ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED
   DATE: 02-FEB-2020  TIME: 1600  HOURS
   STRUCTURAL DAMAGE
   CRANE
   OTHER LIFTING
   DAMAGED/DISABLED SAFETY SYS.
   INCIDENT >$25K
   H2S/15MIN./20PPM
   REQUIRED MUSTER
   SHUTDOWN FROM GAS RELEASE
   OTHER

2. OPERATOR: Shell Offshore Inc.
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: Danos & Curole Marine Contracto
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: G11455
   AREA: GB
   BLOCK: 128

5. PLATFORM: A-Enchilada
   RIG NAME:

6. ACTIVITY:
   EXPLOSION (POE)
   DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
   HISTORIC INJURY
   REQUIRED EVACUATION
   OPERATOR  CONTRACTOR
   LTA (1-3 days)  0  1
   LTA (>3 days)  
   RW/JT (1-3 days)  0  1
   RW/JT (>3 days)  
   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.
   OTHER

9. CAUSE:
   EQUIPMENT FAILURE
   HUMAN ERROR
   EXTERNAL DAMAGE
   SLIP/TRIP/FALL
   WEATHER RELATED
   LEAK
   UPSET H2O TREATING
   OVERBOARD DRILLING FLUID
   OTHER

10. WATER DEPTH: 705 FT.

11. DISTANCE FROM SHORE: 102 MI.

12. WIND DIRECTION:

13. CURRENT DIRECTION:

MMS - FORM 2010
EV2010R
07-JUL-2020
On February 2, 2020, at approximately 1600 hours Shell Offshore Inc. had an injury requiring evacuation at Garden Banks 128-A while conducting sandblasting operations. The incident involves a worker losing control of the sandblaster nozzle while attempting to sandblast an I-beam. The nozzle became lodged under the sandblaster’s right arm pit and blasted through his clothes. The Injured person evacuated to Terrebonne General Medical Center for treatment. At 1811 hours on February 2nd, 2020, Shell notified the bureau of Safety and Environmental Enforcement Lafayette District by email. The BSEE Lafayette District conducted an onsite investigation February 3, 2020.

A sandblaster was attempting to blast an I-beam while standing on a 12-foot scaffold board. One end of the board was placed on the Free Water Knockout and the other end of the board was placed on the Bulk Oil Treater. The board was tied with rope from the ends of the board to outlets located at the bottom of the vessels. According to the Job Safety Analysis and the Working at Heights Fall Rescue Plan, constant visual contact would be maintained on the workers. There were no names listed on the Job Safety Analysis or any other documents to suggest an employee was designated to maintain a constant visual. The hazards of failing to secure the boards and placing the boards across two vessels was not detected.

The sandblaster held on to an I-beam with his left hand and the blasting nozzle was in his right hand. As the sandblaster attempted to reposition himself, the board shifted causing him to lose his grip on the blasting nozzle. The blasting nozzle contained 85 lbs of pressure causing it to whip once the sandblaster released the blasting nozzle. The blasting nozzle became lodged under the sandblaster’s right arm pit and blasted through his clothing near the bicep before the blasting hose could bleed down. The sandblaster stated once he lost his grip on the blasting nozzle, the dead-man switch delayed prior to shutting down. The sandblaster sustained a laceration near the right bicep. The sandblaster was transported to Terrebonne General Medical Center for treatment. A medical provider cleaned the wound of debris and sutured.

The BSEE Lafayette District conducted an onsite investigation February 3, 2020.

During the BSEE onsite investigation, an inspector was able to easily move the board due to the board not being secured properly. A scaffold could have been constructed between the vessels to conduct blasting operations in a safe and workmanlike manner.

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

Human Performance Error – Not following proper procedures: The lessee did not follow the Danos Abrasive Blasting Operations – 6.2.2.8 Working at Elevation Policy which states, working from scaffolds, not ladders or other antiquated elevating items. The scaffold board was not properly secured, and a scaffold could have been constructed to conduct blasting operations in a safe and workmanlike manner.

Equipment Failure – inoperable equipment safety device: the dead-man switch delayed prior to shutting down.

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

Supervision-Inadequate pre-Job Safety meeting

· The Working at Heights Fall Rescue Plan states a designated person would maintain constant visual contact with workers. The hazard of using the scaffold board that was not properly secured and placed across two vessels instead of constructing a scaffold was not identified by the designated person or on the Job Safety Analysis.
• According to the Corrective Action(s) Implementation Plan located in the Danos Root Cause Report, Danos recognized the hazard of the boards being placed across the vessels. The Corrective Action(s) states Danos will incorporate a do’s and don’ts into the Cable Rigging training course which will include not laying boards from vessel to vessel.

• Also listed under the Corrective Action(s) is incorporating depressurization of hoses prior to moving or repositioning yourself as best practice in the Abrasive Blasting Procedure and documented on the Job Safety Analysis.

• According to the Job Safety Analysis and the Working at Heights Fall Rescue Plan, constant visual contact would be maintained on the workers. There were no names listed on the Job Safety Analysis or any other documents to suggest an employee was designated to maintain a constant visual. The hazards of failing to secure the boards and placing the boards across two vessels was not detected.

20. LIST THE ADDITIONAL INFORMATION

21. PROPERTY DAMAGED: NA

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District office makes no recommendations to the Regional Office of Incident Investigations (OII).

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

INC G-110 is issued to document that Shell Offshore Inc. failed to protect health, safety and the environment by not performing operations in a safe and workmanlike manner as follows: While conducting sandblasting operations, the contractor failed to secure/construct a scaffold board that could have prevented the incident referenced below, as per the Danos Abrasive Blasting Operations 6.2.28 Working at Elevations Policy. A contractor was injured while conducting sandblasting operations on a scaffold board that was placed across the top of two separators. The contractor was attempting to blast an I-beam when the board he was standing on shifted, due to the force of the blasting hose. As the board shifted, the contractor lost his balance and released the blasting hose. The contractor grabbed the I-beam with his left hand while attempting to grab the blasting hose.
with his right hand, he missed. As the blasting hose dropped, the sand blasted through the contractor’s clothing and caused injuries under his right arm. The lessee did not follow the Danos Abrasive Blasting Operations - 6.2.2.8 Working at Elevation Policy which states, working from scaffolds, not ladders or other antiquated elevating items. The scaffold board was not properly secured, and a scaffold could have been constructed to conduct blasting operations in a safe and workmanlike manner.

25. DATE OF ONSITE INVESTIGATION:

03-FEB-2020

26. INVESTIGATION TEAM MEMBERS:

Jeremy LeMieux / Wade Guillotte /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Robert Ranney

APPROVED

DATE: 28-JUN-2020