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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
DATE: **14-MAR-2007** TIME: **0200** HOURS

2. OPERATOR: **Energy XXI GOM, LLC**
REPRESENTATIVE: **Kay Morgan**
TELEPHONE: **(409) 379-3739**
CONTRACTOR: **HERCULES OFFSHORE DRILLING**
REPRESENTATIVE: **Tim Youngblood**
TELEPHONE: **(409) 379-3739**

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

4. LEASE: **00263**
AREA: **ST** LATITUDE:
BLOCK: **21** LONGITUDE:

5. PLATFORM: **GA**
RIG NAME: **HERCULES 11**

6. ACTIVITY:
- [ ] EXPLORATION(POE)
- [X] 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)
  - [X] Other Injury **1 Slight Bruising To Foot**
- [ ] 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
- [X] OTHER **Gas Bubble to Surface**

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

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

9. WATER DEPTH: **40** FT.

10. DISTANCE FROM SHORE: **3** MI.

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

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

13. SEA STATE: FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On 14 March 2007, at approximately 0200 hrs, rig personnel were retrieving an RTTS (Retrievable, Testing, Treating and Squeeze Tool) Packer. Unbeknownst to them a gas bubble had formed below the packer, which was set at 500ft measured depth. When the packer was retrieved (released) the trapped gas was released, pushing the 9.1ppg Calcium Chloride (CaCl) workover fluid above it through the rotary. The fluid pushed the two rotary bushings out of the rotary. One of the rotary bushings fell into the water and the other rotary bushing landed on the drill floor which tipped over onto the Floorman's steel toed boot. Additionally two service personnel were splashed with the 9.1ppg CaCl workover fluid. The Hydril was closed and the SICP was measured at 100psi. The drill pipe and casing were circulated with 9.1 CaC1 workover fluids to kill the well. No pollution resulted from this incident.

The RTTS, also known as a storm packer, was set at 500ft with approximately 4000ft of drill pipe hanging below the packer to provide weight to set the packer. Prior to setting the packer the well was losing fluid at approximately 2 to 3 bbls per hour. The storm packer was set and tested to 1000psi. The existing tubing head was then changed out for a new tubing head and the BOP stack was tested to 250psi low and 5000psi high. The storm packer retrieving tool was run to 500' MD and engaged the packer with a closed TIW valve at the surface. The TIW valve was then opened and the drill pipe was observed to be on a vacuum indicating there was no pressure below the packer. The packer was released with straight pickup on the drill string and the 9.1 CaC1 workover fluids immediately came up through the rotary resulting in the incident described above.

The service personnel which were splashed with the 9.1ppg CaC1 took showers and suffered no injuries. The Floorman which had the rotary bushing tip over on his steel toed boot suffered minor swelling and bruising to his foot.

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

The cause of the incident was a build up of gas under the set storm packer. During release/retrieval of this storm packer, rig personnel were not aware of this gas bubble that formed under the packer. If the Annular Blowout Preventers had been closed before the release (unseating) of the packer, the fluid would not have reached the rig floor, thus eliminating the incident.

It was later revealed that a Halliburton tool man was not present during the unseating of the storm packer. If a Halliburton tool man had been present, this incident may not have occurred.

Also the lack of a detailed procedure covering the unseating of this RTTS Packer may have also been a major contributing factor in this incident.

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

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

This incident had only a slight injury associated with it. However this incident could have been very serious. The Houma District hereby recommends that a Safety Alert be issued.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:

Brad Hunter / Kelly Bouzigard / Darrel Griffin / Amy Wilson /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Michael J. Saucier

APPROVED

DATE: **18-APR-2007**

INJURY/FATALITY/WITNESS ATTACHMENT

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

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: (TOTAL OFFSHORE EXPERIENCE: EARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE: