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

ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED
DATE: **10-NOV-2024** TIME: **0145** HOURS

2. OPERATOR: **Murphy Exploration & Production C**
REPRESENTATIVE:
TELEPHONE:
CONTRACTOR: **TRANSOCEAN OIL 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: **G32504**
AREA: **GC** LATITUDE:
BLOCK: **432** LONGITUDE:

5. PLATFORM:
RIG NAME: **T.O. DEEPWATER INVICTUS**

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

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
- [ ] DRILLING
- [X] 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
- [X] SLIP/TRIP/FALL
- [X] WEATHER RELATED
- [ ] LEAK
- [ ] UPSET H2O TREATING
- [ ] OVERBOARD DRILLING FLUID
- [ ] OTHER _____

10. WATER DEPTH: **3449** FT.

11. DISTANCE FROM SHORE: **105** 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 November 10, 2024, an incident occurred on the Transocean (TOI) Drillship Deepwater Invictus, which was working under contract for Murphy Exploration & Production Company – USA (Murphy). Workover operations were being conducted at Green Canyon, Block 432, OCS-G 32504. The Injured Person (IP) went to the aft of the drillship to assist other roustabouts. When he arrived at the job site, the job was completed. The IP then proceeded to the stern of the rig to watch the water. A wave came over the stern striking the IP. He sustained an injury to his right leg. He was evacuated to West Jefferson Hospital.

According to TOI Investigation Report, a pre-tour meeting was held and the Chief Mate (CM) informed all in attendance that the weather was deteriorating, and the seas were building. The CM told all crew members the stern of the ship was secured (crew members not allowed on stern) due to bad weather. The IP was assigned to help the Marine Department install a swing gate on crane 2. He was released from this duty and proceeded to the aft of the rig to assist the roustabout crew pressure washing. When the IP arrived at the work site, the job was complete, and the roustabout crew was cleaning up.

The IP moved to the aft handrail of the drillship to observe the water although he was informed by the CM that the area was secured. Wave height at the time of the incident was about 15 feet. A wave hit the IP causing him to fall and get knocked back approximately 20 feet. It is believed the IP struck a bollard before coming to a stop at the base of a stairwell.

Murphy conducted an onsite investigation and found the following information. Their investigation found the IP was no longer a short service employee, but it was noted that he has only been with the company since March 2024. He decided to go to the aft handrail despite being told the area was secure. The wave that struck the IP led to the physical injury. The IP was diagnosed with a fractured right femur and is recovering at home. His return-to-work date is currently unknown. The investigation led to the implementation of the following corrective actions: Determine if there should be restricted areas on the rig during adverse weather conditions and communicate these locations to all personnel during pre-tour and other relevant meetings. Suggested locations include the moonpool, bow, stern, working at heights, and crane operations. Assess helideck capabilities and challenges for landing under adverse weather conditions. If conditions are deemed unfavorable, non-critical work will be suspended to prioritize safety. If winch-down capabilities are the only viable medivac option, then operations will also be suspended. Place additional restricted access signs around the rig as needed, based on weather-related restrictions set by the PIC. Signage placement will also account for increased risks of marine debris due to high winds, and in the event of significant adverse weather, conduct a safety meeting for each tour in which the main topic is adverse weather awareness and solicit questions from the team.

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 Inspectors (Inspectors) were able to perform an onsite investigation on November 14, 2024, and additional information was obtained. This included the initial incident report, witness statements, and photos. After speaking with Murphy reps conducting an onsite investigation, it was confirmed that the IP was no longer considered an SSE. The TOI Investigation report stated the IP attended the pre-tour safety meeting where the CM warned of the worsening weather and rising sea states. The stern of the drillship was secured due to the dangers the inclement weather. After the pre-tour meeting concluded the roustabout crew held their daily crew meeting where individuals were assigned their specific tasks. The IP was assigned to help the marine crew install a swing gate on crane 2. The IP arrived at the job site and was told his assistance was not needed. The IP moved towards the aft of the drillship to

help the roustabout crew with pressure washing operations. When he arrived at this job site, the roustabout crew was finished with the task and were in the process of storing tools used for the job. Despite being told the stern was secured; the IP went to the aft handrail to observe the water. He was hit by a wave that threw him approximately 20 feet across the rig. The IP may have struck a bollard before coming to rest at the base of a stairwell. The medic was immediately notified, and he stabilized the IP's injured leg. The IP was evacuated to West Jefferson Hospital for further medical treatment.

Conclusion
Upon reviewing pictures, documents, Murphy and TOI's investigation reports, BSEE concluded that the IP's failure to observe the secured area on the stern contributed significantly to the accident. The IP did not have any job duties on the stern of the vessel. His decision to enter this area led to him being struck by a wave resulting in a fractured right femur.

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

Human error performance – The IP has less than one year experience offshore. The IP was unaware of the hazard that wave action presented that night. The IP followed neither the direction of his supervisor nor procedure by entering a secure area.

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

Work environment – Other weather influences were the rising sea states and the unpredictable risk of waves striking the stern of the rig.

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 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:

14-NOV-2024

28. ACCIDENT CLASSIFICATION:

26. Investigation Team Members/Panel Members:

29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

27. OPERATOR REPORT ON FILE:

OCS REPORT:

30. DISTRICT SUPERVISOR:

Amy Gresham