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: **26-NOV-2015** TIME: **0131** HOURS

2. OPERATOR: **EPL Oil & Gas, Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **ROWAN COMPANIES INC.**
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G04464**
   AREA: **ST** LATITUDE:
   BLOCK: **200** LONGITUDE:

5. PLATFORM: **A**
   RIG NAME: **ROWAN GORILLA IV**

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
   - [ ] OTHER

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

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: **131** FT.

10. DISTANCE FROM SHORE: **41** MI.

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

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

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS:

For Public Release

On November 26, 2015, a Floor Hand working on the Rowan Gorilla IV, which was contracted to EPL Oil and Gas/Energy XXI, suffered an injury to his left hand while performing tripping operations on the rig floor.

At approximately 01:25 hours, the Assistant Driller (AD) took over control of the top drive following a change out of the elevators from 6 3/4" to 4". As the AD raised the top drive to pick up the first stand of 4" drill pipe, two Floor Hands were simultaneously positioning the iron roughneck around the pipes collar to break torque on the lifting sub. While the AD was raising the top drive, which was now holding the 4" drill pipe, he noticed the throttle pedal "felt different." He briefly looked down at the pedal, and when he looked up, the drill pipe swung uncontrolled against one of the Floor Hand's wrist. The Injured Person's (IP) wrist and hand were crushed between the drill pipe and the iron roughneck, which caused a laceration to his left hand.

The IP was sent in at 08:05 hours for further medical evaluation via a normally contracted helicopter. The laceration required stitches but no further injuries were identified. The IP was sent back to the rig the same day, but he was placed on restricted work duty.

The normal procedure for running drill pipe called for the top drive to be raised and to stop and wait for the floor hands to be ready to "tail-in" the drill pipe into place. Tail-in means that the Floor Hands would help guide the drill pipe into place, which is a controlled method of running the pipe. The AD took his eyes and attention off of the operation, and during this lapse in attention to the job, he broke from normal procedure by continuing to raise the top drive when he should have stopped and waited for the Floor Hands to move the drill pipe. In addition, the crew on the drill floor failed to follow Rowan's 'Red Zone Policy'. This policy states that no personnel should be in the 'Red Zone' while the top drive is being operated. This would protect the personnel working on the rig floor by keeping them out of harm's way while equipment is moving and being transferred around the rotary. Had the drill crew followed these policies, the incident would likely not have occurred.

Following the incident it was noted that on the tour previous to the incident, the Driller and AD had identified a missing pin in the top drive throttle pedal. They replaced the pin with a nut and bolt, and initially the pedal did stick but after adjustment the pedal operated smoothly. The Maintenance Supervisor inspected the pedal following the incident and determined the pedal to be working correctly.

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

1) Lack of Focus: The primary cause of the incident was lack of attention to the job. The AD took his attention off the job while work was still on-going and this lapse in attention caused him to break from normal procedure. This lead to the drill pipe swinging freely and it crushed the IP's hand between the drill pipe and the iron roughneck.

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

1) Failure to follow Company Policy: Had the crew followed Rowan's 'Red Zone Policy', crew members would not have been in the line of fire when the drill pipe swung toward well center.

For Public Release

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

N/A **N/A**

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Houma District has no recommendations for the Office of Incident Investigations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

On November 26, 2015, while performing Abandonment operations for EPL Oil and Gas/Energy XXI, an incident occurred on the 'Rowan Gorilla IV' when an employee was struck on the hand by a stand of drill pipe while it was being transferred on the rig floor.

At the time of the incident, the Assistant Driller (AD) was in the process of hoisting up a stand of 4" drill pipe in order to transfer it to well center to begin tripping in the hole. During the transfer the AD noticed that "something didn't feel right" with his throttle pedal. The AD looked down to examine the Throttle pedal but failed to set the brake or disengage the clutch. Unaware of the height of his top drive, the AD allowed the stand to reach a height where the pipe was allowed to swing uncontrolled to well center and strike a Floorhand on the hand.

The Injured Party was evacuated for further evaluation. The IP recieved stitches due to a laceration sustained to his left hand and was allowed to return to work under restricted duty.

25. DATE OF ONSITE INVESTIGATION:

For Public Release

26. ONSITE TEAM MEMBERS:
James Richard / Josh Ladner /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan Domangue

APPROVED DATE: **11-FEB-2016**