

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: 22-JUL-2022 TIME: 2203 HOURS

2. OPERATOR: **Murphy Exploration & Production** (
REPRESENTATIVE:
TELEPHONE:
CONTRACTOR: **NOBLE DRILLING (U.S.) INC.**
REPRESENTATIVE:
TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING **Riser Skate**
- 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: 8. OPERATION:

4. LEASE: **G35662**
AREA: **GC** LATITUDE:
BLOCK: **478** LONGITUDE:

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

5. PLATFORM:
RIG NAME: **NOBLE STANLEY LAFOSSE (FKA PACIFIC SHARAV)**

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

9. CAUSE:

7. TYPE:
INJURIES:
 HISTORIC INJURY
OPERATOR CONTRACTOR

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

- REQUIRED EVACUATION
- LTA (1-3 days)
- LTA (>3 days)
- RW/JT (1-3 days)
- RW/JT (>3 days)
- FATALITY
- Other Injury

10. WATER DEPTH: **3760** FT.
11. DISTANCE FROM SHORE: **106** MI.

- POLLUTION
- FIRE
- EXPLOSION

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

LWC HISTORIC BLOWOUT
 UNDERGROUND
 SURFACE
 DEVERTER
 SURFACE EQUIPMENT FAILURE OR PROCEDURES

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

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

14. SEA STATE: FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

On July 22, 2022, an incident occurred on the drillship Noble Stanley Lafosse which was working under contract for Murphy Exploration and Production Company. Completion operations were being conducted at Green Canyon Block 478, OCS-G35662 Well SS002. The driller for Noble was picking up the spanner joint assembly off the riser skate using the topdrive (TDS) while the crane was tailing the other end with a nylon strap attached. When the TDS end of the spanner joint assembly was approximately 29 feet off the floor, the nylon strap broke, and the tail end of the spanner joint dropped approximately 6 feet and came to rest on the riser skate deck. No injuries were reported, and an onsite investigation was initiated.

On the night of July 22, 2022, the drill crew held a Transition to Work (TTW) meeting in the driller's shack prior to the lifting operation of the spanner joint assembly to the drill floor. The TTW meeting was attended by the Noble drill crew, crane crew, and Professional Rental Tools (TRP) Offshore technicians associated with the spanner joint assembly. The driller inspected and approved the lifting gear connected to the spanner joint assembly then returned to the driller's shack to perform the lift. One of the PRT technicians noticed that the wire rope sling was connected to the crane by a swivel shackle that was not rated for lifting the entire weight of the spanner joint assembly. This shackle and wire rope was used to lift the spanner joint onto the riser skate. He immediately notified the crane crew members and informed them of his findings. The suggestion was made by the crane crew to wrap the wire rope sling above the test cap. According to the PRT technician, this would interfere with the control lines on the spanner joint assembly. The decision was made by the crane crew and approved by the PRT technicians, to use a nylon sling to tail the end of the spanner joint assembly utilizing the crane as the driller picked up the other end with the TDS elevators. As the lift commenced, the Driller hoisted the spanner joint assembly off the riser skate, the crane operator picked up the other end of the spanner joint assembly, and the riser skate was retracted from below the lift. The lift continued. The riser skate was clear of the lift and when the TDS elevators were approximately 30 feet above the rig floor the nylon sling connected to the crane parted, allowing the tailing end to fall approximately 6 feet to the riser skate deck. Red Zone Management was in place and the nearest individual was approximately 22 feet away from the incident. An All Stop was called, and an onsite investigation was initiated.

Investigation:

Due to Covid-19 protocols, the Bureau of Safety and Environmental Enforcement (BSEE) team was unable to conduct an onsite investigation until August 4, 2022. The BSEE investigation team, consisting of the Well Operation Accident Investigator and Well Operations Inspectors were able to collect incident documentation and photos from the operator and contractor at the team's request prior to the onsite investigation. The BSEE investigation team reviewed all the provided documentation, noting that the "A" drill crew had just landed the tubing hanger assembly and prepared to pick up the spanner joint assembly. PRT Offshore crew completed a Job Safety Analysis (JSA) on "Spanner Joint Rig-Up" prior to hoisting the spanner joint to the rig floor. The rig's crane crew assembled and prepared to raise the spanner joint. After, a PRT Offshore technician contacted the crane crew, concerning the wrapping of the wire rope sling around the test cap, which could interfere with the controls of the assembly. The crane crew indicated that there was a permit in place to use a nylon sling, so it was connected to the spanner joint. Further investigation by the BSEE team revealed that the Noble Crane Operator and his crew failed to complete a new Permit To Work (PTW) and a Lift Plan for this operation. The previous PTW and Lift Plan was for lifting chrome tubing for the tubing operation. This permit for lifting chrome tubing had expired and the crane crew failed to return the 2 inch by 30 foot nylon sling back to the control locker. By lifting the spanner joint assembly end with Knuckle Boom Crane (KBC) #3, the crane operator allowed his crew to use the nylon sling without verifying the Safe Working Load (SWL) which was rated to pick up approximately 5,100 pounds in

the choker arrangement. The end of the spanner joint assembly was found to weigh approximately 15,000 pounds.

In addition, when the BSEE investigation team viewed a video of the lift, the team noticed that the spanner joint was lifted utilizing the TDS and crane while the riser skate was retracted. The lift was stopped to check the equipment and a PRT Offshore technician was allowed to walk past the suspended spanner joint in a Temporary Drop Zone just before the nylon sling parted. The Noble crane operator and crane crew allowed the technician to enter the Temporary Drop Zone area without a Permit to Work.

Since the incident, Noble has reviewed and will consider updating the Rigging and Lifting operation to clearly define tandem lifts with multiple lifting devices and include a section with guidelines to follow when lifting third party equipment to and from the drill floor. They will update their JSA on "Making Lifts with Web Slings" to include during transition to work meeting with all agreeing on type of lift being performed and require documentation needed for each specific lift. The crane operator will be coached on the correct way to comply with the Rigging and Lifting, Safe System to Work and DROPS policies and Temporary Drop Zones.

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

1) Not Following Proper Procedures: Crane Operator and crew failed to create a new Permit to Work (PTW) and lift plan for lifting the spanner joint assembly.

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

Improper equipment used: Crane Operator allowed the crew to use the wrong nylon sling without verifying its Safe Working Load.

20. LIST THE ADDITIONAL INFORMATION:

Allowed personnel to enter a Temporary Drop Zone.

21. PROPERTY DAMAGED:	NATURE OF DAMAGE:
Parted 2 inch by 30 foot nylon sling	N/A
ESTIMATED AMOUNT (TOTAL):	\$

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE Houma District has no recommendations for the Office of Incident Investigations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

None

25. DATE OF ONSITE INVESTIGATION:

04-AUG-2022

28. ACCIDENT CLASSIFICATION:

26. Investigation Team Members/Panel Members:
Jeremy Sonnier / Gabe Orellana / Paul Reeves (Author) /

29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR:

APPROVED
DATE: 16-NOV-2022