

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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **14-OCT-2012** TIME: **2230** HOURS

2. OPERATOR: **ConocoPhillips Company**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **Nabors Drilling Inc.**

REPRESENTATIVE:

TELEPHONE:

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

4. LEASE: **G11573**

AREA: **GB** LATITUDE:

BLOCK: **783** LONGITUDE:

5. PLATFORM: **A-Magnolia TLP**

RIG NAME: **NABORS MODS 201**

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

7. TYPE:

HISTORIC INJURY

- REQUIRED EVACUATION 1
- LTA (1-3 days)
- LTA (>3 days)
- RW/JT (1-3 days)
- 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 **Air Hoist**
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER **Finger Injury**

6. OPERATION:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

8. CAUSE:

- EQUIPMENT FAILURE
- HUMAN ERROR
- EXTERNAL DAMAGE
- SLIP/TRIP/FALL
- WEATHER RELATED
- LEAK
- UPSET H2O TREATING
- OVERBOARD DRILLING FLUID
- OTHER _____

9. WATER DEPTH: **4670** FT.

10. DISTANCE FROM SHORE: **148** MI.

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

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

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS:

At approximately 2230 hours on 14 October 2012, a Toolpusher employed by Nabors Offshore (Nabors), was injured while performing supervision activities on board the Nabors 201 platform rig located in the Garden Banks 783 Block that was leased by ConocoPhillips Company (ConocoPhillips). At the time of injury, rig personnel were trouble shooting leaks found during pressure testing of the Blowout Preventer. The focus of the leaks was on the bell nipple profile that is part of the riser system. The injured person (IP) was located on a 9 foot (ft) by 5 ft platform area located below the rig floor as he was supervising a team of Floorhands that were rigging down the hose package associated with the bell nipple/riser package system. At the same time, the Assistant Driller was on the upper deck supervising three additional Floorhands that were rigging up the air hoist slings to the bell nipple lifting anchors and rigging down the splash guards that left an 11 ft gap between on the outermost part of the bell nipple. The two halves of the splash guards were then placed into the drip pan located under the rig floor and over the 9 ft by 5 ft platform. Rig floor personnel then instructed a Floorhand operating the air hoist to lift up on the bell nipple. As the air hoist began to lift up, the outside profile of the bell nipple caught the splash guard sides that caused one of the splash guard halves to fall in between the 11 ft gap of the bell nipple and the drip pan that struck the IP's left ring finger. The IP received medical attention on-site for a fractured finger and was flown to Our Lady of Lourdes Hospital located in Lafayette, Louisiana for further treatment.

Nabors' investigation revealed that there was inadequate communication between personnel on the 9 ft by 5 ft platform and personnel on the upper deck. The Job Safety Analysis (JSA) did not capture the remedial action of lifting the bell nipple and consequently the hazards associated with the tasks were not identified and proper hand placement was not emphasized. The lighting was poor at the time of accident and workers had an obscured view of potential falling hazards. The splash guards were not secured once they had been placed in the drip pan.

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

As stated in Nabors' accident investigation, listed below are the probable causes of the accident:

1. Inadequate communication between the rig floor and personnel on the work platform.
2. Improper hand placement by the IP.

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

Presented below are the possible contributing causes of the accident:

1. The JSA did not capture the remedial action of lifting the bell nipple.
2. Inadequate lighting and obstructed view of potential falling hazards.
3. Splash guards were not secured when placed in the drip pan.

20. LIST THE ADDITIONAL INFORMATION:

- 1) BSEE Photographs
- 2) Nabors Job Safety Analysis, Dated October 14, 2012
- 3) ConocoPhillips Investigation Report
- 4) Nabors Investigation Report
- 5) Incident of Noncompliance Transmittal Letter, Dated December 6, 2012
- 6) Incident of Noncompliance issued to ConocoPhillips, Dated December 6, 2012

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

No property damaged occurred during this incident. Not Applicable

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The BSEE Lafayette District makes no recommendations for the Agency.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

Based on the accident investigation findings, a G-110 Incident of Noncompliance (INC) was issued "After the Fact" to document that the operator failed to perform all operations in a safe and workmanlike manner that resulted in a rig worker sustaining a fracture finger during lifting operations of the bell nipple with an air hoist. Additionally, the operator failed to authorize this operation and insure that effective job planning was conducted for this type of lifting activity.

25. DATE OF ONSITE INVESTIGATION:

16-OCT-2012

26. ONSITE TEAM MEMBERS:

Ernest Carmouche /

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED

DATE:

10-DEC-2012

