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: 29-SEP-2012 TIME: 0345 HOURS

2. OPERATOR: Murphy Exploration & Production Co
REPRESENTATIVE:
TELEPHONE:
CONTRACTOR:
REPRESENTATIVE:
TELEPHONE:

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

4. LEASE: G21790
AREA: GC LATITUDE:
BLOCK: 338 LONGITUDE:

5. PLATFORM: A-Front Runner
RIG NAME:

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

7. TYPE:
[ ] HISTORIC INJURY
[ ] REQUIRED EVACUATION 1
LTA (1-3 days) 1
LTA (>3 days) 1
RW/JT (1-3 days) 1
RW/JT (>3 days) 1
[ ] 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

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

9. WATER DEPTH: 3330 FT.

10. DISTANCE FROM SHORE: 110 MI.

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

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

13. SEA STATE: 4 FT.
17. INVESTIGATION FINDINGS:

On September 29, 2012, a Roustabout working on the Nabors MODS 200 drilling rig had his left Index Finger and left Middle Finger crushed while in the process of moving a stand of 4 inch drill pipe from the rotary to the setback mats on the drill floor.

On the day of the accident, the rig was working for Murphy Exploration & Production Company. The rig was set up on Murphy's 'A-Frontrunner' platform; located at Green Canyon 338, OCS-G21790. The drill crew had been in the process of pulling out of the hole with 4 inch drill pipe. Some of the Floorhands were being paired with Roustabouts to assist in training them on the operations that take place on the rig floor. The Injured Person (IP), a new Roustabout, was assisting one of the Floorhands with disconnecting the joints of pipe as they were pulling out of the hole and repositioning them into the racks on the derrick to be stored. After pulling stand 129, the two employees proceeded to push the drill pipe over towards the setback area. The IP had his hand near the bottom of the pipe and failed to move his hand up as the Driller began to lower the pipe. Just before the stand of pipe contacted the setback mat, the IP's left hand slipped off of the pipe and down onto the floor as he tried to stop himself from falling. His hand landed underneath the pipe that was being set down and his index and middle fingers were crushed by the pipe. The Roustabout that was working the backup tongs noticed the IP pulling on his hand. He then noticed the IP's fingers were trapped under the stand of pipe and signaled for the Driller to pick the pipe back up. The Derrickhand placed the stand of pipe back into the elevators and it was lifted off of the IP's fingers.

The accident was reported and a helicopter carrying an Acadian Medic arrived on location at approximately 06:15. The IP was flown to Terrebonne General Medical Center for treatment. The accident was reported to the United States Coast Guard at 11:30 on September 29, 2012. The Bureau of Safety and Environmental Enforcement was notified via e-Well on October 1, 2012. The IP's left Index Finger and left Middle Finger had to be amputated due to his injuries. The IP was placed on restrictive duty.

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

The probable cause of this incident was bad body placement. The employee was unaware of the dangers of keeping his hands so close to the bottom of the stand of drill pipe while it was being lowered to the setback mat.

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

1) Inexperience could have played a part in the accident. Employee had been a Roustabout for less than 6 months at the time of the accident.

2) Lack of training and supervision could have also been a factor in the accident. More training on the proper way to rack back pipe and more thorough supervision by the Driller and Floorhand in charge of training the new Roustabout may have decreased the chances of the accident occurring.

20. LIST THE ADDITIONAL INFORMATION:
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:

   02-OCT-2012

26. ONSITE TEAM MEMBERS:

   Troy Boudreaux / Clinton Campo / James Richard /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

   OCS REPORT:

30. DISTRICT SUPERVISOR:

   Bryan Domangue

   APPROVED DATE: 11-JUL-2013
INJURY/FATALITY/WITNESS ATTACHMENT

☐ OPERATOR REPRESENTATIVE ☐ INJURY
☒ CONTRACTOR REPRESENTATIVE ☐ FATALITY
☐ OTHER _________________________ ☐ WITNESS

NAME:
HOME ADDRESS:
CITY: STATE:
WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:
BUSINESS ADDRESS:
CITY: STATE:
ZIP CODE: