

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: 02-MAY-2016 TIME: 2300 HOURS

2. OPERATOR:

Chevron U.S.A. Inc.

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: Pacific Drilling Services Inc.

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- 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:

6. OPERATION:

4. LEASE: G33531

AREA: KC LATITUDE:

BLOCK: 96 LONGITUDE:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

5. PLATFORM:

RIG NAME: PACIFIC SANTA ANA

6. ACTIVITY:

- EXPLORATION(POE)
- DEVELOPMENT/PRODUCTION
(DOCD/POD)

8. CAUSE:

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

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

9. WATER DEPTH: 4847 FT.

10. DISTANCE FROM SHORE: 268 MI.

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

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

13. SEA STATE: FT.

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

On May 2, 2016, while rig personnel were removing the second tensioner cable from the number five tensioner sheave, the braided wire sling rigged to the tensioner cable parted. When the sling parted the tensioner cable fell back on to the sheave while part of the sling eye (weighing approximately 1.9 pounds) fell thirty two feet on to the starboard side marine riser tensioner platform. The marine riser tensioner deck had been barricaded off and no personnel were in the area when the sling eye fell.

API RP 2D [F.10.2.(a)] states that suitable protection should be provided between the sling and sharp surfaces of the load to be lifted. It also states [7.5.2.(n)] that only Qualified Riggers that have successfully completed rigger training according to the RP should perform rigger functions. In this case, the certification tag on the sling was improperly rigged with the tag between the wraps of the sling by two personnel who were not Qualified Riggers at the time of the incident. During the lift, the compression of the wire sling caused the certification tag to cut the braided wire sling.

BSEE Investigators discovered that during the job task, personnel rotated a deck light that was blinding them and positioned it in the direction of the crane boom camera. This action prevented the Crane Operator from utilizing the crane boom camera to verify the crane line was directly over the load. The Crane Operator did not utilize Stop Work Authority, even though he/she was unable to utilize the images provided by the crane boom camera.

The procedure for removing the tensioner cable from the sheave utilized the handrails around the work platform to secure the tensioner cable. BSEE Investigators noted that the crew did not take into account the load capacity of the handrails while executing this procedure, thereby failing to properly assess the hazards associated with using the handrails to secure the tensioner cable.

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

Failure to adhere to recommended practices regarding the use of slings by allowing personnel other than Qualified Riggers to improperly rig the sling.

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

- Failure to adhere to safe work practices by not utilizing Stop Work Authority.
- Failure to properly assess hazards associated with the job task.

20. LIST THE ADDITIONAL INFORMATION:

None

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

For Public Release

Braided wire sling

Parted/cut braided wire sling

ESTIMATED AMOUNT (TOTAL): \$73

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

No recommendations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 (C)

After review of all documents, statements and inspection of the incident scene, it was found the lessee failed to perform all operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment in the following ways:

1. The two subsea personnel who rigged the braided wire sling to the tensioner cable were not rigger certified at the time of the incident.
2. Sling was improperly rigged with the certification tag between the wrap of the sling.
3. During the job task, personnel rotated a deck light that was blinding them and positioned it in the direction of the crane boom camera. This action prevented the Crane Operator from utilizing crane boom camera to verify the crane line was directly over the load. The Crane Operator failed to utilize Stop Work Authority to have the deck light repositioned in a more suitable direction so he could utilize the crane boom camera.
4. The procedure utilized the handrails around the work platform to secure the tensioner cable being removed from the tensioner. Personnel involved in the job task, failed to properly assess the hazards of securing the tensioner cables to handrails.
5. Document OPS-WWD_WIN-13.014, under step (e) failed to state how the cable would be secured to the surrounding frame work.
6. According to the Written Work Planning form for Overhauling MRT Sheaves, rig personnel involved in the job task failed to recognize or document any lessons learned after the incident occurred.

25. DATE OF ONSITE INVESTIGATION:

04-MAY-2016

26. ONSITE TEAM MEMBERS:

James Holmes / Daniel Gonzalez /
Alvin O'Brien / Casey Conklin /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

John McCarroll

APPROVED

DATE:

07-JUN-2016

For Public Release