

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: 29-OCT-2015 TIME: 1740 HOURS

2. OPERATOR: Anadarko Petroleum Corporation

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: Diamond Offshore

REPRESENTATIVE:

TELEPHONE:

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

4. LEASE: G18421

AREA: GC LATITUDE:

BLOCK: 683 LONGITUDE:

5. PLATFORM:

RIG NAME: DIAMOND OCEAN BLACKHORNET

6. ACTIVITY:

EXPLORATION (POE)  
 DEVELOPMENT/PRODUCTION  
(DOCD/POD)

7. TYPE:

HISTORIC INJURY

REQUIRED EVACUATION 1  
 LTA (1-3 days)  
 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  
 WORKOVER  
 COMPLETION  
 HELICOPTER  
 MOTOR VESSEL  
 PIPELINE SEGMENT NO.  
 OTHER

8. CAUSE:

EQUIPMENT FAILURE  
 HUMAN ERROR  
 EXTERNAL DAMAGE  
 SLIP/TRIP/FALL  
 WEATHER RELATED  
 LEAK  
 UPSET H2O TREATING  
 OVERBOARD DRILLING FLUID  
 OTHER \_\_\_\_\_

9. WATER DEPTH: 4473 FT.

10. DISTANCE FROM SHORE: 130 MI.

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

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

13. SEA STATE: FT.

On October 29, 2015, an incident occurred in which the Deck Coordinator onboard the Diamond Ocean Blackhornet sustained severe injuries to his left hand, while attempting to relocate two joints of damaged production tubing on the rig's main deck.

At the time of the incident, the Diamond Ocean Blackhornet was performing completion operations for Anadarko Petroleum Corporation and located in Green Canyon Block 683, Lease Number OCS-G18421. The Toolpusher contacted the Crane Operator and informed him that two joints of damaged production tubing needed to be relocated from the pipe skate, near the rig floor, to the rig's main deck until they could be back loaded onto the boat. Due to a lack of available space on the rig's deck, the decision was made to set the tubing on top of a bundle of 6 5/8 inch piping that was located in the pipe bay area. The Deck Coordinator (IP), along with two Roustabouts, was informed of the task to be performed and given instructions for the lift. The Deck Coordinator was tasked with being the 'Flagger' for the operation. Through the use of hand signals and a handheld radio, his job was to maintain communication with the Crane Operator throughout the lift. The two Roustabouts were stationed in the pipe bay area to guide the tubing into place as the load was set down.

The Roustabouts gathered the materials needed for the job and headed to the job site. Once they arrived to the pipe bay area, the Roustabouts realized that the bundle of pipe they were planning to set the tubing on was not level and would not likely allow the tubing to be set down without trying to roll off. The Roustabouts approached the Deck Coordinator with their concerns and suggested that they find an alternative location to set the tubing. The Deck Coordinator, for reasons unknown, failed to acknowledge the Roustabouts warning and continued flagging the Crane Operator to come down with the load.

The two Roustabouts, aware that the tubing would likely try to roll once landed on the bundle of pipe, relocated themselves inside of an open top cargo box that ran along the length of the bundle of 6 6/8 inch piping in order to position themselves away from any potential pinch points. As the pipe was set down and the chokes of the slings began to loosen, the tubing began to roll off of the piping as the Roustabouts had expected. The rolling of the tubing was stopped when one of the Roustabouts wedged a piece of wood under the tubing. In an attempt to assess the situation, the Deck Coordinator positioned himself between the tubing and the cargo box. Both Roustabouts urged the Deck Coordinator to move out of the area as it was dangerous due to the unsecured tubing. The Deck Coordinator left the area momentarily, but returned shortly after with a piece of angle iron.

Upon his return, the IP again positioned himself in between the cargo box and the tubing. The IP was told a second time by the Roustabouts that his position was unsafe but their concerns were once again ignored. The Deck Coordinator instructed the Roustabout who was stopping the tubing from rolling to remove his wedge so that he could replace it with the piece of angle iron he had collected. The Roustabout stated that the wedge was the only thing holding the tubing in place and that it would continue to roll again if it was removed. The IP ignored the warning from the Roustabout and pushed aside the piece of wood the Roustabout was holding with the intent of quickly wedging the piece of angle iron underneath the tubing. As the tubing began to roll, the IP attempted to wedge the angle iron into place. The weight of the tubing caused the angle iron to flip, crushing the IP's left hand between the tubing and the angle iron. The tubing continued to roll off of the piping, falling to the deck beams and pinning the IP between the cargo box and the tubing.

Some members of the drill crew noticed the incident and quickly flagged to the Crane Operator to swing back over the site. With the use of the crane, the crew was able to lift one end of the tubing up enough to allow the IP to free himself. The IP was met at the scene of the incident by the onboard Medic and brought to the rig hospital to prepare for an evacuation.

The Medivac helicopter arrived on location approximately 2 hours following the incident. The IP was transported to the hospital where surgeons awaited to assess the damage. The IP was immediately brought into surgery where he received pins in his left index finger, left middle finger, and left ring finger. Injuries sustained to his middle finger resulted in a partial amputation having to be performed. The IP was released from the hospital the day after his surgery but has yet to be released to return to work.

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

- 1) Poor Body Placement: The injured employee positioned himself between the tubing and the cargo box.
- 2) IP ignored the Roustabouts advice and warning prior to, and during, the task.
- 3) Crew attempted to set the tubing down on an uneven surface.

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

- 1) The Crane Operator, who was the person over the job, was unable to be directly involved due to having to operate the crane.
- 2) STOP work authority not practiced as intended.
- 3) Attempting to work with an unsecured load.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Houma District has no recommendations for the Regional Office at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT:

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

**21-NOV-2015**

26. ONSITE TEAM MEMBERS:

**Daniel Ballard / Colin Davis / Paul  
Reeves / James Richard /**

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

**Bryan Domangue**

APPROVED

DATE: **24-DEC-2015**