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: **23-NOV-2021** TIME: **1530** HOURS

2. OPERATOR: **Shell Offshore Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Helmerich & Payne**
   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: **G08241**
   AREA: **GB** LATITUDE:
   BLOCK: **426** LONGITUDE:

5. PLATFORM: **A-Auger TLP**
   RIG NAME: **H&P 406**

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

7. TYPE:
   INJURIES:
- [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	**0**	**1**
[ ] 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:
- [ ] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [X] OTHER **Abandonment**

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: **2860** FT.
11. DISTANCE FROM SHORE: **136** 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:

Incident Summary:
At approximately 1545 hours on 23 November 2021, a Helmerich & Payne, Inc. (H&P) employee sustained a hand injury during Well A019 decompletion operations on the H&P 406 rig that is permanently fixed on Shell Offshore Inc.'s (Shell) Auger Tension Leg Platform (TLP) located at Garden Banks (GB) Block 426A. The H&P employee required evacuation from the facility for medical treatment that resulted in Restricted Work (RW) greater than three days.

Sequence of Events:
On 23 November 2021, during Well A019 decompletion operations, a H&P crew was running in the hole to retrieve a split wear bushing from the hanger profile. A retrieval stand was stood up on a rubber rotary mat for backing off the split wear bushing from the running tool. Two lifting eyes were installed in the split wear bushing by the crew to use as handles and to J-out the split wear bushing off the running tool. Two H&P floorhands, one that was a short service employee (SSE) only on his second hitch as a floorhand, used the lifting eyes to turn and release the split wear bushing from the running tool. As the split wear bushing came off the running tool, it dropped approximately eight inches onto the rubber mat then bounced back three inches striking the H&P SSE floorhand's right-hand that was positioned between the top of the split wear bushing and the bottom of the running tool.

The H&P SSE floorhand was immediately taken to the rig hospital for medical care. After consulting with the onshore physician, the H&P SSE floorhand was evacuated at 1840 hours on 23 November 2021 on a Medevac flight and transported to an onshore medical facility. The H&P SSE floorhand suffered internal injuries to the right-hand little finger, and he received 22 sutures to close a wound to the right-hand ring finger. He was placed on restricted work beginning on 24 November 2021 for a period of approximately five days.

BSEE Investigation:
On 21 December 2021, a Bureau of Safety and Environmental Enforcement (BSEE) Lafayette District Investigators conducted a regularly scheduled monthly inspection of the H&P 406 rig at the Auger TLP platform. During the inspection, BSEE inquired about any additional information that maybe available that Shell hasn't already submitted to BSEE. BSEE was informed by Shell all incident information was already delivered to BSEE and there were no additional incident-related documents. BSEE confirmed that Shell had delivered all investigation-related documents requested from BSEE for this incident.

The BSEE Incident Investigation Team determined that the incident was due to improper hand placement between the split wear bushing and the running tool by a H&P SSE floorhand. The H&P SSE had worked for H&P since 8 February 2021, but this was only his second hitch as a floorhand and he was inexperience doing this task. The H&P Job Safety Analysis (JSA) failed to identify that bouncing tools off the rubber rotary mat may pose a hazard; not utilizing support lines attached to the lifting eyes as recommended in the TechnipFMC Work Procedure for Decompletion Activity for removal of wear bushing from running tool; and not utilizing hands-free tools to minimize the potential for pinch points.

A post investigation report revealed that cause of the incident was due to improper hand placement between the split wear bushing and the running tool by H&P SSE floorhand and not utilizing hands-free tools as recommended to minimize the potential for pinch points.

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

Human performance error:
- **Improper hand placement - hand placement between the split wear bushing and the running tool by a H&P SSE floorhand.**
- **Not following proper procedures - not utilizing support lines attached to the lifting eyes and/or hands-free tools to minimize the potential for pinch points.**

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

Human performance error:
- **Inexperience Offshore - H&P SSE on his second hitch as a floorhand.**
- **Not following proper procedures - not following the recommendations stated in the TechnipFMC Work Procedure for Decompletion Activity for removal of wear bushing from running tool.**

Management system: inadequate hazard analysis - the H&P Job Safety Analysis (JSA) failed to identify that bouncing tools off the rubber rotary mat may pose a hazard.

20. LIST THE ADDITIONAL INFORMATION:

Contributing factors:
Work environment – congested workspace - a jet sub was made up below the wear bushing running tool that prevented the spilt wear bushing to be placed on the floor safely.

21. PROPERTY DAMAGED:

No property was damaged during this incident.

NATURE OF DAMAGE:

Not applicable.

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 A019 decompletion operations using the Helmerich & Payne, Inc. (H&P) 406 rig on the Auger TLP located at Garden Banks Block 426A. On 23 November 2021, a H&P Short Service Employee (SSE) floorhand sustained a right-hand injury when removing a split wear bushing from a wear bushing running tool. The injury was due to improper hand placement between the split wear bushing and the running tool by H&P SSE floorhand. The H&P SSE floorhand was evacuated to a hospital and required surgical repair

of a lacerated tendon to the right-hand little finger, and he also received 22 sutures to close a wound to the right-hand ring finger. The H&P SSE was placed on restricted work beginning 24 November 2021 for approximately five days.

A BSEE Incident Follow-up Investigation Team determined that the injury to the H&P SSE floorhand's right-hand was a result of: 1) improper hand placement; 2) the H&P SSE only his second hitch as a floorhand was inexperience in performing this task; 3) the H&P Job Safety Analysis (JSA) failed to identify that bouncing tools off the rubber rotary mat may pose a hazard; 4) not utilizing support lines attached to the lifting eyes as recommended in the TechnipFMC Work Procedure for Decompletion Activity for removal of wear bushing from running tool; 5) a jet sub was made up below the wear bushing running tool that prevented the spilt wear bushing to be placed safely on the floor; and 6) not utilizing hands-free tools to minimize the potential for pinch points.

25. DATE OF ONSITE INVESTIGATION:

21-DEC-2021

26. INVESTIGATION TEAM MEMBERS:

Johnny Serrette (Onsite) / Ernest Carmouche (Onsite) / Troy Naquin (Report Author) /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Marty Rinaudo

For Public Release

APPROVED DATE: **23-FEB-2022**