UNITED STATES DEPARTMENT OF THE INTERIOR
MARINE MINERALS ADMINISTRATION
GULF OF AMERICA REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **04-FEB-2026** TIME: **1705** HOURS
2. OPERATOR: **Walter Oil & Gas Corporation**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Helmerich & Payne**
   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: **G27982**
   AREA: **EW** LATITUDE:
   BLOCK: **834** LONGITUDE:

5. PLATFORM:
   RIG NAME: **H&P 203**

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)		
[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
- [X] HUMAN ERROR
- [ ] EXTERNAL DAMAGE
- [ ] SLIP/TRIP/FALL
- [ ] WEATHER RELATED
- [ ] LEAK
- [ ] UPSET H2O TREATING
- [ ] OVERBOARD DRILLING FLUID
- [X] OTHER **Management Systems**

10. WATER DEPTH: **1186** FT.
11. DISTANCE FROM SHORE: **62** MI.
12. WIND DIRECTION: **N**
    SPEED: **24** M.P.H.
13. CURRENT DIRECTION: **SE**
    SPEED: M.P.H.
14. SEA STATE: **0** FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

INCIDENT SUMMARY:

On 4 February 2026, the crew from Helmerich & Payne LLC (H&P) were operating the H&P 203 rig on the EW 834 “A” platform (lease: G27982), Well: A003, for Walter Oil and Gas, when a stand of drill pipe became displaced and fell across the derrick. During recovery efforts, the stand shifted across the rig floor and pinned an H&P Rig floorman’s right foot between the pipe and nearby drilling equipment. The injured person (IP) was evaluated by the rig medic, airlifted to shore and later diagnosed with multiple foot fractures resulting in lost work time. Walter Oil and Gas reported the incident to the Bureau of Safety and Environmental Enforcement (BSEE) New Orleans District (NOD).

At the time of the investigation, Marine Minerals Administration (MMA) personnel were operating under the former Bureau of Safety and Environmental Enforcement (BSEE). Therefore, all MMA personnel referenced in this report will be identified as BSEE personnel.

SEQUENCE OF EVENTS:

On 4 February 2026, at approximately 17:00 Central Daylight Time, the H&P drill crew were conducting tripping operations, which involved lowering drill pipe and Tubular Conveyed Perforating (TCP) guns into the well. During the operation, a joint of drill pipe, being lowered through the rotary with the top drive, was not fully secured in the elevators. As a result, this stand of drill pipe became displaced and fell across the derrick structure. Tripping operations were suspended to recover and secure the displaced stand.

The H&P Driller initially instructed the H&P Derrickman to utilize the derrick winch, a winch line located in the derrick, to reposition the displaced stand back toward the monkey board. The monkey board is an elevated work platform in the derrick where the Derrickman handles and organizes stands of pipe during tripping operations. The Derrickman advised the Driller that the derrick winch could not effectively reach the displaced stand. The Driller then instructed the H&P Floormen to utilize the off-driller side 5,000-pound-rated air hoist, a pneumatically powered hoist used to lift or reposition equipment from the rig floor, to assist with the recovery operations.

Before tension was applied to the stand of drill pipe with the air hoist, the H&P Rig Manager directed the H&P drill crew to stabilize the lower portion of the displaced stand by securing it to adjacent stands of drill pipe. In response, the H&P Floorman, the injured person (IP), wrapped a separate tugger line around the displaced stand. However, the line was attached in a manner that caused it to pull in the wrong direction. After the line was attached, the Driller signaled the Air Hoist Operator, another H&P floorman, to remove slack from the hoist cable. As slack was removed, the pull back tugger configuration caused the lower portion of the stand to lift and move laterally across the rig floor mat toward the IP.

The displaced stand then struck the IP and pinned the IP’s right foot between the stand and a spare set of rotary bushings staged near the rig floor handrail. Operations were halted and H&P rig floor personnel began efforts to remove the IP from the pinch point. The IP’s right foot remained inside the work boot while pinned between the pipe and rotary bushings, requiring personnel to remove the IP’s foot from the boot before the IP could be extracted.

After being removed from the pinch point, the IP was transported to the rig medic for initial medical evaluation and was subsequently evacuated by helicopter to the hospital for further evaluation and treatment. The operator's initial notification indicated that no fractures were identified during the hospital examination. However, during a follow-up medical appointment on 10 February 2026, additional X-rays identified multiple fractures in the IP's foot. As a result of the injury the IP missed approximately four weeks of work.

BSEE INVESTIGATIONS:

The BSEE assigned investigator reviewed operator-submitted emails, phone communications, witness statements, video footage, JSA documentation and H&P procedures related to the incident. The injured person was not contacted during this investigation.

Witness statements and video footage showed that, after the stand of drill pipe became displaced across the derrick and rig floor, the crew attempted to recover the stand using available rig equipment, including an air hoist and rig floor tugger. The same evidence showed personnel on the rig floor near the rotary area during recovery. When tension was applied the displaced stand moved laterally across the rig floor, struck the IP and caused the injury.

The submitted JSA documentation included a start of shift JSA for tripping operations. The documents provided did not include a task-specific JSA, toolbox talk, or documented hazard reassessment for recovery of the displaced stand after conditions changed.

The evidence reviewed did not identify a documented red zone, exclusion area, or other line of fire controls established before tension was applied to the displaced stand.

The BSEE investigation identified an H&P displaced pipe recovery procedure dated 23-MAY-2011. The procedure referenced use of a "Drop Stand Kit," including a shackle intended to be secured to the V-door. The procedure displayed a different operator's logo. The submitted records did not establish whether the crew reviewed the procedure or used the Drop Stand Kit during the recovery.

IN CONCLUSION:

The BSEE investigation determined that the injury resulted from inadequate hazard recognition, task planning, supervisory oversight, and control of personnel exposure during recovery of the displaced stand of drill pipe.

After the stand became displaced, the recovery effort presented a changed and non-routine condition. Work was not effectively paused to conduct a task specific hazard assessment, assign recovery responsibilities, verify the stand was secured, or establish red zone and line of fire controls before tension was applied.

Although a JSA had been completed for tripping operations, It did not address the hazards associated with recovery of a displaced stand of drill pipe. Additionally, H&P had an existing displaced pipe recovery procedure referencing use of a Drip Stand Kit; however, the procedure was not effectively implemented during the recovery.

Based on the investigation findings, the incident was preventable. The failure to stop work, reassess the changed conditions, control personnel exposure, follow or implement the available recovery procedure and maintain effective supervisory oversight directly contributed to the IP's exposure and resulting injury.

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

- Inadequate hazard analysis / Stop work implementation. Work was not stopped after the stand became displaced to conduct a task-specific hazard assessment, evaluate changed conditions, assign recovery responsibilities, or establish appropriate controls.

- Inadequate implementation of procedures. The displaced stand was not verified as secured and controlled before recovery continued and the available displaced pipe recovery procedure was not effectively implemented.

- Inadequate control of personnel exposure/line of fire controls. Red zones, exclusion area, or other line of fire controls were not established before tension was applied, allowing personnel to remain exposed within the potential path of movement of the displaced stand.

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

- Inadequate supervisory oversight during the recovery operation. Supervisory personnel did not ensure the job was paused, reassessed and controlled before recovery operations continued. Supervisory personnel also did not ensure that applicable recovery procedures were reviewed or that the available Drop Stand Kit was identified and utilized.

- Inadequate communication and assignment of responsibilities. Roles and responsibilities for the recovery operation were not clearly assigned. The investigation could not determine whether the crew was aware of H&Ps existing procedure. This indicates the procedure and associated recovery equipment may not have been effectively communicated or recognized as applicable to the operation.

- Lack of a recovery specific toolbox talk. No toolbox talk was conducted before the recovery began, which may have prevented the crew from identifying the changed conditions, personnel exposure and controls needed for the task.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

No damage to equipment

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans District does not have any recommendations for the Office of Incident Investigations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G110 – 30 CFR 250.107 (C)
The operator failed to ensure that the recovery of a displaced stand of drill pipe was properly planned, supervised and controlled before work continued. Specifically, after the stand became displaced across the derrick the operator did not stop the operation to conduct a task-specific hazard assessment, did not conduct a recovery-specific toolbox talk, and did not verify that the stand was secured before tension was applied. These failures allowed personnel to remain exposed on the rig floor within the potential path of movement of the stand. As a result, the stand moved uncontrolled across the rig floor, struck the injured person resulting in multiple fractures and missing 4 weeks of work.

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: **Brody Vial**

APPROVED DATE: **30-JUN-2026**