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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **08-MAY-2025** TIME: **0430** HOURS

2. OPERATOR: **BP Exploration & Production Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **TRANSOCEAN OIL INC.**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **chain fall**
- [ ] 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: **G33859**
   AREA: **GC** LATITUDE:
   BLOCK: **868** LONGITUDE:

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

6. ACTIVITY:
- [ ] EXPLORATION(POE)
- [X] 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)		
[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
- [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
- [X] HUMAN ERROR
- [ ] EXTERNAL DAMAGE
- [ ] SLIP/TRIP/FALL
- [ ] WEATHER RELATED
- [ ] LEAK
- [ ] UPSET H2O TREATING
- [ ] OVERBOARD DRILLING FLUID
- [ ] OTHER _____

10. WATER DEPTH: **4367** FT.

11. DISTANCE FROM SHORE: **115** 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 May 8, 2025, a lifting incident involving injury to personnel occurred on the Transocean (TOI) Drillship Deepwater Invictus, which was working for BP Exploration & Production Inc. (BP). Drilling operations were being conducted at Green Canyon, Block 868, OCS-G 33859, Well 001. Two TOI employees, the 2nd Engineer (2E) and the 3rd Engineer (IP), were transferring nine sections of Hawse piping from the deck to a designated three-tier storage rack. After placing the eighth pipe section on the top tier, the 2E went to retrieve a U-bolt for securing the pipe while the IP was preparing the next pipe section for lifting. The unsecured section of piping rolled off the rack smashing the IP's middle finger on his right hand. The IP was evacuated from the facility by medivac helicopter to University Hospital in New Orleans for treatment. The IP was treated for an amputation of the fingertip of middle finger of his right hand and released on restricted duty.

Sequence of Key Events:

Nine sections of Hawse pipe, each section approximately 10 feet long and approximately 6 inches in diameter were stored on the deck of the Thruster 2 machinery space. The 2E and IP were tasked with relocating the nine sections of Hawse piping from the deck to the designated storage rack adjacent to the deck space using 2 chain falls. 2E and the IP conducted a pre-job briefing using the Hazard ID prompt card (HIPC) to identify potential risks and assign responsibilities. The task went on without incident until the crewmembers began rigging up to lift/store the last section of piping.

The 2E and the IP were positioned on opposite ends of the pipe. Each worker hoisted their respective end of pipe in unison. Each chain fall was hooked up to a shackle rigged at either end of the pipe's flanges. After placing the 8th section of pipe on the third (uppermost) tier of the storage rack, the 2E and IP removed the chain falls from the pipe. 2E turned away to retrieve a U-bolt to secure the section of piping while the IP knelt to prepare the last section of piping for the lift by rigging a shackle to its flange. The unsecured pipe section rolled from the rack, fell approximately 3 feet, and smashed the IP's right middle finger as he knelt rigging up the next section of pipe that was still on deck.

The task was suspended and the area was secured after the incident. 2E notified the bridge and the IP was escorted to the rig hospital for an initial evaluation. TOI assembled an investigation team and started an investigation into the incident. The IP was evacuated from the facility by medivac helicopter to University Hospital in New Orleans for treatment. The IP was treated for an amputation of the fingertip to the Distal Interphalangeal joint (DIP joint) of the of middle finger of his right hand and released on restricted duty. The TOI investigation team identified multiple causes of the incident in their report. The investigation team noted the immediate cause of the injury was the unsecured pipe rolled from the third row of the storage rack and fell three feet to the deck below. Another immediate cause identified in the report was that IP placed himself in danger when he knelt on the deck to rig up the next section of Hawse pipe before the previously lifted section of pipe had been secured. The HIPC for the task did not identify the need for securing the pipe on the rack before removing the chain falls and did not identify the hazard of unsecured pipes rolling. The design of the rack may not be suitable for pipe support without additional restraints. The 2E and IP conducted the task without incident until the last lift was being rigged up. As 2E was retrieving a U-bolt to secure the section of pipe that was just placed on the rack, the IP proceeded to begin rigging up the next section of pipe. Neither 2E nor the IP were aware of the immediate danger. Finally, the TOI investigation revealed several root causes to the accident. The rack was designed to secure the sections of pipe to the rack with U-bolts. The TOI report identified improvements like chalks, bumpers, grooves, etc. to be installed on the supports and increasing the angle of the supports.

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 conduct an onsite investigation on June 10, 2025, and photos, witness statements, and the HIPC were obtained. After reviewing the HIPC, BSEE found it to be inadequate. Although, the HIPC did identify pinch points as a hazard, the HIPC did not specify where the hazard existed. The HIPC also did not identify the design of the rack being a hazard. The HIPC failed to recognize unsecured pipe rolling off the rack creating a potential crush point. The HIPC also identified safe lifting practices as part of the plan. It did not identify chocking or securing the piping before removing the chain falls. A positive from the HIPC was that proper PPE was to be worn. The IP's witness statement confirmed that he was wearing the proper PPE. It was also noted there was no written job procedure for the task being performed.

After reviewing pictures, documents and the TOI investigation report, BSEE concluded the largest factor in this incident was the failure to secure the pipe before removing the chain falls. Also, hazard identification was a major factor. The HIPC noted pinch points as a generic hazard. 2E and the IP failed to observe the hazard of unsecured pipes on the rack. BSEE believes that a proper hazard analysis would have prevented this incident.

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

Equipment failure – flawed design of the storage rack
Human Performance Error – 2E and the IP were not aware of the hazards of the unsecured pipe
Management system – Inadequate hazard analysis

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

Management system – No written job procedure

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 recommends the BSEE Office of Safety Management do an evaluation of the Hazard ID Prompt (HIPC) card used by Transocean.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

10-JUN-2025

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

APPROVED DATE: **03-SEP-2025**