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: **22-JUL-2013** TIME: **1745** HOURS

2. OPERATOR: **Cobalt International Energy, L.P.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G31765**
   AREA: **GC** LATITUDE:
   BLOCK: **896** LONGITUDE:

5. PLATFORM:
   RIG NAME: **ENSCO 8503**

6. ACTIVITY:
- [X] EXPLORATION(POE)
- [ ] 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)
- [ ] 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
- [X] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER

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

9. WATER DEPTH: **5510** FT.

10. DISTANCE FROM SHORE: **150** MI.

11. WIND DIRECTION: **N**
    SPEED: **1** M.P.H.

12. CURRENT DIRECTION: **N**
    SPEED: **1** M.P.H.

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS: -

On July 22, 2013, a Floorman working on the Ensco 8503 drilling rig was struck on his upper right side by a stand of drill pipe while the crew was attempting to relocate it. On the day of the accident, the Ensco 8503 drilling rig was working for Cobalt International Energy located at Green Canyon Block 896.

The accident occurred while the drill crew was using a teflon rabbit to drift 5 7/8 inch drill pipe. Drifting is a process of running a "rabbit" through a stand of drill pipe to ensure that the pipe is clear of any obstructions before running it into the wellbore. The Derrickman, who was operating the bridge racker at the time, retrieved a stand of drill pipe from row 13 of the racking system and brought the stand out to the finger board. The Derrickman then guided the bridge racker to a pre-determined area towards the well's center in an attempt to get it into the "rabbit position" where the crew would have access to drift the pipe. While the stand was being transported to the rabbit position, it came in contact with the lower belly board latch on row 12 which caused the stand to become stuck and begin to bow. The Derrickman working the bridge racker did not notice that the stand of drill pipe was hung up and continued trying to move it from the controls. The injured person (IP), a Floorman who had been in his position for twelve months, had just numbered a stand of pipe in the setback area. After he finished, the IP began to make his way towards the hydraulic slip control when he noticed that the drill pipe was hung up. The IP immediately turned toward the driller's cabin and began to try to get the Derrickman's attention. At this time, the drill pipe became dislodged from the lower guide arm head on the bridge racker allowing the pipe to swing and strike the IP in the upper right side of his back.

All operations were stopped and the Rig Medic reported to the rig floor to evaluate the IP. Supervisors were notified and IP was brought to the rigs sick bay for further examination. IP started developing more pain and swelling over his right clavicle area and it was noted that was a 1 1/2 inch abrasion on his right hip. Rig Medic consulted with onshore Physician and was ordered to administer medicine for pain and swelling. At approximately 18:51 hours, the IP was evacuated from the vessel in route to Terrebonne General Hospital in Houma. After further evaluation, it was found that the IP suffered from a slight concussion and a fracture to his right clavicle. IP had surgery on August 1st, 2013 and is expected to make a full recovery.

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

1) Lack of Attention to the Task at Hand

-Derrickman failed to realize that the pipe was hung up in the fingerboard and continued with operating the controls.

2) Poor Body Placement / Poor Judgment

-Even after identifying the hazard, the IP left himself in the line of fire instead of getting out of harm's way before trying to stop the job

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

-Work Instructions did not properly highlight areas where personnel cannot be located while Bridge Racker is in use.

20. LIST THE ADDITIONAL INFORMATION:

In the wake of this accident, corrective measures have been put into place. These measures are as follows:

-The bottom of the lower belly board fingers are to be painted white for increased visibility.

-The Assistant Driller is to verbally inform the Driller that the lower belly board finger is up and the pathway clear before moving each stand.

-The work instructions are to be revised to highlight areas where personnel cannot be located while the bridge racker is in use.

21. PROPERTY DAMAGED:

N/A -

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Houma District has no recommendations at this time.

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: -

James Richard / James Benetaos /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED
DATE: **14-JAN-2014**