

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

ACCIDENT INVESTIGATION REPORT

**For Public Release**

1. OCCURRED

DATE: 05-MAR-2012 TIME: 1415 HOURS

2. OPERATOR: Rooster Petroleum, LLC  
REPRESENTATIVE:  
TELEPHONE:  
CONTRACTOR: Chet Morrison Contractors Inc.  
REPRESENTATIVE:  
TELEPHONE:

STRUCTURAL DAMAGE  
 CRANE  
 OTHER LIFTING DEVICE  
 DAMAGED/DISABLED SAFETY SYS.  
 INCIDENT >\$25K  
 H2S/15MIN./20PPM  
 REQUIRED MUSTER  
 SHUTDOWN FROM GAS RELEASE  
 OTHER **Falling Object**

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

6. OPERATION:

4. LEASE: G14364  
AREA: EC LATITUDE:  
BLOCK: 129 LONGITUDE:

PRODUCTION  
 DRILLING  
 WORKOVER  
 COMPLETION  
 HELICOPTER  
 MOTOR VESSEL  
 PIPELINE SEGMENT NO.  
 OTHER **P&A**

5. PLATFORM: A (SEAHORSE)  
RIG NAME:

6. ACTIVITY:  EXPLORATION (POE)  
 DEVELOPMENT/PRODUCTION (DOCD/POD)

8. CAUSE:

7. TYPE:  
 HISTORIC INJURY  
 REQUIRED EVACUATION 1  
 LTA (1-3 days)  
 LTA (>3 days) 1  
 RW/JT (1-3 days)  
 RW/JT (>3 days)  
 Other Injury

EQUIPMENT FAILURE  
 HUMAN ERROR  
 EXTERNAL DAMAGE  
 SLIP/TRIP/FALL  
 WEATHER RELATED  
 LEAK  
 UPSET H2O TREATING  
 OVERBOARD DRILLING FLUID  
 OTHER

FATALITY  
 POLLUTION  
 FIRE  
 EXPLOSION

LWC  HISTORIC BLOWOUT  
 UNDERGROUND  
 SURFACE  
 DEVERTER  
 SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION  HISTORIC  >\$25K  <=\$25K

9. WATER DEPTH: 81 FT.  
10. DISTANCE FROM SHORE: 33 MI.  
11. WIND DIRECTION:  
SPEED: M.P.H.  
12. CURRENT DIRECTION:  
SPEED: M.P.H.  
13. SEA STATE: FT.  
14. PICTURES TAKEN: YES  
15. STATEMENT TAKEN: YES

17. INVESTIGATION FINDINGS:

On 03-05-2012 at 1425 hours, during P&A operations on the EC-129 Well A-01 a well service assistant working for the contractor Chet Morrison Well Sevrvices (CMWS), was the Injured Person (IP)who suffered head and face injuries.

The IP was returning from the lower deck of the platform to assist two other well service assistants on the upper deck via a spiral stair case located next to well A-01. The two assistants on the upper deck were in the process of replacing a grating panel approximately three feet wide by six feet long weighing in excess of one hundred pounds over the barricaded open hole above well A-01. During the process of sliding the grating cover over the hole, the panel slid through the hole and fell to the deck below. The panel bounced off the stair case and struck the IP, who was ascending the stairs, on the top front of his hard hat impacting the nose and facial area.

The IP sustained lacerations to face, nose and lips, with a possibility of a broken nose, and was given immediate first aid and air transported at 1600 hours to University of Texas Medical Branch (UTMB) Surgery Hospital in Galveston, Texas for additional medical treatment.

After reviewing multiple Job Safety Analysis (JSA) for the day of the accident BSEE inspectors were unable to locate a JSA for the specific task of replacing grating in the barricaded open hole over well # A-1. None of the JSAs available mentioned open-hole awareness.

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

Human error: Two personnel attempting to replace a heavy piece of grating over an open hole without the aid of a crane, or securing the grating with a safety tie down. The IP was walking directly under an open hole with personnel working on the level above.

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

There was human error by the IP and, the lack of supervision at the job site. There was an attempt by two assistants to replace heavy grating over an open hole without the aid of proper slings, use of crane, or other safety securing devices for grating.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

**The Lake Charles District has no recommendations to make to the Regional Office of Safety Management.**

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

**G-110 Authority: 107 (a) Safe Workmanlike Operations**

**1) Planning for the operation was inadequate.**

**2) The JSA meeting failed to identify or discuss the danger of the open hole.**

**3) Lack of proper supervision.**

25. DATE OF ONSITE INVESTIGATION:

**06-MAR-2012**

28. ACCIDENT CLASSIFICATION:

**MAJOR**

26. ONSITE TEAM MEMBERS:

**Wayne Meaux / Mitchell Klumpp /  
William Olive /**

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

**Williamson, Larry**

27. OPERATOR REPORT ON FILE: **YES**

APPROVED

DATE: **05-MAY-2012**

# INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE  
 CONTRACTOR REPRESENTATIVE  
 OTHER Assistant

INJURY  
 FATALITY  
 WITNESS

NAME :

HOME ADDRESS :

CITY :

STATE :

WORK PHONE :

TOTAL OFFSHORE EXPERIENCE :

YEARS

EMPLOYED BY :

BUSINESS ADDRESS :

CITY :

STATE :

ZIP CODE :

OPERATOR REPRESENTATIVE  
 CONTRACTOR REPRESENTATIVE  
 OTHER E Line Operator

INJURY  
 FATALITY  
 WITNESS

NAME :

HOME ADDRESS :

CITY :

STATE :

WORK PHONE :

TOTAL OFFSHORE EXPERIENCE :

YEARS

EMPLOYED BY :

BUSINESS ADDRESS :

CITY :

STATE :

ZIP CODE :

# INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER Pump Operator

WITNESS

NAME :

HOME ADDRESS :

CITY :

STATE :

WORK PHONE :

TOTAL OFFSHORE EXPERIENCE :

YEARS

EMPLOYED BY :

BUSINESS ADDRESS :

CITY :

STATE :

ZIP CODE :

