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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **25-DEC-2024** TIME: **1330** HOURS
2. OPERATOR: **BP Exploration & Production Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **NOBLE DRILLING (U.S.) INC.**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **Welding shop trolley & lift**
- [ ] 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: **G36297**
   AREA: **GC** LATITUDE:
   BLOCK: **584** LONGITUDE:
5. PLATFORM:
   RIG NAME: **DIAMOND OCEAN BLACKHORNET**
6. ACTIVITY:
   - [X] EXPLORATION(POE)
   - [ ] DEVELOPMENT/PRODUCTION (DOCD/POD)
   - [ ] DECOMMISSIONING

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

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	0	2
[ ] LTA (1-3 days)		
[X] LTA (>3 days)	0	2
[ ] 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

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

10. WATER DEPTH: **4089** FT.
11. DISTANCE FROM SHORE: **118** 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 December 25, 2024, a lifting incident occurred on the Noble Drillship Blackhornet, which was working for BP Exploration & Production Inc (BP). Drilling operations were being conducted at Green Canyon Block 584, OCS-G 36297. The Noble welder (IP1) and Noble roustabout (IP2) were preparing to lower a 3/8" steel plate weighing approximately 340 lbs to the deck. The plate disengaged from the heavy magnetic lifting device falling 47" and striking both IP1 and IP2 on the top of the left foot. Both personnel reported to the medic and were evacuated to University Hospital in New Orleans, LA.

Noble's investigation found that IP1 was assigned to repair the corrosion on the pup joint rack. IP1 opened an operational work order for welding and cutting in all areas at the start of his shift. While this work order covered the hazards associated with the hot work being performed, it did not adequately cover the specific hazards associated with the lifting equipment that would be required to lift the sheet of 3/8" plate. IP1 surveyed the job and decided he would need to cut a couple of strips from a sheet of 3/8" plate along with a couple of collars from various size pipe. The plate was stored vertically in the safe welding area. IP1 moved the plate that weighed approximately 490 lbs from the rack using a pneumatic chain hoist and a plate clamp. The sheet was lowered to the deck of the safe welding area and laid out in the horizontal position to lift it onto 42" tall work stands with the magnetic heavy lifting device. The lift was made, the pieces of plate cut, and IP1 shut down for lunch. After lunch, IP1 returned to the work site and resumed working. In the meantime, IP2 was using a pallet jack to move a stack of wooden pallets through the safe welding area where IP1 was working. IP2 and another Noble roustabout did not have enough room to maneuver the pallets around the plate left on the work stands. IP1 stopped what he was doing so he could move the remaining plate back into the rack. IP1 rigged up the magnetic heavy lifting device on the partial sheet of plate. IP2 inserted himself into the job by moving the stands after the plate was lifted. The job was not stopped, a timeout for safety (TOFS) was not called, and the potential hazards of the job were not discussed.

IP1 lifted the plate while IP2 removed the stands. IP1 began lowering the plate while both were in proximity of the suspended plate. The plate prematurely released from the magnetic heavy lifting device dropping in the horizontal position to the deck below. The plate landed on the left foot of each injured person (IP). Both IP1 and IP2 had swelling and contusions because of the incident.

Noble's investigation team conducted multiple tests using the same magnetic heavy lifting device and the same sheet of plate but were unable to duplicate the load releasing early when the handle was in the proper locked position. There is a multi-part action that is required to unlock the handle when locked properly. Manufacturer tests were conducted and the magnetic heavy lifting device was determined to be defective. Per manufacturer, "Pole shoes are in rough shape, whenever a big ding or hard landing causing dents on pole shoes allows air gaps between the pole shoe and part being lifted, this will cause the tool to not lift to its full capacity." Note: manufacturer would not provide a formal test report stating what percentage of the lifting capacity the magnetic heavy lifting device failed at.

The Bureau of Safety and Environmental enforcement (BSEE) Houma District office was notified orally and a written report was submitted within 15 days. The BSEE Houma District Investigators (Investigators) were able to perform an onsite investigation on January 3, 2025, and additional documents and pictures were obtained. The Noble incident report noted that IP2 and another roustabout were moving pallets but could not pass through the welding area due to the plate blocking the walkway. According to Noble's investigation report, IP1 realized the route was blocked and the roustabouts had to offload/backload a boat later in the afternoon, so he decided to help move the plate. IP1 picked up the cut materials then rigged up the magnetic heavy lifting device on the partial sheet of plate with the intent of setting it back on the deck.

Noble's investigation report also stated IP2 made a personal decision to help IP1 without stopping the job, calling a TOFS, or reviewing the JSA that was in place. IP1 hoisted the plate while IP2 removed the stands. IP1 began lowering the plate and the plate released falling on the left foot of both IP1 and IP2. According to the Noble incident report, several tests were conducted with the magnetic heavy lifting device and the same sheet of plate, but the investigation team was unable to replicate the load releasing when the handle was in the proper position. It was noted in the Noble incident report that the 340 lbs plate is less than ½ of the stated safe working load of the magnetic heavy lifting device. The BSEE investigation found the magnetic heavy lifting device was certified on March 19, 2024, by a 3rd party company, as part of an annual lifting gear inspection. The BSEE Investigators reviewed the 3rd party annual lifting gear inspection report and verified that, at the time of that inspection, the equipment was documented to be in good working order. Finally, BSEE Investigators reviewed the results of the manufacturer's testing of the magnetic heavy lifting device that had been conducted following the incident. The BSEE Investigators did not find any inconsistencies with the operator's report that the device was defective at the time the incident occurred. The manufacturer's findings stated the pole shoes were damaged likely by impacts or hard landings which caused dents on pole shoes creating air gaps that affected the device to have a decreased lifting capacity.
The manufacturer declined to provide a formal test report stating what percentage of the lifting capacity the device failed at.

Upon reviewing pictures, documents, and Noble's investigation reports, BSEE Investigators concluded IP1 and IP2 exhibited employee perceived haste by not stopping the job and reviewing the JSA. BSEE Investigators found the JSA to be inadequate. While the JSA did note Pinch, Caught Between, and Struck by as a hazard, it did not specifically identify the magnetic heavy lifting device prematurely releasing the plate as a hazard. Noble's investigation noted that the magnetic heavy lifting device was damaged and not capable of lifting to its full capacity. Operating the damaged lifting device had the potential to result in catastrophic injuries including death.

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

Human performance error – IP1 and IP2 rushed to get the job done. They were not aware of the hazards of the plate falling from the lifting device prematurely. Management systems – The JSA did not have a proper hazard analysis. The JSA did not have a proper management of change. There was inadequate stop work authority.
Work environment – The walkway was blocked by the plate not allowing IP2 and the other roustabout enough room to pass with the pallets.
Supervision – IP1 did not take the time to review the JSA with IP2.

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

Equipment failure – It was noted by the manufacturer that the magnetic heavy lifting device was damaged and could not lift to its full capacity.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

N/A
ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Houma District recommends the Office of Incident Investigations issue a safety alert/bulletin regarding this incident.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

03-JAN-2025

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: **21-MAR-2025**