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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **08-JUL-2024** TIME: **1908** HOURS

2. OPERATOR: **Cantium, LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Enterprise Offshore Drilling**
   REPRESENTATIVE: TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **Draworks**
- [ ] 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: **00166**
   AREA: **ST** LATITUDE:
   BLOCK: **23** LONGITUDE:

5. PLATFORM: **CC**
   RIG NAME: **ENTERPRISE 205**

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

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
- [X] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER
- [ ] TEMP ABAND
- [ ] PERM ABAND
- [ ] DECOM PIPELINE
- [ ] DECOM FACILITY
- [ ] SITE CLEARANCE

9. CAUSE:
- [ ] EQUIPMENT FAILURE
- [ ] HUMAN ERROR
- [ ] EXTERNAL DAMAGE
- [ ] SLIP/TRIP/FALL
- [ ] WEATHER RELATED
- [ ] LEAK
- [ ] UPSET H2O TREATING
- [ ] OVERBOARD DRILLING FLUID
- [ ] OTHER _____

10. WATER DEPTH: **50** FT.

11. DISTANCE FROM SHORE: **7** 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 July 8, 2024, a lifting incident occurred on the jack-up, Enterprise 205, which was working under contract for Cantium, LLC. Drilling operations were being conducted at South Timbalier Block 23, OCS-G00166, Well CC003. While the driller slowly pulled out of the hole with drill pipe, the traveling block struck the crown saver assembly with approximately 117,000 lbs overpull resulting in $11,210.00 in damages.

The drill crew consisting of the driller (DR1), assistant driller (AD), and two floorhands, were preparing to pull out of the hole (POOH) with drill pipe. A Job Safety Analysis (JSA) was completed for the task. DR1 planned to pull the first stand of drill pipe to check the crown-o-matic (COM) and rack it back in the derrick. The AD was organizing equipment near the drawworks. Floorhand one (FH1) was wiping drilling fluid off the ascending drill pipe and floorhand two (FH2) was on the monkey board.

The DR1 engaged the drawworks to pull the first stand of pipe. With the drawworks still engaged, the DR1 decided to focus his attention on the pipe tally. According to Cantium's report, the drill line contacted the COM, but it did not move the barrel enough to trip the COM. This allowed the traveling block to continue moving upwards allowing the traveling block to strike the crown saver assembly. DR1 heard a change in sound as the traveling block struck the crown saver assembly with 117,000 lbs overpull. He disengaged the drawworks clutch stopping the upward movement.

After the incident took place, DR1 slacked off the traveling block approximately 10 feet. He locked the brake down and reported the incident. The crown block was then inspected for damage. Well operations were suspended until inspectors could check the condition of the block, wire rope, and crown. The only damage noted on the inspection was to the crown saver assembly. A Root Cause Investigation was conducted by both the contractor and operator.

The Bureau of Safety and Environmental Enforcement (BSEE) Houma District was not orally notified of this incident. The incident was submitted in eWell within 15 days. BSEE Houma District inspectors (inspectors) performed an incident follow-up on July 11, 2024, to gather additional pictures, documents, and witness statements. Although a JSA was used for pulling out of the hole, it did not state the hazard of the traveling block striking the crown block assembly. FH1, who was wiping the ascending drill pipe, was not counting tool joints as the drill pipe was being pulled. Also, DR1 stated, "While picking up to check the crown-o-matic and rack back stand, I looked at the pipe tally to count stands to top of liner and C.O.M. didn't trip. Saw weight indicator jump up so I slacked off." DR1 lost situational awareness by checking the pipe tally while pulling out of the hole. DR1 also failed to have a drill crew member watch the wire rope as he was checking the COM. Finally, the COM failed to trip when contacted by the wire rope because the barrel wasn't set properly. When asked for a copy of the rig specific procedure for checking the (COM), the operator could not provide it. During the August monthly inspection, the driller (DR2) was asked how he checks the (COM). He stated that when running drill pipe in the hole he checks it with the first stand by doing the following: post a crew member to count the wraps on the drum until the COM trips, latch onto the stand of drill pipe, and pick up until the drill line trips the COM. When POOH he stated the following: POOH with the first stand, break out stand from drill string, post a crew member to count the wraps until the drill line trips the COM, and pick up stand until the drill line trips the COM. During the same inspection, the Offshore Installation Manager OIM was asked for a rig specific procedure for checking the COM, he stated they did not have a step-by-step procedure for checking the COM.

Upon reviewing pictures, documents, the operator's incident report, and witness statements, BSEE concluded that failing to identify the hazard of the traveling block striking the crown block contributed significantly to this incident. Lack of

situational awareness by DR1 and FH1 led to the traveling block striking the crown saver. Another cause was the COM failing to trip when contacted by the wire rope because the barrel wasn't set properly. Finally, there was no rig specific procedure for checking the COM.

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

Human Performance Error – DR1 and FH1 were not paying attention to the task of POOH with drill pipe to check the COM and rack back the stand.

Management system – Inadequate hazard analysis of the traveling block contacting the crown block.

Equipment failure - The barrel of the COM was not set properly. This allowed the drill line to move past the COM resulting in the the traveling block striking the crown block.

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

Communication – Inadequate job instructions were provided for POOH with drill pipe and checking the COM.

Management System – Inadequate fleetwide procedure for checking the COM and no rig specific procedure for checking the (COM).

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

Crown saver damaged. **Needed replacement**

ESTIMATED AMOUNT (TOTAL): **$11,210**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Houma District has no recommendations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

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On July 8th, 2024, at approximately 19:00 while tripping out of hole, the traveling block made contact with the Crown Saver causing an overpull of 117K.

pounds resulting in damage to the Crown-O-Matic and Crown Saver. The Operator failed to immediately notify The BSEE Houma District of the

incident and it was first reported on July 9th, 2024, at 10:57AM.

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On July 8, 2024, a material handling incident occurred on the Enterprise 205. While pulling out of the hole with drill pipe, the traveling block contacted the crown saver due to following an inadequate procedure. The procedure did not have any risk assessment associated with the task being performed. Cantium was asked for a job specific procedure and JSA for the operation, but neither could be produced. Note: The Operator must submit a letter of explanation to the BSEE Houma District addressing this incident of noncompliance and detail how it will be prevented from happening in the future.

25. DATE OF ONSITE INVESTIGATION:

11-JUL-2024

26. Investigation Team Members/Panel Members:

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Amy Gresham

APPROVED DATE: **18-SEP-2024**