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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **07-APR-2006** TIME: **2245** HOURS

2. OPERATOR: **Chevron U.S.A. Inc.**

REPRESENTATIVE: **John Telano**

TELEPHONE: **(662) 285-2537**

3. LEASE: **G04903**

AREA: **MP** LATITUDE:

BLOCK: **30** LONGITUDE:

4. PLATFORM:

RIG NAME: **DIAMOND OCEAN DRAKE**

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

6. TYPE:
- [ ] FIRE
- [ ] EXPLOSION
- [ ] BLOWOUT
- [ ] COLLISION
- [X] INJURY NO. **1**
- [ ] FATALITY NO. **0**
- [ ] POLLUTION
- [ ] OTHER

7. OPERATION:
- [ ] PRODUCTION
- [X] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] 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
- [X] OTHER **Inadequate JSA**

9. WATER DEPTH: **133** FT.

10. DISTANCE FROM SHORE: **70** MI.

11. WIND DIRECTION: **SSW**

SPEED: **9** M.P.H.

12. CURRENT DIRECTION:

SPEED: M.P.H.

13. SEA STATE: **5** FT.

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

John Telano

CONTRACTOR: **Diamond Offshore Drilling, Inc.**

CONTRACTOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:

Billy Blair

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

While tripping in the hole with 5 1/2" drill pipe, the Derrick hand was operating the . After a connection, a malfunction occurred with the spinner wrench chain. The Derrick hand used his hand to push the chain of the spinner wrench. At the same time he used his other hand to hold the spinner wrench steady due to weather and unknowingly grab the close lever and not the designed handle. This caused the jaws of the wrench to close around his hand and arm causing serious injury to his left forearm and thumb. The injury is classified as a loss time accident.

Findings:

The incident investigation took place 4/8/06 @ 1600 hours.

1. The was not recognized as needing to be isolated (Lockout, Tagout) before making adjustments or repairs to unit.

2. Employees appear to be accustomed to fixing the chain on the spinning wrench whenever it's not lying properly. The culture onboard accepted this as common practice and didn't recognize the hazard.

3. No equipment specific JSA was written on use of this . Hazards are mentioned in the JSA for tripping pipe (JSA # 117-DRL-C-00l) which was reviewed before the operation. However, it is not extensive enough to ensure a safe operation.

4. Injured Person has been on this rig and in this position for a significant amount of time and apparently has performed this action repeatedly in the past while operating the spinning wrench.

5. Control levers on unit are not marked as to which lever is the clamp and which is the spin lever. The two levers are only one inch apart and apparently came this way from the manufacturer.

6. Simulated operation of the Spinner Hawk showed no deficiencies in operation. Chain stretch was within tolerance, control levers functioned properly, and warning labels noted on each side.

7. Injured Person began operating at 18:30 hours. Time of injury was 22:45.

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

Employees appear to be accustomed to fixing the chain on the spinning wrench with their hands whenever it's not lying properly. The culture onboard accepted this as common practice and didn't recognize the hazard.

Injured Person has been on this rig and in this position for a significant amount of time and apparently has performed this action repeatedly in the past while operating the spinning wrench.

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

The was not recognized as needing to be isolated (Lockout, Tagout) before making adjustments or repairs to unit.

No equipment specific JSA was written on use of this . Hazards are mentioned in the JSA for tripping pipe (JSA # 117-DRL-C-00l) which was reviewed before the operation. However, it is not extensive enough to ensure a safe operation.

Control levers on unit are not marked as to which lever is the clamp and which is the spin lever. The two levers are only one inch apart and apparently came this way from the manufacturer.

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

None **None**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

No Reccomendation to MMS.

The New Orleans District concurs with the Operator's recommendation to prevent recurrance.

1. All personnel onboard will move forward the date of their annual Lockout/Tagout training and complete same. Isolation is not just electrical, but pneumatic and hydraulic as well.

2. Develop an equipment specific JSA for use of the and review prior to using unit.

3. Designate competent Spinning Wrench operators on each crew. Formal training will be given to these individuals. They will read the operating manual, review the JSA, and demonstrate skills to OIM to ensure they can properly handle the unit. Proper body placement will be included based on prior accident earlier in the day.

4. Label or stencil control levers "Clamp" and "Spin" respectively.

5. Evaluate replacing this chain unit with a roller type spinning wrench with a safety mechanism that will not allow jaws to clamp if not around drill pipe. (ex. Varco SSW-40)

6. Develop HSE Alert to distribute to all rigs in DODI fleet and also to the IADC.

7. Develop a PowerPoint picture presentation onboard the rig with pictures showing all types of equipment needing isolation. Include equipment with electrical, mechanical, hydraulic, and pneumatic isolation needs. This will help address culture of "electrical lock out only".

8. Install an isolation valve on the hydraulic supply to the Spinning Wrench to assist in isolation of unit when repairs are needed.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

10-APR-2006

26. ONSITE TEAM MEMBERS:

Perry Jennings / Justin Josey /

29. ACCIDENT INVESTIGATION PANEL FORMED: No

OCS REPORT:

30. DISTRICT SUPERVISOR:

Troy Trosclair

APPROVED

DATE: **22-MAY-2006**

INJURY/FATALITY/WITNESS ATTACHMENT

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

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: **(713) 378-7816** TOTAL OFFSHORE EXPERIENCE: EARS

EMPLOYED BY: **Diamond Offshore Drilling, Inc. / 20293**

BUSINESS ADDRESS: **111 Veterans Memorial Blvd.**

CITY: **Metairie** STATE: **LA**

ZIP CODE: **70005**