UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **16-FEB-2024** TIME: **1335** HOURS
2. OPERATOR: **Chevron U.S.A. 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

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

4. LEASE: **G16942**
   AREA: **WR** LATITUDE:
   BLOCK: **29** LONGITUDE:

5. PLATFORM:
   RIG NAME: **NABORS MODS 400**

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

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	**0**	**1**
[ ] LTA (1-3 days)		
[X] LTA (>3 days)	**0**	**1**
[ ] 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
   - [X] DRILLING
   - [ ] WORKOVER
   - [ ] 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: **5190** FT.
11. DISTANCE FROM SHORE: **138** 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 February 16, 2024, an incident occurred on the Nabors platform rig MODS 400, which was working under contract for Chevron USA Inc (Chevron). Drilling operations were being conducted at Walker Ridge Block 29, OCS-G16942, Well A002. During daylight crane operations, 16" casing was being offloaded from a supply vessel to the pipe deck. The deck foreman (IP) was supervising the work and verifying the casing tally while a load of casing was in the process of being set down. The IP turned his back to the load before the casing was set down and wasn't aware that the casing started to move in his direction. The casing struck the IP in the waist area as he stood next to the sub-rack basket, which resulted in a caught between incident. The crane operator safely landed the bundle of casing and the IP was attended to by the rig medic. The decision was made to evacuate the IP for transport to the nearest hospital.

Offloading of the 16" casing began at 07:00 hours on February 16, 2024. Weather conditions was 1-2' seas with 5-10 mph winds and sunny. Conditions remained the same throughout the day. A blind lift Job Safety Analysis (JSA) was in use with General Permit to Work (PTW) and Start-Work Checklist (SWC). At 13:27 hours, the crane operator picks up bundle #16 consisting of 2 joints of 16" casing weighing approximately 11,500 lbs. At 13:28 hours, the crane operator swings the bundle of casing over the flare boom towards the lay down area. A designated flagger and six riggers handle the load with taglines and push-pull sticks. At 13:29, the crane operator has bundle in position and lowers it down to waist height. The measured extension of the crane boom was 135-140' putting the boom angle at 31 degrees. Riggers use shepherd hooks to grab tag lines. IP has his back turned to the load while verifying the casing tally. The bundle swings West Northwest and is in line with the joints that were previously laid out. A rigger yells at the IP to move out of the way. The IP glanced at the load before turning his back to the load. He did not realize he was in between the bundle of casing and the sub-rack. The bundle then swings to the Southeast in the direction of the IP. All riggers yell at the IP to move from his position. The IP turns to his right then the bundle of casing strikes him on the right hip forcing his left hip into the sub-rack basket.
The crane operator lands the load safely and the IP is attended to. The on-site medic tends to the IP and the decision is made to medivac the IP directly to a hospital in the greater New Orleans area with an ETA of 16:30 hours. The IP arrives at the hospital and patient care was transferred to the UMC medical staff. At 12:45 hours, on February 20, 2024, the IP was discharged with three fractures in the pelvic region.

The Bureau of Safety and Environmental Enforcement (BSEE) Houma District office was notified orally and a written report was submitted in eWell within 15 days. The BSEE Houma District inspectors (inspectors) were able to collect some documents, pictures and a video related to the incident from the operator prior to the onsite investigation. A BSEE onsite investigation was conducted on March 7, 2024, and additional documents were gathered. The IP did not follow the JSA that was utilized for the operation. The JSA identified the caught between hazard and recommended not to walk under or between loads while they are suspended. The JSA advised workers to stay 8' from the load while the load is in transit. The IP failed to heed the warning shout from the first rigger that yelled for him to get out of the way. The IP also turned his back to a suspended load. It was also discovered that the IP was not only the supervisor of the operation, but he was also responsible for the casing tally. The IP and riggers failed to recognize the hazard presented by the change of the impact zone (area between the casing and sub-rack). Finally, the crane operator and riggers failed to use stop work authority (SWA).
Upon reviewing pictures, documents, Nabors and Chevron's investigation reports, BSEE concluded that failure to open the impact zone by adjusting the sub rack was the probable cause of the incident. Failure to recognize this hazard by the IP, crane operator, and riggers lead the IP to think he was continuing to work in a safe area. It was 6.5 hours from the start of the job until the incident. If the changing work area would have been recognized as a hazard, mitigations would have been put in place.

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

Human performance error – failure to identify the hazard of the impact zone getting smaller as the job continued. IP turning his back to a suspended load.

Communication – IP failed to listen to riggers when told to move out of the pinch point. SWA was not used.

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

Human performance error - Not following the hazards and mitigations of the JSA utilized. IP not maintaining situational awareness. IP not listening to the warnings from the riggers. IP was supervising the offloading operations while tending to the casing tally.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

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:

N/A

25. DATE OF ONSITE INVESTIGATION:

07-MAR-2024

28. ACCIDENT CLASSIFICATION:

26. Investigation Team Members/Panel Members:

29. ACCIDENT INVESTIGATION PANEL FORMED:

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR:

Amy Pellegrin

APPROVED DATE: **27-JUN-2024**