy Solutions Q-4000 semisubmersible vessel during well workover (enhance production) operations for Talos ERT LLC (Talos) at Garden Banks (GB) Block 506.

Sequence of Events:
On 20 March 2024, a Schlumberger Pump Operator, the Injured Party (IP), sustained a left shoulder injury while attempting to jump across from the Coil Tubing Control Cabin onto the Coil Tubing Reel Platform located about 12 feet in height above the deck to install the Universal Tubing Length Monitor (UTLM) onto the Coil Tubing Guide Counter Head. During the transition over the four-foot gap with a one-foot eight-inch rise in elevation, the IP lost his footing, and started to fall from the Coil Tubing Cabin. As he was falling, he grabbed the Coil Tubing Cabin crash frame with his left hand injuring his left shoulder. The IP was evacuated from the Helix Q-4000 for onshore medical evaluation at 1010 hours on a medevac helicopter. The IP was diagnosed with a dislocated shoulder and a torn labrum. He was released to restricted work duty.

BSEE Investigation:
On 20 March 2024, the Bureau of Safety and Environmental Enforcement (BSEE) Lafayette District conducted an onsite Incident Follow-up Investigation on the Helix Q-4000. BSEE met with Talos representatives and gathered incident related documents including Schlumberger Job Safety Analysis, Schlumberger Permit to Work, Schlumberger photographic documentation, and witness statements. BSEE inspected and conducted photographic documentation of the incident scene. BSEE learned that at the time of the incident, the IP was wearing a fall protection harness attached with a self-retracting lanyard for vertical fall protection.

The BSEE Incident Investigation Team concluded that the IP failed to follow the Schlumberger working at heights Job Safety Analysis. The Job Safety Analysis called for the use of a ladder to access the Coil Tubing Guide Counter. The IP made the decision to jump from the Coil Tubing Control Cabin to the Coil Tubing Reel Platform.

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

Human Performance Error: The BSEE Incident Investigation Team determined that the probable cause of the incident was due to human error/poor judgement by the Schlumberger Pump Operator, the IP, who attempted to jump across a 4-foot gap to the Coil Tubing Reel Platform from the Coil Tubing Cabin.

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

Management Systems: BSEE’s investigation into this incident identified that the Schlumberger Pump Operator, the IP, failed to follow working at heights requirements as stated in the Working at Heights section of the Job Safety Analysis that included making use of a ladder of adequate height.

20. LIST THE ADDITIONAL INFORMATION:

List of Appendices:

21. PROPERTY DAMAGED:

No property was damaged during this incident.

NATURE OF DAMAGE:

Not applicable.

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District makes no recommendations to the Office of Incident Investigations regarding this incident.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

A G-110 Incident of Non-Compliance was issued on 2 April 2024 to document that Talos ERT LLC Corporation (Talos) failed to comply with the regulatory requirement to operate in a safe and workmanlike manner. On 20 March 2024, a Schlumberger Pump Operator injured his left shoulder while attempting to cross over from the Coil Tubing Control Cabin onto the Coil Tubing Reel Platform without the use of a required ladder as stated in the Job Safety Analysis. On 20 March 2024, Lafayette District BSEE Inspectors arrived on location and conducted an Incident Follow-up Investigation. BSEE discovered that the Schlumberger Pump Operator, the Injured Person (IP), had stepped outside of the Coil Tubing Cabin crash frame while attached to a fall protection harness with a Self-Retracting Lanyard and attempted to cross over onto the Coil Tubing Reel platform to install the Encoder (UTLM) onto the Coil Tubing Guide Counter Head. During the transition over the four-foot gap with a one-foot eight-inch rise in elevation, the IP lost his footing, started to fall from the Coil Tubing Cabin and during the fall, he grabbed the Coil Tubing Cabin crash with his left hand injuring his left shoulder. The IP required evacuation from the Helix Q-4000 for onshore medical evaluation and required medical treatment beyond first aid.

Talos ERT LLC must provide a letter of explanation within 14 days to the Lafayette District Well Operations Supervisor on the above Incident of Noncompliance along with its plans to prevent any future incidents of this nature.

25. DATE OF ONSITE INVESTIGATION:

20-MAR-2024

28. ACCIDENT CLASSIFICATION:

26. Investigation Team Members/Panel Members:

29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR:

Mark Malbrue

APPROVED DATE: **20-JUN-2024**