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-NOV-2021** TIME: **1620** HOURS
2. OPERATOR: **Anadarko Petroleum Corporation**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Diamond Offshore**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **Elevators**
- [ ] 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: **G21801**
   AREA: **GC** LATITUDE:
   BLOCK: **518** LONGITUDE:

5. PLATFORM:
   RIG NAME: **DIAMOND OCEAN BLACKHAWK**

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
   - [X] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] OTHER

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: **4300** FT.
11. DISTANCE FROM SHORE: **150** MI.
12. WIND DIRECTION: **NNW**
    SPEED: **21** M.P.H.
13. CURRENT DIRECTION:
    SPEED: M.P.H.
14. SEA STATE: **6** FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

On November 13, 2021, an incident occurred onboard the Diamond Offshore Black Hawk working for Anadarko Petroleum Corporation. Abandonment operations were being conducted at Green Canyon Block 518 OCS-G 21801 Well #2. The Driller attempted to lift a stand of drill pipe, when it slid thru the elevators and fell across the derrick coming to rest against the lower belly board. No injuries were reported, and an onsite investigation was initiated. This incident had high severity dropped object potential.

At noon, on November 13, 2021, the drill crew came on tour with the task to pull out of the wellbore with the Cast Iron Bridge Plug (CIBP) on rented 4.5-inch rental drill pipe. A Job Safety Analysis (JSA) on "Pulling out of the Hole" was reviewed and signed by all participating drill crew members involved with this operation. In addition, the drill crew reviewed and signed the Operational Work Order Details document, "Pulling out of the hole with CIBP".

In preparation to make up the new running tool, a 4.5-inch double drill pipe with an EZSV stinger (4.5" double assembly), weighing approximately 1,500 pounds, was to be moved to the auxiliary drill floor side using the Hydra-racker. The use of the auxiliary drill floor would prevent any objects from falling into the active well on the main drill floor side. Before the 4.5" double assembly could be latched in the elevators hanging from the auxiliary top drive, the elevator inserts were required to be changed to 4.5-inch. Once the inserts were replaced, as per procedure, the Assistant Driller checked to verify all safety pins and secondary retention were in place. The 4.5" double assembly was then transferred from the Hydra-racker to the elevators and the elevators were confirmed closed by a Floorhand. The Driller proceeded to rotate the elevators on the top drive, retract the link tilt (which extended the elevators out to latch the double drill pipe from the Hydra-racker), and lower the 4.5-inch double assembly to 1 foot above the deck as two Floorhands steadied the pipe with their hands. As the link tilt retracted, the 4.5-inch double assembly unexpectedly came out of the drill pipe elevators and fell approximately one foot to the deck. The 4.5-inch double assembly fell across the derrick, coming to rest against the lower belly fingerboard. Both Floorhands, located approximately two feet away from the pipe, used the designated route to escape the area. A Time Out for Safety was called, and an investigation was initiated while a plan was developed to retrieve the 4.5-inch double assembly from the derrick.

Due to the Covid-19 pandemic, the Bureau of Safety and Environmental Enforcement (BSEE) investigation team was unable to conduct an initial onsite investigation at the time of this incident. However, an investigation team was able to collect documentation and pictures furnished by the operator at the team's request. The investigation team reviewed the documentation and noted:

- A JSA and a Operational Work Order was reviewed and signed by all personnel involved in the operation on the drill floor.

-As work commenced, it was decided to move the 4.5-inch double drill pipe to the auxiliary drill floor side as a precaution to prevent any objects from accidentally falling into the active well on the main drill floor side. Preparation began on the auxiliary side which included replacing the proper inserts into the top drive elevators for 4.5-inch drill pipe. The Driller knew that the inserts in the elevators were the wrong size, so he proceeded out of the drillers shack to instruct the drill crew on which inserts to install.

A stamp was located on the top of the inserts indicating the drill pipe size to identify the correct inserts. The Assistant Driller confirmed the 4.5-inch inserts were installed and the safety pins and secondary retention were secured as per procedure, then proceeded to transfer the 4.5-inch double drill pipe with the Hydra-racker operated from the Main Drill floor side.

-Once the pipe was latched in the elevators and confirmed by a Floorhand, the weight was transferred to the elevators. The Driller the proceeded to rotate the elevators, retract the link tilt on the top drive, and lower the 4.5” double assembly when the 4.5-inch double assembly came free and dropped approximately one foot onto the rotary.

-There were two Floorhands using their hands to steady the drill pipe as link tilt was activated. Both were approximately two feet away when the drill pipe dropped and used the designated escape route to get out of harms way.

-The investigation revealed that the inserts installed in the elevators were the incorrect size according to the Drill Pipe Performance Data Sheet provided with the rental drill pipe. The required elevator inserts for this rental drill pipe were 4-inch EU – 4.5-inch IEU. The Driller identified some 4.5-inch inserts in front of the drillers shack and instructed the crew to install them in the elevators. The inserts were 4.5-inch EU – 5-inch IEU, not the size recommended by the rental drill pipe data sheet. The Assistant Driller did not positively confirm that the correct 4.5-inch inserts were installed prior to use.

-Diamond has since updated the Step-by-Step Procedure (SSP) to include “Change Inserts in Elevators” including verification with the appropriate Drill Pipe Performance Data Sheet to compare for the proper size of insert to be installed in the elevators for each change out when using rental pipe.

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

Positive confirmation was not made for the proper drill pipe elevator inserts.

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

Human Error: The Driller or Assistant Driller verified that the correct drill pipe inserts were installed as per the Performance Drill Pipe Data Sheet.

20. LIST THE ADDITIONAL INFORMATION:

n/a

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE Houma District has no recommendations 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:

N/A

25. DATE OF ONSITE INVESTIGATION:

26. INVESTIGATION TEAM MEMBERS:

Paul Reeves (Author) /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Amy Pellegrin

For Public Release

APPROVED DATE: **15-MAR-2022**