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: **21-FEB-2022** TIME: **1215** HOURS
2. OPERATOR: **Equinor Gulf of Mexico LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Seadrill Limited**
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G35733**
   AREA: **WR** LATITUDE:
   BLOCK: **315** LONGITUDE:

5. PLATFORM:
   RIG NAME: **SEADRILL WEST VELA**

6. ACTIVITY:
   - [X] 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

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **Material handling with tugger**
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

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
   - [X] OTHER **Dropped object**

10. WATER DEPTH: **6543** FT.
11. DISTANCE FROM SHORE: **170** MI.
12. WIND DIRECTION:
    SPEED: M.P.H.
13. CURRENT DIRECTION:
    SPEED: M.P.H.
14. SEA STATE: FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

On February 21, 2022, an incident occurred on board the Seadrill West Vela drillship working for Equinor Gulf of Mexico LLC. Drilling operations were being conducted at Walker Ridge Block 315 OCS-G35733 Well #001. The drill crew was in the process of replacing the Hydra-racker hoist wire rope when the wire rope slipped from its rigging and fell approximately 114 feet to the drill floor. No injuries were reported, and an onsite investigation was initiated. This incident had a high severity dropped object potential.

On the morning of February 21, 2022, the drill crew was assigned to cleaning the main and auxiliary Hydra-rackers on the rig floor. The main Hydra-racker was positioned on the auxiliary side due to wireline operations taking place on the main side of the drill floor. While in the process of cleaning the main Hydra-racker, a drill crew member noticed there was damage to the main Hydra-racker wire rope and reported it to his supervisor. The supervisor made the decision to replace the damaged wire rope with a new one. A Pre-job meeting was held and a "Task Based Risk Assessment "(TBRA) and a "Step by Step Procedure" (SSP) form was reviewed and signed by all personnel involved with this process. The drill crew proceeded to disconnect the lower thimble on the damaged cable and connect it to the new cable. Utilizing the racker winch and the damaged wire rope, the drill crew rigged and pulled the new wire rope up to a staged position. After securing the new wire rope to the racker beam, the drill crew slacked off the damaged wire rope and disconnected it from the new one. Once disconnected, the old wire rope was rigged up to a tugger to pull it completely off the winch drum and spooled up on a cable drum. The drill crew attached the new wire rope to the tugger and released the hang off rigging in order to stab the tail end of the cable into the drum clamps. While the drill crew was attempting to secure the new wire rope to the drum clamps, the rigging came free and dropped the wire rope approximately 114 feet to the rig floor. There was no damage to equipment and no injuries were reported.

Investigation:

Due to Covid-19 pandemic protocols, the Bureau of Safety and Environmental Enforcement (BSEE) investigation team was not able to conduct an initial onsite investigation immediately. The investigation team was able to collect incident documentation, photos and witness statements furnished by the operator at the team's request. The investigation team reviewed the incident documentation and noted:

The investigation team found a pre-job meeting was held and a TBRA and SSP was reviewed and signed by all personnel involved in the operation on the auxiliary side of the drill floor.

As work commenced, the drill crew removed the lower thimble on the damaged wire rope and rigged it up the new wire rope. Utilizing the damaged wire rope and racker winch, the drill crew pulled the new wire rope to the winch location using a nylon strap and hung it off on the racker beam. After disconnecting the damaged wire rope from the new wire rope, the drill crew spooled up the damaged wire rope onto a cable drum. The tugger was then rigged to the nylon strap holding the new wire rope attached at the racker beam. As the drill crew connected the new wire rope rigging to the tugger, removing the weight from the racker beam, it was possible to connect the tail end to the clamps on the winch drum. While the drill crew was attaching the cable, the new wire rope came free from the nylon strap and fell approximately 114 feet to the drill floor.

The investigation team also noted that the rigging procedure utilizing the nylon strap was not carried out as per the TBRA. The procedure calls for the use of a 1-3/8" clamp connected to the dead-end side of the wire rope. The drill crew was unable to locate that clamp but proceeded anyway, using several wraps and multiple half hitches of the nylon strap to the new wire rope to hoist into place. The nylon strap used in this

process was not located in the Seadrill onboard sling registry and had no inspection certifications. It was not a Seadrill sling issued by any of their vendors and it is unclear where the sling originated. It was also noted in the final company report that possibly the preservative used to coat the new wire rope could have saturated the nylon strap allowing the wire rope to slip out.

Seadrill action plans are to update the appropriate maintenance procedure with the proper manufacturer procedure and ensure that the proper wire snakes are available on board to use for the wire rope replacement. Also, Seadrill has updated the appropriate TBRA's and SSP's to reflect change in the manufacturer's procedure.

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

Failure to follow the Task Based Risk Assessment, a 1-3/8" clamp was not used as specified.
Failure to follow manufacturer's wire change procedure.

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

1-3/8" clamp was unavaialble as the procedure specified.

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:

None

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**

APPROVED DATE: **30-JUN-2022**