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

ACCIDENT INVESTIGATION REPORT

1.	OCCURRED DATE: 01-MAR-2009 TIME: 1200 HOURS	STRUCTURAL DAMAGE CRANE OTHER LIFTING DEVICE
2.	OPERATOR: LLOG Exploration Offshore, Inc. REPRESENTATIVE: Weydert, Brian TELEPHONE: (504) 833-7700 CONTRACTOR: HERCULES OFFSHORE DRILLING REPRESENTATIVE: Webster Young TELEPHONE: (337) 457-8588	DAMAGED/DISABLED SAFETY SYS. INCIDENT >\$25K H2S/15MIN./20PPM REQUIRED MUSTER SHUTDOWN FROM GAS RELEASE OTHER
3.	OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:	6. OPERATION:
	LEASE: G31435 AREA: MP LATITUDE: 29.55450317 BLOCK: 107 LONGITUDE: -88.68709047 PLATFORM: D	PRODUCTION DRILLING WORKOVER COMPLETION HELICOPTER MOTOR VESSEL PIPELINE SEGMENT NO.
	RIG NAME: HERCULES 204	OTHER
	ACTIVITY: EXPLORATION (POE) X DEVELOPMENT/PRODUCTION (DOCD/POD) TYPE: HISTORIC INJURY X REQUIRED EVACUATION 1	8. CAUSE: EQUIPMENT FAILURE X HUMAN ERROR EXTERNAL DAMAGE SLIP/TRIP/FALL WEATHER RELATED LEAK UPSET H20 TREATING OVERBOARD DRILLING FLUID OTHER
	Other Injury FATALITY	9. WATER DEPTH: 63 FT.
	POLLUTION FIRE	10. DISTANCE FROM SHORE: 18 MI.
	LWC HISTORIC BLOWOUT UNDERGROUND	11. WIND DIRECTION: N SPEED: 40 M.P.H.
	SURFACE DEVERTER SURFACE EQUIPMENT FAILURE OR PROCEDURES	12. CURRENT DIRECTION: SPEED: M.P.H.
	COLLISION HISTORIC >\$25K <=\$25K	13. SEA STATE: 10 FT.

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On March 1, 2009, at approximately 1145 hours, on the Hercules 204 located at LLOG Exploration Offshore, Inc.'s Lease OCS-G 31435, Main Pass Block 107, rig floorhands were attempting to break three joints of tubing (one stand) and lay the tubing on the casing deck. The stand of tubing was in the mouse hole, and one joint was broken and laid down. The rig personnel decided prior to starting the job, that 36 inch pipe wrenches would be used to break the tubing, in lieu of the hydraulic tongs that were available on the floor for this specific job. Rig personnel were using the hydraulic tong that was located on the rig floor as a stop to support the back-up 36 inch pipe wrench. The hydraulic tong was not connected to the tugger and was sitting in the up right position. When pressure was applied against the tong, the tong fell over. The hanging cylinder for the tong was connected to the top of the tong and rested downward towards the deck with a four part shackle connected on the end with a cotton pin. When the tong fell over, the cylinder resting from the top lifted upward and the shackle on the end of the cylinder, with the cotton pin, struck the Injured Person (IP) in the face, resulting in a 1 $\frac{1}{2}$ " laceration to his left cheek. The IP was treated by the medic and was evacuated for medical treatment, where he received stitches and was given a full release to return to work.

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

Human Error:

- 1) Rig personnel used an unstable hydraulic tong as a back-up stop for a 36 inch wrench while breaking tubing.
- 2) Rig personnel used 36 inch wrenches to break the tubing when the correct tongs for the job were available on the rig floor.
- 19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:
 - 1) There was no Job Safety Analysis (JSA) performed. Rig personnel only had a verbal safety meeting prior to job.
 - 2) There was poor job planning, since numerous safer options were available in lieu of a back-up wrench; e.g., chain, rig-up tongs, etc.
 - 3) Rig personnel failed to use Stop Work Authority (SWA)
 - 4) Rig personnel should have considered that the height of the tong as compared to the width of the tong, would make the tong top heavy and not suitable to have back-up force applied to it.
- 20. LIST THE ADDITIONAL INFORMATION:

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21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

None None

ESTIMATED AMOUNT (TOTAL):

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22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The MMS New Orleans District makes no recommendations to the MMS Regional Office of Safety Management (OSM).

- 23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES
- 24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

There may be a possible violation due to using the hydraulic tong as a stop for the back-up wrench. This was a short cut in lieu of rigging up the proper hydraulic tong or properly connecting a chain or cable for supporting the back-up wrench.

25. DATE OF ONSITE INVESTIGATION:

02-MAR-2009

26. ONSITE TEAM MEMBERS:

Peter Botros / Justin Josey /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

David Trocquet

APPROVED

DATE: 24-JUN-2009

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INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE CONTRACTOR REPRESENTATIVE MOTHER Floorhand	INJURY FATALITY WITNESS	
NAME: HOME ADDRESS: CITY: WORK PHONE: EMPLOYED BY: BUSINESS ADDRESS: CITY:	STATE: TOTAL OFFSHORE EXPERIENCE: STATE:	YEARS
ZIP CODE:		
OPERATOR REPRESENTATIVE CONTRACTOR REPRESENTATIVE TOTHER Floorhand NAME: HOME ADDRESS: CITY: WORK PHONE: EMPLOYED BY: BUSINESS ADDRESS: CITY: ZIP CODE:	INJURY FATALITY WITNESS STATE: TOTAL OFFSHORE EXPERIENCE: STATE:	YEARS

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INJURY/FATALITY/WITNESS ATTACHMENT

INJURY FATALITY WITNESS	
STATE: TOTAL OFFSHORE EXPERIENCE:	YEARS
STATE:	
INJURY FATALITY WITNESS	
STATE: TOTAL OFFSHORE EXPERIENCE: 10	YEARS
•	STATE: TOTAL OFFSHORE EXPERIENCE: STATE: INJURY FATALITY X WITNESS STATE:

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INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE CONTRACTOR REPRESENTATIVE OTHER		
NAME:		
HOME ADDRESS:		
CITY:	STATE:	
WORK PHONE:	TOTAL OFFSHORE EXPERIENCE:	YEARS
EMPLOYED BY:		
BUSINESS ADDRESS:		
CITY:	STATE:	
ZIP CODE:		

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