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: **10-AUG-2012** TIME: **1035** HOURS

2. OPERATOR: **Shell Offshore Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G04131**
   AREA: **GC** LATITUDE:
   BLOCK: **19** LONGITUDE:

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

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

7. TYPE:
   - [ ] HISTORIC INJURY
     - [x] REQUIRED EVACUATION 1
     - [ ] LTA (1-3 days)
     - [ ] LTA (>3 days
     - [ ] RW/JT (1-3 days)
     - [x] RW/JT (>3 days) 1
     - [ ] Other Injury
   - [ ] FATALITY
   - [ ] POLLUTION
   - [ ] FIRE
   - [ ] EXPLOSION
   - LWC
     - [ ] HISTORIC BLOWOUT
     - [ ] UNDERGROUND
     - [ ] SURFACE
     - [ ] DEVERTER
     - [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES
   - COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K
   - [ ] STRUCTURAL DAMAGE
   - [ ] CRANE
   - [ ] OTHER LIFTING DEVICE
   - [ ] DAMAGED/DISABLED SAFETY SYS.
   - [ ] INCIDENT >$25K
   - [ ] H2S/15MIN./20PPM
   - [ ] REQUIRED MUSTER
   - [ ] SHUTDOWN FROM GAS RELEASE
   - [x] OTHER **Hand Injury**

6. OPERATION:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [x] OTHER **Construction-Abnmnt Opers.**

8. CAUSE:
   - [ ] EQUIPMENT FAILURE
   - [x] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER

9. WATER DEPTH: **750** FT.

10. DISTANCE FROM SHORE: **75** MI.

11. WIND DIRECTION: **N**
    SPEED: **1** M.P.H.

12. CURRENT DIRECTION: **N**
    SPEED: **1** M.P.H.

13. SEA STATE: **1** FT.

17. INVESTIGATION FINDINGS:

On August 10, 2012, an injury occurred on the Boxer Platform located in Green Canyon 19. The injury occurred when the injured person (IP) was using a grinder with a cutting disk to cut off the top two feet of a ladder cage. The IP was positioned on the outside of the ladder cage cutting the vertical running pieces. The IP had successfully cut four of the flat bar pieces using the safe technique of pushing the grinder away from your body. Before cutting the fifth piece, the IP had to adjust his position due to an obstruction. In doing so, the IP would change his cutting technique to where he was pulling the grinder toward his body instead of pushing it away. Before finishing the cut, the IP lost control of the grinder resulting in a significant cut to the back of his hand. The IP was sent onshore to receive medical treatment and underwent surgery the same day. The IP was released that evening and reassigned to light duty and finished his hitch working in a yard.

Further investigation shows that the IP switched the orientation of the handle for the grinder from right-handed to left-handed. However, the IP did not change the guard position to the left-handed orientation. According to the Job Safety Analysis (JSA), the guard was in the correct position when job started; however, the JSA did not have anything listed about when/if the orientation of the cutting tool was to be changed during the job.

The probable cause of this incident was determined to be strictly human error. If the guard would have been placed in the correct position and the person performing the job would have used proper techniques the incident would not have occurred. The investigation also revealed that a torch cutter would have been a more appropriate tool for the work to be performed.

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

1. Human error due to the incorrect position of the guard.
2. Incorrect tool for the job.

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

20. LIST THE ADDITIONAL INFORMATION:

If changes take place in how a tool is held or used, the designed safety equipment for that tool must accomodate those changes. In this case, a statement should have been placed in the JSA preventing the handle being changed without the safety shield also being changed.

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

None **None**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Houma District has no recommendations for OSM at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:

Paul Nelson /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED DATE: **08-NOV-2012**

INJURY/FATALITY/WITNESS ATTACHMENT

[x] OPERATOR REPRESENTATIVE
[ ] CONTRACTOR REPRESENTATIVE
[ ] OTHER ______________________________

[x] INJURY
[ ] FATALITY
[ ] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE: