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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
DATE: **17-JUL-2025** TIME: **0752** HOURS

2. OPERATOR: **Anadarko Petroleum Corporation**
REPRESENTATIVE:
TELEPHONE:
CONTRACTOR: **NOBLE DRILLING CORPORATION**
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: **G09216**
AREA: **GB** LATITUDE:
BLOCK: **215** LONGITUDE:

5. PLATFORM:
RIG NAME: **DIAMOND OCEAN BLACKHAWK**

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

7. TYPE:
INJURIES:
- [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	0	3
[ ] LTA (1-3 days)		
[ ] LTA (>3 days)		
[ ] RW/JT (1-3 days)		
[ ] RW/JT (>3 days)		
[ ] FATALITY		
[X] Other Injury	0	3

First Aid Only

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

10. WATER DEPTH:
11. DISTANCE FROM SHORE:
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 17 July 2025, three individuals sustained injuries during workover operations being conducted by Anadarko Petroleum Corporation (Anadarko) at Garden Banks Block 215. All three injuries did not require medical attention beyond first aid.

Sequence of Events:
On 17 July 2025 at 0752 hours, during the process of blowing down a coil tubing reel with nitrogen, a 0.375-inch-high pressure hose ruptured, struck and injured a Noble Assistant Driller on his left arm and an Oil States employee on the left side of his face. Also, a Schlumberger (SLB) Operator injured his knee when moving to avoid being struck by the hose. All personnel reported to the Rig Medic for evaluation. After the medical evaluations, the decision was made to send the Noble Assistant Driller and SLB Operator in for further evaluation. On 17 July 2025, the Noble Assistant Driller and SLB Operator departed the Noble Blackhawk for an onshore medical evaluation. On 18 July 2025, the Oil States Tech who was initially evaluated and cleared by the Rig Medic immediately after the incident, was reevaluated and a decision was made to send him in for further evaluation. All parties received a full return to work release, and this incident was classified as First Aid Only.

BSEE Investigation:
On 21 July 2025, the Bureau of Safety and Environmental Enforcement (BSEE) Lafayette District conducted an onsite Incident Follow-up Investigation. BSEE met with Anadarko and Noble representatives and gathered all available incident-related documents.

The 0.375-inch-high pressure hose was submitted to a laboratory for forensic analysis and the cause of the failure was attributed to chlorides corrosion coupled with rapid oxidation of wire reinforcement strands. At the time of the incident, the 3000 per square inch (psi) pressure rated hose was only in use for approximately 6 months and it was only pressurized up to 2400 psi when it ruptured.

The BSEE Incident Investigation Team determined that the cause of the injuries was due to there being no safety restraints connected to the manifold as recommended in Oil States Standard Operation Procedure for Flow Iron and Restraint Installation. As a result, when the 0.375-inch high-pressure hose ruptured, it struck and injured two of the three employees. The BSEE Incident Investigation Team also reviewed the operator's reports and concurred with the operator's findings that there was no established hose inspection procedure or maintenance program in place and that the hose failed due to chlorides corrosion combined with rapid oxidation of the wire mesh.

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

Human Performance Error:
• Not aware of hazards. There were no safety restraints or whip checks installed on the high-pressure hose as recommended in Oil States Standard Operation Procedure for Flow Iron and Restraint Installation.

Equipment failure:
• Flawed equipment design. Laboratory analysis of the 0.375-inch high-pressure hose determined that the hose ruptured due to chlorides corrosion coupled with rapid oxidation of wire reinforcement strands. In addition, the 3000-psi rated hose was only in use for about 6 months and was only pressured to 2400 psi when it failed.

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

Equipment failure:
• Inadequate preventive maintenance. There was no preventative maintenance program to evaluate the hose’s operational condition. The hose failed due to internal corrosion along with rapid oxidation of the wire mesh reinforcement strands.

• **Inadequate equipment inspection. There is no formal hose inspection procedure in place.**

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

A 0.375-inch-high pressure hose was damaged during this incident.

NATURE OF DAMAGE:

A 0.375-inch-high pressure hose ruptured.

ESTIMATED AMOUNT (TOTAL): **$1,500**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District makes no recommendations to the Office of Incident Investigations regarding this incident.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

Not applicable.

25. DATE OF ONSITE INVESTIGATION:

21-JUL-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:

Mark Malbrue

APPROVED DATE: **21-OCT-2025**