UNITED STATES DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
DATE: **10-FEB-2006** TIME: **0800** HOURS

2. OPERATOR: **BP Exploration & Production Inc.**
REPRESENTATIVE: **Teri Halverson**
TELEPHONE: **(281) 366-6292**
CONTRACTOR:
REPRESENTATIVE:
TELEPHONE:

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

4. LEASE: **00838**
AREA: **WD** LATITUDE:
BLOCK: **71** LONGITUDE:

5. PLATFORM: **Y**
RIG NAME:

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

7. TYPE:
- [X] HISTORIC INJURY
  - [ ] REQUIRED EVACUATION
  - [ ] LTA (1-3 days)
  - [ ] LTA (>3 days
  - [ ] RW/JT (1-3 days)
  - [ ] RW/JT (>3 days)
  - [ ] Other Injury
- [ ] FATALITY **0**
- [ ] POLLUTION
- [ ] FIRE
- [ ] EXPLOSION
- LWC
  - [ ] HISTORIC BLOWOUT
  - [ ] UNDERGROUND
  - [ ] SURFACE
  - [ ] DEVERTER
  - [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES
- COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K
- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [ ] OTHER LIFTING DEVICE
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

6. OPERATION:
- [X] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER

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

9. WATER DEPTH: **149** FT.

10. DISTANCE FROM SHORE: **23** MI.

11. WIND DIRECTION: **SSE**
SPEED: **15** M.P.H.

12. CURRENT DIRECTION:
SPEED: M.P.H.

13. SEA STATE: **5** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

Sequence of Events Leading Up To the Incident:

Following Hurricane Katrina (August 29, 2005), the Shelf had significant damage to its assets. A number of platforms were under water and the focus shifted from production to repair and decommissioning. Preliminary site assessments were conducted to establish the extent of the platform damage. The site assessment teams were provided a Safe Boarding Plan" which incorporated mitigation methods to safely perform their assessments. Shelf leadership determined that a different type of organization structure and composition was required for this new focus. The following highlight some of the decisions and context that led to the Shelf experiencing a significant amount of organizational change in a span of less than 6 months:

1) Due to the massive scope of the work, the Construction Superintendent was assigned as Single Point of Accountability to oversee all post-hurricane damage assessment and construction activity across the Shelf. In the past, Production Supervisors have been accountable for overseeing damage assessment in their fields and coordinating with the Construction Superintendent on construction activity. Based on interviews by the Incident Investigation Team, the decision to realign accountabilities was questioned, not understood or not fully supported.

2) Given the nature of the work and the size and scale of the business, the decision was made to shift the ratio of BP to contract staff from roughly 45% contract to 65% contract. As such, a number of BP employees were encouraged to apply for roles outside the Shelf. Where necessary, moves were made within the Shelf to backfill critical positions (so movement was seen across fields, including movement for those in leadership roles).

3) Other priority areas for BP had a critical need for talent (such as Deepwater and Sakhalin). This further supported the Shelf's decision to shift their ratio of BP to contract staff and made it easy for Shelf employees to quickly find roles in other parts of BP.

4) Contract construction crews were swapped across the GI 43 area and GI 41/47 area. Management's intent in making this swap was to get people out of their comfort zone and to help individuals to not become complacent. Some thought it was due to a lack of performance. Eventually, the crews were swapped back to their original work areas.

5) Production supervision was downsized within the GI field. Upon accepting additional responsibility, platform assessments were initiated by the Production Supervisor in order to establish a plan to provide 'Safe Access" to the downfield platforms.

6) On January 19, 2006, Shelf leadership announced that an evaluation of strategic alternatives for the Shelf was being conducted. Potential outcomes range from reorganization to divestment.

7) A GIS Construction Supervisor was reassigned from the field at BPs request around January 20, 2006. Through interviews, with both BP and GIS employees, some individuals supported the decision to reassign the supervisor while others questioned it (i.e., did not understand or support the decision). There was a perception from some interviewed personnel that the reassignment was due to concerns about lack of productivity.

8) The individual appointed to replace the GIS Supervisor was on-shore attending a training course during the hitch on which the incident occurred. An additional individual was then 'stepped up" and acting as a Relief Supervisor.

Incident Summary:

On February 10, 2006 current operations called for a 6-man crew (one BP Operator/One GIS Relief Supervisor, three GIS workers and one Brand Scaffold worker) to provide "safe access" to the WD 71 Y platform. A platform assessment punch list was - provided to the crew with expectations communicated verbally to start at the bottom and work your way up." The crew boarded the M/V Stymie at approximately 10:30 am and proceeded to make various delivery stops in the field. They arrived at WD 71 Y at 2:00 pm.

Due to the timing of their arrival (late with respect to daylight hours), expected deteriorating sea conditions, and a concern about the integrity of the swing ropes, a decision by the crew was made not to proceed with the original work plan which was to set up equipment and prepare the site for hot work and repair handrails and grating at the +10 boat landing. Prior to boarding, no new risk assessment was completed for the tasks they were planning to undertake (e.g., performing a platform assessment, crossing the hole and replacing the swing rope).

The crew decided to board the platform to make further assessments to determine what additional materials would be required to complete the repairs for providing the platform with safe access". The 6-man crew, led by the BP QP, proceeded up the stairs and came upon the opening in the walkway (missing piece of grating 34" x 34"). They all stepped across the open hole and proceeded to the upper decks. After performing their assessment, they proceeded down to the boat landing, again crossing the open hole, and swung off to the boat. (Note: The spare grating on the boat had not been pre-cut to size and therefore a piece could not be set in place to cover the hole. At that moment, no thoughts or attempts were made by the crew to cover the hole.)

The crew had felt that they had been unproductive for the day and a final decision was made to begin changing out the two swing ropes. The BP QP stayed on the boat and proceeded to wait inside the cabin while this task was performed. A 5-man crew, led by a GIS relief supervisor, then boarded the platform and proceeded over the open hole to obtain access to the swing rope connection. Two men came back down to assist operations and then back up to finish the task.

As all five members were proceeding down to depart the platform, a GIS employee fell through the open hole approximately 20 feet and into the Gulf of Mexico. Approximately midway through the fall, the individual made contact with a diagonal structural member causing injury to his tailbone before landing in the water. The individual was wearing a Type I PFD which cushioned his fall and kept his body and head afloat.

Incident Response:

The boat captain announced "man overboard" and sounded the alarm. A member of the boat crew and the BP QP were able to use the hook to guide the individual alongside the boat to the "rescue zone" and proceeded with assisting the individual onto the boat.

The immediate on-scene response by the crew who were involved with the incident was quick and without hesitation. This allowed the severity of the injuries to be kept at a minimum.

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

Execution of prodedures/polices; everyone (6-man crew) at the job site crossed over the open hole with no mitigation of hazards and nobody stopped the job.
a) Violation by group
b) Improper decision making or lack of judgement
c) Inadequate guards or protective devices.

Major desire by the crew to demonstrate some productivity for the days work.

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

Poor judgement
Improper supervisory example at job site.
Employee perceived haste
Inadequate leadership a job site (GIS & BP QP)
Inadequate identification of worksite/job hazards
Inadequate communication of PSP (GIS barricade policy)
Confusing directions/demands
Inadequate management of change
Inadequate work planning
Lack of JSEA or work plan fo the redefined scope of work

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

N/A **N/A**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

No recommendations to MMS.
The New Orleans District concurs with the operator's recommendation to prevent recurrance.

Reassess organization's understanding and implementation of Safe Boarding Procedures, barricading and open hole repair requirements.

Provide space to Field Supervision to spend quality time in the field to provide context and verify that safe systems of work are functioning as intended (e.g Tuesdays in the field" - NAG)

Line leadership regularly review data together from ASA'S and field visits. Feedback from issues/concerns within the verification of HSSE systems (safe systems of work).

GIS will conduct a 1-day workshop, perception survey, and will send HSE Rep to field each week for at least a month to coach & observe work crews.

GIS has offered to provide training or a workshop relative to construction hazards & safety to continue educating the production workforce.

Demonstrate to the workforce that BP Shelf leadership is not only committed to safety, but also aligned as a team, provide local context & rationale for changes & supportive of one another (i.e., organize a session whose objectives are to "clear the air" within the organization, agree on common ground to collectively move forward, and manage the organizational changes with clarity and understanding by stakeholders)

Review the learnings from the incident in safety meetings to reinforce that safety is more important than productivity.

Consider extending IIF Instructor training to contractor workforce may help with relevancy and ownership.

Consider opportunities to improve processes relative to work planning job risk assessment and scheduling of work.

Consider implementing formal guidance around manual transfer of materials from boats.

25. DATE OF ONSITE INVESTIGATION:

27-FEB-2006

26. ONSITE TEAM MEMBERS:

Justin Josey / Steve Lucky /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

TTrosclair

APPROVED

DATE: **11-JAN-2007**

INJURY/FATALITY/WITNESS ATTACHMENT

☐ OPERATOR REPRESENTATIVE	☒ INJURY
☒ CONTRACTOR REPRESENTATIVE	☐ FATALITY
☐ OTHER _____	☐ WITNESS

NAME:

HOME ADDRESS:

STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE: