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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **26-OCT-2005** TIME: **0505** HOURS

2. OPERATOR: **Gulf of Mexico Oil and Gas Properties LLC**

REPRESENTATIVE: **Bill Voss - Engineer Mgr**

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

3. LEASE: **00434**

AREA: **SS** LATITUDE:

BLOCK: **149** LONGITUDE:

4. PLATFORM: **G**

RIG NAME **PRIDE FLORIDA**

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 **Fall**

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

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

9. WATER DEPTH: **50** FT.

10. DISTANCE FROM SHORE: **38** MI.

11. WIND DIRECTION:

SPEED: M.P.H.

12. CURRENT DIRECTION:

SPEED: M.P.H.

13. SEA STATE: FT.

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

Barry Owen

CITY: **Houston** STATE: **LA**

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

CONTRACTOR: **Pride Offshore**

CONTRACTOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:

Greg Bullock

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

TELEPHONE: **(985) 872-4700**

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

The Driller and the Derrick man, held a meeting on the catwalk to discuss picking up the choke hose so as to prepare to rig the Texas deck. They then planned to skid the rig out to run drive pipe. The rotary beams and pan had been removed to prepare for driving a 60 inch casing by making a 9 feet X 9 feet opening. A barrier (barracade) had been placed around the opening with 1¼ inch pipe, and a ½ inch wire rope for a top railing. The men discussed their plans to pick up the choke hose and tie it out of the way. The Derrick man was to go to the rig floor and operate the air hoist and the Driller was going to be on the deck so as to tie it to the hose. The Driller was planning to use the rig intercom, but decided to get a set of radios from the Offshore Installation Manager's (OIM's) office. When he returned to the deck, he threw the radio upwards, through the opening in the rig floor, to the Derrick man on the above deck (the rig floor). The Derrick man caught the radio and fell forward onto the barricade which then collapsed. The Driller witnessed the Derrick man falling. Before the Derrick man's feet left contact with the rig floor, he leaped to the other side of the rotary and struck the rotary pan on the other side, in the vicinity of his upper arm. The Derrick man then fell to the deck and landed at an angle on his feet and fell onto a deck beam. The Derrick man had fallen approximately 25 feet to the deck. The Driller immediately notified the Rig Safety and Training Representative (RSTR) and the Night Tool Pusher (NTP) to report to the deck. Shortly after the RSTR arrived, the Derrick man regained consciousness and was able to respond to questions. The Derrick man had a laceration approximately 1 1/4 inches long on his chin and a bump and scrape at his hair line, on the right side of his forehead. The Derrick man was checked in areas and was able to feel extremity stimulation. The crew brought the Derrick man inside to the TV room and his vitals were taken at 5 to 10 minute intervals. Medi-Vac had been notified by a W&T dispatcher at West Jefferson Hospital shortly after the fall. Paramedics arrived at 07:20 hours. They questioned the Derrick man and he was moved outside to the personnel basket where he was carried to the heliport and loaded on the helicopter.

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

The barricade, surrounding the opening in the deck, was not constructed to the Contractor's normal standards and not strong enough to support a man leaning against it. To this same point, the welding beads that held the barricade together, had gaps and were not substantial. A Job Safety Analysis (JSA) was not prepared which may have prevented the need to throw a radio up to the rig floor. Also the poor safety practice of throwing objects from one deck to another can cause injury to people and damage to equipment. The early removal of the rotary and pan from the drill floor (deck) was not part of their normal routine and left a large opening in the drill longer than necessary.

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

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

None

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Due to the 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:

26. ONSITE TEAM MEMBERS:

Brad Hunter /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Michael J. Saucier

APPROVED

DATE: **17-NOV-2005**

INJURY/FATALITY/WITNESS ATTACHMENT

[ ] OPERATOR REPRESENTATIVE
[X] CONTRACTOR REPRESENTATIVE
[ ] OTHER _____

[X] INJURY
[ ] FATALITY
[ ] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY: **Pride Offshore / 20386**

BUSINESS ADDRESS: **410 South Van Avenue**

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

ZIP CODE: **70363**

[ ] OPERATOR REPRESENTATIVE
[X] CONTRACTOR REPRESENTATIVE
[ ] OTHER _____

[ ] INJURY
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