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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **10-DEC-2019** TIME: **1245** HOURS

2. OPERATOR: **Chevron U.S.A. Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Nabors Offshore Corporation**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **lift nubb**
- [ ] 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:

4. LEASE: **G16942**
   AREA: **WR** LATITUDE:
   BLOCK: **29** LONGITUDE:

5. PLATFORM: **A-Big Foot**
   RIG NAME: **NABORS MODS 400**

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

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
- [ ] OTHER _____

10. WATER DEPTH: **5185** FT.
11. DISTANCE FROM SHORE: **149** 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:

17. INVESTIGATION FINDINGS:

On December 10, 2019, an incident occurred on the Nabors MODS-400 platform rig while under contract for Chevron. The MODS-400, operating on Chevron's Big Foot production facility, located in Walker Ridge Block 29 OCS-G16942 at the time of the incident.

A single 4,205 pound joint of 13-3/4" casing fell across the rig floor after it was hoisted into the air using the wrong size casing lift nubbin which was suspended from the top drive. There were no injuries reported.

On Wednesday, December 9, 2019, at approximately 23:00 hours, the "B" drill crew was in the process of rigging down the drill pipe handling equipment in preparation to run 13-3/4" casing. Prior to commencing work, the Chevron Drill Site Representative (DSR) led the "B" drill crew through a pre-job safety meeting on the rig floor. The drill crew consisted of 1 Toolpusher, 1 Driller, 1 Assistant Driller, 4 Floorhands, 2 Roustabouts, 8 Weatherford casing hands, and 1 Tubular Solutions Incorporated (TSI) Inspector. A Plan of Action (POA) was generated by Chevron with all necessary personnel, tools, equipment, and Job Safety Analysis (JSA's). Chevron also designated Safe Zones for personnel to stay in while lifting the casing to install in the well. All documents were reviewed and signed by the crew, and work commenced by picking up the first joint of casing, which was a 13-5/8" casing shoe joint (joint number 1). It was ran into the hole (RIH) using the 13-5/8" lift nubbin, and was left on the casing to protect the threads. Following the 13 5/8" casing shoe joint, the rest of the casing to be ran was 13-3/4" casing, which would be ran with the 13-3/4" lift nubbin. One joint of 13-3/4" casing (joint number 2) was RIH with the correct lift nubbin, but when the 13 5/8" lift nubbin was removed from joint number 1 (13-5/8" casing) to install joint number 2 (13 3/4" casing), the 13-5/8" lift nubbin was left on the rig floor. The next joint of 13-3/4" casing (joint number 3) was prepared to RIH, and the 13-5/8" lift nubbin was installed on joint number 3,a 13-3/4" casing. A Nabors Floor Hand suspected that the incorrect lift nubbin was installed on joint number 3 and called an "All Stop." The TSI Inspector inspected the lift nubbin and the casing, and he confirmed (incorrectly) that the correct lift nubbin was on the casing and work resumed. Joint number 3 (13-3/4" casing) was RIH with the 13-5/8" lift nubbin, and the 13-5/8" lift nubbin was again left on the casing to protect the threads. Joint number 4 (13-3/4" casing) was successfully RIH with the 13-3/4" lift nubbin, and that lift nubbin was left on joint number 4 to protect the casing threads. Joint number 5 (13-3/4" casing) was then lifted with the 13-5/8" lift nubbin, but when the casing reached approximately 28 ft, the casing slipped out of the nubbin and fell to the rig floor, impacting the catwalk machine (CWM), casing tongs, and iron roughneck.

All personnel were in the designated Safe Zones and there were no injuries as a result of this incident.

The Bureau of Safety and Environmental Enforcement (BSEE) conducted an onsite investigation on January 15, 2020, which included interviewing personnel and collecting documentation. The investigation team confirmed that the 13-5/8" lift nubbin was used to hoist the 13-3/4" casing. The 13-5/8" lift nubbin had actually been used to lift a lighter joint of 13-3/4" casing prior to dropping joint number 5. The 13-5/8" lift nubbin was installed onto joint number 3 (13-3/4" casing), and a Floorhand used Stop Work Authority to shut down the job and have the lift nubbin and casing inspected. The TSI Inspector visually examined the lift nubbin connection and gave approval for operations to continue. Joint number 3 weighed approximately 1,873 pounds, was successfully lifted and installed. Joint number 5 was substantially heavier, weighing approximately 4,025 pounds. The close tolerance between the two nubbins allowed for the lighter joint of casing to be lifted, but the weight of joint number 5 was substantial enough to overcome the incorrectly sized lift nubbin threads. The casing pulled free from the lift nubbin threads once it was hoisted to approximately 45 degrees. The BSEE inspection team noted that the lift nubbins had their sizes stenciled on the top. It appeared as though the TSI Inspector did not

verify the size of the nubbin by reviewing the size stamped onto the nubbin. According to witnesses, the TSI Inspector briefly walked up to the nubbin and looked at it, but never physically touched it or examined it in detail. If the TSI Inspector had read the stenciled information on the lift nubbin, he would have seen that it was intended for 13-5/8” casing only. In reviewing both Nabors and Weatherford’s JSA’s, there is no mention of using different size lift nubbins on this casing run.

Since the incident, Chevron, Nabors and third party companies have started using the Operation Assurance Briefing (OAB) and checklist before the start of each task. The OAB is led by a Chevron DSR and attended by key Nabors personnel (Toolpusher and Driller if possible) and the main representative of the service company involved. The task is reviewed. Then, they confirm all necessary equipment is ready, proper JSA’s are prepared, and discuss any questions on the POA. Work procedures that will be used are then verified. Nabors and Weatherford have revised their JSA’s to address the hazards when using different size lift nubbins when running multiple size casings. In addition, the JSA will identify the lift nubbins by color coding, size, and proper location within a safe storage area. Chevron and Nabors have created a flowchart to indicate a flow path once “Stop Work” is called by any crew member, with the task supervisor approving the return to work before proceeding forward.

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

The wrong size lift nubbin was used to pick up casing to run into the wellbore.

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

Human error. The TSI inspector did not identify the 13-5/8" lift nubbin was the wrong size for the 13-3/4" casing joint.

JSA's did not identify the correct nubbin for the size casing that was picked up to put in the well.

Task supervisor had no type of guidance as to who needs to re-start the job after an "All Stop" is called.

20. LIST THE ADDITIONAL INFORMATION:

None

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:

15-JAN-2020

26. INVESTIGATION TEAM MEMBERS:

Chris Treland / Gabe Orellana / Troy Boudreaux / Robert Reeves /

27. OPERATOR REPORT ON FILE: **YES**

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR: **Amy Pellegrin**

APPROVED DATE: **25-AUG-2020**