

UNITED STATES DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: 11-DEC-2009 TIME: 0930 HOURS

2. OPERATOR: StatoilHydro USA E&P, Inc.
REPRESENTATIVE: Worsham, Michael
TELEPHONE: (713) 579-9900
CONTRACTOR:
REPRESENTATIVE:
TELEPHONE:

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

4. LEASE: G20341
AREA: WR LATITUDE:
BLOCK: 543 LONGITUDE:

5. PLATFORM:
RIG NAME: MAERSK DEVELOPER

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 VDM Gripper Head
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER

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: 6606 FT.

10. DISTANCE FROM SHORE: 182 MI.

11. WIND DIRECTION: N
SPEED: 23 M.P.H.

12. CURRENT DIRECTION: NNW
SPEED: 1 M.P.H.

13. SEA STATE: 3 FT.

17. INVESTIGATION FINDINGS:

On 11-Dec-2009 at 0930 hours, the Maersk Developer Rig was picking up 16-inch casing joints from the Aux Riser Pipe Shuttle (RPS) with the VDoor Machine (VDM) Gripper heads to build three-joint stands of casing. There were already two joints of casing screwed together in the slips when the Assistant Driller went to go pick up the last joint from the RPS to complete the stand.

Once the RPS elevated the back end of the last joint of casing, the VDM was lowered so that the VDM's head covered the outer diameter of the casing. Once the outer diameter of the casing was fully covered, the VDM Guides closed over the casing joint. The VDM Guides are not designed to support the loads weight; only the VDM Gripper. The only purpose of the VDM Guides is to centralize the casing joints. Once the VDM Guides closed over the casing, the VDM Guide's Close Screen should be illuminated.

After the VDM Guides closed around the casing, the VDM Gripper was to close around the casing as well, however; the Assistant Driller assumed that the VDM Guides were closed and activated the VDM Gripper before the VDM Guides received positive feedback. If the VDM Gripper is activated before the VDM Guides receive positive feedback, the VDM Gripper will not close. Because the VDM Gripper was open at the time of the lift, the joint of casing was then hoisted only using the VDM Guides which could not support the casing weight. As the 3690 pound casing joint rose approximately 36 feet with the VDM, the casing slipped out of the VDM head. The casing then slid back down into the RPS, falling off the pipe tailing arm as it fully re-entered the RPS.

At the time of the incident, there were no personnel located in the Red Zone with the exception of one authorized individual during movement of the pipe and or equipment. There were no personnel injuries associated with this incident.

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

The 16-inch joint of casing fell from the VDM due to hoisting the joint with the VDM Guides while the VDM Gripper remained open.

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

Operator error resulting from a lack of communication between the VDM Operator and the Weatherford Operator.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

There was no property damaged in this incident. N/A

ESTIMATED AMOUNT (TOTAL): \$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

Due to the specific nature of this incident, the Houma District has no recommendations to report to the 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:

Casey Bisso /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED

DATE: 09-MAR-2010