

UNITED STATES DEPARTMENT OF THE INTERIOR -
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT -
GULF OF MEXICO REGION -

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **12-NOV-2015** TIME: **0100** HOURS

2. OPERATOR: **Shell Offshore Inc.**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: -

REPRESENTATIVE: -

TELEPHONE:

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

4. LEASE: **G17565**

AREA: **AC** LATITUDE:

BLOCK: **857** LONGITUDE:

5. PLATFORM:

RIG NAME: **NOBLE DON TAYLOR**

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 **Crown cluster crack**

H2S/15MIN./20PPM

REQUIRED MUSTER

SHUTDOWN FROM GAS RELEASE

OTHER **Lifting Device**

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: **7835** FT.

10. DISTANCE FROM SHORE: **140** MI.

11. WIND DIRECTION: **N**
SPEED: **5** M.P.H.

12. CURRENT DIRECTION: **N**
SPEED: **2** M.P.H.

13. SEA STATE: **1** FT.

17. INVESTIGATION FINDINGS: -

On November 12, 2015, at approximately 0100 hours, the drill crew was tripping in the hole (TIH) with 22 inch casing on the landing string. A Floor Man monitoring the hydra racker drag chain noticed the derrick shaking more than normal and observed smoke coming from the main side crown cluster and called an "All Stop." Simultaneously, the Driller noticed a change in hook load and ceased operations. It was discovered after further inspection the first reduction 78 inch sheave in the crown cluster had a vertical crack and had shifted downward approximately 3 inches.

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

Weld defects near the root of the weld between the web plates and the hub as noted in NOV Product Bulletin No. 87819987.

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

None

20. LIST THE ADDITIONAL INFORMATION:

Crown cluster was replaced.

21. PROPERTY DAMAGED:

Crown cluster 78 inch sheave

NATURE OF DAMAGE:

Vertical crack crown cluster sheave

ESTIMATED AMOUNT (TOTAL): \$330,787

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

No recommendations 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:

18-NOV-2015

26. ONSITE TEAM MEMBERS:

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

Michael Fornia / David Kearns /
James Holmes /

30. DISTRICT SUPERVISOR:
John McCarroll -

APPROVED
DATE: 22-FEB-2016