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

# ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **22-APR-2024** TIME: **0815** HOURS
2. OPERATOR: **Murphy Exploration & Production (**
   REPRESENTATIVE:
   TELEPHONE: CONTRACTOR: **NOBLE DRILLING (U.S.) INC.** 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: **G35864**
   AREA: **GC** LATITUDE:
   BLOCK: **389** LONGITUDE:

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

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) | | |
| [ ] LTA (>3 days) | | |
| [ ] RW/JT (1-3 days) | | |
| [X] RW/JT (>3 days) | **0** | **1** |
| [ ] 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
- [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: **3604** FT.
11. DISTANCE FROM SHORE: **125** 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:

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17. INVESTIGATION FINDINGS:

**On April 22, 2024, a hand injury requiring evacuation occurred on the drillship Noble Stanley Lafosse, which was working under contract for Murphy Exploration & Production Company – USA (Murphy). Completion operations were being conducted at Green Canyon Block 389, OCS-G35864, Well SS003. The injured person (IP) was assisting the wireline helper (helper) disconnect wireline tools when his hand was caught between the upper C-plate with tools weighing 175 lbs and lower C-plate causing lacerations to the right hand ring and middle fingertips.**

**Wireline operations were scheduled to take place on April 22, 2024. The drill crew secured a rescue plan and a Permit to Work (PTW) for working at heights. The wireline crew provided the Job Safety and Environmental Analysis (JSEA) for the job. Also, a transition to work meeting was conducted with the wireline crew and the drill crew prior to starting operations. The helper and IP got in the work basket and ascended to the wireline tools once the sheaves and lubricator were set in place. They attempted to disconnect the wireline tools when the helper noticed the wireline operator slacked off too much. The helper had the wireline operator raise the tool string and he raised the tools positioning the top C-plate approximately 4” above the bottom C-plate. The IP repositioned himself in the basket so the helper had better access to the tool string. The IP placed his right hand under the upper C-plate to stabilize the tool string. The helper released the tools and they fell 4” smashing the IP’s right hand in between the C-plates.**

**The IP told the helper that he needed to report to his supervisor. The job was stopped and the worksite secured. The IP lowered and exited the work basket. Next, he walked to the treatment room to be evaluated by the rig medic. The initial evaluation confirmed the IP sustained lacerations to his right hand ring and middle fingertips. The IP was evacuated from the rig to an onshore facility for further evaluation. There it was discovered that the IP broke the tip of his right ring finger and he needed 14 stiches for the cuts sustained in the incident. The IP was released to light duty on 4/22/24. The IP was released to full duty on 5/22/24.**

**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 all documents and pictures related to the incident from the operator without an onsite investigation. The IP did not sign the JSEA. Although the JSEA did address disassembling tools, hand placement, and pinch points, it failed to address the possibility of lifting the tool string too high and it failed to address how to handle the C-plates safely and the existing hazard of caught between C-plates. It was discovered that this was the helper’s first deepwater wireline run and the IP was not properly trained on disassembling wireline tools. The investigation also showed there was poor communication between the helper and IP when the hazard of lifting the tool string too high was brought into the operation. Stop Work Authority (SWA) was not used by the helper or IP. Neither the helper nor the IP maintained situational awareness during the operation. The helper did not realize the tools would fall 4” once released and the IP failed to see his right hand was in a pinch point.**

**Upon reviewing pictures, documents, Noble’s and Murphy’s investigation reports, BSEE concluded that the helper’s lack of deepwater experience and the IP’s lack of training on wireline tools were probable causes of the incident. Another probable cause was the IP not identifying the hazard of handling the C-plates and the possible pinch point between C-plates. Lack of communication is the last cause identified in the investigation. Neither the helper nor the IP communicated the hazard of lifting the tools too high and the fact that the IP’s hand was in a pinch point. If the helper had more experience, the IP had proper training, and good communication was used, the hazard could have been identified and mitigated.**

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

**Personnel training – The IP was not properly trained on wireline tools.**

**Communication – There was inadequate communication between the helper and the IP about the hazard of lifting the tools too high and the pinch point between the C-plates.**

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

**Human performance error - The helper was not experienced in deepwater operations.**

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:

**16-MAY-2024**

26. Investigation Team Members/Panel Members:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

27. OPERATOR REPORT ON FILE:

OCS REPORT:

30. DISTRICT SUPERVISOR:

**Amy Pellegrin**

APPROVED DATE: **08-AUG-2024**