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: **25-JUN-2021** TIME: **1045** HOURS

2. OPERATOR: **Shell Offshore Inc.**
REPRESENTATIVE:
TELEPHONE:
CONTRACTOR:
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: **G07963**
AREA: **MC** LATITUDE:
BLOCK: **807** LONGITUDE:

5. PLATFORM: **B(Olympus)**
RIG NAME:

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

7. TYPE:
INJURIES:
- [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	1	
[ ] LTA (1-3 days)		
[X] LTA (>3 days)	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:
- [X] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER

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: **3028** FT.
11. DISTANCE FROM SHORE: **72** 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:

INCIDENT SUMMARY:

On 25 June 2021 at 1045 hours, one deck operator at Mississippi Canyon (MC) 807 B (Olympus), Lease OCS-G 07963, received lacerations to the hand while removing liners from the produced water Hydrocyclones (MBM-401,402,403). The incident is recorded as a Lost Time Accident (LTA) greater than 3 days. MC 807 B is a manned production facility, and the operator on record is Shell Offshore Inc.

SEQUENCE OF EVENTS:

The morning of 25 June 2021, Shell operators began the procedures necessary to pull and inspect/replace liner tubes in the produced water hydrocyclones. Personnel verified isolation, drained and bled down piping, performed Lock Out/Tag Out, and signed off the Job Safety Analysis (JSA). Personnel also ensured containment with portable skid pans and absorbent pads in place. Next, the operators removed the nuts and studs to gain access to the 3 ft long and 1 in diameter liner. The liner was observed to be held in place by a heavy build up of scale and debris. A come-a-long pulling tool was attached to an eye hole on the end of the liner that allows a hook to attach to it. As the operator ratcheted the come-a-long tool, the liner suddenly popped free. The Injured Person's (IP's) right hand was in the path of contact when the liner broke free. The IP immediately reported to the Medic, where first aid was administered. A Medivac was called, and the IP was flown to the hospital where he was diagnosed with contusion and laceration of the right hand. He received treatment beyond first aid. The IP received a medical release indicating that the IP was under doctor's care from 25 June 2021 to 5 July 2021. The IP returned to work on 6 July 2021 at full duty without restrictions.

BSEE INVESTIGATION:

The BSEE New Orleans District Accident Investigator reviewed the incident in eWell and then requested and received copies of the JSEA, the POB list, Liner removal procedures, Hydrocyclone flow diagram, and Physician Assessment & Medical Release documents. The platform Offshore Installation Manager (OIM) on board at the time of the incident indicated that the first attempt to remove the liner failed due to a build up of scale around the liner. The BSEE investigation determined that the hydrocyclone's manufacturer recommends a specific pulling tool to remove the liner, however, it was not on location at the time of the incident. The operators instead, attempted to use a come-a-long pulling tool. However, once the liner freed up it suddenly popped out and then struck the IP's hand. Since the incident, the recommended pulling tool has been acquired.

CONCLUSIONS:

Shell did not have the recommended tool on hand for removing the liner and decided to use an alternate pulling tool that allowed the liner to suddenly be released. The IP also used poor body positioning, placing his hand in the path of potential contact.

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

Equipment Failure: Inadequate/improper tools or equipment used.

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

Human Performance Error: Not following proper procedures. Poor body placement.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

N/A

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

02-JUL-2021

26. INVESTIGATION TEAM MEMBERS:

Gerald Taylor /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

David Trocquet

APPROVED DATE: **09-JAN-2022**