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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
DATE: **17-FEB-2025** TIME: **1645** HOURS

2. OPERATOR: **Murphy Exploration & Production C**
REPRESENTATIVE:
TELEPHONE:
CONTRACTOR: **Expro Americas Inc.**
REPRESENTATIVE:
TELEPHONE:

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

4. LEASE: **G32504**
AREA: **GC** LATITUDE:
BLOCK: **432** LONGITUDE:

5. PLATFORM:
RIG NAME: **NOBLE GLOBETROTTER**

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)		
[ ] 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

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **Man Rider**
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

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
- [ ] SLIP/TRIP/FALL
- [ ] 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:

INCIDENT SUMMARY:

On February 17, 2025, a personnel handling incident occurred on the Noble Drillship Globetrotter 1, which was working for Murphy Exploration and Production Company (Murphy). Workover operations were being conducted at Green Canyon Block 432, OCS-G 32504, Well SS003. An Expro Americas Inc. employee (AP) used the forward man rider to access the Coil Tubing Lift Frame (CTLF) to tighten a leaking hose. The task was completed and AP signaled the Noble hoist operator (hoist operator) to lower him to the rig floor. The man rider began to descend to the rig floor at an accelerated rate until AP came to rest on the rig floor. AP did not appear injured but as a precaution he was sent to an onshore medical facility via medivac for further evaluation and was cleared for full duty.

SEQUENCE OF EVENTS:

Noble's investigation found that AP was assigned to tighten the leaking hose on the CTLF. A Control of Work meeting (COW) was issued for a "Man riding – Derrick (work at Height)" task to address a leaking hydraulic hose. A Job Safety Analysis (JSA) was completed and reviewed by Noble's Tour Pusher, Noble's banksman, hoist operator, and the AP. The hoist operator used the forward man rider to lift AP approximately 100' to the loose hose. AP tightened the hose and signaled via radio for the hoist operator to lower him to the rig floor.

The hoist operator began to lower AP to the rig floor. The man rider started to descend to the rig floor at an accelerated rate. According to the hoist operator's witness statement, the first action he took was to move the control to the hoist position, but the man rider continued to descend at the same rate. The hoist operator stated he attempted to hit the emergency stop, but AP was on the floor before the button could be pressed.

Noble's investigation team conducted a joint investigation with the winch manufacturer's technicians. The investigation revealed that the original equipment manufacture's (OEM's) Programing and Control Logic (PCL) was altered at some point. Due to the nature of PCL not having memory storage or password protection, it is unknown as to who or when the logic was altered. The investigation team also noted environmentally induced deterioration of the drive motor and encoder. Lack of preventive maintenance by the contractor and insufficient inspections performed by subcontracted third-party inspectors were found to be contributing factors by the investigation team. The team also found some administrative deficiencies during the investigation. Neither the winch operator nor AP were specified in the COW. Although the Tour Pusher attended the transition to work meeting, he was not listed in the COW. The Tour Pusher should supervise man riding operations as per contractor policy but was not present during the event. No secondary fall protection was worn by AP.

BSEE INVESTIGATION:

The Bureau of Safety and Environmental Enforcement (BSEE) Houma District office was notified orally, and a written report was submitted in 15 days. The BSEE Houma District Inspectors (Inspectors) were able to perform an onsite investigation on February 24, 2025, and the COW, JSA, witness statements, videos, and photos were obtained. According to the contractor's incident report the first factor of this incident was the OEM programing changed from "Default" to "Warning" settings. This allowed three separate system faults: Slack line, Upper / Lower Travel Limit, and Encoder performance / speed resolution to be overridden. This also prevented the control logic from engaging either of the two load brakes, stopping the initiation of the lift cycle, or stopping the lifting / lowering operation once it was underway.

Because of this bypass, the brakes did not engage allowing AP to be lowered uncontrolled. The Noble report states "The COW permit included a control to ensure the winch operator maintained visual with the person man riding at all times and prevented blind lifts." Despite this, the winch control console was positioned at an elevated location that obstructed the operator's view of the CTLF and the emergency stop was not activated during the event. The environment played a substantial part in this incident. It was noted in the contractor's report that the encoder housing was cracked with a faulty connecting cable and the drive motor was so corroded that it was only performing at 10% of its original rated output. This may have contributed to the hoist continuing to descend when the hoist operator went to neutral and when he hoisted up. Although the contractor has a preventative maintenance schedule in place, the final report pointed out lack of maintenance as another factor. The lack of maintenance and lack of attention during pre-use inspections led to the failure of the hoist operators to identify problems associated with the safety and functionality of the man rider and associated equipment.

IN CONCLUSION:

Upon reviewing pictures, videos, documents, and the contractor's investigation report, BSEE agrees with the contractor's findings. The changing of the (OEM) settings was the largest factor in this incident. The lack of preventive maintenance and lack of attention to detail on pre-use inspection is another factor. The environmental degradation of the man rider should have been observed during maintenance checks and pre-use inspections. The contractor's investigation noted administrative deficiencies, but BSEE does not believe these were factors in the failure of the man rider.

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

Human performance error- Changing of the OEM settings by unknown personnel. Equipment failure- inadequate preventive maintenance. Insufficient inspections performed by a subcontracted third-party agency.

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

Supervision- Inadequate supervision on maintenance checks and pre-use inspections. Work environment – Hoist operator could not maintain visual contact with AP during man riding event.

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:

The 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:

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: **17-JUN-2025**