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: **16-DEC-2012** TIME: **1800** HOURS

2. OPERATOR: **Arena Offshore, LP**
REPRESENTATIVE:
TELEPHONE:
CONTRACTOR: **Hercules Offshore Drilling**
REPRESENTATIVE:
TELEPHONE:

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

4. LEASE: **G33608**
AREA: **VR** LATITUDE:
BLOCK: **342** LONGITUDE:

5. PLATFORM: **A**
RIG NAME: **HERCULES 300**

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

7. TYPE:
- [ ] HISTORIC INJURY
- [X] REQUIRED EVACUATION **1**
- [X] LTA (1-3 days) **1**
- [ ] 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
- [X] OTHER **Head Injury**

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: **223** FT.

10. DISTANCE FROM SHORE: **95** MI.

11. WIND DIRECTION: **S**
SPEED: **20** M.P.H.

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

13. SEA STATE: **3** FT.

17. INVESTIGATION FINDINGS:

The Lake Charles District conducted an investigation into a personnel injury that occurred on the Hercules 300 which was working for Arena Offshore at VR-342A on 16-DEC-2012 that resulted in a Required Evacuation. At the time of the incident, the crew was tripping pipe out of the hole. The inner bushings were removed using the bushing puller attached to the air hoist cable on the port side of the rig floor. The bushing puller tool and air hoist hook were secured to an anchor post after the bushings were replaced. The traveling block and top drive were lowered to the rig floor and the elevators were latched onto the liner running tool that was still in the hole. When the driller engaged the traveling block and top drive to pull the liner setting tool, the anchor post broke causing either the anchor post or the bushing puller tool to strike the Injured Party (IP) in the face and head.

The rig medic evaluated the IP and determined that he needed to be evacuated due to swelling on the head and lacerations on the face. The IP was cleared of head injuries by a CAT scan and received stitches inside and outside of his mouth. The IP was scheduled to see a dentist for a loose tooth. He was then released from the hospital for duty.

On 18-DEC-2012 BSEE inspectors conducted an onsite accident investigation. It was determined by witness statements that the air hoist cable had become entangled with the kelly hose safety clamp during the replacement of the inner bushings. It was also observed that the entangled air hoist cable was in a blind spot of the drillers view from inside the drillers shack. No personnel on the rig floor ensured the cable was clear of obstructions before the driller engaged traveling block and top drive. The movement of the traveling block and top drive put an undetermined amount of force on the cable and anchor post. The anchor post was not designed for load bearing purposes thus breaking from the rig floor allowing either the anchor post or the bushing puller tool to strike the IP.

The Job Safety Analysis (JSA) presented to BSEE was generic in nature. Although it mentioned some of the typical potential hazards (e.g. pinch hands or feet, strain back) associated with the task of tripping pipe out of hole, it did not cover the very critical hazards, specifically the blind spots of the driller and ensuring all air hoist cables are clear of the traveling block and top drive prior to engagement. It was also found that there was no documentation that the IP attended the safety meeting in which the JSA was discussed. Although there was a signature list of all participants the IP was not on it.

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

The air hoist cable had become entangled with the kelly hose safety clamp during the replacement of the inner bushings. The movement of the traveling block and top drive put an undetermined amount of force on the cable and anchor post which was not designed for load bearing purposes thus breaking the post from the rig floor and striking the IP.

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

Human error by all parties involved:
1. The JSA presented to BSEE was generic in nature, it did not cover the very critical hazards, specifically the blind spots of the driller and ensuring all air hoist cables are clear of the traveling block and top drive.
2. No one on the rig floor ensured the cable was clear of the traveling block and top drive.

3. The driller did not ensure his blind spots were clear before engaging the traveling block and top drive.

20. LIST THE ADDITIONAL INFORMATION:

It was also found that there was no documentation that the IP attended the safety meeting in which the JSA was discussed. Although there was a signature list of all participants the IP was not on it.

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Charles District Office has no recommendations for the Regional Office of Safety Management.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 (C):
1. The port side air hoist cable had become entangled with the kelly hose safety clamp during the replacement of the inner bushings and was not removed prior to the driller engaging traveling block and top drive. The movement of the traveling block and top drive put an undetermined amount of force on the anchor post breaking the post from the rig floor resulting in an injury.
2. Planning of the operation was inadequate:
(a) There was no documentation that the IP attended the safety meeting in which the JSA was discussed. Although there was a signature list of all participants the IP was not on it.
(b) The JSA did not mention the blind spots of the driller.
(c) The JSA did not mention whose responsibility was it on the rig floor to ensure the cables of the air hoist were clear of obstructions prior to the driller engaging the traveling block and top drive.

25. DATE OF ONSITE INVESTIGATION:

18-OCT-2012

26. ONSITE TEAM MEMBERS:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Miller / Mitchell Klumpp / **Williamson, Larry**

APPROVED
DATE: **05-FEB-2013**

INJURY/FATALITY/WITNESS ATTACHMENT

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

[ ] INJURY
[ ] FATALITY
[X] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE:

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

[ ] INJURY
[ ] FATALITY
[X] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE:

INJURY/FATALITY/WITNESS ATTACHMENT

☐ OPERATOR REPRESENTATIVE	☐ INJURY
☒ CONTRACTOR REPRESENTATIVE	☐ FATALITY
☐ OTHER _____	☒ WITNESS

NAME:

HOME ADDRESS:

CITY STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE: