

UNITED STATES DEPARTMENT OF THE INTERIOR  
 MINERALS MANAGEMENT SERVICE  
 GULF OF MEXICO REGION  
**ACCIDENT INVESTIGATION REPORT**

1. OCCURRED

DATE: 15-JUL-2009 TIME: 2150 HOURS

2. OPERATOR: BP Exploration & Production Inc.

REPRESENTATIVE: Sustala, Dennis

TELEPHONE: (281) 366-0898

CONTRACTOR: Transocean Offshore

REPRESENTATIVE: Barber, Dennis

TELEPHONE: (832) 587-6933

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

4. LEASE: G15607

AREA: GC LATITUDE:

BLOCK: 743 LONGITUDE:

5. PLATFORM:

RIG NAME: GSF DEVELOPMENT DRILLER II

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
- FATALITY
- POLLUTION
- FIRE
- EXPLOSION

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

COLLISION  HISTORIC  >\$25K  <=\$25K

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K \$275,000
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER Dropped BHA

6. OPERATION:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

8. CAUSE:

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

9. WATER DEPTH: 6820 FT.

10. DISTANCE FROM SHORE: 122 MI.

11. WIND DIRECTION:  
 SPEED: 1 M.P.H.

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

13. SEA STATE: 1 FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On 15 July 2009 at 2150 hours, while conducting drilling operations for BP Exploration and Production Inc. (BP), Transocean's Development Driller II dropped 81 feet of Bottom Hole Assembly (BHA) consisting of a mud motor, stabilizer, under reamer and one 9-1/2" drill collar from the aft rotary table to the sea floor. After running casing from the main drill floor, the crew was breaking down the BHA on the auxillary floor. The Driller observed the lift-sub was rotating with the BHA, but he did not recognize a threat and turned his attention to concurrent operations on the main drill floor. As rotation continued the lift-sub backed out of the BHA. When the made-up assembly was raised from the rotary table and the slips removed, the few threads left on the lift-sub failed and the BHA fell to the sea floor. There were no injuries sustained from this incident.

The Task Specific Think Procedure (TSTP) for laying down BHA's had not been fully transcribed nor monitored.

No video cameras were being used to monitor the lift-sub connection.

The Driller was inexperienced and had never broken down a BHA.

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

The Driller's lack of experience and supervision, in conjunction with the floor hands working on other tasks and not paying attention to the lift-sub make-up, are the leading causes to this incident. In addition, other Supervisors were focused on the main drill floor operations since the perceived risk of breaking-down the BHA was low.

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

\*All hazards associated with the lift-sub backing-out during make-up were not identified in the TSTP. Since the lift-sub was not flagged in the TSTP, no one was assigned to watch it for movement.

20. LIST THE ADDITIONAL INFORMATION:

The following steps were implemented by Transocean to prevent further occurrences of this nature:

- \*The TSTP is to be updated to cover all hazards with all levels of management to take a more proactive role in reviewing TSTP's for increased monitoring.
- \*Video cameras are to be used to monitor the lift-sub connection.
- \*The line scribed on the lift-sub during make-up is to be made more visible.
- \*Ensure the Drillers experience levels are acceptable.
- \*Evaluate alternate methods of making-up/spinning-up BHA components.
- \*Consider torquing lift-sub with power equipment prior to setting in the rotary table.

21. PROPERTY DAMAGED: NATURE OF DAMAGE:  
81 feet of Bottom Hole Assembly Lost on the sea floor  
(mud motor, stabilizer, under reamer, and  
9-1/2" drill collar)

ESTIMATED AMOUNT (TOTAL): \$275,000

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:  
Due to the specific nature of this incident, the MMS Houma District has no  
recommendations to report to the MMS Regional Office.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:

Josh Ladner /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED

DATE: 10-SEP-2009