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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **06-DEC-2007** TIME: **1645** HOURS

2. OPERATOR: **BHP Billiton Petroleum (GOM) Inc.**
   REPRESENTATIVE: **Watson, Sarah**
   TELEPHONE: **(713) 599-6248**
   CONTRACTOR: **NOBLE DRILLING CORPORATION**
   REPRESENTATIVE: **Briggs, Mike**
   TELEPHONE: **(281) 276-6703**

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

4. LEASE: **G20113**
   AREA: **GC** LATITUDE:
   BLOCK: **953** LONGITUDE:

5. PLATFORM:
   RIG NAME: **NOBLE PAUL ROMANO**

6. ACTIVITY:
- [X] EXPLORATION(POE)
- [ ] 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
- [ ] OTHER

6. OPERATION:
- [ ] PRODUCTION
- [X] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] 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: **4790** FT.

10. DISTANCE FROM SHORE: **145** MI.

11. WIND DIRECTION: **N**
    SPEED: **22** M.P.H.

12. CURRENT DIRECTION: **ESE**
    SPEED: **1** M.P.H.

13. SEA STATE: **2** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On Thursday December 6, 2007 at approximately 0600 hours, the Injured Person (IP) started as Trainee Assistant Driller on the Semi-Submersible Drilling Rig the Noble Paul Romano. The IP is in an Operations Management Training Program that requires candidates to be exposed to all operational positions and duties on the rig. The IP had worked for several months as Roustabout, Roughneck, and Derrickman on this drilling rig and other Mobile Offshore Drilling Unit's (MODU's).

At approximately 1130 hours, the IP attended the Pre-Tour Safety Meeting prior to the regular shift change. At that meeting an event was reviewed from earlier in the week on the Global Santa Fe DD1 drilling rig where an Electrician was 'caught between' a fixed structure and mobile rig floor equipment. Following the Pre-Tour Safety Meeting the rig floor crew reviewed the Job Safety Analysis (JSA) for 'Tripping Pipe' and racking it back in the derrick. Steps identified as hazards on that assessment included major pinch points, notably between the Pipe Racking System (PRS) and stands of drill pipe that had already been racked back.

At approximately 1200 hours, the rig floor crew continued the previous operation of tripping and racking back drill pipe that began with the previous rig floor crew.

At approximately 1400 hours, operations ceased to allow for maintenance to rig floor equipment and the slipping and cutting of the drill line. A JSA for the activity was completed along with a further review of the earlier assessment for tripping pipe. Maintenance activities continued until completed at approximately 1600 hours and the crews recommenced tripping pipe operations.

During the maintenance period a grease gun, with its associated drum and line, had been used on the PRS and Topdrive. The grease gun line was coiled up and placed away from operations. At approximately 1645 hours, after another 14 stands of drill pipe had been racked back, it is understood that the IP was unhappy with the condition of the grease gun unit and proceeded to lay out the line for the unit in preparation to coil it up again. After laying out the line the IP went behind the drill pipe in the set back area and used the restroom located at the back of the rig floor. He returned to the rig floor through a gap between the drill pipe in the set back area and was not seen by other rig floor personnel. The Iron Roughneck and PRS totally obstructed the view of the gap from the Drillers Station and the PRS Station, which are on the opposite side of the drill floor. The IP then tried to move behind the PRS back to his original position with the grease gun when the PRS was activated. As the PRS turned, a crash frame mounted over the motor unit caught the IP crushing him between the frame and the drill pipe then pulling him through the said gap and pushed him out the other side. A scream was heard and all operations were immediately stopped as the crew investigated. The IP was found lying on the deck by the PRS in severe pain but with no obvious injury.

During these periods the IP had not been allocated a specific task and was seen during the day doing housekeeping and minor maintenance tasks. It was noted at post-event interviews with witnesses that they didn't know what the IP was supposed to be doing and he had not been identified with any specific crew or task.

The medic was called to the rig floor and the IP was assessed, stabilized, and transferred to the medical room on the rig to await the Medevac helicopter. A Medevac Rescue (Air Care 1) was requested by the rig at approximately 1700 hours. The IP was taken to East Jefferson Hospital Trauma Center in New Orleans where he was diagnosed with multiple fractures to his pelvis that are consistent with a severe

crash injury.

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

The IP recognized the hazard but believed he had enough time to move between the PRS and drill pipe before the PRS would move.

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

The IP was new to the position and rig floor crew. The rig floor crew did not understand the IP's role or duties and as operation progressed he became detached from the team and lost by the 'buddy system'.

The IP was in a new position as Trainee Assistant Driller. His activities at the time were self directed and there was an apparent lack of direct supervision.

At the time of the event the IP had become preoccupied with correcting the grease gun line and walked into a crush point between the PRS and drill pipe.

20. LIST THE ADDITIONAL INFORMATION:

No additional information.

21. PROPERTY DAMAGED:

None.

NATURE OF DAMAGE:

None.

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Houma District has no recommendations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:

Ben Coco /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan Domangue

APPROVED

DATE: **14-FEB-2007**