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: 24-JUN-2013  TIME: 0015  HOURS

2. OPERATOR: Anadarko Petroleum Corporation
   REPRESENTATIVE: -
   TELEPHONE: -
   CONTRACTOR: Nabors Drilling Inc.
   REPRESENTATIVE: -
   TELEPHONE: -

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

4. LEASE:
   AREA: EB  LATITUDE: -
   BLOCK: 602  LONGITUDE: -

5. PLATFORM:
   RIG NAME: NABORS POOL 140

6. ACTIVITY:
   EXPLORATION (POE)
   DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
   HISTORIC INJURY -
   REQUIRED EVACUATION
   LTA (1-3 days)
   LTA (>3 days)
   RW/JT (1-3 days)
   RW/JT (>3 days)
   Other Injury -

   PATALITY
   POLLUTION
   FIRE
   EXPLOSION

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

   COLLISION
   HISTORIC
   $>25K
   <=$25K

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

9. WATER DEPTH: 3675 FT.

10. DISTANCE FROM SHORE: 178 MI.

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

12. CURRENT DIRECTION:
    SPEED: M.P.H.

13. SEA STATE: FT.
17. INVESTIGATION FINDINGS:

Plug and Abandonment (P&A) Operations were removing 9 5/8 inch riser. While ballasting down the buoyancy can supporting the A-2 riser, the buoyancy force supplied by the can was reduced to less than the force required to fully support the can. Studs used to secure the riser adapter to the buoyancy can fell approximately 20 feet. The falling work platform caught an adjacent well's hydraulic umbilical line resulting in a loss of production.

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

1) Hazard analysis failed to identify improper torque on the studs.
2) Procedures did not address the securing of the hydraulic umbilical lines of adjacent wells.
3) Equipment and procedures utilized were inadequate to safely lift the buoyancy can.

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

Procedures failed to utilize the use of a secondary mechanical safety device in case of a bolt failure. Studs were unable to be inspected after installation due to initial design.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The District does not have any recommendations to the regional office for this event.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

1) Equipment and procedures were inadequate to safely lift buoyancy can.
2) Procedures failed to address securing of the adjacent hydraulic umbilical lines prior to starting operations.
3) Hazard analysis failed to identify the over torquing of the bolts.
4) Procedures failed to utilize the use of a secondary mechanical safety device in case of a bolt failure.

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:
   OSCAR TORRES / JAMES HOLMES /

29. ACCIDENT INVESTIGATION PANEL FORMED:

30. DISTRICT SUPERVISOR:
    OCS REPORT:
    John McCarroll

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APPROVED
DATE: 15-SEP-2014