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: **21-APR-2013** TIME: **0745** HOURS

2. OPERATOR: **Anadarko Petroleum Corporation**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Nabors Drilling Inc.**
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G14205**
   AREA: **EB** LATITUDE:
   BLOCK: **602** LONGITUDE:

5. PLATFORM: **A(NANSEN SPAR)**
   RIG NAME: **NABORS POOL 140**

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

7. TYPE:
- [ ] HISTORIC INJURY
- [X] REQUIRED EVACUATION **1**
- [ ] LTA (1-3 days)
- [ ] LTA (>3 days
- [ ] RW/JT (1-3 days)
- [ ] RW/JT (>3 days)
- [X] Other Injury **1** **RW/Fractured Finger**
- [ ] 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.
- [X] OTHER **PA Operations**

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

9. WATER DEPTH: **3675** FT.

10. DISTANCE FROM SHORE: **117** MI.

11. WIND DIRECTION: **E**
    SPEED: **24** M.P.H.

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

13. SEA STATE: **7** FT.

17. INVESTIGATION FINDINGS:

While making up BOP test assembly and latching the elevators which were positioned over the mouse hole, Injured Person (IP) along with another Floorhand assisted by pushing on the bales. As the elevators were latched the rig rocked causing the test assembly to rotate in the mouse hole. Injured Person's left pinky finger was caught between the 1502 side entry pump-in sub and the bales.

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

Improper hand placement on equipment -
Location of equipment -
Position of equipment -

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

Rig was rocking causing side sub entry to spin around striking IP on left pinky finger

20. LIST THE ADDITIONAL INFORMATION:

IP was sent to shore for further medical evaluation and treatment -
IP had fractured left pinky finger which required surgery -

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Ensure proper and safe hand placement
Initiate Stop Work Authority anytime something changes or an unsafe situation arises.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 Component Shut-In 250.107(a)(1) -
At the time of the accident investigation, it was found that Lessee failed to perform all operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment in the following ways: -

Lessee failed to use Stop Work Authority when a situation changed and continued to perform the task. -
Rig floor personnel failed to utilize proper hand placement practices leading to a hand injury. Injured Person was evacuated for further treatment. -

On the day of the incident a Job Safety Analysis(JSA) was written and discussed with the rig crew. Topic was (Testing BOP's). All of the rig crew signed JSA, including Injured Person. Some of the potential hazards identified were: struck by, pinch points, wrong tools, made up incorrectly, over/under torque, and wrong measurements while making up BOP testing assembly.
While making up BOP testing assembly the Derrickman was injured.Statements obtained from witnesses verify Injured Person was wearing (High Impact Gloves) at the time of the incident.

A Root Cause/Root Action Analysis report was conducted after the incident, and the contributing cause mentioned was, "rig was rocking causing side sub entry to spin around striking Injured employee on left pinky knuckle."

None of the documentation indicated or considered use of Stop Work Authority until after the incident occurred.

Lessee has a Stop Work Authority Policy, which states, "Stop Work Authority may be exercised whenever that person identifies an actual or perceived unsafe or potentially damaging condition, act, error, omission or lack of understanding that could result in an undesirable event."
When a change in the job task, personnel, equipment, weather, or procedure occurs, Stop Work Authority should be utilized. All changes should be documented on the JSA and discussed with all personnel involved in the job task.

25. DATE OF ONSITE INVESTIGATION:

23-APR-2013

26. ONSITE TEAM MEMBERS:

James Holmes /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

John McCarroll

APPROVED DATE: **26-NOV-2013**