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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

   DATE: **11-JAN-2006** TIME: **0121** HOURS

2. OPERATOR: **BP America Production Company**

   REPRESENTATIVE: **Mr. Carroll Dugas**

   TELEPHONE: **(337) 735-4854**

3. LEASE: **G06898**

   AREA: **VK** LATITUDE:

   BLOCK: **989** LONGITUDE:

4. PLATFORM: **A-Pompano**

   RIG NAME

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

6. TYPE:
   - [ ] FIRE
   - [ ] EXPLOSION
   - [ ] BLOWOUT
   - [ ] COLLISION
   - [X] INJURY NO. **1**
   - [ ] FATALITY NO.
   - [ ] POLLUTION
   - [ ] OTHER

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

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

9. WATER DEPTH: **1290** FT.

10. DISTANCE FROM SHORE: **20** MI.

11. WIND DIRECTION: **SW**

    SPEED: **12** M.P.H.

12. CURRENT DIRECTION: **NE**

    SPEED: **1** M.P.H.

13. SEA STATE: **4** FT.

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

    Mr. Joseph Roberts

    CITY: **Lafayette** STATE: **LA**

    TELEPHONE: **(337) 735-4854**

    CONTRACTOR: **Dynamic Industries, Inc.**

    CONTRACTOR REPRESENTATIVE/
    SUPERVISOR ON SITE AT TIME OF INCIDENT:

    Mr.Wes Frentz

    CITY: **Lafayette** STATE: **LA**

    TELEPHONE: **(337) 735-4854**

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

A construction crew was removing a damaged forty foot 10" overflow pipe left by prior drilling operations. The pipe was located below the lower deck on the platform and extended to the waterline. The plan was to cut the pipe into sections so that it could be brought over the handrails and lowered onto the +15 deck and secured. An air tugger was installed on the cellar deck and routed through the grating to secure the pipe.

The air tugger was not able to properly spool due to the line passing through the grating. As the air tugger was operated, the line began to spool improperly gathering in the center of the drum. The operator noticed the problem and made an attempt to fix it. However, he did not stop the operation to correct the error.

After the pipe was cut and raised, it was determined by the crew that it was not necessary to cut it into sections. It was possible to lift the entire pipe over the handrails lay it down and properly secure it in one large piece.

The two workers manually directed the load into position. One individual was pushing on the load while the other individual was pulling it. As the pipe was being lowered, the line that had been spooled up in the center of the air tugger drum slipped to one side. The movement of the air tugger cable caused the load to suddenly drop. As the pipe dropped, it landed on the knee of one of the workers who was manually directing the load. The individual's right leg sustained a compound fracture.

FINDINGS:
A) January 11, 2006, the supervisor created a Job Plan and JSEA based on previous day's work and BP Supervisor signed off without clear understanding of the work involved. (1) First opportunity to stop the job.

B) During the morning meeting the entire crew met to review all three JSEA's for the day and all signed off on each JSEA. (1) Everyone in the group signed off without uderstanding the job or knowing what they were working on.

C) Construction supervisor assigned three men to remove the line. The supervisor stayed to assist with the primary job for the day-critical lift. (1) Due to other work, the supervisor was unable to observe a non-routine lift.

D) Workers began working on the line. Tugger operator noticed improper spooling on the line. (1) Second opportunity to stop the job.

E) Once the line was cut the lead operator realized that the pipe could easily be brought over the handrails and did not need to be cut into sections. (1) Scope of work changed and new hazards were not evaluated.

F) The two men decided to manually handle the load. (1) Third opportunity to stop the job.

G) Line on tugger slipped causing the pipe to land on worker knee. (1) Incident occurred.

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

A) Job plan was not followed nor was it revisited when the job sequence changed.
B) The two workers on the +15 deck violated the lifting procedure by not using tag lines.
C) There was no supervisor oversight of this operation.
D) Job should have been stopped when tugger began spooling improperly.

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

A) A lack of understanding of the stop work authority by contract employees.
B) A lack of understanding by Contract personnel of Operator's lifting policy as well as other policies pertaining to the job.
C) Lack of understanding of workers of understanding of equipment and equipment limitations.

CONTINUED FROM ITEM 22:

Actions In Progress:

A policy for tugger use is being developed.

The Contractor Performance & Evaluation Team is planning to meet with Dynamic to discuss BP's expectations for Contract Supervision and Control of Work.

A periodic assessment of JSEA quality will be performed by Performance Unit Leader, Operations Manager, or HSE Advisor.

A new platform orientation will be developed which includes sections on adherence to BP Policy and Practices on the use of JSEA's and lifting practices.

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

None **N/A**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

No Recommendations to MMS.

The New Orleans District concurs with BP to prevent recurrence as listed below: Organizational change - The Construction Manager contracted by BP to oversee this project now reports through the BP Maintenance Team Leader. The previous reporting relationship was directly to the Offshore Platform Manager (OPM).

The JSEA approval process was revised.
(1) Two additional signatures were added to the JSEA to ensure the work scope is well understood. In addition to the OPM, the responsible BP Team Leader and the HSE Advisor now also sign off.
(2) JSEA review meetings have been redesigned to allow more time for review and discussion to ensure comprehension.

The individual morning Safety Meetings have been combined into one single safety meeting that includes all platform personnel. This will improve coordination of all work on the platform, thereby ensuring supervision availability during key activities. Work pace on Pompano will also be more rigorously managed to ensure supervision availability.

A rotation involving the 6 Leadership Team members has been adopted to ensure there is always at least one BP supervisor on deck during construction and maintenance activities. In addition, safety critical work will not be conducted without a BP Leadership Team Member on deck. This is a new work process and documentation is currently under development.

All tuggers on the platform have been re-inspected.

BP reviewed the tugger maintenance program and determined it was adequate.

BP reviewed the training records of the Mr. Mendiola and crew and determined that BP's internal required lifting training requirements, including the use of tag lines, had been met.

SEE ITEM 20 FOR ADDITION INFORMATION. (Actions In Progress)

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

INC G-116 (W) was written for operations not conducted in accordance with approved plans (JSA).

Operator failed to follow the job plan (JSA) for this job. No supervisor was present on the job site. No tag lines were used during lifting operations as

required by BP policy.

25. DATE OF ONSITE INVESTIGATION:

18-JAN-2006

26. ONSITE TEAM MEMBERS:

Justin L. Josey / Randall E. Josey /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

APPROVED

DATE:

INJURY/FATALITY/WITNESS ATTACHMENT

[ ] OPERATOR REPRESENTATIVE	[X] INJURY
[X] CONTRACTOR REPRESENTATIVE	[ ] FATALITY
[ ] OTHER _____	[ ] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: **(337) 735-4854** TOTAL OFFSHORE EXPERIENCE: **14** YEARS

EMPLOYED BY: **Dynamic Industries, Inc. / 20352**

BUSINESS ADDRESS: **Post Office Box 9406**

CITY: **New Iberia** STATE: **LA**

ZIP CODE: **70562**