UNITED STATES DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: 28-MAR-2004 TIME: 0800 HOURS

2. OPERATOR: Unocal Exploration Corporation

REPRESENTATIVE:

TELEPHONE:

3. LEASE: G02592

AREA: SM LATITUDE:

BLOCK: 149 LONGITUDE:

4. PLATFORM:

RIG NAME ROWAN ARCH ROWAN

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

6. TYPE: [ ] FIRE
[ ] EXPLOSION
[ ] BLOWOUT
[ ] COLLISION
[X] INJURY NO. 1
[ ] FATALITY NO. ____
[ ] POLLUTION
[ ] OTHER ____

7. OPERATION: [ ] PRODUCTION
[X] DRILLING
[ ] WORKOVER
[ ] COMPLETION
[ ] MOTOR VESSEL
[ ] PIPELINE SEGMENT NO. ____
[ ] OTHER ____

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: 228 FT.

10. DISTANCE FROM SHORE: 95 MI.

11. WIND DIRECTION:

SPEED: M.P.H.

12. CURRENT DIRECTION:

SPEED: M.P.H.

13. SEA STATE: FT.

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

CITY: STATE:

TELEPHONE:

CONTRACTOR:

CONTRACTOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:

CITY: STATE:

TELEPHONE:

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

The rig welder and roustabout had attached a three-quarter (3/4) inch rope to a 5 inch mooring line that was being lowered to the port side of the drilling rig by the crane operator. The rig welder's leg was struck by the 5 inch mooring line and was pinned against a handrail resulting in a fracture of his tibia. A JSA was conducted prior to the rig crew removing the mooring line. The injured worker was attended to by medics on the rig and was later transported by medic-vac to Terrebonne General in Houma, La.
Note: The crane operator had received training in crane operations and the roustabout and welder had received training in rigging operations.

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

The welder apparently failed to realize that the weight of the 5 inch mooring line would excellerate the mooring line rate of descent to the point that it was uncontrollable. The welder inadvertently placed himself between the handrail and mooring line as the mooring line was being lowered from the rig deck.

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

None

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

None

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

No recommendation by MMS, however, MMS agrees with the procedure outlined in the Rowan safety alert.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

None

25. DATE OF ONSITE INVESTIGATION:

01-APR-2004

26. ONSITE TEAM MEMBERS:

Leo Dartez / Johnny Serrette /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott Smith

APPROVED

DATE: **13-MAY-2004**