

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: 06-JAN-2016 TIME: 0810 HOURS

2. OPERATOR: Chevron U.S.A. Inc.
REPRESENTATIVE:
TELEPHONE:
CONTRACTOR: Transocean Offshore
REPRESENTATIVE:
TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER Deck damage 5" hole

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

6. OPERATION:

4. LEASE: G25804
AREA: KC LATITUDE:
BLOCK: 770 LONGITUDE:

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

5. PLATFORM:
RIG NAME: T.O. DISCOVERER INDIA

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

8. CAUSE:

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

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

FATALITY
 POLLUTION
 FIRE
 EXPLOSION

9. WATER DEPTH: 6555 FT.

LWC HISTORIC BLOWOUT
 UNDERGROUND
 SURFACE
 DEVERTER
 SURFACE EQUIPMENT FAILURE OR PROCEDURES

10. DISTANCE FROM SHORE: 239 MI.

11. WIND DIRECTION: E
SPEED: 10 M.P.H.

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

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

13. SEA STATE: 4 FT.

At approximately 08:10 hour on 6 January 2016, a joint of drill pipe fell from the aft pipe transfer conveyor onto the aft pipe deck on the Transocean Discoverer India (DID) drill ship while conducting drilling operations for Chevron U.S.A. (Chevron) on Well #1 (Sicily #1) located in Keathley Canyon Block 770. There were no injuries to personnel during this incident.

At the time of the incident, the Transocean Aft Crew was in the process of transferring drill pipe to the rig floor using the aft pipe transfer conveyor for making up the bottom hole assembly (BHA) and the Forward Crew was running the riser. At approximately 05:00 hour, Transocean decided to discontinue aft rotary operations since the running riser and making up the BHA operations could not take place simultaneously due to lack of personnel. The Crane Operator notified the Driller at 05:30 hour that two joints of pipe remained to be placed on the conveyor loading arms at which time the Aft and Crane Crews broke for lunch. During the time the Aft Crew was at lunch, the utility cart was repositioned to pick up a component for the BHA. The Aft Crew returned to the rig floor from lunch and resumed operations of making up the BHA. When another joint of drill pipe was needed on the conveyor arms for the BHA, the Assistant Driller (AD) walked partially down the conveyor, performed a visual inspection of the aft transfer conveyor and pipe, and concluded that it was safe to resume operations. The AD then returned to the drill floor and engaged the loading arms for transferring a joint of pipe onto the aft conveyor. However, as the loading arms were raised, the box end of the drill pipe became trapped underneath the utility cart that caused the pin end of the drill pipe to elevate above the loading arms. The AD initiated an emergency stop with the drill pipe suspended above the loading arms; however, the drill pipe rolled to the port side and fell over the hand rails impaling pin side down into the aft deck below creating a 5-inch diameter hole. The box end of the drill pipe came to rest damaging a section of hand rails below the aft transfer conveyor. Since the aft pipe deck below the aft transfer conveyor was barricaded off to personnel as per Transocean's policy, there were no injuries. The incident was reported to the Tool Pusher and Offshore Installation Manager and Transocean conducted a preliminary investigation into the incident. After the preliminary investigation was completed, the drill pipe was lowered and secured.

On the evening of 6 January 2016, Transocean issued a Quick Share alert to its fleet describing the incident and the initial actions taken that consisted of a safety shutdown and conducting of a preliminary investigation into the barriers that failed to prevent this type of incident.

On 13 January 2016, BSEE inspectors mobilized to the Transocean DID and conducted photographic document of the incident scene and gathered all pertinent documents related to the incident.

According to the Transocean Level II Investigation Report, the probable causes of the incident were listed as follows: 1) a safety time out was not utilized given the tasks and hazards had changed related to the tasks; 2) failure to follow established Transocean work risk assessment procedures; and 3) the absence of a procedure or work risk assessment associated with the utility cart positioning.

Possible contributing causes for the incident stated in the Transocean Level II Investigation Report include the following: 1) use of the loading arms and the pipe transfer conveyor were considered as "normal operations" that operates in an "Auto Sequence" mode; 2) failure to follow the job tasks stated in the written risk assessment; 3) an interruption during the operations of picking up the BHA to conduct running riser activities that led to an inadequate number of crew members required to conduct both operations; 4) crew members failed to follow the established Transocean management of change process since operations that required five crew members but

only two crew members were available; 5) inadequate handoff during crew changes after meal breaks; 6) failure to implement the "THINK" process and to recognize the hazard conflict between the location of the utility cart relative to transfer conveyor pipe load arms; 7) the "watchmen" did not adequately inspect the work area and verify that transferring drill pipe operations with the loading arms was safe to resume; and 8) the lack of procedures or hazard assessment related to the utility cart positioning.

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

According to the Transocean Level II Investigation Report, the probable causes of the incident were listed as follows: 1) a safety time out was not utilized given the tasks and hazards had changed related to the tasks; 2) failure to follow established Transocean work risk assessment procedures; and 3) the absence of a procedure or work risk assessment associated with the utility cart positioning.

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

Possible contributing causes for the incident stated in the Transocean Level II Investigation Report include the following: 1) use of the loading arms and the pipe transfer conveyor were considered as "normal operations" that operates in an "Auto Sequence" mode; 2) failure to follow the job tasks stated in the written risk assessment; 3) an interruption during the operations of picking up the BHA to conduct running riser activities that led to an inadequate number of crew members required to conduct both operations; 4) crew members failed to follow the established Transocean management of change process since operations that required five crew members but only two crew members were available; 5) inadequate handoff during crew changes after meal breaks; 6) failure to implement the "THINK" process and to recognize the hazard conflict between the location of the utility cart relative to transfer conveyor pipe load arms; 7) the "watchmen" did not adequately inspect the work area and verify that transferring drill pipe operations with the loading arms was safe to resume; and 8) the lack of procedures or hazard assessment related to the utility cart positioning.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

Drill pipe, aft pipe deck and a hand rail.

NATURE OF DAMAGE:

The dropped drill pipe sustained damaged along with a section of hand rail and a 5-inch diameter hole in aft deck created from the drill pipe's impact.

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ESTIMATED AMOUNT (TOTAL): \$3,626

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The BSEE Lafayette District recommends that the Office of Safety Management issue a Safety Alert identifying the potential hazards concerning the positioning of utility carts relative to the transfer conveyor loading arms that may result in falling objects.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

A G-110(W) Incident of Noncompliance (INC) was issued "After the Fact" to document Chevron U.S.A.'s (Chevron) failure to oversee that operations were performed in a safe and workmanlike manner. On 6 January 2016, a joint of drill pipe was dropped from a transfer conveyor onto a deck below. This incident was a result of Chevron's failure to: 1) provide oversight to ensure that Transocean was following established work risk assessment procedures and 2) the failure to evaluate the hazards associated with the positioning of the aft utility cart in relation to the aft conveyor loading arms. As a result, during transfer operations of a joint of drill pipe onto the aft conveyor using the loading arms, the box end of the drill pipe became wedged under the aft utility cart that caused it to roll and fall on the aft deck below creating a 5-inch diameter hole and damaging a section of hand rail. As a result, during transfer operations of a joint of drill pipe onto the aft conveyor using the loading arms, the box end of the drill pipe became wedged under the aft utility cart that caused it to roll and fall on the aft deck below creating a 5-inch diameter hole and damaging a section of hand rail.

25. DATE OF ONSITE INVESTIGATION:

13-JAN-2016

26. ONSITE TEAM MEMBERS:

Troy Naquin / Jack Angelle /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED

DATE: 28-MAR-2016