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

ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED
   DATE: **13-SEP-2022** TIME: **1245** HOURS
2. OPERATOR: **Chevron U.S.A. Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Parker Drilling Company**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [x] CRANE
- [ ] OTHER LIFTING
- [ ] 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:
4. LEASE: **G05911**
   AREA: **GC** LATITUDE:
   BLOCK: **205** LONGITUDE:
5. PLATFORM: **A-Genesis Spar**
   RIG NAME:
6. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [x] DEVELOPMENT/PRODUCTION (DOCD/POD)
7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

   OPERATOR CONTRACTOR

   - [ ] REQUIRED EVACUATION
   - [ ] LTA (1-3 days)
   - [ ] LTA (>3 days)
   - [ ] RW/JT (1-3 days)
   - [ ] RW/JT (>3 days)
   - [ ] FATALITY
   - [ ] Other Injury

   - [ ] POLLUTION
   - [ ] FIRE
   - [ ] EXPLOSION

   LWC
   - [ ] HISTORIC BLOWOUT
   - [ ] UNDERGROUND
   - [ ] SURFACE
   - [ ] DEVERTER
   - [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES

   COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

8. OPERATION:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [x] OTHER **P&A**
9. CAUSE:
   - [x] EQUIPMENT FAILURE
   - [x] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER ______
10. WATER DEPTH: **2590** FT.
11. DISTANCE FROM SHORE: **60** MI.
12. WIND DIRECTION:
    SPEED: M.P.H.
13. CURRENT DIRECTION:
    SPEED: M.P.H.
14. SEA STATE: FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

17. INVESTIGATION FINDINGS:

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On September 13, 2022, an incident occurred on the Parker Rig 14 working on A-Genesis Spar under contract for Chevron U.S.A., Inc. Crane operations were being conducted at Green Canyon Block 205, OCS-G 05911 Well A-5. The rig crew was attempting to coil 140 feet of cut drill line using the crane. The drill line was secured with a nylon strap, hoisted, and suspended over the catwalk to be coiled up. As the rig crew was working to coil the drill line, the drill line slipped through the strap and fell approximately 80 feet to the catwalk below. No injuries were reported, and an onsite investigation was initiated. Though no injuries occurred, personnel were in the area where the drill line fell causing this incident to have a high potential for harm.

On the night of September 12, 2022, a pre-tour meeting was held with the rig crew and the operator for slipping and cutting the drill line from the draw works. A Job Safety Analysis (JSA) was reviewed and signed by all rig crew members involved with this process before work commenced. The drill line was cut and laid out on the catwalk to be coiled up and disposed of.

On September 13, 2022, at approximately 0035 hours, the Derrickman attached a 2-inch nylon strap with 2 wraps and a double half hitch 3 to 4 feet from the tail end of the cut drill line. The Crane Operator was contacted to position the crane over the catwalk to assist by lifting the drill line. The Crane Operator then hoisted the drill line approximately 80 feet above the catwalk for the rig crew to coil it up. After making 3 coils of the drill line on the catwalk, the drill line slipped through the nylon strap and fell to the catwalk into an area where the rig crew were working then fell to the platform's main deck. An All Stop was initiated, and rig management was notified followed by a stand down with all crews on board.

Investigation:

The Bureau of Safety and Environmental Enforcement (BSEE) investigation team conducted an onsite inspection and investigation on October 21, 2022 and collected incident documentation from the operator. The investigation team reviewed all the provided documentation and noted that a JSA was created, reviewed, and signed by the rig crew involved in this operation. BSEE noted that the JSA lacked steps pertaining to the process of coiling and disposing of the 148 feet of 1 3/8 inch drill line cut from the draw works drum. Also, there was no Well Site Representative (WSR) on location during the event. The night WSR went in earlier that day due to no work being planned for the evening. The Team learned that there was no Standard Operation Procedure (SOP) in place for slipping and cutting drill line and coiling it up for disposal. Immediately following lunch, the rig crew went directly to the catwalk area and began coiling up the drill line without any discussion or JSA review with the crane or rig crew. The rig crew failed to identify the Red Zone area and were working under a suspended load.

Documentation provided indicated that the rigging applied to the cut drill line with the 2-inch nylon strap was inadequate. The strap was too wide and thick which prevented the proper cinching/choking on the drill line.

**Since the incident, the contractor has developed a rig specific Work Safe Procedure (WSP) and SOP for slipping and cutting drill line. The JSA for slipping and cutting drill line will include all necessary steps and risk mitigation. The Drill Site Representative (DSR) the operator’s Health Safety and Environmental (HSE) Representative will attend the JSA discussions, pre-job meetings and sign the JSA’s prior to work
commencing. The drill line will be cut in manageable sections to be placed in the scrap basket manually and the crane will no longer utilized in the cutting and coiling operation.**

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

Equipment Failure: Improper tools being used. The nylon strap was too thick to properly secure the drill line for hoisting.
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Supervision: No supervision. The nisgt WSR was not on location at the time.

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

Management Systems: No written job procedure. Lack of established methods of performing the task.

20. LIST THE ADDITIONAL INFORMATION:

Contributing factors: Personnel working under a suspended load increased the potential for harm.

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE Houma District has no resommendations for the Office of Incident Investigations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

21-OCT-2022

26. Investigation Team Members/Panel Members:

Jason Lirette / Tim Boudreaux / Gabe Orellana / Paul Reeves - Author /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Amy Pellegrin

APPROVED DATE: **02-JUN-2023**