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: **03-JUL-2023** TIME: **1500** HOURS
2. OPERATOR: **Gulf Offshore LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Enterprise Offshore Drilling**
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE:
   AREA: **VR** LATITUDE:
   BLOCK: **170** LONGITUDE:

5. PLATFORM: **A**
   RIG NAME: **ENTERPRISE 264**

6. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [X] DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	**0**	**1**
[X] LTA (1-3 days)	**0**	**1**
[ ] LTA (>3 days)		
[ ] RW/JT (1-3 days)		
[ ] RW/JT (>3 days)		
[ ] FATALITY		
[ ] Other Injury		

- [ ] POLLUTION
- [ ] FIRE
- [ ] EXPLOSION

LWC
- [ ] HISTORIC BLOWOUT
- [ ] UNDERGROUND
- [ ] SURFACE
- [ ] DEVERTER
- [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [ ] OTHER LIFTING
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

8. OPERATION:
   - [ ] PRODUCTION
   - [X] DRILLING
   - [ ] WORKOVER
   - [X] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] DECOMMISSIONING
     - [ ] PA [ ] PIPELINE [ ] SITE CLEARANCE
     - [ ] TA [ ] PLATFORM
   - [ ] OTHER

9. CAUSE:
   - [ ] EQUIPMENT FAILURE
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER _____

10. WATER DEPTH: **87** FT.
11. DISTANCE FROM SHORE: **42** MI.
12. WIND DIRECTION:
    SPEED: M.P.H.
13. CURRENT DIRECTION:
    SPEED: M.P.H.
14. SEA STATE: FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

On July 3, 2023, an incident occurred on the Enterprise 264 drilling rig (EOD) at Vermillion Block 170 for Gulf Offshore LLC. The spinning wrench (wrench) rotated and struck the EOD Assistant Driller (AD) on the rig floor during drilling operations. On July 5, 2023, at 1:00 am, Gulf Offshore evacuated the AD to shore by boat for a medical evaluation.

At approximately 3:00 pm, the AD positioned the wrench on the 5-inch drill pipe above the tool joint and engaged the throttle to spin out the drill pipe. The wrench rotated toward the AD striking him in the hard hat and head while he was standing at the wrench controls. The AD refused aid and continued working on the rig floor. On July 4, 2023, at 6:30 am, the AD reported to the EOD Offshore Installation Manager (OIM) that he was not feeling well from the incident the day before. On July 5, 2023, at 1:00 am, Gulf Offshore evacuated the AD to shore by boat for an injury evaluation. At 9:44 am, the Bureau of Safety and Environmental Enforcement (BSEE), Lake Charles District Office, received an email reporting the evacuation of the AD.

On July 10, 2023, the BSEE Lake Charles District investigators (investigators) conducted an onsite incident follow-up inspection. During the incident follow-up, investigators collected all available documents on the rig; requested all unavailable documents not on the rig; and requested the video footage of the incident from the rig floor be emailed to the investigators. Investigators asked the OIM for the wrench operating procedures provided to the rig personnel. The OIM informed the investigators that rig personnel are trained on the job and not provided with written procedures. Investigators requested to see the user manual for the spinning wrench. However, the OIM, nor rig personnel, were able to find the user manual during the inspection.

On July 12, 2023, The BSEE Lake Charles District investigators conducted a second onsite incident follow-up inspection. Investigators watched the video of the incident that took place on the rig floor. The wrench rotated clockwise approximately a quarter round, or approximately 30 inches, striking the AD standing at the wrench controls. The investigators inspected the wrench on the rig floor and found no visible broken components. The wrench was suspended approximately 5 feet above the rig floor from a cable attached to the vertical positioning cylinder on the wrench. The wrench had two supplied shackles at the rear of the wrench. One of the supplied shackles had a second shackle connected to the back-up line attached to a metal post on the rig floor. The rig floor personnel connected a picking hook to the unused supplied shackle, to secure the wrench to the metal post when not in use.

Investigators received the User Manual for the spinning wrench July 12, 2023, by email. The Installation and Commissioning section within the User Manual provided the Installation Procedure for the wrench. There were 4 steps in the installation procedure, Step four stated, “Attach TWO back-up cables to the shackles provided at the rear of the wrench to restrict rotational movement to 12 inches in either direction. Do not cross cables.” Directly below step four, a caution symbol appeared on the page with the message, “WARNING: If only one back-up line is attached, the wrench can swing into the operator causing injury.” Investigators saw only one back-up line in use during the inspection.

In the Operation Normal usage section, the caution symbol stated, “CAUTION: Back up lines must be attached to limit rotational movement to 1 foot (0.3m) in each direction.” This section had a Note symbol directing the user to an installation diagram within that same section. The Note stated, “Check to be sure that back-up lines are properly attached (see Section 2).” According to Section 2, Figure 1-1 of that same section showed the supplied shackle connected directly to the back-up line in the diagram. Investigators saw a second shackle attached to the supplied shackle with the back-up line attached to the second shackle during the inspection.

The description for the caution symbol in the Notes, Cautions and Warning section states, "The caution symbol indicates that potential damage to equipment or injury to personnel exists. Follow instructions explicitly. Extreme care should be taken when performing operations or procedures preceded by this caution symbol." On July 13, 2023, the BSEE Lake Charles District lead Inspector contacted the Gulf Offshore representative regarding the investigative findings. Gulf Offshore and the OIM added the second back-up line to prevent the wrench from rotating more than 12 inches in any one direction. On July 18, 2023, at 1:00 pm, the BSEE Lake Charles District investigation team conducted a phone interview with the AD. During the interview the AD reported he was diagnosed with a concussion.

Investigators concluded the wrench was not installed as the manufacturer required in the user manual. During the installation of the wrench, only one back-up line was installed. This allowed the wrench to rotate more than 12 inches towards the operator while standing at the wrench controls, which resulted in an injury. The wrench User Manual cautions and warnings states "If only one back-up line is attached, the wrench can swing into the operator causing injury." The user manual for the spinning wrench was not readily available to the rig floor personnel.

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

Management Systems:
The spinning wrench rotated clockwise approximately a quarter round, or approximately 30 inches, striking the AD at the wrench controls.

The spinning wrench was not installed as the manufacturer required in the user manual. Only one back-up line was attached to the rear of the wrench. A second shackle was attached to the supplied shackle.

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

Personnel Training:
The user manual for the spinning wrench was not readily available to the rig floor personnel. Rig personnel are trained on the job and not provided with written procedures.

Warnings, cautions, and notes in the user manual for the spinning wrench were not followed during the installation and operation of the wrench.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

N/A **N/A**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

N/A

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 30 CFR 250.107
The spinning wrench rotated and struck the Assistant Driller on the rig floor during drilling operations resulting in an injury. The spinning wrench was not installed as the manufacturer required in the user manual; Only one back-up line was attached to the rear of the wrench. A second shackle was attached to the supplied shackle.

The user manual for the spinning wrench was not readily available to the rig floor personnel. Warnings, cautions, and notes in the user manual for the spinning wrench were not followed during the installation and operation of the wrench.

G-132 30 CFR 250.188 Issued on July 7, 2023
On 07/03/2023, the Assistant Driller was struck on the hard hat by the spinning wrench on the rig floor. Gulf Offshore LLC. submitted the Daily Activity Report to BSEE by email for 07/05/2023 at 9:44am, the email reported the Assistant Driller was sent onshore at 1:00am 07/05/2023 to see a doctor. Evacuations require an immediate oral notification per NTL NO. 2019-N05.

25. DATE OF ONSITE INVESTIGATION:

10-JUL-2023

26. Investigation Team Members/Panel Members:

Mitchell Klumpp / Preston White / Guy Bertrand /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Beau Boudreaux

APPROVED DATE: **21-SEP-2023**