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: **09-DEC-2019** TIME: **0700** HOURS
2. OPERATOR: **Fieldwood SD Offshore LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   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: **G02647**
   AREA: **EB** LATITUDE:
   BLOCK: **160** LONGITUDE:

5. PLATFORM: **A-Cerveza**
   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 **Plug & Abandonment**

9. CAUSE:
   - [ ] EQUIPMENT FAILURE
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER _____

10. WATER DEPTH: **935** FT.
11. DISTANCE FROM SHORE: **87** 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:

On 9-December-2019, at East Breaks 160 A, at approximately 0700 hours, Plug and Abandoment(P&A) personnel were in the process of conducting a blind lift, pulling 41 joints of 3-1/2" drill pipe with Bottom Hole Assembly(BHA)and mechanical cutters. The crew attempted to pull the BHA through a window which was milled into the 16" casing of Well A12, utilizing the East platform crane. The total drill pipe string weight of 19,900 lbs. was identified by the Crane Operator. During the lift, the weight indicator increased to 24,000 lbs. The Crane Operator immediately stopped and slacked off to decrease the load weight. P&A personnel set DU-Regular slips into the Quik Pac lower bowls and the Crane Operator began to lower the single joint elevators to allow the crew to unlatch from the drill pipe. After lowering the drill pipe approximately four feet, the work string began to fall through the slips. When the tool joint made contact with the single joint elevators, the work string stopped and the crane was shock loaded. Prior to disconnecting the elevators, the crew attached a safety collar on top of the slips. Once the crane was free of the load, it was placed back in the boom craddle and placed out-of-service until an inspection could be completed.

The Root Cause: BSEE discovered the lessee failed to ensure personnel were properly inspecting the slips and bowls and operating all equipment as per Manufacture's Operations/Maintenance Instruction Manual prior to use.

Contributing causes:
1. Personnel failed to ensure slips completely seated into the bowls.
2. Personnel failed to ensure the slips and bowls were properly lubricated prior to use.
3. Job Safety Analysis (JSA) did not contain steps to ensure slips and bowls were properly cleaned and greased prior to use.

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

The Root Cause: Lessee failed to ensure personnel were properly inspecting the slips and bowls and operating all equipment as per Manufacturer's Operations/Maintenance Instruction Manual prior to use.

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

1. Personnel failed to ensure slips completely seated into the bowls.
2. Personnel failed to ensure the slips and bowls were properly lubricated prior to use.
3. Job Safety Analysis (JSA) did not contain steps to ensure slips and bowls were properly cleaned and greased prior to use.

20. LIST THE ADDITIONAL INFORMATION:

Lessee has a history of crane incidents while performing Plug & Abandonment operations.

21. PROPERTY DAMAGED: **None**

NATURE OF DAMAGE: **None**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Jackson District does not have any recommendations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 (C)

The Lessee failed to perform all operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment in the following ways:

1. The Lessee failed to ensure all equipment was properly utilized and thoroughly inspected prior to use; such as: type of slips, condition of slips, condition of bowls, and condition of safety collar.
a. The Job Safety Analysis (JSA) did not address proper inspection or maintenance of slips, bowls, and safety collar utilized during the operation.
b. The Lessee failed to properly set the slips onto the work string in order to ensure the work string was secure and unable to fall down the wellbore.
c. The Lessee utilized the same slips (DU-Regular) that failed to hold work string in order to down rig the crane from the work string. The Lessee later changed the slips out with DU-Long slips prior to resuming abandonment operations.
d. While securing the load (work string) after the crane was shock loaded, personnel used a safety collar that had a missing die insert.
2. The Lessee failed to ensure the DU Regular slips were fully set in the bowls, which then allowed the work string to fall eight to ten feet, causing a shock load to the crane. The recoil of the shock load ejected the slips out onto the deck.
3. The Lessee failed to ensure the load was free to be lifted out of the hole as per API RP 2D B.3.2.3. The crane was pulling the work string due to the Bottom Hole Assembly (BHA) being caught on the milled casing window, which caused the load to not be free and clear to be lifted.
4. The Lessee failed to use the correct load chart at the time of the incident. The Crane Operator was utilizing the static load chart (onboard capacity)instead of the dynamic load chart (offboard capacity).

25. DATE OF ONSITE INVESTIGATION:

09-DEC-2019

26. INVESTIGATION TEAM MEMBERS:

James Holmes typed report / David Kearns / John Orsini /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Stephen Martinez

APPROVED DATE: **27-MAY-2020**