UNITED STATES DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **10-OCT-2006** TIME: **0950** HOURS

2. OPERATOR: **Chevron U.S.A. Inc.**
   REPRESENTATIVE: **Noel George**
   TELEPHONE: **(504) 583-2670**
   CONTRACTOR: **Nabors Drilling Inc.**
   REPRESENTATIVE: **James Bridges**
   TELEPHONE: **(281) 618-2684**

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

4. LEASE: **G01241**
   AREA: **ST** LATITUDE:
   BLOCK: **52** LONGITUDE:

5. PLATFORM:
   RIG NAME: **NABORS POOL 53**

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

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

LWC
- [ ] HISTORIC BLOWOUT
- [ ] UNDERGROUND
- [ ] SURFACE
- [ ] DEVERTER
- [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [ ] OTHER LIFTING DEVICE
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

6. OPERATION:
- [ ] PRODUCTION
- [ ] DRILLING
- [X] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER

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

9. WATER DEPTH: **50** FT.

10. DISTANCE FROM SHORE: **15** MI.

11. WIND DIRECTION: **N**
    SPEED: **1** M.P.H.

12. CURRENT DIRECTION: **N**
    SPEED: **1** M.P.H.

13. SEA STATE: FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

Some combination of the floorhand pulling the elevators open and the derrickhand stopping the blocks for a second time caused the bottom of the tubing joint to move erratically. The bottom of the tubing joint struck the roustabout, who was standing at the bottom of the v-door, in the forehead. His hard hat and safety glasses were knocked off and he fell to the deck. Another roustabout helped him sit up. The roustabout was taken to Terrebonne General Hospital where medical evaluation indicated that he had an aneurism in his brain that ruptured and bled causing concern. He was placed in intensive care and remained there until October 12, 2006. He was discharged from the hostpital on October 16, 2006.The crew was in the process of laying down production tubing. The tubing was being laid down using a procedure where single joints were pulled, broken, and then pushed directly out of the v-door. The blocks were lowered and the elevators opened when they reached the manual working height above the rig floor. The crew was not using the mousehole. Fifteen joints were being placed in the v-door before the rig crew would pause to measure the joints and wrap all fifteen with slings and move the entire bundle to the pipe rack. Then the process began again to pull and lay down another fifteen joints of tubing.

The day crew completed a JSA prior to going to work on the rig floor. However, the JSA made no mention of the roustabouts manually controlling the bottom of the tubing joints. The day crew stated that a few of the joints had fallen either off of the v-door or off of the catwalk. This was one of the reasons why the roustabouts were manually controlling the bottom of the tubing joints. The other reasons were to keep the tubing straight so the crew would not have to adjust the tubing before measuring it and to prevent any joints from being pushed over the retainer and sliding uncontrolled out onto the catwalk.

At the time of the incident, the derrickhand was running the drawworks so the driller could take a bathroom break. The derrickhand stopped the traveling block and one of the floorhands pulled on the rope to unlatch the elevators, but they did not open. The derrickhand allowed the blocks to come down further to allow the floorhand to open the elevators, this time they opened. However, the tubing did not fall out because it was hung up in the elevators. When this occurred previously, the floorhand would have to grab the elevators by the horns and give them a shake to get the tubing to drop out. At the time of the incident, the floorhand did not have time to shake the elevators.

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

The rig crew had trouble controlling the tubing during the time it was being lowered out of the v-door and catwalk other than manual guiding. The roustabouts believed that manually guiding the tubing joints was part of their job. Laying out singles and manually unlatching the elevators was not the best procedure for this job.

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

n/a

21. PROPERTY DAMAGED: **None**

NATURE OF DAMAGE: **n/a**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Due to the specific nature of this incident, the Houma District has no recommendations to report to the Regional Office.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

none

25. DATE OF ONSITE INVESTIGATION:

11-OCT-2006

26. ONSITE TEAM MEMBERS:

Amy Wilson /

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Michael J. Saucier

APPROVED

DATE: **14-DEC-2006**