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: 03-NOV-2015 TIME: 1640 HOURS

2. OPERATOR: Fieldwood SD Offshore LLC
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: G02647
   AREA: EB LATITUDE:
   BLOCK: 160 LONGITUDE:

5. PLATFORM: A-Cerveza
   RIG NAME:

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

7. TYPE:
   ■ HISTORIC INJURY
     □ REQUIRED EVACUATION 1
     □ LTA (1-3 days)
     □ LTA (>3 days)
     □ RW/JT (1-3 days) 1
     □ RW/JT (>3 days)
     □ Other Injury
   ■ FATALITY
   ■ POLLUTION
   ■ FIRE
   ■ EXPLOSION
   □ HISTORIC BLOWOUT
     ■ UNDERGROUND
     ■ SURFACE
     ■ DEVERTER
     ■ SURFACE EQUIPMENT FAILURE OR PROCEDURES
   ■ COLLISION
     □ HISTORIC □ >$25K □ <=$25K

6. OPERATION:
   ■ PRODUCTION
   ■ DRILLING
   ■ WORKOVER
   ■ COMPLETION
   ■ HELICOPTER
   ■ MOTOR VESSEL
   ■ PIPELINE SEGMENT NO.
   □ OTHER    Decom. T&A Well #6 and #26

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

9. WATER DEPTH: 935 FT.

10. DISTANCE FROM SHORE: 87 MI.

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

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

13. SEA STATE: FT.
17. INVESTIGATION FINDINGS:

After completing temporary abandonment operations by pumping a cement balance plug in the A-26 well with 2200 psi shut in tubing pressure (SITP), the Injured Person (IP) went down to the well bay area to close the Lower Manual Master Valve on the production tree. The valve was hard to close due to trapped pressure so the IP used a thirty-six inch aluminum pipe wrench (APW) on the valve handle to close the lower master valve. The IP was standing on the left side of the valve pushing the APW away from his body with no success at closing the valve. He then repositioned himself on the other side of the valve and bent down on his right knee, repositioned the APW on the valve wheel and began to pull the APW towards himself. After several turns of the valve wheel, the APW slipped off the valve wheel and the end of the thirty-six inch APW struck the IP in the mouth, breaking the two top front teeth and caused a minor laceration to the lower lip.

The IP was evaluated by a medic on site and it was later determined by Fieldwood Energy to send the IP in to be further evaluated by a licensed physician. After being evaluated at UTMB Galveston, results indicated that the injuries were isolated to the IP's lower lip and to the two top front teeth only.

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

Improper tool selection to close the Lower Manual Master Valve.
Used a thirty-six inch aluminum pipe wrench instead of a valve wrench.

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

Improper body position
Improper tool selection

20. LIST THE ADDITIONAL INFORMATION:

Recommend using a valve wrench for turning a valve wheel.

21. PROPERTY DAMAGED: None  NATURE OF DAMAGE: None

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Jackson District has no recommendations to the Regional office.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:
During the Incident Investigation which required medical evacuation:

The Lessee failed to perform all operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment.

During a Temporary Abandonment Operation on the A-26 well, the Injured Party (IP) was closing the Lower Manual Master Valve (LMMV) utilizing a 36 inch Aluminum Pipe Wrench (APW). The APW slipped off the hand wheel of the LMMV and struck the IP in the mouth. The impact of the APW broke both Incisors (Front Teeth) and caused a minor laceration to the IP's lower lip which required medical evacuation.

25. DATE OF ONSITE INVESTIGATION:
   04-NOV-2015

26. ONSITE TEAM MEMBERS:
   Jacob Trevino / Mike Hankamer /

29. ACCIDENT INVESTIGATION
   PANEL FORMED: NO

   OCS REPORT:

30. DISTRICT SUPERVISOR:
   John McCarroll

APPROVED
DATE: 22-DEC-2015