

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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **10-NOV-2009** TIME: **1357** HOURS

2. OPERATOR: **BP Exploration & Production Inc.**
REPRESENTATIVE: **Sustala, Dennis**
TELEPHONE: **(281) 366-0898**
CONTRACTOR: **Transocean Offshore**
REPRESENTATIVE: **Barber, Dennis**
TELEPHONE: **(832) 587-6933**

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

4. LEASE: **G15607**
AREA: **GC** LATITUDE: **27.22501861**
BLOCK: **743** LONGITUDE: **-90.03194833**

5. PLATFORM:
RIG NAME: **GSF DEVELOPMENT DRILLER II**

6. ACTIVITY: EXPLORATION (POE)
 DEVELOPMENT/PRODUCTION
(DOCD/POD)

7. TYPE:

- HISTORIC INJURY
- REQUIRED EVACUATION
 - 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
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

8. CAUSE:

- EQUIPMENT FAILURE
- HUMAN ERROR
- EXTERNAL DAMAGE
- SLIP/TRIP/FALL
- WEATHER RELATED
- LEAK
- UPSET H2O TREATING
- OVERBOARD DRILLING FLUID
- OTHER Choke line detached

9. WATER DEPTH: **6824** FT.

10. DISTANCE FROM SHORE: **122** MI.

11. WIND DIRECTION: **N**
SPEED: **22** M.P.H.

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

13. SEA STATE: **1** FT.

17. INVESTIGATION FINDINGS:

On 10-Nov-2009, the Development Driller II rig was performing operations of flushing the kill, boost and choke lines with 11.7 ppg Synthetic Oil Base Mud (SBM). While this operation was being conducted, the rig was also preparing to repair the main top drive service loop. The rig decided to pump through the choke line with the SBM when there was a loss of observed pump pressure and a rapid drop in mud volume at the mud pits.

At 1740 hours the choke line was observed to be detached from the gooseneck on the slip joint and was hanging in the water releasing the SBM overboard. The source was immediately contained by shutting down and securing the systems to prevent additional spillage overboard. The incident was immediately reported to all appropriate parties. The mud engineer calculated that a total of 97 bbls (4074 gal.) of SBM had been discharged through the choke line due to a siphon effect which forced the mud through the mud pump by the charging pump. None of the mud was recovered and it was noted that sixty two percent (60 bbls) of the SBM was the actual synthetic oil portion.

BP conducted a preliminary investigation and discovered that the choke line tie-in points onto the slip joint had been changed in June 2009 while the rig was out of service. When the gooseneck connection was replaced it was installed incorrectly and, although pressure tested numerous times, it eventually parted at the gooseneck swivel.

BP completed a failure analysis on all boost, kill and choke line connections, resulting in the chokeline gooseneck being replaced. Also, a safety line was installed on the slip joints to prevent the line from discharging overboard. The kill and boost line goosenecks were not required to be replaced since they were installed in the correct manner.

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

The choke line detached from the slip joint's gooseneck.

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

The slip joint's gooseneck connection was installed incorrectly when the rig was out of service.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

The choke line gooseneck was damaged and N/A was replaced. A total of 97 bbls of Synthetic Oil Base Mud was lost overboard.

ESTIMATED AMOUNT (TOTAL): \$43,750

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

Due to the specific nature of this incident, the Houma District has no recommendations to report to the Regional Office.

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:

Casey Bisso / Ben Coco /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED

DATE: 10-FEB-2010

