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: 05-APR-2016 TIME: 2020 HOURS

2. OPERATOR: Anadarko Petroleum Corporation
REPRESENTATIVE:
TELEPHONE:
CONTRACTOR: ROWAN DRILLING
REPRESENTATIVE:
TELEPHONE:

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

4. LEASE: G17408
AREA: GB LATITUDE: 669
BLOCK: LONGITUDE:

5. PLATFORM:
RIG NAME: ROWAN RESOLUTE

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

7. TYPE:
□ HISTORIC INJURY
X REQUIRED EVACUATION 1
LTA (1-3 days)
LTA (>3 days)
RW/JT (1-3 days)
X RW/JT (>3 days) 1
Other Injury

□ FATALITY
□ POLLUTION
□ FIRE
□ EXPLOSION

LWC □ 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.
X OTHER Abandonment

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

9. WATER DEPTH: 2962 FT.

10. DISTANCE FROM SHORE: 205 MI.

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

12. CURRENT DIRECTION: NE
SPEED: 10 M.P.H.

13. SEA STATE: 3 FT.
During an ongoing inspection, BSEE Inspectors were notified Friday morning April 8, 2016, an incident occurred aboard the Rowan Resolute on Tuesday, April 5, 2016, at approximately 20:20. Anadarko notified BSEE concerning the incident at approximately 1700 on April 7, 2016, via the district after hours phone. BSEE Inspectors were on location at the Rowan Resolute all day on Thursday, April 7, 2016, and there was no mention of an injury by any Anadarko or Rowan representatives.

The Injured Person (IP) was lowering a 1,500 pound hatch with a 2,500 pound rated winch. The IP lost his grip on the winch handle and the handle whipped around striking his right hand between his index and middle finger. The contact caused an immediate half inch laceration between the two fingers. The IP was treated by the Medic immediately following the injury. The Captain of the Rowan Resolute was present for the IP’s treatment in the medical clinic by the Medic. A decision was made by Rowan staff to reevaluate the IP first thing in the morning. The following morning at approximately 05:45, a decision was made to have the IP evacuated via helicopter to be evaluated by medical staff on land. The decision was due to swelling around the lower middle finger which had not been present during initial evaluation. X-Rays of the IP’s right hand indicated a hairline fracture of his middle finger. IP was put into a half hand cast and released back to the Rowan Resolute for light duty. The IP arrived back to the Rowan Resolute at approximately 09:00 on Thursday, April 7, 2016. IP has been placed on light duty and will be reevaluated by medical staff after the end of his hitch in two to three weeks.

BSEE Investigators arrived on Friday, April 8, 2016, to conduct an accident investigation (AI). The Captain mentioned there had been previous mention of issues of injury and/or malfunction of the winches involved in the IP’s injury. The Captain also mentioned the winches have been removed from service and approval has been given to have new pneumatic winches installed. The new winches will eliminate the chance of freewheeling or loss of control while lowering equipment with the winches. During the interview process, the IP stated he had noticed the winch did not have a ratcheting or a controlled way of lowering the 1,500 pound hatch other than man power. The IP mentioned there would be no braking except for what he could expel physically. This risk was covered in the ‘Traffic Light Card’; which is used by Rowan employees to access and mitigate risks not covered in the Rig Specific Operating Procedures (RSOP), and the IP determined the task had a low risk rating. The RSOP for the job did not identify the use of the winch to raise or lower the hatch door to access the items to be moved in the engine compartment. The Captain did mention the step should have been included, after being asked by BSEE Investigators whether or not this step should be identified in the RSOP. The IP and his direct supervisor decided to continue with operations using the winch even though it did not have a ratcheting and/ or breaking mechanism to assist in a controlled descent of the 1,500 pound hatch.

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

Equipment was not suitable for the job task he was working. Deficiency of the equipment was not relayed to the rig crew.
19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:
   1. OIM aware of equipment deficiency. Information not passed on to rig crew.
   2. Rig Crew identified hazard associated with using the winch; however, they proceeded to perform the job without using stop work authority.
   3. Rig Specific Operating Procedures (RSOP) did not include the known hazard associated with the winch while lowering loads.

20. LIST THE ADDITIONAL INFORMATION:

   NONE

---

21. PROPERTY DAMAGED: None
   NATURE OF DAMAGE: None

---

ESTIMATED AMOUNT (TOTAL): $

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:
   Lake Jackson has no recommendations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:
   G-132 W
   G-110 C (bullet #9)

25. DATE OF ONSITE INVESTIGATION:
   08-APR-2016

26. ONSITE TEAM MEMBERS:
   John Orsini / Casey Conklin /

29. ACCIDENT INVESTIGATION PANEL FORMED:
   NO

30. DISTRICT SUPERVISOR:
   John McCarroll

APPROVED DATE: 24-MAY-2016