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: **21-MAR-2023** TIME: **1645** HOURS

2. OPERATOR: **Shell Offshore Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Helmerich & Payne**
   REPRESENTATIVE:
   TELEPHONE:

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

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

4. LEASE:
   AREA: **MC** LATITUDE: **28.15402604**
   BLOCK: **854** LONGITUDE: **-89.10355357**

5. PLATFORM:
   RIG NAME: **H&P 204**

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)		
[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
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [X] OTHER **Crane Operation**

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: **3970** FT.
11. DISTANCE FROM SHORE: **62** MI.
12. WIND DIRECTION: **W**
    SPEED: **14** M.P.H.
13. CURRENT DIRECTION: **SW**
    SPEED: **1** M.P.H.
14. SEA STATE: **3** FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

17. INVESTIGATION FINDINGS:

INCIDENT SUMMARY:

On March 21, 2023, at approximately 16:45 hours, Shell Offshore INC. (Shell) had an injury on the Helmerich and Payne (H&P) 204 platform rig at Mississippi Canyon 809 after a gas lift orifice installation. Shell reported the incident to the Bureau of Safety and Environmental Enforcement (BSEE) New Orleans District the same day.

SEQUENCE OF KEY EVENTS:

On March 21, 2023, the H&P crane crew was performing crane operations to stage a wireline riser, approximately 19 feet in length, into a transfer basket on the plus 50 level of the platform. This was a blind lift and radio communication was being used to guide the Crane Operator. The H&P crane crew attached the crane hook to the shackle on the top end of the red gate valve with a riser section attached below. Tag lines were attached to the riser and were being held at the time by the crane crew.

After removing the riser and gate valve assembly from the well, the Crane Operator moved the gate valve assembly to a cargo basket with the intent of laying it down from a vertical position to a horizontal position into the cargo basket. The area where the riser was being landed into the cargo basket was not barricaded. The only barricade used was on the top deck around the A-4 well where the riser was being lifted from.

The H&P crane crew was removing a sling leg to make room for the riser and gate valve assembly when a rigger positioned himself between the basket they were working in and another adjacent basket to pull the sling leg out of the way.

As the upper end of the lifted assembly was lowered and while positioning the piping with the crane, the lower end closest to the rigger shifted, causing him to be caught between the pipe and the basket. Riggers called all stop to the Crane Operator and immediately pulled the tag lines so the riser and gate valve assembly would lift off the rigger.

The injured rigger (Injured Person (IP)) was assisted by the crane crew to the platform Medic. The Shell Medic/H&P Medic called the Shell Offshore Installation Manager immediately for a medical evacuation and an Incident Command System response was initiated to gather first responders to assist with the Medic. The IP received medicine onboard the rig/platform then was flown in via a Search and Rescue helicopter for further evaluation. He was admitted to University Medical Center in New Orleans. The IP was diagnosed with a nondisplaced L4 fracture, traumatic hernia, and pelvic muscle tear, all of which were expected to heal on their own.

BSEE INVESTIGATION:

On March 28, 2023, the BSEE Accident Investigator requested and received pictures of the relevant equipment involved in the incident, a Job Safety Analysis (JSA) for the job being performed, a diagram of the platform with the location of the incident, the job permit, the Crane Operator certification, and Rigger certifications for the crew members that were involved with this incident.

CONCLUSION:

BSEE reviewed the documentation and concludes that due to the Designated Signal Person (DSP) and other members of the H&P rigging crew not identifying the hazard of a pinch point and not calling an "All Stop" or using their Stop work Authority when someone was in a pinch point location resulted in an injury to one of the crew members. The result of this injury was a nondisplaced L4 fracture, traumatic hernia, and pelvic muscle tears.

The H&P Compass card that was used for this operation had several questions that when asked, would have helped identify the hazards with this operation. The crew members did not follow the recommended Compass card questions/advisories as follows: 1) What are the recommended safe practices to eliminate/safeguard the potential hazards, 2) Everyone has the authority and responsibility to stop work they believe is unsafe and 3) What are the potential hazards?

The Lifebelt Rules to Live By card has a statement that says "Keep Out of The Path of Moving Equipment" that was not followed.

The H&P JSA in the Recommended Safe Practice section states to "Have a planned escape route and do not stand in a pinch and/or crush points," and was not followed.

The Shell Work Permit (URSA-00-5195079) states hard barricades will be installed around the well and hatch, so no barricade was needed in the area where the incident occurred. The work permit also has a selected Life Saving Rule which states "Keep yourself and others out of the line of fire".

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

Work Environment
- Congested workspace: the basket was placed in a position against other baskets and equipment so that an individual couldn't work around the basket without being in a pinch point.

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

Human Performance Error
- Individual standing in a pinch point
- DSP did not identify individual was in a pinch point

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

No Damage to the equipment **N/A**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans District has no recommendations for the Office of Incident Investigations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

26. Investigation Team Members/Panel Members:
Frank Musacchia /

29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

27. OPERATOR REPORT ON FILE:

OCS REPORT:

30. DISTRICT SUPERVISOR:
David Trocquet

APPROVED DATE: **19-JUL-2023**