

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT  
GULF OF MEXICO REGION

# ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **07-NOV-2012** TIME: **0145** HOURS

2. OPERATOR: **Statoil USA E&P Inc.**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **Transocean Offshore**

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER **Fingerboard Near Miss**

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

6. OPERATION:

4. LEASE: **G26287**

AREA: **GC** LATITUDE:

BLOCK: **36** LONGITUDE:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

5. PLATFORM:

RIG NAME: **T.O. DISCOVERER AMERICAS**

6. ACTIVITY:  EXPLORATION(POE)

DEVELOPMENT/PRODUCTION  
(DOCD/POD)

8. CAUSE:

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

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

9. WATER DEPTH: **1941** FT.

10. DISTANCE FROM SHORE: **79** MI.

11. WIND DIRECTION: **N**  
SPEED: **1** M.P.H.

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

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

COLLISION  HISTORIC  >\$25K  <=\$25K

17. INVESTIGATION FINDINGS:

On November 7, 2012, while in the process of running 14 inch casing, a single joint of casing slipped past the fingerboard gate and came to rest against the side of the derrick. Crew had just finished running 13 5/8 inch casing and had moved over to start running 14 inch casing. The Roughneck went up the derrick and removed the ratchet strap from the casing, which was the secondary retention for the casing after the fingerboards. Two joints of 14 inch casing had been run; when at 01:45, one of the joints came lose and fell against the side of the derrick. No damage was sustained to either the casing or the derrick and no personnel were injured during the incident.

Operations on the rig were suspended, and the casing was retrieved and put back in place. After casing was back in the fingerboards it was observed that the spacing and alignment of the fingerboard was offset, allowing the casing to move out of place. Adjustments were made and rig proceeded with operations until getting to a safe point in the well to further investigate the causes of the incident. BSEE inspectors issued an INC on November 8, 2012 for failure to maintain fingerboards in proper working order.

After the investigation was complete, the rig determined that revisions to both their Rig Recommended Practice (RRP) and the Written Risk Assessment (WRA) would be made to cover the importance of proper alignment and a better procedure for spacing out the fingerboards.

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

- A failure to recognize the misalignment of the fingerboard allowed the casing to move out of place and fall against the derrick.

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

- Neither the procedures nor the WRA covered the importance of measuring both ends of the fingerboard to ensure proper alignment.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECCURANCE NARRATIVE:  
N/A

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

A G-111 was issued on November 8, 2012 stating the following:

"The lessee did not maintain all equipment in a safe condition. Equipment failure occurred [sic] on 11-7-2012 at 1:45 AM. A stand of 14" casing fell across the derrick. The finger board fingers did not hold the casing securely in place. The finger in question can not [sic] be used until repaired or replaced and approved by BSEE Houma District."

"The operator will submit a letter of explanation to the BSDEE Houma District office with the corrected green copy of the INC and the incident investigation findings and corrective actions within 14 days."

25. DATE OF ONSITE INVESTIGATION:

08-NOV-2012

26. ONSITE TEAM MEMBERS:

James Richard / Jeramie Liner /  
Jerry Freeman /

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

**Bryan Domangue**

APPROVED

DATE: **15-JAN-2013**

