

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **08-DEC-2023** TIME: **0845** HOURS

2. OPERATOR: **Shell Offshore Inc.**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **NOBLE DRILLING CORPORATION**

REPRESENTATIVE: TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING **Top Drive Trolley**
- 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:

4. LEASE:

AREA: **AC** LATITUDE:
BLOCK: **735** LONGITUDE:

5. PLATFORM:

RIG NAME: **NOBLE GLOBETROTTER II**

6. ACTIVITY:

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

7. TYPE:

INJURIES:

- HISTORIC INJURY
 - REQUIRED EVACUATION
 - LTA (1-3 days)
 - LTA (>3 days)
 - RW/JT (1-3 days)
 - RW/JT (>3 days)
 - FATALITY
 - Other Injury
- | | OPERATOR | CONTRACTOR |
|---|----------|------------|
| <input checked="" type="checkbox"/> REQUIRED EVACUATION | 0 | 1 |
| <input type="checkbox"/> LTA (1-3 days) | | |
| <input checked="" type="checkbox"/> LTA (>3 days) | 0 | 1 |
| <input type="checkbox"/> RW/JT (1-3 days) | | |
| <input type="checkbox"/> RW/JT (>3 days) | | |
| <input type="checkbox"/> FATALITY | | |
| <input type="checkbox"/> Other Injury | | |

- POLLUTION
- FIRE
- EXPLOSION

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

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

8. OPERATION:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- DECOMMISSIONING
- PA PIPELINE SITE CLEARANCE
- TA PLATFORM
- OTHER

9. CAUSE:

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

10. WATER DEPTH: **7962** FT.

11. DISTANCE FROM SHORE: **170** 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 8 December 2023, at approximately 08:30 am, a lost time injury occurred during drilling activities on board the Noble Globetrotter II, located at Alaminos Canyon 735, OCS-G-34771, operated by Shell Offshore Inc. The injury was the result of the Top Drive System (TDS) contacting the Injured Person (IP) positioned on the port pipe racker upper access platform.

Prior to the incident, the IP was positioned on the main floor port carousel access platform verifying the internal diameter of the drill pipe by drifting a tool called a rabbit. The drill crew was tripping 6 5/8-inch drill pipe into the hole when a "slack rope detected" alarm occurred on the port pipe racker. Next, the Driller used a handheld radio to request the IP's assistance with trouble shooting the "slack rope detected" alarm by observing the condition of the wire rope on the spool for the port side pipe racker. The IP descended from the port carousel access platform to the port pipe racker upper access platform to get a closer look at the spool causing the "slack rope detected" alarm. The Driller was able to clear the "slack rope detected" alarm, and at this time the IP returned to the port carousel access platform to finish his task of drifting the drill pipe. The Assistant Driller (AD) was operating the pipe racker and the Driller was operating the TDS. The Driller raised the TDS to the upper position awaiting the next stand of drill pipe from the pipe racker. As the AD functioned the port pipe racker to transit the next stand of drill pipe, the "slack rope detected" alarmed again. The AD was able to clear the "slack rope detected" alarm and continued to transit a stand of 6 5/8-inch drill pipe from the port carousel to well center. The drill pipe was then latched into the TDS elevators, stabbed into the drill string, and torqued appropriately. The AD returned the port pipe racker to the port carousel to retrieve the next stand of drill pipe. The IP overheard the "slack rope detected" alarm and returned to the port pipe racker upper access platform without notifying the Driller. The Driller raised the drill string with the TDS, the pipe slips disengaged from the drill string, and the Driller began to lower the TDS. When the TDS passed the port pipe racker upper access platform, the lower port TDS roller assembly contacted the IP folding his upper torso around the outside handrail while the IP's legs remained stationary and inside the port pipe racker upper access platform. Once the TDS passed the IP, the IP fell back onto the port pipe racker upper access platform. The IP used their handheld radio to request assistance. The job was stopped. The Tool-pusher and the auxiliary floor AD used the multi-purpose tower's internal elevator while the main floor AD used the internal stairway to access the port pipe racker upper access platform where the IP was located. The Tool-pusher and both ADs escorted the IP down the elevator and to the onboard medical facility. After consultation with the medic the IP was evacuated to UTMB Galveston, Texas and diagnosed with a punctured lung, fractured ribs, and a fractured scapula. Company actions after incident. All stop and safety stand down with all crews. Added red barricade chain and sign for permit to work on ladder leading down to carrousel upper platform. Sent alert to all rigs with multipurpose tower configuration.

On 12 December BSEE investigators conducted an onsite visit. During the onsite visit BSEE investigators ascended the multi-purpose tower and accessed the port pipe racker upper access platform, where the injury occurred approximately 80 feet above the drill floor. BSEE investigators noticed there were no warnings or cautions identifying the moving equipment hazard on or around the port pipe racker upper access platform. BSEE investigators reviewed a photograph which measured the distance inches between the TDS and the port pipe racker upper access platform handrail which was found to be three inches at its nearest. BSEE investigators noted the TDS moving equipment hazard was not identified on the JSA (Job Safety Analysis) used for verifying drill pipe internal diameter. The only moving equipment hazards identified on the JSA were for the pipe racker and the pipe storage carousel. BSEE investigators took pictures of the area where the incident occurred, conducted interviews, and reviewed video of the incident. Additionally, BSEE investigators reviewed witness statements, JSA's, KSA's (Knowledge

and Skills Assessment), Shell Newsflash, Coast Guard casualty report and company investigation report.

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

Communication - Inadequate communication between IP and Driller, Driller was not aware of the IP's position on the port pipe racker upper access platform. IP failed to notify the drill floor that they were moving from the port carousel access platform (IP's expected location) back to the port pipe racker upper access platform and into the line of fire

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

Management systems - Inadequate hazard analysis and engineering control. The TDS has a 3-inch clearance between TDS and the handrail of the port pipe racker upper access platform. An engineered barrier preventing access to the port pipe racker upper access platform during operations or until safe clearance is granted would have prevented the injury from occurring. Also, this hazard was not identified on the JSA used by the IP for drifting the drill pipe.

Communication - There was no posted or visible warning, caution or moving equipment advisories on the port pipe racker upper access platform identifying the moving equipment hazard. This may have given the IP a false sense of safety while on the port pipe racker upper access platform.

20. LIST THE ADDITIONAL INFORMATION:

The port pipe racker upper access platform is approximately 80 feet above the drill floor. The IP was not required to don a safety harness since the port pipe racker upper access platform is protected by handrails. This incident could have resulted in the death of the IP.

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

None

Not applicable

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE Lake Jackson District has no recommendations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

Lessee failed to provide for the safety of all personnel and take all necessary precautions to remove safety hazards.

On 8 December 2023, a Floorhand sustained multiple injuries when the injured party was caught between the top drive assembly and the port pipe handler access platform which was approximately 80 feet above the rig floor. Lessee failed to identify the moving top drive assembly as a safety hazard while personnel are accessing the port pipe handler access platform. There was no engineering barrier to prevent or alert personnel of the hazard. Communication breakdown prevented all crew members from knowing the safe location of each member during operations. Lessee failed to take necessary precautions to correct or remove the safety hazard as required by 30 CFR 250.107.

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

12-DEC-2023

26. Investigation Team Members/Panel Members:

Perry Brady / Dylan Mire / David Kearns

/

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

For Public Release

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR

Stephen P. Martinez

APPROVED

DATE: **23-JAN-2024**