

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

1. OCCURRED

DATE: **04-AUG-2008** TIME: **0130** HOURS

2. OPERATOR:

Chevron U.S.A. Inc.

REPRESENTATIVE: **Matthews, Justin**

TELEPHONE: **(337) 989-3435**

CONTRACTOR: **Parker Drilling Company**

REPRESENTATIVE: **Broussard, Leroy**

TELEPHONE: **(337) 364-3122**

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

4. LEASE:

00310

AREA: **SM** LATITUDE: **29.48024015**

BLOCK: **212** LONGITUDE: **-92.0514282**

5. PLATFORM:

232

RIG NAME: **PARKER 76-B**

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 **TBA hit Crown Block**
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K **\$56,500**
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER **TBA hit Crown Block**

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: **12 FT.**
- 10. DISTANCE FROM SHORE: **7 MI.**
- 11. WIND DIRECTION: **N**
 SPEED: **30 M.P.H.**
- 12. CURRENT DIRECTION: **E**
 SPEED: **5 M.P.H.**
- 13. SEA STATE: **5 FT.**

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

At 2200 hours on August 3, 2008, the drill crew began pulling out of the hole (POOH) with a cement retainer running tool. Once completed, the plan was to pick up a bit and bottom hole assembly and trip in the hole to bottom while waiting on weather (approaching tropical depression). At approximately midnight, the Night Tool Pusher (NTP) relieved the driller. The NTP attempted to POOH in high/high gear, but was unsuccessful due to the string weight being 250K. As the Night Driller (ND) returned to the drill floor, the NTP suggested to the ND to POOH in high/high gear once the string weight was reduced to 200K. As they continued to POOH and the string weight was gradually reduced to 200K, the ND continued in high/high gear. At 0130 hours on August 4, 2008, after pulling approximately 30 stands in high/high gear and with a string weight of 150K, the Traveling Block Assembly (TBA) struck the Crown Block. The Crown-O-Matic (COM) was activated, but due to the speed of the TBA the activation of the COM was not enough to stop the TBA from striking the Crown Block. All operations were shut down due to the severe damage of the TBA and Crown Block, with no report of injury or pollution.

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

Probable Causes of the Accident are listed below:

1. The ND was focused on his instrumentation and missed the 2nd tool joint as it came through the rotary. The ND assumed that the 3rd tool joint through the rotary was the 2nd, but then glanced at the drum realize that it was the 3rd tool joint.
2. Due to the speed of the TBA, the COM was unable to prevent the TBA from striking the crown sills. The COM did activate, however, due to the speed of the TBA the momentum was sufficient to allow the TBA to hit the Crown Block.
3. Lack of communication between Chevron and Parker personnel led to the ND not following the standard Parker 76-B rig operating procedure of not POOH in high/high gear.

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

Possible Contributing Causes of the Accident are listed below:

1. There was a sense of urgency by all parties to POOH and trip back in the hole due to an approaching tropical storm.
2. Although the ND had 7 years drilling experience, 3 months of that with Parker Drilling, he had never POOH in high/high gear on the Parker 76-B rig.
3. A pre-job safety meeting was conducted prior to POOH. A decision was made to ping the 3rd joint as it came through the rotary (the pinging procedure is conducted by the floor hands as they are counting each tool joint as it passes through the rotary table). This would have alerted the driller when the 3rd tool joint passed the rotary. No one person, however, was designated to ping the pipe. There was a lack of communication between the ND and floor hands on the importance of designating one floor hand to perform the pinging operation.

20. LIST THE ADDITIONAL INFORMATION:

The following information was submitted to prevent a recurrence of the incident:

1. When POOH the Driller is responsible for counting tool joints and should not rely solely on the pinging of the pipe to notify him that a certain tool joint is through the rotary.
2. Drillers should be cautioned about pulling pipe in high/high gear.
3. When deviating from standard operating procedures, a hazard analysis should be done to identify any hazards. The hazard analysis should involve personnel from the Operator and Rig Contractor to ensure all aspects of the analysis are properly communicated.
4. The Operator and Drilling Contractor are currently researching the purchase and installation of a secondary Crown Block detection system.
5. A Safety Alert has been communicated to all rigs concerning the incident.
6. The distance from the top of the TBA, once the COM is activated, to the Crown Block will be posted on all rigs in the Driller's shack.
7. All Drillers will explain to the floor hands the importance and reason for counting tool joints and pinging as necessary. One floor hand will be designated to ping the pipe, and a designee will always be on the rig floor.

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

The Traveling and Crown blocks were severely damaged and had to be repaired. The rig's drill line was also damaged and replaced.

Traveling block hit the Crown block causing damage to both blocks and the drill line.

ESTIMATED AMOUNT (TOTAL): \$56,500

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The MMS Lafayette District recommends to the MMS Regional Office of Safety Management that a Safety Alert be issued to industry describing the incident with the following recommendations:

1. Before deviating from any standard operating procedure, the Operator and Rig Contractor should conduct a hazard analysis to identify and evaluate potential hazards.
2. Rig Contractors should research and consider installing a secondary Crown Block detection system.
3. Drilling Rigs originally installed with a Power Swivel/Kelly drilling system that have been upgraded with a Top Drive System should ensure that the distance from the top of the TBA, once the COM is activated, is sufficient to allow for the TBA to stop before striking the Crown Block.
4. To encourage safety awareness, the distance from the top of the TBA, once the COM is activated, to the Crown Block should be posted in the Driller's shack.
5. Driller's should be cautioned about pulling pipe in high/high gear.
6. When POOH the Driller is ultimately responsible for counting tool joints, and should not rely solely on pinging of the pipe to notify him that a certain joint has cleared the rotary.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

A G-110, Incident of Noncompliance (INC), was issued as an "After-the-Fact INC" to document that Chevron U.S.A. Inc. failed to protect health, safety and the environment by not performing operations in a safe and workmanlike manner. Chevron U.S.A. Inc. failed to properly supervise rig operations to prevent severe damage to the rig. The evidence provided by the MMS onsite investigation clearly indicated that the lessee did not perform rig operations in a safe manner.

25. DATE OF ONSITE INVESTIGATION:

07-AUG-2008

28. ACCIDENT CLASSIFICATION:

MINOR

26. ONSITE TEAM MEMBERS:

Johnny Serrette / Marty Rinaudo /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

27. OPERATOR REPORT ON FILE: YES

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED

DATE: 18-SEP-2008