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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

   DATE: **29-JUL-2005** TIME: **0150** HOURS

2. OPERATOR: **W & T Offshore, L.L.C.**

   REPRESENTATIVE: **J. P. Slattery**

   TELEPHONE: **(504) 831-4171**

3. LEASE: **G12008**

   AREA: **SS** LATITUDE: **28.0614663**

   BLOCK: **349** LONGITUDE: **-91.06181877**

4. PLATFORM:

   RIG NAME **ROWAN GORILLA IV**

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

6. TYPE:
   - [ ] FIRE
   - [ ] EXPLOSION
   - [ ] BLOWOUT
   - [ ] COLLISION
   - [x] INJURY NO. 1
   - [ ] FATALITY NO. 0
   - [ ] POLLUTION
   - [x] OTHER **dropped rig traveling block**

7. OPERATION:
   - [ ] PRODUCTION
   - [x] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO. ________
   - [ ] OTHER ________

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

9. WATER DEPTH: **375** FT.

10. DISTANCE FROM SHORE: **90** MI.

11. WIND DIRECTION: **S**

    SPEED: **5** M.P.H.

12. CURRENT DIRECTION:

    SPEED: M.P.H.

13. SEA STATE: **2** FT.

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

    Dave Pace

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

    TELEPHONE: **(504) 831-4171**

    CONTRACTOR: **ROWAN DRILLING**

    CONTRACTOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:

    Freddie Thompson

    CITY: **Houston** STATE: **TX**

    TELEPHONE: **(713) 960-7546**

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On July 27,2005, the 13 5/8" casing shoe set at MD was drilled out and a FIT was performed and drilling continued to feet. The Driller had just finished back reaming the hole and was making preparation to make a connection to drill ahead. The Driller was lowering the drill string in order to make the connection when the drill line parted causing the block to fall to the rig floor. The pipe handler was approximately 5' from the rig floor at the time the drill line parted. There were two roughnecks on the rig floor for the connection when the drill line parted. The slips were not in the rotary. Part of the block's pipe handling equipment hit and trapped the right foot of . Hydraulic jacks were utilized to lift the pipe handling equipment and free the injured person's foot. First aid was performed on site to the injured person. A medivac helicopter was dispatched to location and the injured person was evacuated to Terrebonne General Medical Center.

The crown block was rated to 1.5 million pounds and 10 lines were strung on the sheaves. One roller guide was installed on the fast line about 30 feet above the drum. The weight of the 13.625 inch casing was pounds when run into the hole.

Note that all personnel were accounted for and there were no pollution.

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

The traveling block and top drive fell due to the drill line parting. The drill line was damaged by the sheaves due to excessive viberation in the drill line caused by impact loading while running the 13.625 inch casing.

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

A contributing cause of the incident could be isolated defective drill line manufacturing.

20. LIST THE ADDITIONAL INFORMATION:

Rig personnel inspected and assessed the damage and implemented an action plan to secure the block and start repairs. The drill line and traveling block were replaced. A magnetic particle inspection was performed on the crown sheaves and no defects were found. The traveling block and drill line were sent in for inspection by a third party. The top drive was completely dissembled and inspected. All damaged parts were replaced or repaired. No internal damage to the top drive was found due to the incident. The wire rope manufacturer, Bethlehem Wirerope, was contacted and the age or design of the drill line was not considered to be a contributing factor. The drill line was manufactured in 2003 and installed on the rig in March of 2005.

A slip and cut program was in place and normal wear is not considered to be a contributing factor in this incident. Rowan's slip and cut program is implemented between 3,000 and 3,700 ton miles and uses a cutting objective of one foot per 35 ton miles. The drill line record indicated 1,923 ton miles on the drill line when the incident occurred.

ROWAN RECOMMENDATIONS: Visual inspections of the drill line and hoisting equipment must be performed routinely and take precedence over a predetermined cutting program if any defects are discovered. Verify loads being applied are with in the design of the drill line and hoisting system. Drill line maintenance should be review by the OIM Contract Supervisor and Company Representative on a routine basis and prior to performing heavy loads such as running casing.

21. PROPERTY DAMAGED:

Sheaves in the traveling block, top drive pipe guide, elevator, the block dolly and derrick track.

NATURE OF DAMAGE:

Damaged sheave in the traveling block. The top drive pipe guide and elevator latch were broken. The block dolly, derrick track, elevator bails and counter balance between the block and top drive were bent.

ESTIMATED AMOUNT (TOTAL): **$218,000**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

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

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

29-JUL-2005

26. ONSITE TEAM MEMBERS:

Amy Gresham / Jay Cheramie / Jerry Freeman / John McCarroll /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Michael J. Saucier

APPROVED

DATE: **11-OCT-2005**