

# ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **19-MAR-2024** TIME: **1330** HOURS

2. OPERATOR: **Chevron U.S.A. Inc.**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **Valaris**

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING **Riser Lifting Tool**
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K **Property damage**
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER

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

4. LEASE: **G34451**

AREA: **MC** LATITUDE: **28.37238666**

BLOCK: **607** LONGITUDE: **-88.24322457**

5. PLATFORM:

RIG NAME: **VALARIS DS-18 (ROWAN RELENTLESS)**

6. ACTIVITY:  EXPLORATION(POE)

DEVELOPMENT/PRODUCTION (DOCD/POD)

DECOMMISSIONING

8. OPERATION:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER
- TEMP ABAND
- PERM ABAND
- DECOM PIPELINE
- DECOM FACILITY
- SITE CLEARANCE

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

9. CAUSE:

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

POLLUTION

FIRE

EXPLOSION

LWC  HISTORIC BLOWOUT

UNDERGROUND

SURFACE

DEVERTER

SURFACE EQUIPMENT FAILURE OR PROCEDURES

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

10. WATER DEPTH: **6539** FT.

11. DISTANCE FROM SHORE: **123** MI.

12. WIND DIRECTION: **NE**  
SPEED: **14** M.P.H.

13. CURRENT DIRECTION: **N**  
SPEED: **1** M.P.H.

14. SEA STATE: **0** FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

## INCIDENT SUMMARY:

On March 19, 2024, at 13:30 hrs, Chevron U.S.A. Inc (Chevron) incurred an incident on board the Valaris DS-18 (Rowan Relentless) drillship while performing Blow Out Preventor (BOP) deployment operations in Mississippi Canyon Block 607 Well BP002 (OCS-G 34451, API # 608174149600). The incident involved dropping a joint of riser onto the forward conveyor skate. No one was injured in this incident. Chevron reported the incident to BSEE New Orleans District (NOD) on March 19, 2024.

## SEQUENCE OF EVENTS:

Per Valaris' Investigation Report, the sequence of events were follows:

"On 19 Mar 24 @ 12:00 hrs, Riser Joints #1 through #30 had been run successfully. The riser test cap was installed, and riser conduits tested. Testing equipment was rigged down, and crews prepared to continue running riser. The Cameron HRRT was installed and locked into Joint #31. Locks were double verified by two Floor hands on the spider and at the Driller's console. The crew cleared the red zone and went to the assigned safe area (15ft away) per the Restricted Zone Analysis (RZA). The Floor hand operating the riser cart control gave the thumbs up that the riser cart shuttle was in the free-wheel mode.

On 19 Mar 24 @ 13:30 hrs, as joint #31 was hoisted to approximately 30 feet above the rig floor, the riser cart shuttle did not free-wheel, causing the riser flange to be pulled out of the cart shuttle and landed on the cart (approximately 28"). The Cameron Hydraulic Riser Running Tool (HRRT) removable shank mandrel parted, allowing the riser joint to fall back onto the riser cart."

## BSEE INVESTIGATION:

The BSEE NOD Accident Investigator (AI) received and reviewed information submitted to BSEE via emails, phone communications, and witness statements regarding the riser running tool. On March 21, 2024, the BSEE investigation team conducted an onsite investigation at the Valaris DS-18. The team requested photographs, the magnetic particle inspection report, daily reports for March 18 and 19, maintenance alerts, and metallurgical evaluation of the fractured shaft (mandrel) from the hydraulic riser running and test tool. Job template is not detailed enough on how to inspect all load path components of the HRRT. While on location, photos were also taken of the damage to the riser skate tailing arms, skate lift bucket, HRRT, and the floatation on the riser joint.

## CONCLUSIONS:

At 13:30 hrs on March 19, 2024, the Valaris DS-18 was conducting a BOP deployment/riser run. The Valaris driller utilized the rig top drive system to engage and lock the riser running tool into riser joint #31 and prepared to lift the joint from the forward conveyor. The driller verified the riser running tool was locked in place with visual verification on the control panel inside the drill shack. The driller also received two separate verbal communications from the Valaris floor hands on the rig floor, indicating the bucket/skate was in "freewheel" for the forward conveyor system. The driller then hoisted the riser joint with the top drive. During this movement, the conveyor bucket, which was holding the opposite end of the riser, stopped moving. The riser cart shuttle valve brake wire was loose, which caused a fuse to blow and not allow the cart to freewheel. The hydraulic brake on the riser cart shuttle did not release. The driller did not notice this failure and continued to hoist the riser joint. The continued hoisting movement caused one end of the riser joint to come out of the conveyor bucket. Simultaneously, as the riser joint came out

of the conveyor bucket, the riser running tool parted. Once the tool parted, the riser joint fell onto the conveyor. This action damaged two arms on the conveyor assembly. The job was stopped immediately by the toolpusher and the area was secured.

The Valaris offshore installation manager (OIM), Valaris lead subsea drilling representative (LSDR), Chevron drilling supervisor representative (DSR), and Chevron health safety and environment (HSE) personnel were promptly notified. A safety stand-down commenced and all operations were halted. Witness accounts of the events were collected during the safety stand-down in the driller's shack. After the safety stand-down, Chevron and Valaris personnel started their investigation process. The HRRT was sent off for metallurgical evaluation of the fractured shaft. From this testing and report, it appears that the shock impact from the riser falling out of the bucket caused the failure. One end of the riser was lifted 30 ft above the rig floor with approximately 25,000 lbs of hook load when it pulled out of the conveyor bucket.

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

There was a loose wire on the riser cart shuttle brake, which caused a fuse to blow and not allow the cart to freewheel. The hydraulic brake on the riser cart shuttle did not release, causing riser joint #31 to come out the riser cart shuttle.

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

Job template is not detailed enough on how to inspect all load path components of the HRRT.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

Riser skate tailing arms, skate lift bucket, HRRT. and floatation on the riser joint.

ESTIMATED AMOUNT (TOTAL): \$418,000

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans 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:

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

21-MAR-2024

26. Investigation Team Members/Panel Members:

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

27. OPERATOR REPORT ON FILE:

OCS REPORT:

30. DISTRICT SUPERVISOR:

APPROVED

DATE: 10-DEC-2024