## 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: 08-FEB-2016 TIME: 1315 HOURS	STRUCTURAL DAMAGE CRANE
2.	OPERATOR: Shell Offshore Inc.  REPRESENTATIVE:  TELEPHONE:  CONTRACTOR: Helmerich & Payne  REPRESENTATIVE:  TELEPHONE:	OTHER LIFTING DEVICE  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:	6. OPERATION:
4.	LEASE: G17565  AREA: AC LATITUDE: BLOCK: 857 LONGITUDE:	PRODUCTION  X DRILLING WORKOVER COMPLETION HELICOPTER MOTOR VESSEL
5.	PLATFORM: A(Perdido) RIG NAME: H&P 205	PIPELINE SEGMENT NO. OTHER
	ACTIVITY:    X	8. CAUSE:  EQUIPMENT FAILURE  HUMAN ERROR EXTERNAL DAMAGE SLIP/TRIP/FALL WEATHER RELATED LEAK UPSET H20 TREATING OVERBOARD DRILLING FLUID OTHER
	Other Injury	9. WATER DEPTH: <b>7817</b> FT.
	POLLUTION FIRE	10. DISTANCE FROM SHORE: 132 MI.
	LWC HISTORIC BLOWOUT UNDERGROUND	11. WIND DIRECTION: N SPEED: 35 M.P.H.
	SURFACE DEVERTER SURFACE EQUIPMENT FAILURE OR PROCEDURES	12. CURRENT DIRECTION: SPEED: M.P.H.
	COLLISION   HISTORIC   >\$25K   <=\$25K	13 SEA STATE: 10 FT

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EV2010R 15-MAR-2016

On February 8, 2016, an injury occurred during drilling activities at Alaminos Canyon 857, H & P 205 Rig, OCS-G-17565, operated by Shell Offshore, Inc. The injury occurred on Well GA006 (API#608054004401) during general rig maintenance. An H & P Mechanic was struck in the face by a flange associated with a butterfly valve for a saltwater filter, causing lacerations above his right eyebrow and down the bridge of his nose. The H & P Mechanic was medevaced to a medical facility for stitches and returned to the rig the next day.

H & P 205 Rig Mechanic was in the process of tightening bolts to a flange connection for a butterfly valve secured in a bench vise. While torqueing the second to last bolt on the flange connection, the flange rotated in the vise due to the force applied, causing the flange to release from the vise striking the injured party in the face. Factors which caused the injury include improper body position and excessive force applied to the tool being utilized.

Personnel should not apply excessive force to a tool while pulling toward their body or stand in the direct path of impact should equipment fail. The vice utilized during the incident was replaced due to excessive wear on the jaw. Standing in line with the open part of the jaw reduces the vice's clamping force on the object being held, and may allow the object to be released directly toward personnel.

The Job Safety Analysis (JSA) for the work to be done on the flange connection to the butterfly valve was filled out and signed by the rig Mechanic. Steps five and six of the JSA recommend proper body positioning and proper tool selection for the job to be conducted. H & P 205 management have addressed the issues related to the incident and submitted corrective actions fleet wide.

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

Flange connection released from the vice due to excessive force applied and improper body positioning within the line of fire.

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

Vice had excessive wear on the jaws, it was replaced. Proper tool selection would have prevented this injury.

20. LIST THE ADDITIONAL INFORMATION:

None

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

None None

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22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

None

- 23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES
- 24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

At the time of the incident February 8, 2016, Lessee failed to conduct operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment.

An injury was sustained on the H & P 205 rig, which required medical evacuation and treatment for facial laceration. The incident occurred when the injured party was tightening bolts for a flange connection to a butterfly valve. The flange was set in a bench vice, and a wrench was used to torque down the bolts. The injured party was positioned to the side of the vice, and was pulling towards his body when the flange slipped out of the vice. The flange struck the injured party in the face causing a laceration above his eyebrow and down the bridge of his nose. The JSA form completed on February 8, 2016, states in steps five and six the need for correct body positioning and proper tool use to prevent injury.

25. DATE OF ONSITE INVESTIGATION:

08-FEB-2016

26. ONSITE TEAM MEMBERS:

Michael Fornea / James Holmes / David Kearns /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

John McCarroll

APPROVED

DATE: 15-MAR-2016

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