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: **13-JUN-2014** TIME: **0800** HOURS

2. OPERATOR: **Shell Offshore Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: -
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G17565**
   AREA: **AC** LATITUDE:
   BLOCK: **857** LONGITUDE: -

5. PLATFORM:
   RIG NAME: **H&P 205**

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

7. TYPE:
   - [ ] HISTORIC INJURY -
     - [X] REQUIRED EVACUATION **1** -
     - [ ] LTA (1-3 days)
     - [ ] LTA (>3 days
     - [ ] RW/JT (1-3 days)
     - [X] RW/JT (>3 days) **1** -
     - [ ] Other Injury -
   - [ ] FATALITY
   - [ ] POLLUTION
   - [ ] FIRE
   - [ ] EXPLOSION
   - LWC - [ ] HISTORIC BLOWOUT
     - [ ] UNDERGROUND
     - [ ] SURFACE
     - [ ] DEVERTER
     - [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES
   - COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K
   - [ ] STRUCTURAL DAMAGE
   - [ ] CRANE
   - [ ] OTHER LIFTING DEVICE
   - [ ] DAMAGED/DISABLED SAFETY SYS.
   - [ ] INCIDENT >$25K
   - [ ] H2S/15MIN./20PPM
   - [ ] REQUIRED MUSTER
   - [ ] SHUTDOWN FROM GAS RELEASE
   - [ ] OTHER

6. OPERATION:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [X] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] OTHER

8. CAUSE:
   - [ ] EQUIPMENT FAILURE
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE -
   - [ ] SLIP/TRIP/FALL -
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER _____

9. WATER DEPTH: **7824** FT.

10. DISTANCE FROM SHORE: **185** MI.

11. WIND DIRECTION: **SSE** -
    SPEED: **10** M.P.H.

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

13. SEA STATE: **2** FT.

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17. INVESTIGATION FINDINGS: -

During Stab-Rite change out operation, the Injured Person (IP) was in the process of cutting all- thread bolts (weight - 10 lbs., 1 inch in diameter, 4 feet in length) on the Stab-Rite bracket. IP was using an air operated band saw to cut the bolts. IP had removed nine bolts and was attempting to cut the tenth bolt when the remaining bolt snapped causing the top metal plate to shift approximately three inches swinging the bolt vertical contacting the IP,s mouth. IP reported to the Rig Medic and was evaluated. The decision was made to send IP ashore on the next crew change helicopter to seek further medical attention. IP received stitches to the bottom lip and was also evaluated by a Dentist for chipped teeth.

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

1.Stab-Rite equipment was not properly secured to eliminate the movement of the top plate when the bolt snapped causing the bolt to swing vertically. -
2.Job Safety Analysis utilized failed to identify all hazards associated with the job task. -

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

1. Hazard of bolts snapping while being cut was not addressed in the Job Safety Analysis until after the incident occurred. -
2. Job Safety Analysis did not address the use of a band saw to cut bolts or the hazards of utilizing a band saw.

20. LIST THE ADDITIONAL INFORMATION:

No additional information at this time.

21. PROPERTY DAMAGED: **None**

NATURE OF DAMAGE: **None**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Jackson District has no recommendations to the Regional office for this event.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 (W) 250.107 (a) -
At the time of the investigation, it was discovered lessee failed to perform all

operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment in the following ways:

On June 13, 2014, the rig crew along with a Frank's representative was in the process of changing out Frank's Stab-Rite equipment. The procedure was to use an air operated band saw to cut bolts while being held in place by an air tugger line from the rig floor. Nine all-thread bolts had been cut and the crew was in the process of cutting the tenth bolt when the bolt snapped causing the top plate of the Stab-Rite to move vertical causing the bolt to kick out striking the Injured Person (IP) in the mouth lacerating his lip and chipping his front teeth. IP was seen by the Rig Medic. The decision was made to send IP ashore for further treatment. Upon review of all documents submitted to BSEE it was discovered:
1. Job Safety Analysis utilized failed to identify all hazards associated with the job task.
2. The Stab-Rite equipment was not properly secured to eliminate the movement of the top plate when the bolt snapped causing the bolt to swing vertically.
3. While utilizing the band saw to cut the all-thread bolts, rig personnel failed to use a face shield along with other PPE to properly protect from flying debris.
4. Job Safety Analysis failed to address the use of a band saw until after incident occurred. (Hand written on Job Safety Analysis).

25. DATE OF ONSITE INVESTIGATION:

16-JUN-2014

26. ONSITE TEAM MEMBERS:

James Holmes /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

John McCarroll

APPROVED DATE: **15-SEP-2014**