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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **20-JUL-2024** TIME: **2200** HOURS

2. OPERATOR: **Talos ERT LLC**
   REPRESENTATIVE:
   TELEPHONE: CONTRACTOR: **DHD Offshore Services** 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: **G01023**
   AREA: **SS** LATITUDE:
   BLOCK: **224** LONGITUDE:

5. PLATFORM: **D**
   RIG NAME:

6. ACTIVITY:
- [ ] EXPLORATION(POE)
- [X] DEVELOPMENT/PRODUCTION (DOCD/POD)
- [X] DECOMMISSIONING

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
- [X] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER
- [ ] TEMP ABAND
- [X] PERM ABAND
- [ ] DECOM PIPELINE
- [ ] DECOM FACILITY
- [ ] SITE CLEARANCE

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: **156** FT.

11. DISTANCE FROM SHORE: **46** 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:

On July 20, 2024, an injury requiring the evacuation of the Injured Person (IP) occurred at Ship Shoal 224 D platform, at OCS-G01023, owned by Talos ERT LLC. At the time of the incident, abandonment operations were being conducted on Well D005. The IP, who was working as a rigger, was helping recover a casing cutter tool (CCT) from the wellbore. While guiding the tool through the decks, the IP placed his hand on the crane block. His right hand was caught between the crane cable and the crane block sheave resulting in lacerations to his ring finger and partial amputation of his pinky finger.

On the night of July 20, 2024, abandonment operations were scheduled to take place. Job Safety Analyses (JSA) were performed for the following tasks: Abrasive Cutting Operations, Crane Ops for night shift 1800-0600, General Work on Deck and Removing Conductors. Wire rope slings were attached to the CCT and married into the umbilical every 50'. The crane block was lowered through the decks to launch the tool. Note: In order to launch and recover the CCT, the IP was positioned on the main deck, while a second rigger (R1) was positioned on a lower deck.

The IP and R1 were posted in these positions to keep the crane cable, crane block, wire rope slings and umbilical from rubbing on the grating and I-beams on each deck. The IP was using his hands to guide the crane block through the deck opening when his ring finger and pinky finger on his right hand were caught between the crane cable and the crane block sheave.

Once the IP realized his fingers were caught in the sheave and cable of the crane, he called for the crane to stop. Another member of the casing cutting team heard the IP yell out in pain. When he noticed the IP's hand caught in the sheave, he ran over to another team member with a radio and called for an all stop. He then instructed the crane operator (CO) to lower the block until the IP's hand was free from the block. The IP was taken to the galley for evaluation. The decision was made to evacuate him for further medical treatment. All operations were shut down for investigation and a stand-down was held. The focus of the stand-down was line of fire and hand placement during crane operations. Additional wire rope slings were added to the rigging to prevent the crane block from having to be lowered through the opening in the deck. Personnel were reminded to keep radio communications clear and to use the buddy system.

The Bureau of Safety and Environmental Enforcement (BSEE) Houma District office was notified orally and a written report was submitted in eWell within 15 days. The BSEE Houma District inspectors performed an onsite investigation on July 23, 2024, to gather additional documentation, pictures, and witness statements.

JSA's were completed for Abrasive Cutting Operations, Crane Ops for night shift 1800-0600, General Work on Deck, and Removing Conductors. Although blind lifts and hand placement was discussed in the pre-tour meeting, these hazards were not identified in any JSA used that night. All lifts were blind lifts due to the lift boat being jacked-up to the top of its legs. The top deck of the platform was higher than the crane cab on the lift boat's crane, therefore all lifts required the use of radios. The operator did not enforce its Safe Operating Practices (TSOP-PCD-50) Material Handling and the IP did not follow this policy. The operator's Material Handling policy specifies using push poles to guide suspended loads. It was also noted that the IP is a certified rigger.

Upon reviewing pictures, documents, incident reports, and witness statements, BSEE concluded that the IP guiding the load with his hands contributed significantly to this incident. The JSA's did not identify the hazard of being caught between the crane's cable and sheave. Also, Stop Work Authority (SWA) was not used when the IP started guiding the load with his hands instead of a push pole. SWA was used, but

only after the IP's hand was caught between the crane's cable and sheave.

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

Supervision – The operator did not enforce the use of push poles to guide suspended loads as per their policy - Safe Operating Practices (TSOP-PCD-50) Material Handling.

Human error performance – IP used his hands to guide the load instead of using push poles.

Human error performance - IP was not aware of the pinch between the crane's cable and sheave.

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

Communication – The JSA's were inadequate because they did not identify the hazard of blind lifts or the pinch point between the crane's cable and sheave.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Houma District has no recommendations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

23-JUL-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:

Amy Gresham

APPROVED DATE: **09-DEC-2024**