

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: 31-AUG-2015 TIME: 0100 HOURS

2. OPERATOR: Statoil Gulf of Mexico LLC

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: Transocean Offshore

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE Pipe Racking System
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER

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

6. OPERATION:

4. LEASE: G34634

AREA: WR LATITUDE:

BLOCK: 160 LONGITUDE:

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

5. PLATFORM:

RIG NAME: T.O. DISCOVERER AMERICAS

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

8. CAUSE:

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

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

9. WATER DEPTH: 5868 FT.

10. DISTANCE FROM SHORE: 158 MI.

11. WIND DIRECTION: NW
SPEED: 4 M.P.H.

12. CURRENT DIRECTION: NW
SPEED: 2 M.P.H.

13. SEA STATE: FT.

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

On August 31, 2015, while performing drilling operations on Statoil's Yeti #002 well, an incident occurred onboard the Transocean Discoverer Americas in which a stand of drill pipe fell free of the rig's Modular Derrick Drilling Machine (MDDM) and laid diagonally across the derrick, coming to rest against the rig's pipe rack.

At the time of the incident, the drill crew was in the process of transferring a stand of drill pipe from the Pipe Racking System (PRS) to the MDDM so that a connection could be made. The Driller was running the rig's MDDM while the PRS was being operated by the rig's Assistant Driller (AD). While attempting to make one of the connections, the crew failed to properly align the female end of the stand of drill pipe and the male end of the pipe at the rotary. As the crew made the connection, the male end of the drill pipe landed on the top face of the female connection rather than inside the box, which allowed the pipe to spin without the threads being made up. The Driller began rotating the pipe and simultaneously slacking off on the MDDM to increase the weight on the pipe to assist in making up the threads. Once the Assistant Driller noticed the drill pipe spinning, he released the PRS's arms from around the drill pipe, assuming the pipe was being made up and was secure. As the Driller continued to lower the MDDM, he noticed that the reading on the weight indicator was not what it should have been. It was at this time that the crew noticed that the drill pipe was beginning to bow. When the Driller noticed the bowing of the pipe, he immediately pulled up on the MDDM in an attempt to release the weight that was being applied to the pipe. The tension released from the pipe as the MDDM was raised caused the pipe to jump, falling off of the pipe in the rotary and falling free of the MDDM. The drill pipe, now completely unsecured, fell diagonally across the derrick and came to rest against the pipe rack. The rig floor was cleared of all personnel and the Driller proceeded to screw the MDDM into the stump in order to continue circulation of the well. Once the well was secure, an investigation into the incident was initiated.

The investigation following the incident showed human error as the primary cause. Both Transocean's MDDM Connection Procedure and Written Risk Assessment were updated to help ensure that the drill pipe will remain secure at all times while connections are being made. The first modification states that the rig's PRS shall remain around the drill pipe, with the arms engaged, until the connection into the stump has been verified. The second procedure update states that the elevators on the rig's MDDM shall remain latched around the drill pipe to serve as a second barrier should the drill pipe fall free of the MDDM. No harm to personnel, equipment, or the environment occurred as a result of this incident.

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

- (1) Failure of the crew to recognize that the connection was improperly made up before proceeding with operations.
- (2) Failure to secure maintain control of the drill pipe until a secure connection was verified.

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

- (1) Failure to provide detailed procedures to the crew for connection operations.
- (2) The rig crew's failure to identify all possible hazards associated with making connections on the rig floor.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Houma District has no recommendations for the Regional Office at this time.

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:

**Clinton Campo / James Richard /
Troy Boudreaux /**

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan Domangue

APPROVED
DATE:

07-DEC-2015

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