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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
GULF OF AMERICA REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **23-FEB-2025** TIME: **0830** HOURS

2. OPERATOR: **Shell Offshore Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **SafeZone Safety Systems, LLC**
   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: **G05868**
   AREA: **MC** LATITUDE: **28.15402604**
   BLOCK: **809** LONGITUDE: **-89.10355357**

5. PLATFORM: **A (Ursa)**
   RIG NAME:

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

7. TYPE:
   INJURIES:
- [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[ ] REQUIRED EVACUATION		
[ ] LTA (1-3 days)		
[ ] LTA (>3 days)		
[ ] RW/JT (1-3 days)		
[X] RW/JT (>3 days)	**0**	**1**
[ ] 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
- [ ] TEMP ABAND
- [ ] PERM ABAND
- [ ] DECOM PIPELINE
- [ ] DECOM FACILITY
- [ ] SITE CLEARANCE

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: **3790** FT.

11. DISTANCE FROM SHORE: **62** 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:

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INCIDENT SUMMARY:

On 23 February 2025, an incident occurred at Mississippi Canyon (MC) 809, platform A (Ursa). Ursa is a Tension Leg Platform that is owned and operated by Shell Offshore Inc (Shell). At the time of the incident, the Injured Person (IP) lost his footing and slipped while he was in the process of securing felt to cover sheet metal flooring and cleaning inside of the Pressurized Welding Enclosure (PWE).When the IP slipped backwards, his right leg contacted a jagged edge of an I-beam, resulting in a 3-to-4-inch laceration on his right leg. The IP was Medically Evacuated (Medevac'd) by helicopter from MC 809 A and received medical treatment at the Medical Center.

SEQUENCE OF EVENTS:

On 23 February 2025, at approximately 0830 hours, a SafeZone worker, referred to as the IP, was securing Panther felt and cleaning inside a PWE. The IP took a step back from an elevated working surface, lost his footing and slipped backwards. While slipping , the IP's leg contacted a jagged edge of an I-beam, which resulted in a laceration to the IP's right leg. At 0845 hours, the incident was reported to the platform medic, who completed an assessment of the IP's injuries. A decision was made to send the IP to a medical facility for further evaluation onshore. The IP then left MC 809 A on a Medevac helicopter at 1010 hours and landed at Bristow heliport in Houma, Louisiana at 1136 hours. The IP was then transported to the Medical Center at 1150 hours. At 1203 hours, a company representative for SafeZone, the IP's employer, arrived at the the Medical Center to accompany the IP.

When the IP arrived at the Medical Center , he had X-rays performed, which were completed at 1412 hours. In addition to receiving X-rays, the IP received 11 staples and 4 stitches for the lacerations at 1438 hours. Upon receiving stitches and staples on the lacerated area, the IP was then released from the Medical Center at 1506 hours and placed on light duty status. The IP returned to work on 24 February 2025 at the SafeZone office on light duty. The IP did not return offshore to MC 809 A, Ursa platform.

BSEE INVESTIGATIONS :

On 23 February 2025, Shell notified the Bureau of Safety and Environmental Enforcement (BSEE) afterhours engineer via phone call and follow up email, of a leg injury that occurred offshore while an IP was working in a PWE. On 27 February 2025, Shell followed up the original notification by submitting a formal incident report. The incident report included the following: photographs of the injury, description of incident location, the Job Safety Analysis (JSA) used identify the hazards of the work being performed, a witness statement, a work permit, and a medical release form identifying the IP's light duty status when released from the hospital.

The BSEE Accident Investigator (AI) began an in-office investigation of the incident on 28 February 2025. During the office investigation, the AI requested additional photographs of the incident area, further details concerning the incident and the medical treatment report from the Medical Center.

During the BSEE investigation, the AI found that the initial JSA hazard identification for the work being performed did not mention jagged edges inside the work area or uneven surfaces creating hazards for personnel. The lack of supervision and these items having not been identified during the initial hazard identification allowed existing hazards to remain unaddressed throughout the operation. The IP was working at heights, which required him to wear fall protection personal protective equipment (PPE), consisting of self-retracting lifeline (SRL) at the time of the incident. Even

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though the IP was wearing the required fall protection, the uneven surface that the IP was working on had a 12-18 inch drop down to the next working level. When the IP slipped and lost his footing, he fell 12-18 inches from the upper level to the lower level. This slight difference in elevation was not a great enough drop to deploy the IP's fall protection, which contributed to the lacerations he received on his leg.

Upon further review of the information provided by Shell, it was noted that Stop Work Authority (SWA) was utilized by the on-site personnel immediately following the incident. In addition, a safety standdown was conducted with the rest of the crew to address any safety concerns. The crew was able to identify the potential exposures of sharp pieces of metal that were present and mitigate the hazard by wrapping any protruding pieces of metals that were found. The JSA was then revised and added the potential for jagged edges and uneven surfaces as hazards and determined how to safely mitigate those hazards.

IN CONCLUSION:

On 23 February 2025, during the initial hazard assessment of the working area, the unidentified hazards contributed to the IP injuring his leg. Had the jagged edges and uneven surfaces been identified on the JSA and discussed with the workers prior to commencing work, the injury could have been prevented by taking the proper steps to mitigate these hazards. BSEE's investigation found that the probable causes of the incident were the lack of supervision and human error due to the inadequacy of the pre-job assessment. By not identifying all hazards, the workers in the area were exposed to additional risk that could have resulted in more serious injuries than those sustained by the IP. In the future, the work area should have a more thorough hazard assessment performed, and all personnel should be made aware of these hazards before starting work. Hazards identified at the time off the assessment should be mitigated to reduce or eliminate the threat to personnel before starting work.

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

Supervision – Inadequate supervision while identifying the hazards in the work area during hazard assessment and mitigation for the hazards.

Human Error - The lack of identifying the jagged edges on the I-beam in the work area by the IP.

Human Error – The lack of awareness by the IP concerning the uneven surfaces and foot placement during the job risk analysis and while performing the work.

Slip, trip and fall hazards – Unidentified slip, trip and fall hazards present during the work being performed

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

Management system – Inadequate documentation of hazard analysis and job procedures on the JSA that was being utilized for the operations.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

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ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE New Orleans District recommends the Office of Incident Investigations should consider issuing a Safety Alert regarding the incident.

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:
/

29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

27. OPERATOR REPORT ON FILE:

OCS REPORT:

30. DISTRICT SUPERVISOR:

Michael J. Saucier

APPROVED DATE: **29-APR-2025**