

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: 10-JUL-2021 TIME: 1815 HOURS

2. OPERATOR: Eni US Operating Co. Inc.

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: Nabors Offshore Corporation

REPRESENTATIVE:

TELEPHONE:

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

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

4. LEASE: G19996

AREA: MC LATITUDE: 28.20861466

BLOCK: 773 LONGITUDE: -88.73756761

5. PLATFORM: A (DEVILS TOWER)
RIG NAME: NABORS MODS 140

6. ACTIVITY: EXPLORATION (POE)
 DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:

INJURIES:

HISTORIC INJURY

OPERATOR CONTRACTOR

REQUIRED EVACUATION

LTA (1-3 days)

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

8. OPERATION:

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

9. CAUSE:

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

10. WATER DEPTH: 5610 FT.

11. DISTANCE FROM SHORE: 110 MI.

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

13. CURRENT DIRECTION: SE
SPEED: 13 M.P.H.

14. SEA STATE: 2 FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

INCIDENT SUMMARY:

On July 10, 2021, at approximately 18:15 hours, ENI US Operating CO. Inc. (ENI) had a dropped object incident on the Nabors MODS 140 rig while using the South crane during sidetrack operations on the A005 well at Mississippi Canyon (MC) Block 773. ENI reported the incident to the Bureau of Safety and Environmental Enforcement (BSEE), New Orleans District.

SEQUENCE OF EVENTS:

On July 10, 2021, at approximately 18:15 hours, during the "drill floor toolbox meeting," the crane operator decided to use the South crane to move a crossover (sub for making up the drill string bottom hole assembly) to the rig floor with the help of a roustabout and floor hand. While lifting the crossover sub using a set of 35-foot slings and stinger, the roustabout used a tag line to guide the crossover through the V-Door to the rig floor. Once the floor hand assumed the load was secure, the roustabout then moved down the catwalk, away from the load. According to the crane operator, this is when the floor hand signaled with his head to raise the load so the crossover sub could be manually pulled to the rig floor. Note: the slings were 35 ft in length which increased the stinger hook's height when the crossover sub was lifted horizontally to the rig floor.

As the Crane Operator proceeded to raise the load, which was perpendicular to the walkway above on the derrick, the stinger hook hit the walkway's top handrail. Due to the impact of the stinger hook, a portion of the handrail was pulled apart and broke off. The broken handrail was 5-1/2 ft by 1-1/2 in of square tubing weighing 13.6 lbs. The handrail fell approximately 75 ft to the deck below, and no injuries occurred with one person being 6 ft from where the handrail landed.

BSEE INVESTIGATION:

On July 14, 2021, BSEE conducted an on-site incident follow-up investigation. During the incident follow-up, investigators collected all available documents related to the incident including JSAs, pictures, and the lift plan from the Company and HSE representative.

CONCLUSIONS:

BSEE determined the root cause of this incident to be proper tools and equipment were not identified prior to performing this task. It was determined by Nabors the incorrect crane slings were used; they were too long at 35' in length. Also, there was no communication between the driller and crane operator (leadership positions) prior to the commencement of this operation. It is imperative that the driller be involved or have situation awareness of all activities involving the drill floor. In this instance, the driller was not aware of this lift and did not have the opportunity to suggest other means of moving the crossover sub to the drill floor or to ensure proper equipment and personnel were utilized.

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

- Incorrect crane slings were used (slings were determined by Nabors to be too long at 35 ft in length).
- There was no designated person giving hand signals or communicating with the crane operator.

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

- There was no communication between the driller and crane operator (leadership positions) prior to the commencement of this operation.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

Top Handrail on Walkway

The top handrail was pulled off the walkway.

ESTIMATED AMOUNT (TOTAL): \$500

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans District has no recommendations for the Office of Incident Investigations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

PINC #G110, Enforcement Action: W, Authority: 30 CFR 250.107

DOES THE LESSEE PERFORM ALL OPERATIONS IN A SAFE AND WORKMANLIKE MANNER AND PROVIDE FOR THE PRESERVATION AND CONSERVATION OF PROPERTY AND THE ENVIRONMENT?

At the time of the onsite investigation and reviewing documentation with regards to this incident, the proper tools and equipment were not recognized prior to performing this task. Incorrect crane slings were used. (Slings were too long, 35 dt in length). Also, there was no communication between the driller and crane operator (leadership positions)

prior to the commencement of this operation.

For Public Release

25. DATE OF ONSITE INVESTIGATION:

14-JUL-2021

26. INVESTIGATION TEAM MEMBERS:

**Earl Roy / Jason Schollian / Frank
Musacchia /**

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

David Trocquet

APPROVED

DATE:

09-JAN-2022