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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
DATE: **31-MAY-2011** TIME: **0945** HOURS

2. OPERATOR: **LLOG Exploration Offshore, L.L.C.**
REPRESENTATIVE: **Richard, John**
TELEPHONE: **(985) 801-4300**
CONTRACTOR: **NOBLE DRILLING CORPORATION**
REPRESENTATIVE: **Robert Causey**
TELEPHONE: **(601) 684-4152**

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

4. LEASE: **G33175**
AREA: **MC** LATITUDE:
BLOCK: **751** LONGITUDE:

5. PLATFORM:
RIG NAME: **NOBLE AMOS RUNNER**

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

7. TYPE:
- [ ] HISTORIC INJURY
- [X] REQUIRED EVACUATION **1**
- [ ] LTA (1-3 days)
- [X] 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

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [ ] OTHER LIFTING DEVICE
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [X] OTHER **Pipe Rack Handler**

6. OPERATION:
- [ ] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [X] OTHER **Tripping in the hole**

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: **1628** FT.

10. DISTANCE FROM SHORE: **61** MI.

11. WIND DIRECTION:
SPEED: **15** M.P.H.

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

13. SEA STATE: FT.

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17. INVESTIGATION FINDINGS:

At the time of the accident, the rig crew was conducting simultaneous operations (anchoring and removal of the guide assembly). A Job Safety Analysis (JSA) # 0068-001656, dated 25 September 2007 was in effect and stated, "Make sure permit is signed by all personnel involved, including management." The JSA was revised (JSA# 0073-001805, dated 31 May 2011) after the incident and the requirement for signatures was left out. The required signed permit as per JSA# 0068-001656 was not provided upon our request. The Injured Person (IP) is a floorhand and although his position suggests his duties are on the rig floor, it's unclear as to why the IP was on the floor in the position behind the Pipe Rack Handler (PRH). The drill crew was picking up the Dril Quip retrieval tool and tripping in the hole to 660'. The IP was positioned between the PRH and the Iron Rough Neck. During the course of operations, the PRH was rotated forward and the IP was wedged between the lower linear motor and the travel motor and pulled through the mechanism to the opposite side. The IP was not seen until the time the individual fell onto the rig floor. The IP was transported by a Medical Helicopter to East Jefferson Hospital.

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

*** Personnel did not sign in as prescribed by JSA #0068-001656 dated September 2007. The JSA was revised on the date of the accident (JSA #0073-001805), but the revision omitted the requirement, "Make sure permit is signed by all personnel involved including management."**
*** The IP's lack of situational awareness resulting from being trapped in a crush/pinch point.**
*** Other drill crew members were unaware of whom/where personnel were located on the drill floor.**
*** A general overall complacency resulting from the lack of communication between all personnel.**

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

*** Improper positioning of the IP on the rig floor.**
*** Color of the coveralls blended in with the color of the PRH, causing a camouflaging effect making the IP difficult to see.**
*** A lack of span of control by the driller by not properly supervising the operation.**

20. LIST THE ADDITIONAL INFORMATION:

The IP was sedated in the ICU and unable to provide a statement. At the time of the investigation, all witnesses made crew change prior to BOEMRE representatives arrival onboard to conduct the investigation; therefore, no witnesses were available.

New Orleans District's recommendations to the drilling contractor to prevent recurrence include:
*** Improved span of control by driller or other drill floor supervisor.**
*** Improved communicating between crew members.**
*** Check-in procedures to the drill floor for certain specified operations.**
*** Change color of coveralls to prevent blending in with surrounding equipment.**

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21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BOEMRE New Orleans District makes no recommendations to the Agency.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 Description: On 5-31-2011 an accident involving injury occurred; permit was not signed as required by the JSA.

25. DATE OF ONSITE INVESTIGATION:

8-JUN-2011

26. ONSITE TEAM MEMBERS:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

David Trocquet

APPROVED DATE: **31-JAN-2012**

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INJURY/FATALITY/WITNESS ATTACHMENT

[ ] OPERATOR REPRESENTATIVE
[X] CONTRACTOR REPRESENTATIVE
[ ] OTHER _____

[ ] INJURY
[ ] FATALITY
[X] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE:

[ ] OPERATOR REPRESENTATIVE
[X] CONTRACTOR REPRESENTATIVE
[ ] OTHER _____

[ ] INJURY
[ ] FATALITY
[X] WITNESS

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