1. OCCURRED

   DATE: 20-JAN-2020  TIME: 1000 HOURS

2. OPERATOR: EnVen Energy Ventures, LLC
   REPRESENTATIVE:
   TELEPHONE: 
   CONTRACTOR: Nabors Offshore Corporation
   REPRESENTATIVE:
   TELEPHONE: 

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

4. LEASE: G02638
   AREA: MC  LATITUDE: 28.790953
   BLOCK: 194  LONGITUDE: -89.056403

5. PLATFORM: A-Cognac
   RIG NAME: NABORS 202

6. ACTIVITY: EXPLORATION (POE)
   DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
   INJURIES:
   HISTORIC INJURY
   REQUIRED EVACUATION
   CRANE
   OTHER LIFTING
   DAMAGED/DISABLED SAFETY SYS.
   INCIDENT >$25K
   H2S/15MIN./20PPM
   REQUIRED MUSTER
   SHUTDOWN FROM GAS RELEASE
   OTHER
   CONTRACTOR
   TELEPHONE:

8. OPERATION:

9. CAUSE:

10. WATER DEPTH: 1024 FT.

11. DISTANCE FROM SHORE: 13 MI.

12. WIND DIRECTION: NE
    SPEED: 30 M.P.H.

13. CURRENT DIRECTION: S
    SPEED: 2 M.P.H.

14. SEA STATE: 5 FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:
On January 20, 2020 at 10:00 hours, Enven Energy Ventures (EnVen) had a dropped object incident on board the Nabors 202 rig while conducting drilling operations at Mississippi Canyon 194 well A23, ST2 OCS-G 02638. The incident involved a joint of 10 3/4 inch (in) casing falling out of the elevators into the V-Door. The dropped casing contacted another joint of casing, causing it to slide out of the V-Door and through the kick plate onto the walkway, then coming to rest on the pipe rack against the handrail. EnVen reported the incident to the Bureau of Safety and Environmental Enforcement (BSEE) New Orleans District. There was one minor injury sustained; an employee tripped and fell while moving away from the area when the incident occurred.

The Nabors 202 drill crew was running 10.75 in casing into the well. Approximately 10,095 feet of casing had been run when the crew picked up the 207th joint. A signalman was in place outside the driller’s shack assisting the driller while picking up the casing with the single joint elevators out of the V-door. While lifting the casing, the elevators hit the derrick A-frame and compromised the elevators' integrity. The casing joint was dislodged from the elevators, causing it to fall into the V-door and striking another joint of 10.75 in casing which was resting in the V-door. The 10.75 in casing then slid out of the V-door and through the kick plate landing on the pipe rack.

After the casing was secured on the pipe rack, there was a "safety stand down" with all personnel involved in running casing. The well was monitored on the trip tank during the “safety stand down.”

According to EnVen investigation report, the sequence of events was as follows:

1) 10.75 in was being run in the hole.
2) The crew picked up the 207th joint of 10.75 in casing from the V-door using the single joint elevators.
3) As they were picking up the joint, the elevators came in contact with the derrick A-frame.
4) The flagger motioned to stop and the driller released the throttle.
5) Contacting the A-frame caused the single joint elevators to fail at the hinge, shearing the pin, and allowing the joint of casing to fall back into the V-door.
6) When the joint of casing fell back into the V-door, it contacted the other joint of casing, causing it to slide out of the V-door and through the kick plate on the walkway, and coming to rest on the pipe rack, against the handrails.
7) The joint that fell from the elevators bounced out of the V-door damaging a section of the handrail and coming to rest against a tote tank, which was located on the pipe rack.
8) One employee tripped while trying to remove himself from harm’s way. He received first aid, was sent to shore for further medical evaluation, he was released and returned to full duty. The employee was not in the direct line of fire.
9) The damage sustained during the incident was two sections of handrail and a tote tank.

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

Management Systems:

The JSA and the Nabors procedure “OPS-WIN-019” did not contain specific instructions on how to slow the block speed; and to set the overpull to accommodate the weight of the block and single casing joint.
19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

The crane was not used to control the free lower end of the joint of casing through the V-door, which would have helped change the positioning of the casing while picking it up into the derrick.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

2- sections of handrail ($)
1- tote tank ($)
The cost to repair two handrails and replace one tote tank was a total of $2675.00.

ESTIMATED AMOUNT (TOTAL): $2,675

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

At this time the New Orleans District has no recommendations.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION: 22-JAN-2020

26. INVESTIGATION TEAM MEMBERS:

Frank Musacchia /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

David Trocquet

APPROVED DATE: 16-OCT-2020