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

ACCIDENT INVESTIGATION REPORT

1.	OCCURRED	STRUCTURAL DAMAGE
	DATE: 14-APR-2022 TIME: 000 HOURS	CRANE
2		OTHER LIFTING
2.		DAMAGED/DISABLED SAFETY SYS.
		INCIDENT >\$25K H2S/15MIN./20PPM
		REQUIRED MUSTER
	REPRESENTATIVE:	SHUTDOWN FROM GAS RELEASE
	TELEPHONE:	OTHER
3.	OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:	8. OPERATION:
		PRODUCTION
4.	LEASE: G08241	DRILLING
	AREA: GB LATITUDE:	WORKOVER COMPLETION
	BLOCK: 426 LONGITUDE:	HELICOPTER
		MOTOR VESSEL
5.	PLATFORM: A-Auger TLP	PIPELINE SEGMENT NO.
	RIG NAME: H&P 406	X OTHER Abandonment
	ACTIVITY: EXPLORATION (POE) DEVELOPMENT/PRODUCTION (DOCD/POD)	9. CAUSE:
7.	TYPE:	EQUIPMENT FAILURE
	INJURIES:	X HUMAN ERROR
	HISTORIC INJURY OPERATOR CONTRACT	EXTERNAL DAMAGE
	Image: The second sec	
	LTA (1-3 days)	• WEATHER RELATED
	x LTA (>3 days) 0 1	
	RW/JT (1-3 days)	OVERBOARD DRILLING FLUID
	RW/JT (>3 days)	OTHER
	FATALITY	
	Other Injury	10. WATER DEPTH: 2860 FT.
		11. DISTANCE FROM SHORE: 136 MI.
	POLLUTION	12. WIND DIRECTION: SE
	FIRE EXPLOSION	SPEED: 29 M.P.H.
	LWC 🔲 HISTORIC BLOWOUT	13. CURRENT DIRECTION:
	UNDERGROUND	SPEED: M.P.H.
	SURFACE	14. SEA STATE: 7 FT.
	DEVERTER	
	SURFACE EQUIPMENT FAILURE OR PROCEDURES	
	COLLISION HISTORIC >\$25K <- \$25K	16. STATEMENT TAKEN:

Incident Summary:

At approximately 0030 hours on 14 April 2022, a Helmerich & Payne, Inc. (H&P) Driller sustained a back injury during Well A017 operations on the H&P 406 rig on Shell Offshore Inc.'s (Shell) Auger Tension Leg Platform (TLP) located at Garden Banks Block 426A. The H&P Driller required evacuation from the rig for a medical evaluation.

Sequence of Events:

On 14 April 2022, an H&P crew was installing the lower and upper working platforms around the H&P 406 rig's 18.75-inch blowout preventer (BOP) on Well A017. A H&P Driller was preparing to secure washers and nuts onto the bolts to the upper platform leg while standing at an opening to the lower platform floor. The H&P Driller relocated himself and was looking up while installing the washers and nuts onto the bolts on the upper platform leg when he accidently stepped off the unprotected side of the lower platform and began falling backwards. The H&P Driller turned and attempted to grab a nearby beam to prevent himself from falling but was unsuccessful. The H&P Driller fell backwards approximately 3 feet 3 inches and his left upper back landed first on the BOP skid plate and his left lower back struck the edge of the BOP skid plate that was approximately 2 feet 3 inches in height from the deck. A nearby H&P employee that observed the H&P Driller's fall responded, rendered aid, and escorted him to the Auger TLP medic for medical attention. An onshore physician was consulted about the H&P Driller's injury, and it was recommended that he should be sent in for a medical evaluation. Shell and H&P held a safety stand down with all crews. At 0836 hours, the H&P Driller was evacuated by a medevac helicopter to a Hospital located in Houma, Louisiana where an onshore physician diagnosed that he had sustained fractures to his back. On 17 May 2022, Shell classified the H&P Driller's back injury as a Lost Time Accident greater than 3 days (LTA > 3 days).

BSEE Investigation:

On 14 April 2022, a Bureau of Safety and Environmental Enforcement (BSEE) Lafayette District Inspector conducted an onsite Incident Follow-up Investigation at the H&P406 rig. The BSEE Lafayette District Inspector conducted written and photographic documentation while onsite and gathered documents that included the Shell Auger 18.75inch BOP Assembly Procedure, H&P's Fall Protection Plan, the Job Safety Analysis (JSA), Alleged Incident Reports, and a photographic presentation by both Shell and H&P that documented the incident scene where the H&P Driller was injured. BSEE reviewed and compared H&P's Fall Protect Plan to H&P's JSA for Installing Working Platforms onto BOPs. H&P's JSA specified that "Always remain 100% tied off while working at heights" and "Always use 100% fall protection". However, H&P's Fall Protection Plan stated that a properly fitting body harness with a shock absorbing double-leg lanyard shall be worn while working at heights greater than 4-feet above the working surface measured from the worker's feet level to the floor that was not mentioned in the JSA. BSEE learned that at the time of the incident, the H&P Driller was standing on the lower working platform floor that was approximately 3 feet 3 inches above the deck and that he was not wearing any fall protection gear as recommended in the JSA. Moreover, no guardrails were installed to prevent falls at the access point opening to the lower working platform where the H&P Driller was installing washers and nuts onto bolts on the upper working platform leg. BSEE reviewed the Rig 406 Surface BOP Work Platform General Arrangement and Assembly drawings and discovered that a lower working platform guardrail or swing gate at the access area where the H&P Driller fell was not included in the drawings for that stage of the operation. According to H&P's Investigation Report, "The BOP work platform being assembled was not equipped with protective handrails at the time of event in this stage of the operation. Folding handrails are present, but only after assembly is complete." BSEE noted that a swing gate was installed and secured with tie offs at the access opening to the lower working platform where the H&P Driller fell as a corrective action to avoid any future incidents of this nature.

The BSEE Incident Investigation Team determined that the incident was the result of the lower working platform access opening not having a swing gate secured with tie offs or guardrails installed to prevent falls when standing on the lower working platform while installing washers and nuts onto the bolts on the upper platform leg. Contributing causes for this incident included the H&P Driller was not wearing any fall protection gear as recommended in the JSA and the H&P Driller's lack of situational awareness when repositioning himself and looking up to secure the upper platform leg caused him to step off and fall backwards from the lower platform's unprotected side on and against the edge of the BOP skid plate injuring his back. A contributing factor for this incident was that H&P's JSA for Installing Work Platforms onto BOPs that recommended as a safe practice to "Always use 100% fall protection"; however, it did not address the requirements in H&P's Fall Protection Plan stating that a properly fitting body harness with a shock absorbing double-leg lanyard shall be worn while working at heights greater than 4-feet above the working surface to the deck.

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

Management system: swing gates with tie offs or guardrails were not installed to prevent falls at the access opening to the lower working platform where the H&P Driller was standing while installing the upper working platform.

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

• Management system: the H&P Driller was not wearing any fall protection gear as required in H&P's JSA for Installing Work Platforms onto BOPs that stated to "Always remain 100% tied off while working at heights" and "Always use 100% fall protection".

• Human performance error: Improper body placement - the H&P Driller was looking up when standing on the lower platform floor while installing the nuts and bolts onto the upper platform leg and he was not situationally aware that when he repositioned himself, he stepped off the unprotected side of the lower working platform and fell backwards injuring his back on and against the edge of BOP skid plate.

20. LIST THE ADDITIONAL INFORMATION:

Contributing factor:

• Management system - insufficient JSA - H&P's JSA stated that to "Always remain 100% tied off while working at heights" or "Always use 100% fall protection"; however, it did address H&P's Fall Protection Plan requirements which stated that fall protection gear must be worn while working at heights greater than 4-feet above the working surface to the deck.

MMS - FORM 2010

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

Not applicable.

No property was damaged during this incident. ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District makes no recommendations to the Office of Incident Investigations regarding this incident.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

Based on the incident investigation findings, a G-110 (C) Incident of Noncompliance (INC) is issued to document that Shell Offshore Inc. (Shell) failed to perform operations in a safe and workmanlike manner during Well A017 operations on the Helmerich & Payne, Inc. (H&P) 406 rig on the Shell Auger Tension Leg Platform located at Garden Banks Block 426A. On 14 April 2022, a H&P Driller was injured while securing washers and nuts onto the bolts to the upper working platform leg while standing by an opening to the lower platform when he stepped off the unprotected side of the lower platform and fell backwards approximately 3 feet 3 inches injuring his lower left back when he landed on and struck the edge of the BOP skid plate. The H&P Driller was evacuated from the rig to an onshore physician where he was diagnosed with fractures to his back.

The back injury was the result of: 1) swing gates with tie offs or guardrails were not installed to prevent falls at the access opening to the lower working platform where the H&P Driller was installing washers and nuts onto the bolts to the upper platform leg; 2) the H&P Driller was not wearing any fall protection gear as recommended in the Job Safety Analysis to "Always remain 100% tied off while working at heights" and "Always use 100% fall protection" and 3) the H&P Driller was looking up when standing on the lower platform floor while installing the upper platform leg and he was not situationally aware that when he repositioned himself, he stepped off the lower working platform's unprotected side and fell backwards injuring his back on and against the edge of BOP skid plate.

25. DATE OF ONSITE INVESTIGATION:	28.	ACCIDENT CLASSIFICATION:
14-APR-2022	29.	ACCIDENT INVESTIGATION PANEL FORMED: NO
26. INVESTIGATION TEAM MEMBERS:		OCS REPORT:
Troy Naquin (Report Author) / Ernest Carmouche (Onsite) /	30.	DISTRICT SUPERVISOR:
27. OPERATOR REPORT ON FILE:		Marty Rinaudo

APPROVED	
DATE:	25-JUL-2022