**ACCIDENT INVESTIGATION REPORT**

1. **DATE:** 13-JAN-2015  
   **TIME:** 1455  
   **HOURS**

2. **OPERATOR:** McMoRan Oil & Gas LLC  
   **REPRESENTATIVE:**  
   **TELEPHONE:**

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

4. **LEASE:** G27896  
   **AREA:** SM  
   **LATITUDE:**  
   **BLOCK:** 234  
   **LONGITUDE:**

5. **PLATFORM:**
   **RIG NAME:** ROWAN EXL III

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

7. **TYPE:**
   - **HISTORIC INJURY**
     - **REQUIRED EVACUATION**  
       - LTA (1-3 days)  
       - LTA (>3 days)  
       - RW/JT (1-3 days)  
       - RW/JT (>3 days)  
   - **FATALITY**  
   - **POLLUTION**  
   - **FIRE**  
   - **EXPLOSION**

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

9. **WATER DEPTH:** 20 FT.

10. **DISTANCE FROM SHORE:** 17 MI.

11. **WIND DIRECTION:** NNE  
    **SPEED:** 18 M.P.H.

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

13. **SEA STATE:** 3 FT.
On 13 January 2015, a Rowan Company (Rowan) Assistant Driller (AD) sustained a hand injury on board the Rowan EXL III jack-up rig that was under contract by McMoRan Oil & Gas LLC (McMoRan) to conduct well operations at South Marsh Island (SMI) Block 234. The accident occurred at approximately 14:55 hours while breaking a pipe joint with the Iron Roughneck (IR).

Prior to the accident, Rowan held a Pre-Tour Safety Meeting with the drill crew and had discussed the task of laying drill pipe down using the mouse-hole. The drill crew went over the Rowan standard operating procedures (SOP) and the Job Risk Analysis (JRA) that addressed hazards including pinch points and proper hand placement. As the drill crew were breaking pipe, they encountered a pipe joint that the Frank's Power Tongs was unable to break apart; therefore, it was decided to use the IR instead. The Driller determined that breaking the pipe with the IR would be a complex operation, so he and the AD would perform the job. The Driller manned the IR and the AD positioned the pipe into the IR dies using his left hand and foot. The AD verbally instructed the Driller to close the bottom jaws of the IR. The Driller acknowledged the AD's request and pulled the manual lever to close the IR's bottom jaws; however, the IR spinners engaged and pinned the AD's left hand against the pipe. The Driller opened the IR spinners and immediately stopped the job. The AD was escorted to the Rig Medic for medical treatment of his left hand. Based on the severity of the AD's hand injury, he was evacuated from the rig at 15:30 hours on a crew boat for further medical evaluation at the Our Lady of Lourdes Hospital in Lafayette, Louisiana.

McMoRan informed BSEE that the AD suffered three fractures in his left hand as follows: 1) a comminuted fracture of the left index finger metacarpophalangeal joint, 2) an oblique fracture of the left index finger proximal phalanx, and 3) a comminuted fracture of the left middle finger metacarpophalangeal joint. The AD required surgery by installing pins in all of the fractured fingers and was released from the hospital on 14 January 2015. The AD underwent physical therapy and was released for light duty work on 19 February 2015.

The Rowan Incident Investigation Report indicated that the probable cause was attributed to the lack of proper supervision while laying down drill pipe. Rowan Supervisors allowed the job to be performed without an adequate JRA as required in Rowan's SOP.

Rowan identified the following possible contributing causes: 1) improper placement of the AD's left hand between the IR spinners and pipe, 2) failure to follow Rowan SOP for placement of hands while using power tongs, 3) the Driller accidently engaged IR spinners instead of the IR bottom jaws, 4) the IR manual controls were not labeled or masked due to mud residue, 5) the Rowan SOP did not cover hazards associated with operating the IR, and 6) the failure to stop work and re-evaluate the hazards associated with a change in job scope as required by Rowan's policies and procedures.
19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

Rowan identified the following possible contributing causes: 1) improper placement of the AD's left hand between the IR spinners and pipe, 2) failure to follow Rowan SOP for placement of hands while using power tongs, 3) the Driller accidently engaged IR spinners instead of the IR bottom jaws, 4) the IR manual controls were not labeled or were masked due to mud residue, 5) the Rowan SOP did not cover hazards associated with operating the IR, and 6) the failure to stop work and re-evaluate the hazards associated with a change in job scope as required by Rowan's policies and procedures.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

There was no property damaged during this accident.

ESTIMATED AMOUNT (TOTAL): $

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District Office makes the recommendation to the Office of Safety Management (OSM) to issue a Safety Alert to industry that hydraulic equipment control levers should be properly labeled to avoid an accident of this nature in the future.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

A G-110 Incident of Noncompliance (INC) was issued "After the Fact" to document the failure of McMoRan Oil & Gas LLC to protect health, safety, property, and the environment by performing operations in an unsafe and unworkmanlike manner. The accident that occurred on 13 January 2015 onboard the Rowan EXL III rig was a result of the following: 1) the operator's failure to provide adequate supervision when the scope of work was changed for breaking pipe apart with the IR instead of the Frank's Power Tongs that was identified in the original Job Risk Assessment and 2) missing or masked control labels on the IR that resulted in the Driller engaging the wrong IR component. As a result, a Rowan Assistant Driller (AD) sustained three fractured fingers when the IR spinners pinned his left hand against the pipe that he was centering in the IR for breaking apart. The AD required evacuation to a hospital and was diagnosed with fractures on three fingers of his left hand that required surgery.
25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:
   Troy Naquin /

29. ACCIDENT INVESTIGATION PANEL FORMED:
   NO

   OCS REPORT:

30. DISTRICT SUPERVISOR:
   Elliott S. Smith

APPROVED DATE: 29-APR-2015