

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: 26-APR-2021 TIME: 0100 HOURS

2. OPERATOR: Shell Offshore Inc.

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: Helmerich & Payne Inc.

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING **Traveling Block**
- 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:

8. OPERATION:

4. LEASE: G17565

AREA: AC LATITUDE:

BLOCK: 857 LONGITUDE:

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

5. PLATFORM: Perdido Spar

RIG NAME: H&P 205

6. ACTIVITY:

- EXPLORATION(POE)
- DEVELOPMENT/PRODUCTION (DOCD/POD)

9. CAUSE:

7. TYPE:

INJURIES:

HISTORIC INJURY

OPERATOR CONTRACTOR

REQUIRED EVACUATION

LTA (1-3 days)

LTA (>3 days)

RW/JT (1-3 days)

RW/JT (>3 days)

FATALITY

Other Injury

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

POLLUTION

FIRE

EXPLOSION

LWC HISTORIC BLOWOUT

UNDERGROUND

SURFACE

DEVERTER

SURFACE EQUIPMENT FAILURE OR PROCEDURES

10. WATER DEPTH: 7835 FT.

11. DISTANCE FROM SHORE: 140 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:

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

On April 26, 2021 at 0100 hours, Shell Offshore Inc (Shell) had a travel block lifting incident while conducting well operations with the H&P 205 rig located on AC 857 Perdido Spar. The incident occurred while lifting the Blowout Preventer (BOP) stack using the rigs travel block. This incident resulted in a dropped object and approximately \$2,500.00 damage.

The Facility COVID-19 status restricted travel to and from the facility on the day of and days immediately following the incident that prevented the BSEE Investigator from conducting an on-site investigation. The BSEE investigator did request documents, reviewed Shell's post incident investigation report, and consulted with Shell and Helmerich & Payne Inc. Investigators during their investigation.

According to Shell's post incident investigation, the rig crew proceeded with planned operations of nipping-down the Perdido Surface BOP Stack. The incident occurred while separating the BOP double ram and lifting it off the single BOP ram. The lift was being made using the rigs traveling block with a stand of 5-7/8" V150 drill pipe and a Drill Quip Radial Bolt Connector (RBC) to the top of the BOP. While lifting the Double BOP ram approximately 8" to 10" to clear the studs on the single ram, one of two swivel pad eyes (not in use at time of incident) mounted on the side of RBC contacted a trolley beam. The contact caused the swivel pad eye's mounting Allen bolt to shear allowing the swivel pad eye to separate in four pieces and fall to the deck below.

The four pieces weighed 10.2 pounds (lbs) total and fell 26 feet. The 5.9 lbs lifting pad eye ring landed within 2 feet of a Crewmember working on deck. The Crewmembers did not identify the dropped object risk and therefore were working within a designated Dropped Object Prevention Scheme (DROPS) area.

Visibility of the area where the pad eyes contacted the trolley beam, was difficult since the pad eyes are the same color as the RBC connector, and it was 20+ feet above head height of Crewmembers. The operation did not require the two swivel pad eyes mounted to the side of the RBC connector. The swivel pad eyes made the RBC assembly larger than the opening between the trolley beams. The Job By Design (JBD) and the Job Safety Analysis (JSA) in use, did not mention the tight tolerance between the trolley beams. In previous operations doing the same scope of work, the crew removed the pad-eyes from the RBC connector prior to performing the operation.

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

- The visibility of the area where the pad eyes contacted the trolley beam was difficult. The pad eyes are the same color as the RBC connector, and it was 20+ feet above the head height of the workers.
- The Job By Design (JBD) and the Job Safety Analysis (JSA) in use, did not mention the tight tolerance between the trolley beams. The two swivel pad eyes mounted to the side of the RBC connector made it larger than the opening between the trolley beams.

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT: **None**20. LIST THE ADDITIONAL INFORMATION: **None**

21. PROPERTY DAMAGED:

NATURE OF DAMAGE: **Damage was limited to Swivel Pad Eye and Allen bolt.**

ESTIMATED AMOUNT (TOTAL): **\$2,500**

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

Shell Offshore Inc. recommendations to prevent reoccurrence:

- Shell is updating the JSA to include removal and verification of removal of the pad eyes from the RBC connector.

- Shell is updating the Job By Design (JBD) to move crew further back under safe area. Shell is evaluating if a DROPS shed is needed.

- Shell is reviewing potential DROPS area with all crews.

- Shell will explore with OEM change in coating color of pad eyes to make them more visible and/or evaluate ability to engineer out the need for the pad eyes on the RBC.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE: **None**

28. ACCIDENT CLASSIFICATION:

25. DATE OF ONSITE INVESTIGATION:

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

26. INVESTIGATION TEAM MEMBERS:

OCS REPORT:

Edward Keown - Author

30. DISTRICT SUPERVISOR:

Stephen Martinez

27. OPERATOR REPORT ON FILE:

APPROVED

DATE: **09-AUG-2021**