UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
PACIFIC OCS REGION
ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: 03-OCT-2012 TIME: 1700 HOURS

2. OPERATOR: DCOR, L.L.C.
   REPRESENTATIVE: TELEPHONE:
   CONTRACTOR: REPRESENTATIVE: TELEPHONE:

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

4. LEASE: P00240
   AREA: LA LATITUDE:
   BLOCK: 6659 LONGITUDE:

5. PLATFORM: HILLHOUSE
   RIG NAME:

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

7. TYPE:
   [X] HISTORIC INJURY
   [ ] 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

8. CAUSE:
   [X] EQUIPMENT FAILURE
   [ ] HUMAN ERROR
   [ ] EXTERNAL DAMAGE
   [ ] SLIP/TRIP/FALL
   [ ] WEATHER RELATED
   [ ] LEAK
   [ ] UPSET H2O TREATING
   [ ] OVERBOARD DRILLING FLUID
   [ ] OTHER

9. WATER DEPTH: 190 FT.

10. DISTANCE FROM SHORE: 4 MI.

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

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

13. SEA STATE: FT.

14. PICTURES TAKEN: YES

15. STATEMENT TAKEN: YES

MMS - FORM 2010
EV2010R

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18-MAR-2013
17. INVESTIGATION FINDINGS:

On 10/03/12, crews were replacing the 4160 wiring from the 35Kv to 4160 transformer on the Hillhouse platform. IP was working in the main switch gear room on a ladder prepping new wires that were just installed for splicing. Two sets of 3 wires were pulled in to a J-Box approx 4x4 ft square. The decision was made to power up the 35Kv cable from the beach to the platform. When the power came on, the wires went live & arced in the box causing the person to receive flash burns to his face, hands & to his groin. Burns were classified as 1st to 3rd degree.

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

Upon investigation on the platform, the one line drawings were reviewed. The drawing shows that there is a switch at transformer #1 (35Kv to 4160v) & a breaker at the MCC-1. Power was removed at the beach from the sub-station where the breaker was opened. This happened on 10/01/12. Power was locked out at that point. Breaker on the 35Kv transformer on the platform was left in the closed position & the incoming Hillhouse & shore site main breaker was opened in the MCC-1. The cable was verified to now have power on it by the contract electrician & also the DCOR electrician.

Work began & the conduit was replaced & new wires were pulled.

On 10/03/12, the plan was to power up the cable from the beach to the platform. The 35Kv transformer was closed up & the breaker was verified closed. This was done so that they would not have to close the breaker with 35Kv on it. Communication was made from the beach to the DCOR rep on the platform. The DCOR rep on the platform asked the electrical contract forman if it was ok to power up the line. He stated that all was good & they were clear & ready to go. When the DCOR rep contacted the rep on the beach, the rep on the beach said he needed 15 minutes to fix something. The rep on the beach called back & said that they were ready to go. At the time the breaker on the beach was closed & powered up to then trip out on a ground fault.

The IP was working on the wires that ran from the transformer to the MCC-1. The lines are flashed causing the injuries.

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

The findings are as follows:

01) It was found that there was no isolation permit completed for the isolation of the transformer or for the switch gear in the MCC-1.
02) A hot work permit was filled out for the use of electrical tools.
03) A JHA was filled out but was not completed.
04) Personnel did not make sure that all personnel were clear of work areas & if work was completed before powering up the 35Kv line.
05) Personnel relied on the one line drawings & did not do a job walk to verify the lines that they were working on. One line drawings do not show the J-Box in line.
06) Personnel did not follow DCOR's LOTO procedures.
07) Personnel did not follow DCOR's electrical safety policy.

20. LIST THE ADDITIONAL INFORMATION:
PROPERTY DAMAGED: N/A

NATURE OF DAMAGE: 

ESTIMATED AMOUNT (TOTAL): $ 

RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE: 

POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES 

SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE: 

01) It was found that there was no isolation permit completed for the isolation of the transformer or for the switch gear in the MCC-1. 
02) A hot work permit was filled out for the use of electrical tools. 
03) A JHA was filled out but was not completed. 
04) Personnel did not make sure that all personnel were clear of work areas & if work was completed before powering up the 35Kv line. 
05) Personnel relied on the one line drawings & did not do a job walk to verify the lines that they were working on. One line drawings do not show the J-Box in line. 
06) Personnel did not follow DCOR's LOTO procedures. 
07) Personnel did not follow DCOR's electrical safety policy. 

DATE OF ONSITE INVESTIGATION: 05-OCT-2012 

ACCIDENT CLASSIFICATION: MINOR 

ONSITE TEAM MEMBERS: 
Louis Fernandez / Chet Miller / 

ACCIDENT INVESTIGATION PANEL FORMED: NO 

OCS REPORT: 

DISTRICT SUPERVISOR: 
Mike Mitchell (Acting) 

OPERATOR REPORT ON FILE: NO 

APPROVED DATE: 13-NOV-2012 

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