For Public Release

UNITED STATES DEPARTMENT OF THE INTERIOR -
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT -
GULF OF MEXICO REGION -

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
DATE: 06-AUG-2014 TIME: 0200 HOURS

2. OPERATOR: Energy XXI GOM, LLC
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: Wood Group Production Services
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: G02433
   AREA: HI
   BLOCK: A 368

5. PLATFORM: A
   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)
     RW/JT (>3 days) 1 -
     Other Injury -
   ✓ FIRE

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

9. WATER DEPTH: 314 FT.

10. DISTANCE FROM SHORE: 116 MI.

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

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

13. SEA STATE: ______

MMS - FORM 2010
EV2010R-
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On August 6, 2014 at approximately 2:00 am, the main platform generator shut down at Energy XXI's High Island A368 'A' platform, OCS-G-02433. Two contract operators for Energy XXI were in bed sleeping when the main platform generator shut down. Both operators went downstairs to the main generator to determine the cause of the shut down. Upon investigation, the operators observed the main generator belts had severed causing the engine to overheat and shut down due to high temperature. The operators then went to the backup diesel generator and attempted to start the unit. The backup diesel generator utilizes two 12 volt direct current (VDC) batteries in series to start the generator's diesel engine. The Lead Operator pushed the start switch on the backup diesel generator and the starter engaged briefly then stopped. The 12 VDC batteries were located side by side in separate battery boxes adjacent to the backup diesel generator. The 'A' Operator (Injured Party / IP) removed the cover from the first battery box to check for loose battery post terminal connections and they were secure. The IP then removed the second battery box cover to verify the terminals were secure. When the IP moved the battery terminal connections in battery box #2, it sparked. The sparks from the loose battery terminal connection in battery box #2 are believed to have been the ignition source that caused an accumulation of hydrogen gas in battery box #2 to explode. The explosion caused battery acid to be blown in the face and eyes of the IP.

The Lead Operator flushed the IP's face and eyes with water and contacted the High Island A368 'B' facility to request them to call for the Search and Rescue (SAR) Helicopter for evacuation of the IP. The SAR Helicopter arrived at High Island A368 'A' at approximately 4:30 am and transported the IP to Lake Charles Memorial Hospital.

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

Sparks from a loose battery terminal connection on the #2 battery for the backup diesel generator are suspected to have ignited a hydrogen gas accumulation in the #2 battery box causing the battery to explode.

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

The IP failed to wear Personal Protective Equipment (PPE) to protect face and eyes prior to checking the battery terminal connections on the backup diesel generator.

Both operators were in bed when the Main Generator shut down. Fatigue, darkness, and failure to observe surroundings were possible contributing factors.

20. LIST THE ADDITIONAL INFORMATION:

The IP was released from Doctors' care to full duty on 12-Aug-2014.

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:
Del Star 12 volt battery. Destroyed due to explosion.

ESTIMATED AMOUNT (TOTAL): $200

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

None.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

1 G-110 'C' Incident of Non Compliance was issued to the Lessee on 14-Aug-2014. 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. The investigation revealed that operators were not wearing proper PPE at the time of the incident.

25. DATE OF ONSITE INVESTIGATION:

07-AUG-2014

26. ONSITE TEAM MEMBERS:

Edward Keown /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

30. DISTRICT SUPERVISOR:

Stephen P. Martinez

INJURY/FATALITY/WITNESS ATTACHMENT

☐ OPERATOR REPRESENTATIVE ☑ INJURY

☐ CONTRACTOR REPRESENTATIVE ☐ FATALITY

☐ OTHER ___________________________ ☐ WITNESS

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