

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

ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED

DATE: 29-MAY-2021 TIME: 0500 HOURS

2. OPERATOR: Eni US Operating Co. Inc.

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: Nabors Offshore Corporation

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER **drill line unspooled**

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

4. LEASE: G19996

AREA: MC LATITUDE: 28.20861389

BLOCK: 773 LONGITUDE: -88.73756777

5. PLATFORM: A (DEVILS TOWER)

RIG NAME: NABORS MODS 140

6. ACTIVITY:

- EXPLORATION (POE)
- DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:

INJURIES:

- HISTORIC INJURY
 - REQUIRED EVACUATION
 - LTA (1-3 days)
 - LTA (>3 days)
 - RW/JT (1-3 days)
 - RW/JT (>3 days)
 - FATALITY
 - Other Injury
- OPERATOR CONTRACTOR

- POLLUTION
- FIRE
- EXPLOSION

- LWC
- HISTORIC BLOWOUT
 - UNDERGROUND
 - SURFACE
 - DEVERTER
 - SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION HISTORIC >\$25K <=\$25K

8. OPERATION:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER **Construction**

9. CAUSE:

- EQUIPMENT FAILURE
- HUMAN ERROR
- EXTERNAL DAMAGE
- SLIP/TRIP/FALL
- WEATHER RELATED
- LEAK
- UPSET H2O TREATING
- OVERBOARD DRILLING FLUID
- OTHER _____

10. WATER DEPTH: 5610 FT.

11. DISTANCE FROM SHORE: 110 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 29, 2021 at approximately 05:00 hours, ENI US Operating Co. Inc. (ENI) had a dropped object incident on the Nabors Mods 140 while rigging up to perform sidetrack operations on the A005 well at Mississippi Canyon (MC) Block 773. ENI reported the incident to the Bureau of Safety and Environmental Enforcement (BSEE), New Orleans District.

SEQUENCE OF EVENTS:

At approximately 05:00 hours May 29, 2021, the rig crew was in the process of scoping (extending vertically) the lower intermediate derrick section of the rig. The Toolpusher was operating the drawworks while scoping the derrick when he stopped the (the traveling) block to look at the drill line on the drum (drawworks). The drum had 2 layers of cable and (an estimated) 9 to 11 wraps, 28 wraps of cable to a layer. The Toolpusher then proceeded scoping up the derrick section and set the derrick onto the daws. The shim was installed (or the intermediate derrick is connected and secured to the base derrick) and the (traveling) block slacked off to put slack in the cables to remove it from the scoping sheaves. The Driller stopped the lowering of the block by the Toolpusher about 15 feet from the rig floor, and this allowed the floor hydraulic hoist to be lowered to the rig floor. The Toolpusher then proceeded to slack off the block. When the block was 4' from the floor, the Toolpusher observed the drill line come free from the drawworks and the rig block slowly slacked off to the floor until it set on the rotary table. The fast line from the drawThe works came through the sheave in the crown (block) and fell to the drill floor. This area was a designated a red zone, there were no personnel within 15 feet of the fallen objects, and there were no injuries or equipment damage reported.

BSEE INVESTIGATION:

The BSEE incident investigation consisted of communicating with the Company and HSE Representative on location. BSEE requested daily reports, pictures, Job Safety Analysis (JSA) and procedures.

CONCLUSIONS:

BSEE determined the root cause of this incident to be an inadequate length of drill line spooled on the drum. The inadequate length of drill line prevented the block to from reaching the drill floor once the derrick was all the way scoped (extended) out.

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

- Inadequate length of drill line was spooled on the drum and this did not allow the block to reach the drill floor once the derrick was all the way scoped out.

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

- JSA did not identify hazards & mitigations for spooling drill line inside draw works.

- MODS 140 rig up procedures does not list steps for installing drill line.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

None

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans 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:

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

04-JUN-2021

29. ACCIDENT INVESTIGATION

26. INVESTIGATION TEAM MEMBERS:

PANEL FORMED: NO

OCS REPORT:

Frank Musacchia /

30. DISTRICT SUPERVISOR:

27. OPERATOR REPORT ON FILE:

David Trocquet

APPROVED

DATE:

09-JAN-2022