

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: **29-JUN-2015** TIME: **1200** HOURS

2. OPERATOR: **Shell Offshore Inc.**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: -

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- 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: **G14221**

AREA: **GB** LATITUDE:

BLOCK: **172** LONGITUDE: -

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

5. PLATFORM: - **B (SALSA)**

RIG NAME:

6. ACTIVITY: - EXPLORATION (POE)

DEVELOPMENT/PRODUCTION
(DOCD/POD)

8. CAUSE:

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

7. TYPE:

HISTORIC INJURY -

- REQUIRED EVACUATION 1 -
- LTA (1-3 days)
- LTA (>3 days)
- RW/JT (1-3 days)
- RW/JT (>3 days) 1 -
- Other Injury -

- FATALITY
- POLLUTION
- FIRE
- EXPLOSION

- LWC - HISTORIC BLOWOUT
- UNDERGROUND
 - SURFACE
 - DEVERTER
 - SURFACE EQUIPMENT FAILURE OR PROCEDURES

9. WATER DEPTH: **693** FT.

10. DISTANCE FROM SHORE: **104** MI.

11. WIND DIRECTION: -
SPEED: M.P.H.

12. CURRENT DIRECTION:
SPEED: M.P.H.

13. SEA STATE: FT.

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

On June 29, 2015 at approximately 1200 hours, a contract employee (CE) was injured while attempting to reposition a storage cabinet to be blasted and painted.

Two contract employees were moving a storage cabinet to be blasted and painted. Prior to attempting to move the cabinet to be blasted and painted the contract employees failed to complete a Job Safety Analysis (JSA) for the task that may have reviewed hazards such as pinch points and safer ways to complete the project.

As they positioned the cabinet to the area to be blasted, the employees were going to remove the door on the cabinet but due to the hinges being stuck the employees left the doors on. The cabinet was in the upright position and the employees were attempting to lay the cabinet down. The CE was wearing Hyflex gloves at the time of the incident.

The CE was told by the other employee that he was laying the cabinet down but the CE understood very little English and may not have known the cabinet was being dropped. There was no translator on the facility. As the employee pushed the cabinet, the CE held on to the edge of the cabinet allowing his fingers to be in a pinch point situation. As the cabinet came down, the door flew open and then came back down coming in contact with the CE's left thumb.

When the CE removed his glove he discovered his thumb nail had been nearly detached and was brought to the medic. The CE was flown in for additional treatment and was found to have a fractured left thumb.

The BSEE Lafayette District conducted an onsite investigation July 6, 2015.

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

CE held on to the edge of the cabinet allowing his fingers to be in a pinch point situation.

CE understood very little English and may not have known the cabinet was being dropped. There was no translator on the facility.

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

Failed to complete a Job Safety Analysis (JSA) for the task that may have reviewed hazards such as pinch points and safer ways to complete the project.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL): \$

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District office makes no recommendations to the Office of Safety Management (OSM).

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

INC G-110 is issued "After the Fact" to document that Shell Offshore Inc. failed to protect health, safety and the environment by not performing operations in a safe and workmanlike manner as follows: An employee failed to perform operations in a safe and workmanlike manner while attempting to reposition a storage cabinet for blasting. Two employees were attempting to lay the storage cabinet down but did not discuss how they would do so prior to the task. As the storage cabinet fell, one of the employees had his fingers near the cabinet door. The door made contact with the one of the employees left thumb resulting in a fracture. The employees failed to complete a Job Safety Analysis (JSA) prior to the task that could have possibly identified the hazards involved. Also, the injured employee could not speak very good English and it is unknown if the injured employee understood the job task prior to repositioning the cabinet. There were no translators on board at the time of the incident.

25. DATE OF ONSITE INVESTIGATION:

06-JUL-2015

26. ONSITE TEAM MEMBERS:

Raymond Johnson / Toby Ware / Wade Guillotte /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED

DATE: 31-AUG-2015