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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

   DATE: **17-MAR-2006** TIME: **0800** HOURS

2. OPERATOR: **Noble Energy, Inc.**

   REPRESENTATIVE: **Paul Hutto**

   TELEPHONE: **(713) 378-7821**

3. LEASE: **G24054**

   AREA: **MC** LATITUDE:

   BLOCK: **204** LONGITUDE:

4. PLATFORM:

   RIG NAME: **DIAMOND OCEAN QUEST**

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

6. TYPE:
   - [ ] FIRE
   - [ ] EXPLOSION
   - [ ] BLOWOUT
   - [ ] COLLISION
   - [X] INJURY NO. **1**
   - [ ] FATALITY NO. **0**
   - [ ] POLLUTION
   - [ ] OTHER _____

7. OPERATION:
   - [ ] PRODUCTION
   - [X] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] 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: **3327** FT.

10. DISTANCE FROM SHORE: **37** MI.

11. WIND DIRECTION: **N**

    SPEED: **10** M.P.H.

12. CURRENT DIRECTION: **S**

    SPEED: **1** M.P.H.

13. SEA STATE: **2** FT.

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

Paul Hutto

CONTRACTOR: **Diamond Offshore Drilling, Inc.**

CONTRACTOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:

Evvert Cary

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

At 7:45 a.m. a contract employee was removing shale build up on sides of shaker auger using a paint scraper to remove the build up so that the auger could disperse the cuttings. His supervisor went to get a high pressure hose to clean all the remaining residue, during which time the victim put the scraper down and noticed a large piece of shale was still on the side, he then used his right hand to knock the piece of shale into the trough where the auger dispense it over the side. He stated that when the shale gave way he lost his balance and which caused him to fall foreword and into the trough where his hand came into contact with auger. This resulted in the loss of his right hand's ring finger fingernail being pulled off along with skin on his second finger exposing the flesh and knuckle joint.

During normal operations there is a front cover to prevent mud from being thrown onto walkway.

The auger at time of accident had the front cover removed to gain access to area where shale had built up due to caking.

During drilling operations a high pressure hose is used to wash the built up material into the auger and then send it overboard. The hose was on a lower deck, and shaker personnel were using paint scrapers to clean away the shale build up.

The JSA for the shale shaker does not address the proper methods that personnel should adhere to when removing build up drill cuttings during drilling operations.

The auger is approximately 1'-1½' below the bottom of the drum and is spinning during operations. A cover plate prevents personnel from coming in contact with moving parts. Victim was scraping material directly into the auger without the cover in place, and was working directly above the spinning auger when accident occurred. He was treated by the onboard medic and medivaced to Terrebonne General Hospital in Houma.

Findings:

1) The JSA for operation of this piece of equipment did not contain information on the safe methods of cleaning the auger and related equipment, nor is there any record on board the drilling rig indicating that personnel working with this equipment were briefed in the daily operations and maintenance during drilling operations.

2) Auger system was not locked out while attempt was made to clean dryer frame.

3) The clean up operation was not performed with the supervisor present or in the presence of another employee. The other employee stepped away to check on other equipment at the time of the accident.

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

Auger system should have been locked out while attempt was made to clean dryer frame.

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

The clean up operation should have been preformed with the supervisor present or in the presence of another employee.

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

No recommendations to MMS.

The New Orleans District concurs with the Operator's recommendation to prevent recurrence.

Personnel should never work around unguarded moving equipment.
Personnel should wait for such a time when equipment could be shut down to perform job task.
Train and re-train employees on safe practices of moving equipment.
Stop and assess the problem, write a detailed JSA, get help and have a plan.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

17-MAR-2006

26. ONSITE TEAM MEMBERS:

Elbert Clemens / Robert Neal /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

FPausina for TTrosclair

APPROVED

DATE: **07-JUN-2006**