UNITED STATES DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **06-JUN-2009** TIME: **2130** HOURS

2. OPERATOR: **Repsol E&P USA Inc.**
   REPRESENTATIVE: **Feik, Courtney**
   TELEPHONE: **(281) 578-3388**
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G28066**
   AREA: **GC** LATITUDE:
   BLOCK: **304** LONGITUDE:

5. PLATFORM:
   RIG NAME: **T.O. CAJUN EXPRESS**

6. ACTIVITY:
- [X] 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
- [X] OTHER LIFTING DEVICE **Pipe Handler**
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

6. OPERATION:
- [ ] PRODUCTION
- [X] 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
- [X] OTHER **One Spotter out of position**

9. WATER DEPTH: **3868** FT.

10. DISTANCE FROM SHORE: MI.

11. WIND DIRECTION: **WNW**
    SPEED: **7** M.P.H.

12. CURRENT DIRECTION: **SSE**
    SPEED: **0** M.P.H.

13. SEA STATE: **1** FT.

17. INVESTIGATION FINDINGS:

Pipe handler operation: On 6-Jun-2009 at 2130 hours, the crane crews were in the process of moving one 13 5/8-inch casing joint from the port casing bay to the centerline casing bay using an electro-magnetic pipe handler (pipe handler). This was the 57th joint of casing to be moved by the pipe handler. Due to the deck configuration, the joint of casing had to be first landed in the catwalk machine in order to be correctly positioned to avoid contact with the drilling package during transfer, and it also had to be adjusted so that the pin end of the casing joint was forward in the bay. Markings were placed on the catwalk machine (pipe measurements were identified to be no longer than 45 feet) for the proper alignment to prevent contact with the drilling package. After the casing joint was adjusted in the catwalk, the pipe handler operator picked back up the load to move it to the centerline casing bay. As the joint was being moved to the centerline bay, the box end of the joint came into contact with the riser tensioner on the drilling package. This impact resulted in the joint of casing being knocked free from the pipe handler's magnets that were holding the joint of casing as it was being transferred toward the centerline bay. The load fell to the deck 12 feet from the pin end and 25 feet from the box end.

Investigation Findings: Prior to the start of the job, the pipe handler's travel path was barricaded, a Transocean THINK Plan was utilized and a Stop Work Authority was issued. There was, however, no discussion as to each of the two spotters responsibility during the job, and the two spotters involved in the job changed positions before this joint was to be moved. At the time of the incident, the spotter watching the pin end of the joint did not line up the spotting marks on the catwalk correctly, which contributed to the box end of the joint sticking out too far. The spotter watching the box end of the joint was in a position that did not allow him to see the travel path of the load. There were no injuries involved in the incident.

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

The joint of casing was sticking out further than it was intended, and one of the two spotters was not in the right position to see if the box end of the casing would clear the tensioner assembly.

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

The second spotter did not line up the markings on the catwalk machine properly and both spotters changed positions before the 57th joint was to be moved. Also, there was no discussion as to each spotters responsibility during the job.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

The property that was damaged was the box Threads end of one joint of 13 5/8-inch casing.

ESTIMATED AMOUNT (TOTAL): **$8,000**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Due to the specific nature of this incident, the Houma District has no recommendations to report to the Regional Office of Safety Management.

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:

Ben Coco / Casey Bisso /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED DATE: **10-FEB-2010**

INJURY/FATALITY/WITNESS ATTACHMENT

[ ] OPERATOR REPRESENTATIVE
[X] CONTRACTOR REPRESENTATIVE
[ ] OTHER _____

[ ] INJURY
[ ] FATALITY
[X] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE:

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