

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: 21-NOV-2012 TIME: 1320 HOURS

2. OPERATOR: **Chevron U.S.A. Inc.**  
REPRESENTATIVE:  
TELEPHONE:  
CONTRACTOR:  
REPRESENTATIVE:  
TELEPHONE:

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

4. LEASE: 00310  
AREA: SM LATITUDE:  
BLOCK: 236 LONGITUDE:

5. PLATFORM: A-PRD  
RIG NAME:

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

7. TYPE:  
 HISTORIC INJURY  
 REQUIRED EVACUATION 1  
 LTA (1-3 days)  
 LTA (>3 days) 1  
 RW/JT (1-3 days)  
 RW/JT (>3 days)  
 Other Injury

FATALITY  
 POLLUTION  
 FIRE  
 EXPLOSION

LWC  HISTORIC BLOWOUT  
 UNDERGROUND  
 SURFACE  
 DEVERTER  
 SURFACE EQUIPMENT FAILURE OR PROCEDURES

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

6. OPERATION:  
 STRUCTURAL DAMAGE  
 CRANE  
 OTHER LIFTING DEVICE  
 DAMAGED/DISABLED SAFETY SYS.  
 INCIDENT >\$25K  
 H2S/15MIN./20PPM  
 REQUIRED MUSTER  
 SHUTDOWN FROM GAS RELEASE  
 OTHER **Water Blasting Injury**

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

9. WATER DEPTH: 20 FT.

10. DISTANCE FROM SHORE: 13 MI.

11. WIND DIRECTION:  
SPEED: M.P.H.

12. CURRENT DIRECTION:  
SPEED: M.P.H.

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS:

On November 21, 2012, at approximately 1240 hours, a blasting employee (BE) was severely injured while failing to properly use High Pressure Waterjetting Equipment. The BE was conducting blasting operations on a drain near the pipeline pump area. JSA's were completed but failed to provide specific information concerning the job task including the pump operator maintaining a constant line of sight on the nozzle operator, proper hand placement on the nozzle and proper blasting positions.

The pipeline pump area has three walls that surround it with a door located on the west side. The high pressure pump was located outside the west wall with the hoses positioned through the door. Due to the location of the pump and the obstruction of the west wall, the pump operator was unable to visually monitor the BE.

As blasting operations were in progress the BE arrived at a weld that secured a handrail socket against the inside wall of the drain. Instead of utilizing a needle gun for this task, the BE attempted to use the High Pressure Waterjetting Equipment. Placing his right knee on the deck and his left leg partially extended to the side, the BE extended his arms through the handrails grasping the blasting lance. The blasting lance is equipped with two separate handles and each handle contains a trigger. Due to the awkward position of the blasting lance being outside of the handrails, the BE used his thumbs to activate the blasting lance. As the blasting lance is activated, 30 to 35 lbs. of force is produced which caused the rotating nozzle located at the end of the blasting lance to come in contact with the handrail socket. In an effort to regain control of the blasting lance, the BE overcompensated his adjustment and brought the high pressure stream of water over his left thigh. The high pressure ripped through the BE's slicker suit and jeans causing severe injuries to the BE's left thigh. The BE was flown to Lafayette General for treatment. The BE has underwent further treatment including surgery.

The BSEE Lafayette District conducted an onsite investigation which included visiting the onshore facility where the equipment was being stored after the incident. As the inspectors were examining the equipment, it was observed that the first handle on the lance was not secured. This would not have allowed the BE to properly control the lance in the position he was in at the time of the incident.

Note: Due to this incident, the contractor has revised the Ultra-High Water Blasting Procedure.

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

The BE was not in a position to properly control the lance once the 35 lbs. of force was released. The BE should have had a firm grip on the handles and not with his arms through the handrails.

The BE failed to use the proper tool for the task. A needle gun should have been utilized instead of the High Pressure Waterjetting Equipment.

The handle of the lance should have been secured to prevent the BE from losing control of the lance.

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

The JSA should have included the specific information concerning the job task such as the pump operator maintaining a constant line of sight on the nozzle operator, proper

hand placement on the nozzle and proper blasting positions.

As per the Recommended Practices for the Use of High Pressure Waterjetting Equipment - 10.1.8 Operator Position - The pump operator shall monitor the positions of other team members while the system is in operation, and shall depressurize the system if any team member approaches a hazardous or potentially hazardous position.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

None

NA

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District office makes no recommendations to the Regional BSEE Office of Safety Management (OSM)

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

INC G-110 is issued "After the Fact" to document that Chevron U.S.A. Inc. failed to protect health, safety and the environment by not performing operations in a safe and workmanlike manner as follows: Chevron U.S.A. Inc. failed to properly supervise an employee during blasting operations by failing to adhere to the third party policies and procedures resulting in severe injuries to an employee.

Third party policies and procedures states:

\*Recommended Practices For The Use Of High Pressure Waterjetting Equipment - 10.1.8 Operator Position - The pump operator shall monitor the positions of other team

members while the system is in operation, and shall depressurize the system if any team member approaches a hazardous or potentially hazardous position. The pump operator failed to be in a position to visually monitor the nozzle operator that would allow an emergency shutdown in the event of an incident.

\*As per the manufacture recommendations - Never start up or operate the pump unless the tool is under control. Never point the tool at yourself or another person. Do not allow the waterjet stream to touch any part of your body. Brace yourself when holding the A-3000 Jetlance during start-up, and while running the hand tool.

\*Failed to use the proper tool or equipment for the job as per the JSEA Hazard Identification Preparation Checklist. A needle gun would have been safer to use for this particular task and was accessible to the injured employee prior to the incident.

25. DATE OF ONSITE INVESTIGATION:

07-DEC-2012

26. ONSITE TEAM MEMBERS:

Raymond Johnson / Wade Guillotte /  
Gerald Gonzales /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED

DATE: 28-DEC-2012

# INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER \_\_\_\_\_

WITNESS

NAME :

HOME ADDRESS :

CITY :

STATE :

WORK PHONE :

TOTAL OFFSHORE EXPERIENCE :

YEARS

EMPLOYED BY :

BUSINESS ADDRESS :

CITY :

STATE :

ZIP CODE :

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FATALITY

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