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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **17-MAR-2025** TIME: **2140** HOURS

2. OPERATOR: **Guardian Decommissioning, Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **PetroFac, LLC**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [X] 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: **G02110**
   AREA: **EI** LATITUDE:
   BLOCK: **307** LONGITUDE:

5. PLATFORM: **A**
   RIG NAME:

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

7. TYPE:
   INJURIES:
- [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[ ] REQUIRED EVACUATION		
[ ] LTA (1-3 days)		
[ ] LTA (>3 days)		
[ ] 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
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER
- [ ] TEMP ABAND
- [X] 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: **218** FT.

11. DISTANCE FROM SHORE: **64** MI.

12. WIND DIRECTION: **WNW**
    SPEED: **8** M.P.H.

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

14. SEA STATE: **3** FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

Incident Summary:
On 17 March 2025 at 2140 hours, a near miss dropped object incident occurred during well abandonment operations by Guardian Decommissioning, Inc. (Guardian) at Eugene Island Block 307A. The near miss incident involved a single joint of 3.5-inch pipe that fell approximately 40-feet to a deck. There were no injuries or pollution during this incident and the cost of damages was $4000.

Sequence of Events:
On 17 March 2025, a Guardian well abandonment crew were using the platform crane to trip out of Well A007 with a joint of 3.5-inch pipe. The floor hand, acting as the banksman, inside the elevated hydraulic jack basket latched the elevators onto 3.5-inch pipe and backed away while signaling the crane operator to lift the pipe up and swing it out so it would clear the elevated hydraulic jack basket. The crane operator then boomed down while spooling out attempting to lower the 3.5-inch pipe to the deck. He did not have a clear line of sight of the pin end of the pipe as it came to rest on the Self-Retracting Lifeline (SRL) Arm located in the elevated hydraulic jack basket. The crane operator was unaware that he lowered the joint of pipe down onto the SRL Arm and continued to lower the boom while spooling out. When the floor hand noticed this, he immediately pushed the pin end of the pipe off of the SRL arm causing the pipe to drop down. When the collar end of the pipe hit inside the elevators it caused the elevator door to open unlatching the pipe and causing it to fall approximately 40 feet to the deck below. There were two workers in the area where the 3.5-inch pipe struck, but they were able to move out of the way before the pipe landed on the deck striking a hydraulic hose and wheel unit fire extinguisher handle.

BSEE Investigation:
On 19 March 2025, the Bureau of Safety and Environmental Enforcement (BSEE) Lafayette District conducted an onsite Incident Follow-up Investigation. BSEE met with the Guardian representative, gathered all available incident-related documents and conducted photographic documentation. BSEE inspected the elevators and observed that they were worn and not properly maintained.

BSEE reviewed the Daily Work Plan and found that it did not adequately address the hazards associated with setting down pipe with the crane in a small laydown deck area. BSEE also found that there was inadequate supervision since management failed to follow the Tubing Pulling Procedure which states that the floor hand acting as the banksman was to be identified with a florescent green safety vest or hard hat net.

The BSEE Incident Investigation Team determined that the causes of the incident was:1) The crane operator was conducting a blind lift and did not have adequate controls in place, 2) There was no radio communications with the floor hand in the elevated hydraulic jack basket and the crane operator, 3) The hand signals given by the floor hand in the elevated hydraulic jack basket were inadequate and ignored by crane operator, and 4) The floor hand's decision to push the 3.5-inch pipe off the SLR Arm that caused the elevators to open, allowing the 3.5-inch pipe to drop approximately 40 feet to the deck below.

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

Communication: Inadequate job instructions provided. The floor hand acting as the banksman in the elevated hydraulic jack basket and the crane operator had insufficient communications during pipe lifting operations.

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

Management Systems:
• Inadequate job procedures. The procedure for pulling out of the hole with work string was not followed since there was limited hand communication and no radio

communication between the floor hand and crane operator.
• Inadequate hazards analysis. The deck area where the 3.5-inch pipe was been laid down was very small and not clearly defined in the hazard analysis. There were no barriers in place to define a safe zone or identify potential hazard locations.

Supervision: Inadequate supervision. The Supervisor did not ensure that the floor hand acting as the banksman in the elevated hydraulic jack basket was identified with a fluorescent green safety vest or hard had net as stated in the Tubing Pulling Procedures.

Equipment failure: Inadequate preventive maintenance. The elevators that were being used for the 3.5-inch pipe lift were not properly inspected and maintained. The elevator's latching mechanism malfunctioned and the manufactured spring that holds the elevator's latch closed was worn and very weak.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

A wheel unit fire extinguisher and hydraulic hose were damaged during this incident.

NATURE OF DAMAGE:

The handle on the wheel unit fire extinguisher was replaced along with the punctured hydraulic hose.

ESTIMATED AMOUNT (TOTAL): **$4,000**

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: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

A G-110 (C)Incident of Non-Compliance was issued to Guardian Decommissioning, Inc. (Guardian) on 21 March 2025 to document that Guardian failed to perform well operations in a safe and workmanlike manner during well plug and abandonment activities on the Eugene Island Block 307A platform. On 17 March 2025 at 21:40 hours, Guardian was in the process of tripping 3.5-inch pipe out of the hole on Well A007. A BSEE Incident Follow-up Investigation Team determined that the incident occurred when the bottom joint of 3.5-inch pipe, that was being lowered by crane, struck the fall protection davit located on top of the elevated work basket. When the pipe struck the davit, this caused the elevators to open, allowing the 3.5-inch pipe to drop approximately 40 feet to the deck below.

25. DATE OF ONSITE INVESTIGATION:

21-MAR-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: **09-JUN-2025**