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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

   DATE: **20-FEB-2005** TIME: **1100** HOURS

2. OPERATOR: **Dominion Exploration & Production, Inc.**

   REPRESENTATIVE: **Steven P. Tuttle**

   TELEPHONE: **(504) 593-7193**

3. LEASE: **G16647**

   AREA: **MC** LATITUDE:

   BLOCK: **772** LONGITUDE:

4. PLATFORM:

   RIG NAME **T.O. CAJUN EXPRESS**

5. ACTIVITY:
   - [x] EXPLORATION(POE)
   - [ ] 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
   - [ ] OTHER ____

9. WATER DEPTH: **5413** FT.

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

11. WIND DIRECTION: **S**

    SPEED: **17** M.P.H.

12. CURRENT DIRECTION: **SSE**

    SPEED: **15** M.P.H.

13. SEA STATE: **4** FT.

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

    Bobby Oegal

    CITY: **Houma** STATE: **LA**

    TELEPHONE: **(504) 595-5205**

    CONTRACTOR: **Transocean Offshore**

    CONTRACTOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:

    Bobby Henry

    CITY: **Houma** STATE: **LA**

    TELEPHONE: **(504) 595-5206**

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

A contract employee injured his hand while attempting to unclog a 6" vacuum hose. The hose had become clogged while the crane crew was not available to change out the cuttings box that was full. When the employee released the cam lock and pulled to release the hose, the weight of the hose, which was clogged with mud and cuttings, was too much for the employee, and it fell against a pipe with his hand under it. The resulting injury was a broken index finger with damaged tendon, and a severely bruised and cut thumb.

Findings:

No JSA was prepared by the employee or by the safety man on rig. Also, the overall job could have been planned better by allowing for the use of a chain hoist that is engineered for these types of jobs. This equipment is designed so that one technician can control the process of filling and changing out cutting boxes without the need for relying on the Crane Crew to be focused on the "O Discharge" system at all time to change out full boxes or risk having the system back up. Finally, although this equipment was not used on this job, there was no pre-job coordination with the rig officials regarding an assignment of additional personnel to assist in handling common situations like the clogging vacuum line.

There was a lack of communication and coordination with the representatives of the Drilling Contactor or Operator, regarding the designation of assistance for one man crew if needed.

The employee did not follow correct procedures for dealing with clogged hosed and tried to correct the problem without getting help.

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

1) Lack of Pre-job planning
2) Lack of communication
3) Procedures not followed

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

n/a

21. PROPERTY DAMAGED:

n/a

NATURE OF DAMAGE:

n/a

ESTIMATED AMOUNT (TOTAL): $

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

No Recommendations to MMS

The New Orleans District concurs with Dominion and Transocean recommendations to prevent a recurrence as stated below.

1) Reinforce JSA process by providing refresher training for employees on proper hazard analysis, correct preparation of JSA's, and presenting the JSA to rig officials in order to coordinate recommendations or action items.

2) The equipment described above should always be recommended by our Operations Staff, and whenever possible should be used to help ensure that the job is performed safely and efficiently. Otherwise, we will request the deployment of two of our service hands per shift on all similar jobs in the future unless the rig can provide reliable assistance when it is needed.

3) Address the behavioral safety issues that led to the employee not following the correct job procedures regarding changing out hoses. Specifically, on the abandoning safe work practices in order to keep the job going.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

28-FEB-2005

26. ONSITE TEAM MEMBERS:

Stephen Lucky /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Troy Trosclair

APPROVED

DATE: **12-APR-2005**

INJURY/FATALITY/WITNESS ATTACHMENT

[ ]	OPERATOR REPRESENTATIVE	[X]	INJURY
[X]	CONTRACTOR REPRESENTATIVE	[ ]	FATALITY
[ ]	OTHER ______________________	[ ]	WITNESS

EMPLOYED BY: **Transocean Offshore / 20863**

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

ZIP CODE: