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: **10-JUL-2013** TIME: **2115** HOURS

2. OPERATOR: **Black Elk Energy Offshore Operatio**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G12355**
   AREA: **SS** LATITUDE:
   BLOCK: **198** LONGITUDE:

5. PLATFORM: **I**
   RIG NAME: **HERCULES 205**

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

7. TYPE:
- [ ] HISTORIC INJURY
  - [X] REQUIRED EVACUATION **1**
  - [ ] LTA (1-3 days)
  - [X] 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
- [X] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] 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: **100** FT.

10. DISTANCE FROM SHORE: **44** MI.

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

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

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS: -

On July 10, 2013, a Floorman working on the Hercules 205 drilling rig was injured when a joint of 7 inch casing rolled onto his foot. The Hercules 205 drilling rig was working for Black Elk Energy and was located at Ship Shoal 198.

The day prior to the accident, the A/B crew had been in the process of relocating bundles of casing from the port side of the rig to the starboard side of the rig. They were not able to finish making all of the lifts, but installed cable slings on some of the casing to assist the next crew coming on. After making a crew change, the C/D crew continued with the task of relocating the bundles of casing. A Job Safety Analysis,(JSA), was done with possible hazards identified and the crew began making the lifts. As the Crane Operator started his lift, the crane crew failed to realize how much slack was in the cable. The work continued and the Injured Person, (IP), climbed up onto the pipe rack to assist with the landing of the casing. As the load was coming down, the IP warned a Roustabout that was assisting to stand out of the way in case the bundle shifted once it settled. The load was landed, and as the weight was taken off, the cable was allowed to slack off. The slack in the line allowed the joints of casing to shift enough to roll on top of the IP's left foot. The IP's foot was pinned underneath the joint of casing momentarily until the Crane Operator noticed what had happened and lifted the bundle back up.

After the accident, the IP was brought to the living quarters and treated by the Rig Medic. The operations were put on hold and an investigation was started surrounding the accident. Witnesses were interviewed and corrective actions were put into place before the work continued. The IP was sent to Occupational Medical Specialist in Houma for further evaluation. It was at this time that it was discovered that the IP's left ankle had been broken.

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

- Poor Body Placement

-Failure to stop the job once the initial lift was made and the clamps where identified as possible hazard.-

Witnesses stated that the IP warned another employee to stand back in case the casing slacked off when it was set down. Therefore, he recognized the hazard but failed to take proper action to prevent it.

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

Other contributing causes may have been:
- Failure to identify and properly mitigate the hazards associated with having excessive space between the chockers and the cable clamps.-
- Crane Operator did not check to see if equipment was properly installed before making the lift.-

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

N/A - N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE 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 Benetatos /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

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

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:

BUSINESS ADDRESS:

INJURY/FATALITY/WITNESS ATTACHMENT

CITY: STATE:

ZIP CODE: