

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: 25-JUN-2019 TIME: 2045 HOURS

2. OPERATOR: **Murphy Exploration & Production**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **Transocean Offshore**

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING **Rope socket**
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER **Dropped object**

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

4. LEASE: **G10437**

AREA: **DC** LATITUDE: **28.94429**

BLOCK: **4** LONGITUDE: **-87.72517**

5. PLATFORM:

RIG NAME: **T.O. DEEPWATER ASGARD**

6. ACTIVITY:

- EXPLORATION(POE)
- 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.
- OTHER

9. CAUSE:

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

10. WATER DEPTH: **5843** FT.

11. DISTANCE FROM SHORE: **69** MI.

12. WIND DIRECTION:

SPEED: **2** M.P.H.

13. CURRENT DIRECTION:

SPEED: **2** M.P.H.

14. SEA STATE: **2** FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

On June 25, 2019, Murphy E&P Company USA had a dropped object incident onboard Transocean's Deepwater Asgard Drillship while conducting well completion operations at Desoto Canyon Block 4 Well No. 2. The incident involved a packer setting tool detaching from the wireline rope socket causing the 162 lb packer-setting tool to free fall approximately 40 ft to the rig floor below. There were no injuries; however, there was damage to the drill floor. At 20:45 hours, Murphy reported the incident to the Bureau of Safety and Environmental Enforcement (BSEE) New Orleans District.

Transocean's Deepwater Asgard Drillship successfully landed out the tubing hanger in the production tree on "Dalmatian" Desoto Canyon Block 4 Well No. 2. The crew then rigged up for slickline operations and performed three successful runs.

The next step in the well program was to set a production packer using slickline to isolate the well. The slickline crew made many unsuccessful attempts over the next two days to set the production packer.

Based on BSEE onsite interviews and the Transocean lessons learned report, Murphy decided to run a different style tubing packer to isolate the well. The new style plug had to be run on Electric Line (E-line) which required the rig up and lubricator type to be changed from slickline operations. The wireline crew isolated the well and rigged down the slickline equipment. The wireline crew made all runs up to this point using a slickline unit.

At 20:45 hours, the new style packer (E-line packer) and packer setting tool were picked up and run downhole successfully. During this time, a crew change occurred. The new crew successfully installed the packer in the hole. After setting the packer, the E-line crew pulled the packer setting tool. The packer setting tool was pulled back to surface and the tool was positioned inside the lubricator in preparation to layout the tool.

Due to the change in the wireline rig up, the process to lay down the wireline tools and equipment (i.e. lubricator) becomes more complicated. In the new operational rig up, the travel block supported both the E-line (top) sheave and the winch. The Winch operator controls the tension supporting/lifting the lubricator. The E-line (hoist) operator controls the tension/ lifting force of the wireline (E-line) run through the top sheave and connected to the packer setting tool. If the Winch operator slacks off before the E-line operator, the lubricator weight will be set down on top of the tool string. The new crew coming on tour did not recognize this hazard. Furthermore, the crew did not discuss this hazard during the toolbox talk.

Prior to the incident, two floor hands went up in a workbasket to bleed off the well pressure and detach the lubricator. The crew lifted the lubricator off the wireline valves and positioned it for lowering to the floor. The plan was to lower the packer setting tool and the lubricator to the floor at the same time.

The floor hands, drill shack personnel, the E-line operator, and the Winch operator were in radio communication. During the rigging down operations and before the incident, a breakdown in communication occurred. The Winch operator started slacking off before the E-line operator. This caused the weight of the lubricator to set down on the top of the packer setting tool which allowed the electric line to pull free from the rope socket. The broken rope socket allowed the 162 lb packer setting tool (the spear) to free fall 40 ft to the rig floor. There were no injuries and no major structural damage; however, there was an indentation in the drill floor. The closest person to the incident was 18 ft away.

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

There was a breakdown in communication between the winch operator and the E-line operator which lead to the winch operator to start slacking off before the E-line operator was able to slack off of his tool string.

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

Breakdown in communication

20. LIST THE ADDITIONAL INFORMATION:

To Prevent Reccurance:

- Use a tool trap on the lubricator. This tool will trap the wireline tool string within the lubricator in the event of the wire being accidentally stripped from the rope socket/cable head.
- Radio communication needs to be more descriptive, meaning identifying who is speaking and to whom the command is for.

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

Wireline tool string  
Wooden plank on the drill floor

Wireline, packer setting tool dropped

ESTIMATED AMOUNT (TOTAL):                      \$1,200

22. RECOMMENDATIONS TO PREVENT RECCURANCE NARRATIVE:

The BSEE New Orleans District makes the recommendation to the Office of Incident Investigation OII to consider issuing a safety alert.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT:      NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

11-JUL-2019

26. INVESTIGATION TEAM MEMBERS:  
**Frank Musacchia**

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

*For Public Release*

OCS REPORT:

30. DISTRICT SUPERVISOR:

**David Trocquet**

APPROVED

DATE: **28-MAY-2020**