

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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **01-AUG-2012** TIME: **0020** HOURS

2. OPERATOR:

McMoRan Oil & Gas LLC

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **BLAKE OFFSHORE ENERGY, LLC**

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- 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:

4. LEASE: **G09529**

AREA: **VR** LATITUDE:

BLOCK: **398** LONGITUDE:

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

5. PLATFORM:

A

RIG NAME: **BLAKE 210**

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: **381** FT.

10. DISTANCE FROM SHORE: **102** MI.

11. WIND DIRECTION:
SPEED: M.P.H.

12. CURRENT DIRECTION: **S**
SPEED: **10** M.P.H.

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

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

17. INVESTIGATION FINDINGS:

On August 1, 2012, preparations were made to test the Blowout Preventers (BOPs) after rigging up the Blake 210 rig on location at VR 398 Well A002. The tubing hanger that was installed in the wellhead was found to be severely corroded, preventing testing the BOPs to the maximum anticipated surface pressure (MASP). The decision was made to cut the tubing string in order to remove the leaking tubing hanger and test the BOPs to the MASP. The tubing was cut at 840' on July 25, 2012 with a jet cutter. This cut was made above the DX plug which was previously installed on December 2, 2010 at 869'. The BOPs were then tested to 250/10000 psi. The 2-7/8" tubing stub was engaged with an overshot ran on 3.5" 12.95 ppf workstring. Several attempts were made to open the equalizing port on the DX plug using wireline tools. Reports from the facility indicated, in error, that the equalizing ports had opened and pressure was equalized above and below the plug. Pumping on the tubing string showed a drop in tubing pressure for all three attempts to pump down the tubing. Pump pressure was 3000 psi initially and bled off to 2000 psi during the first attempt and then dropped from 3000 psi to 1000 psi on the second and third attempt. Bailers were then run and recovered approximately 4 ounces of metal from the top of the DX plug. Wireline was once again run and the plug was latched, jarred, and approximately 750 lbs. of pull was put on the plug resulting in the plug not coming free from the profile and wireline tools becoming stuck. The operator was unable to release the overshot and cut the tubing above the wireline fish and pulled workstring and 9.63' of 2-7/8" tubing, leaving the top of fish at approximately 855'. An external cutter was then run on 3.5" workstring to cut the tubing below the DX plug. After approx. 4 minutes of cutting, the tubing parted and the well began to flow resulting in the workstring being ejected from the well. The annular and pipe rams were closed in order to bring the well under control. Approximately 809' of workstring had been ejected before the blind shear rams were closed and the workstring sheared. Visual confirmation during lockdown of the blind shear rams verified closure and shearing of work string. Approximately 77' of workstring and BHA (Bottom Hole Assembly) remained in the well.

Upon examination of the plug after removal from the wellbore, it was determined that the wireline equalizing prong did not completely shift the collet to fully open the equalizing ports. Three attempts were made to pump down the tubing, with all three attempts resulting in a pressure drop and no positive confirmation as to where the pressure was bleeding off. It was later determined that the overshot packoff was leaking, resulting in the loss of pressure into the casing annulus. The pressure drop was assumed to be going down the tubing and into the formation; thus, giving a false indication that the pressure was equalized. The decision was then made to make an external cut on the tubing below the DX plug, resulting in the tubing parting, the trapped pressure below the plug being released into the casing annulus, and the workstring being ejected from the well. Inspection of the DX plug showed that wireline debris from the jet cutter as well as sand from the well was lodged in the DX plug from the top of the fishing neck down to the lower portion of the plug body and the equalizing-sub assembly. The presence of the debris and sand prevented the equalizing ports from being completely opened, as well as prevented fluids from being pumped down below the plug to kill the well. This debris prevented the equalizing prong from seating completely into the equalizing sub in the lower portion of the plug; thus, not allowing the equalizing collet to shift completely open.

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

1. Failure to properly equalize the pressure below and above the DX plug before cutting the tubing contributed directly to the incident.

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

1. Sand and wireline debris in the DX plug prevented equalizing ports of DX plug from opening and restricted flow of fluids from being pumped through the plug.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

Loss of 3.5" work string(approx. 800'), traveling block, elevators, BOP stack replaced, choke manifold, accumulator unit and umbilicals to stack. Approximately 1200' of drill line was also damaged.

NATURE OF DAMAGE:

Exterior damage to traveling block and elevators, distortion and kinking of workstring being used as well as rupturing of an umbilical hose from the accumulator unit to an HCR valve. Drill line was also damaged(approx. 1200')due to kinking.

ESTIMATED AMOUNT (TOTAL): \$289,636

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Charles District recommends that that the BSEE Office of Safety Management issue a Safety Alert related to this incident.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

09-AUG-2012

26. ONSITE TEAM MEMBERS:

Buford, Royce / Matte, Carl / Olive, William /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Williamson, Larry

APPROVED

DATE: 23-OCT-2012

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 :

ZIP CODE :

