

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: 24-OCT-2015 TIME: 2315 HOURS

2. OPERATOR: Statoil Gulf of Mexico LLC

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: Transocean Offshore

REPRESENTATIVE:

TELEPHONE:

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

4. LEASE: G34634

AREA: WR LATITUDE:

BLOCK: 160 LONGITUDE:

5. PLATFORM:

RIG NAME: T.O. DISCOVERER AMERICAS

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 PRS - Dropped objects

DAMAGED/DISABLED SAFETY SYS.

INCIDENT >\$25K

H2S/15MIN./20PPM

REQUIRED MUSTER

SHUTDOWN FROM GAS RELEASE

OTHER

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: 5868 FT.

10. DISTANCE FROM SHORE: 158 MI.

11. WIND DIRECTION: SE
SPEED: 24 M.P.H.

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

13. SEA STATE: 5 FT.

On October 24, 2015, while working for Statoil Gulf of Mexico LLC, an incident occurred onboard Transocean's Discoverer Americas when a collision between a stand of drill pipe and the rig's Pipe Racking System (PRS) led to two pieces of equipment falling approximately 144 feet to the drill floor. At the time of the incident, the rig was performing drilling operations on Statoil's #002 well and was located in Walker Ridge Block 160, Lease OCS-G34634.

At 18:00 hours, the day of the incident, the drill crew onboard the Discoverer Americas performed a shift change and held a pre-job safety meeting with the crew members who were working on the rig floor to discuss the upcoming operations. Although a Written Risk Assessment (WRA) was performed and a safety meeting held before the work began, the crew failed to discuss the hazards involved with transferring 'Tall Stands' of pipe. The Driller stated in an interview that he assumed that the task of transferring the 'Tall Stand' of pipe would be discussed further, and in more detail, once the crew had gotten to that point. A 'Tall Stand' of drill pipe is an average stand of drill pipe that has a crossover installed on the bottom of it. The crossover is installed to allow the crew to transition from one size drill pipe to another when using a tapered drill string. Special attention must be given while transferring these stands of pipe due to limited space on the drill floor.

At approximately 23:00 hours, the drill crew finished running the 5 inch drill pipe and began preparing to run the 5 7/8 inch drill pipe. The Assistant Driller (AD), who was in charge of running the PRS, went out to the drill floor to confirm that all of the proper changes had been made to the equipment before transferring of the 5 7/8 drill pipe began. The AD instructed one of the Floorhands to keep a close watch on the drill pipe as it was transferred from the PRS to well center. The Floorhand positioned himself at a safe distance from the lift while maintaining good visuals of both the PRS and the AD.

Upon returning to the Driller's console, the Driller asked the AD if he had confirmed the Inside Diameter of the elevators and the Outside Diameter of the drill pipe to ensure they were compatible. The AD had only confirmed the size of the elevators and had to return to the drill floor to get measurements on the pipe. Once back in the Driller's console, the Driller reminded the AD to visually verify the clearance between the top of the stand of pipe and the PRS tub by using the rig's camera. He also asked if the Floorhand had been briefed on the operation. The AD confirmed that the Floorhand had been briefed and proceeded to transfer the stand of pipe.

The AD extended the arms of the PRS and grabbed the stand of pipe. With the pipe secured, the bottom latches of the fingerboard were opened. The Floorhand signaled the AD to pick up on the stand of pipe in order to clear the base of the racker. The procedure for picking up a 'Tall Stand' of pipe calls for the stand to be picked a minimum of 2 to 3 inches and then retracted and tilted 45 degrees before continuing to pick up. This step is to ensure that the stand of pipe is able to clear the PRS Tub. Based on the AD's statement, he was focused solely on the instructions given to him by the Floorhand and not on his camera or following the proper procedures as he was making the lift. The AD continued to lift the stand of pipe, unaware of his proximity to the PRS Tub. As the stand of pipe came into contact with the PRS Tub, a loud bang was heard on the drill floor and the PRS automatically lowered the pipe back to the drill floor. The job was stopped and an investigation into the incident began. It was found that the result of the incident was half of the PRS's Support Retainer, weighing 79 lbs., and a Teflon Bearing, weighing 3 lbs., being knocked off of the PRS and falling 144 feet to the drill floor.

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

- Failure to follow the Written Risk Assessment / Procedure for transferring drill pipe.
- Poor Supervision: Failure to ensure crew members involved in the job were competent in their tasks and aware of all procedures associated with that job.

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

- Crew failed to discuss the hazards of transferring the 'Tall Stand' both during the pre-tour safety meeting or before the job began.
- Assistant Driller did not have a clear view of the top of the drill pipe.
- Floorhand was unaware of the location of the top of the pipe but continued flagging the Assistant Driller to pick up anyway.
- The crew failed to identify the hazards involved with transferring the 'Tall Stand' of drill pipe.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

Pipe Racking System Tub and Drag Chain Support Retainer for PRS.

NATURE OF DAMAGE:

Displaced PRS Tub and caused Drag Chain Support Retainer to fall to the drill floor.

ESTIMATED AMOUNT (TOTAL): \$16,282

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:

04-NOV-2015

26. ONSITE TEAM MEMBERS:
Troy Boudreaux / James Richard /

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

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OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan Domangue

APPROVED

DATE: **04-JAN-2016**