

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

For Public Release

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **12-JUL-2025** TIME: **1530** HOURS

2. OPERATOR: **Chevron U.S.A. Inc.**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **Supreme Services, Inc.**

REPRESENTATIVE:

TELEPHONE:

- ☐ STRUCTURAL DAMAGE
☒ CRANE
☐ OTHER LIFTING
☐ DAMAGED/DISABLED SAFETY SYS.
☒ INCIDENT >\$25K **\$38,841**
☐ H2S/15MIN./20PPM
☐ REQUIRED MUSTER
☐ SHUTDOWN FROM GAS RELEASE
☐ OTHER

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

4. LEASE: **00204**

AREA: **VR** LATITUDE:

BLOCK: **38** LONGITUDE:

5. PLATFORM:

RIG NAME: * **LIFT BOAT**

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

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

0

3

0

1

8. OPERATION:

- ☐ PRODUCTION
☐ DRILLING
☐ 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: **23** FT.

11. DISTANCE FROM SHORE: **5** 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:

- ☐ POLLUTION
☐ FIRE
☐ EXPLOSION

LWC ☐ HISTORIC BLOWOUT

☐ UNDERGROUND

☐ SURFACE

☐ DEVERTER

☐ SURFACE EQUIPMENT FAILURE OR PROCEDURES

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

Incident Summary:

On July 12, 2025, at approximately 3:30 p.m., a crane incident injured a Supreme Services (Supreme) employee. The incident occurred on the Vermilion Block 38M Lease Number 00204 (VR-38M) platform, which Chevron U.S.A. Inc. (Chevron) operates. While the port crane of the Helix Energy Solutions (Helix) liftboat Dallas was lifting a 7-inch casing (casing) in well M003 ST05 (Well M3), the casing lifting pin attached to the casing failed. The failed pin struck the Supreme employee (IP), who was later evacuated via medevac helicopter to Lafayette General Hospital.

Chevron was on the VR-38M platform to abandon Well M3. Chevron hired the Helix liftboat Dallas to serve as a work deck and to use its cranes for the abandonment of Well M3. Chevron also hired Supreme to complete the well abandonment operations. Chevron rented two 36-inch-long by 2-inch-diameter casing lifting pins (lifting pin) and one 11-inch 3M by 11-inch 5M spool (spool) from NNW Oil (NNW). Chevron also contracted an NNW employee to cut the inner casings and drill holes to install the lifting pin and riser spool.

Sequence of Events:

On the morning of July 12, 2025, the casing in Well M3 was jet cut. The wellhead was removed, exposing the casing hanger. The workers noticed the casing had fallen out of the casing hanger approximately three feet below the casing hanger. A riser spool was installed on the wellhead along with a bowl for setting casing slips.

On the afternoon of July 12, 2025, a safety meeting was held in preparation for pulling the non-cemented casing in Well M3. During the meeting, Helix personnel completed and signed a Job Safety & Environmental Analysis (JSEA) for the crane operations. Separately, Supreme personnel completed and signed a Behavioral Job Safety & Environmental Analysis (BJSEA) for crane operations. Finally, the Ultimate Work Authority (UWA) reviewed and approved the Chevron Crane Lifting Plan for pulling the non-cemented production tubing and casings.

Supreme used a casing spear to retrieve the first section of casing, raised it 4 feet above the bowls, and then set the slips around the casing. Then NNW, with the assistance of Supreme, drilled two 2.25-inch holes into the casing. Supreme and NNW then installed a lifting pin into the casing and attached the lifting pin to the crane's auxiliary hoist line. The crane lifted the casing until it became stuck in the well; they then set the slips and cut 17.77 feet of casing from this first section. The Helix crane operator lowered the cut casing onto the deck of the liftboat Dallas.

NNW, with the assistance of Supreme, drilled a second set of 2.25-inch holes into the remaining section of casing protruding from Well M3. Then, they installed the lifting pin into the holes of the second section of casing. Next, they signaled the Helix crane operator to lower the main hoist line and then attached the lifting pin to the crane's main block. At approximately 3:30 p.m., a Supreme worker gave the Helix crane operator a signal to raise the casing slowly. Two Supreme workers held the slips, prepared to remove the slips the moment the casing began to move upward. Within seconds of the signal given to raise the casing, the lifting pin failed, bending upwards and striking the IP in the face. The IP fell backwards onto the platform decking. The medic was called to scene immediately following the incident. The medic evaluated the IP and prepared him to be moved. The IP was then placed in a personnel basket to be lifted from the platform to the liftboat. A medevac helicopter was called at 3:36 p.m. While waiting on the helicopter, the IP was moved to the liftboat TV room for observation and first aid. The medevac helicopter landed on the liftboat at 5:45 p.m. and departed with the IP for Lafayette General Hospital at 6:00 p.m.

BSEE Investigation:

On July 14, 2025, Bureau of Safety and Environmental Enforcement (BSEE) investigators from the Lake Charles District (LCD) conducted an onsite incident investigation. During the investigation, investigators requested statements, all job safety analyses (JSAs), a list of persons on board (POB), and pre-tour meeting documentation. The investigators also inspected the work area on the platform where the incident occurred.

While walking towards the platform from the liftboat, the investigators observed a 7-inch casing on the deck of the liftboat cut to 17.77 feet as marked by chalk. The company representative confirmed that this casing was the initial cut from Well M3.

The LCD investigators boarded the platform, and while in the work area of the incident, they observed a riser spool installed on the wellhead. A casing bowl with slips was sitting atop the riser spool, and a 4-foot section of 7-inch casing was above the slips. A safety clamp was also installed on the 7-inch casing above the slips. It was noted that two 2.25-inch holes, drilled for the lifting pin, had elongated upwards.

While on the platform, Supreme workers described to the LCD investigators the steps for rigging the lifting pin into the 7-inch casing: First, they pass the lifting pin through the holes drilled in the casing. Next, they slide the D-rings attached to the sling thimble eye over the lifting pin. Lastly, they slide the retaining washers over the pin and install the retaining bolts in the holes on each end.

LCD investigators departed the platform and returned to the liftboat to gather written statements. In the statements provided, the Supreme workers described the incident. The IP and a co-worker were holding the slips set in the bowl, ready to pull the slips as the casing began its upward motion. A Supreme worker gave the Helix crane operator a signal to raise the casing slowly. According to one eyewitness, "within a split second... it was like a gun went off," adding that they saw the IP "was knocked out." Another worker mentioned asking the crane operator to "come up easy" and at the time of the actual incident seeing "white smoke and IP fell to the deck."

The crane used during the incident features a main hoist that operates in a six-part lifting configuration, with a maximum lift capacity of 300,000 pounds at its highest angle. The auxiliary hoist, which operates in a two-part configuration, has a maximum lift capacity of 24,600 pounds at all angles. The crane operated as designed and no failures were noted that contributed to the incident.

The crane rigging used during the incident consisted of a casing lifting pin, two large washers, two retaining bolts with two nuts for the same, and a two-part sling with suspect failures that were no longer at the location for inspection during the BSEE visit. The rigging items used had been sent to NNW in Carrier, Mississippi, for further testing.

On July 15, 2025, the BSEE Office of Incident Investigations (OII) issued a preservation order for the casing lifting pin, washers, bolts, a two-part sling, first cut casing, casing left in hole, and all documents and pictures related to the day of the incident.

On July 15, 2025, OII sent two investigators to the NNW shop in Carrier, Mississippi. They reviewed the inventory of the equipment used during the incident. This equipment included the 36-inch by 2-inch diameter lifting pin, two 10-inch washers, two retaining bolts with nuts, and a two-part lifting sling.

OII investigators inspected the two-part sling that Supreme used during the incident. The sling is rated for 52,000 pounds at a length of 4 feet with a cable diameter of 1.25 inches and D-rings installed in the thimble eye. The sling was recertified on November 4, 2024, and showed signs of wear including small separations in the strands.

OII investigators inspected the failed casing lifting pin with a safe working load limit of 60,000 pounds. The lifting pin was bent into a U-shape and had gouges where it contacted the 7-inch casing. The OII investigators also observed markings on the bottom of the lifting pin where the washers and D-rings had slid outward. The washers were bowed from striking the retaining bolts, which left impressions in the washers. The investigators collected the "Analysis of the Caisson Pull Pin Evaluation" for the lifting pin used during the incident and the procedures for installing the lifting pin. OII investigators took photographs of equipment inspected.

The LCD investigators reviewed the documents received from the preservation order. As part of the review, the investigators reviewed Chevron's "Crane Lifting Plan for Pulling Non-Cemented Production Tubing and/or Casing." The plan was approved by the UWA on July 12, 2025, using the main hoist line, at 12:00 p.m. The investigators found the following issues with the plan: 1) the field for the name of the crane operator was left blank; 2) the crane operator was listed as the supervisor of the lift; 3) the crane's make/model was left blank; 4) the crane capacity at a boom angle of 65 degrees with a radius of 57.2 feet was calculated on the plan as 110,000 pounds while the load chart on the crane indicates approximately 179,102 pounds for a 65-degree angle at a radius of 57.2 feet; and 5) the max capacity of the crane on the plan is listed incorrectly as 9,900 pounds instead of 99,000 pounds.

According to the Chevron lift plan that was partially completed for the initial casing pull, the Max Weight Capacity to be pulled could not exceed 24,255 pounds. The crane operator's statement indicates that the first attempted lift of the 7-inch casing was using the auxiliary hoist, instead of the main hoist as planned. To facilitate the pull, NNW, with the assistance of Supreme, drilled two 2.25-inch holes into the casing. They then installed a lifting pin into the casing and attached the lifting pin to the crane's auxiliary hoist line. The crane lifted the casing until it became stuck in the well; they then set the slips and cut 17.77 feet of casing from this first section. The Helix crane operator lowered the cut 17.77 feet casing onto the deck of the liftboat Dallas. At this time, NNW, with the assistance of Supreme, drilled a second set of 2.25-inch holes into the remaining section of casing protruding from Well M3. Then, they installed the lifting pin into the new holes of the second section of casing. Next, they signaled the Helix crane operator to lower the main hoist line and then attached the lifting pin to the crane's main block. It should be noted that the auxiliary hoist has a maximum capacity of 24,600 pounds, which is sufficient to pull the Max Weight Capacity of 24,255 pounds calculated on the plan. Therefore, it should not have been necessary to use the main hoist with a greater pulling capacity of 179,102 pounds for a dynamic lift. However, the crane operator's statement noted, "Casing pipe got stuck in hole while using the AUX line block! So, I was ask to bring down big blk to hook up slings and pull casing pipe up," which would indicate that the Max Weight Capacity for this pull was likely over-pulled with the use of a larger capacity main hoist. The Helix crane operations JSEA and Supreme's pulling casing with crane BJSEA did not mention the maximum lifting weight capacity of 24,255 pounds, which was calculated in Chevron's approved lifting plan. An all-stop was also not called to address the stuck casing.

The LCD investigator's review of NNW procedure used for this job, "NNW-PRO-SOP.140 Single String Casing Cut and Retrieve," was written for a drilling rig utilizing a Top

Drive with Bails, not a crane on a liftboat. Furthermore, the procedure incorrectly states that the lifting capacity for 2-inch casing pins is 67,000 pounds; whereas, a certified two-inch pin pull analysis dated October 25, 2019, provided by NNW, states the safe working load limit is 60,000 pounds. In the certified pull pin analysis, there is a note that states, "the pull linkages (D-rings) are required to be adjacent to the caisson in order to minimize bending load on the pin." The pictures taken by OII at the NNW yard at the NNW shop in Carrier, Mississippi, show markings on the pin indicating the D-rings were not adjacent to the casing. It was estimated that the D-rings were approximately two inches from the casing.

A review of the crane documents found that on July 13, 2025, the liftboat Dallas's crane was inspected due to being shock loaded during the incident. The crane technician inspected the main hoist line and stated that he "found 1 strand damaged and 3 other strands with damaged wires." The main hoist line was put out of service. As a result, on July 20, 2025, an S&A Services crane technician at the Helix yard in Fourchon, Louisiana, replaced the damaged main hoist line on the liftboat Dallas's crane. The technician also completed a quarterly inspection, subsequently returning the main hoist to service. On July 22, 2025, the liftboat Dallas returned to VR-38M to complete the temporary abandonment of well M3.

On July 23, 2025, LCD investigators traveled to an independent third party testing facility in New Iberia, Louisiana, to witness pull testing of casing pins. The new casing pins were of the same type, size, and material as the failed pin. The test used the 17.77-foot-long casing removed in the first lift and the two-part sling used during the incident. The casing end with previously drilled holes was fabricated into a test stump to test the new casing pins. The casing pins were inserted into the holes in the casing stump. The D-rings on the sling were placed adjacent to the casing with new washers and two retaining bolts with nuts. The sling was connected to the test cylinder.

The first test had four stopping points, each held for one minute:

- The first stopping point was equivalent to the known weight of the lift: 12,543 pounds.
- The second stopping point was equivalent to the Max Weight Capacity in the lifting plan: 24,255 pounds.
- The third stopping point was equivalent to the casing pin's working load limit: 60,000 pounds.
- The final stopping point was equivalent to the test stump's working load limit: 150,000 pounds.

The test was started and held at each point. After the one-minute hold, the pull weight was lowered to zero, and the casing was visually inspected at each stopping point. After the final pull test of 150,000 pounds, the pin was removed from the test stump and checked against a straight edge. Although the pin had a ¼-inch bow, it passed the test in that it did not bend to failure similarly to the incident.

For the second and final test, a new pin was inserted into the holes in the casing stump. The D-rings on the sling were placed 3 and 4 inches away from the casing with new washers and two retaining bolts with nuts. The sling was then connected to the test cylinder. The purpose of this test was to determine the outcome if the slings were installed incorrectly with the D-rings not adjacent to the casing.

The second test had two stopping points, each held for one minute. The final pull was going to be the failure point of the casing pin; the pin would only be inspected after the failure point.

- The first stopping point was equivalent to the Max Weight Capacity in the lifting plan: 24,255 pounds.
- The second stopping point was equivalent to the casing pin's working load limit: 60,000 pounds.

The test was started and held at each stopping point, then pulled to failure. The casing pin failed at 102,500 pounds. The pin bent similarly to the pin used during the incident; the pin bent into a U-shape and had gouges in the metal with similar markings in paint from washers and D-rings.

Metallurgy test results completed by an independent third party on July 23, 2025, stated the following: "Testing data appears to match the MTR provided and fits the mechanical properties of ASTM A193 B7" and "Hardness values meet the MTR and ASTM A193 Grade B7."

On July 25, 2025, the BSEE LCD received an update on the injured person. The IP received a subdural hematoma, blunt trauma of the face, an open fracture of the right side of the base of the skull, and multiple closed fractures of the facial bones.

On July 29, 2025, LCD investigators went to the VR-38M platform and landed on the Helix liftboat Dallas. The purpose was to witness the retrieval of the stuck casing in well M3. The LCD investigators witnessed the removal of the 11-inch 3M by 11-inch 5M riser spool from well M3. After the spool was removed from the wellhead, the seal ring atop the 7-inch casing was exposed. The Supreme crew speared into the casing. Using the crane, three attempts were made at 20,000 pounds to pull the casing free from the wellhead; all three attempts failed. Chevron then made the decision to use casing jacks to remove the stuck casing.

While the casing jacks were being installed on the well, LCD investigators spoke with the crane operator on duty. The LCD investigators were informed by the crane operator that the auxiliary hoist and main hoist lines are monitored by an onboard display. The crane operator explained that both hoists have audible alarms that sound when reaching the maximum lifting point, which is determined by the crane's radius and boom angle. When the maximum weight limit is reached, the hoists are locked out from lifting a heavier weight. The LCD investigators were also informed the weight indicator had an approximate one second delay from the sensor to the onboard display, which shows the current lifting weight.

When the casing jacks were installed on the wellhead, slips were installed in the bowl on top of the jacks onto the work string. The jack was extended upward freeing the casing. Based on the hydraulic pressure needed to lift the casing, the weight was calculated to be approximately 70,000 pounds.

With the casing freed, the LCD investigators could see the casing collar wedged into the casing hanger and the seal plate atop the hanger. At the LCD investigators' request, the NNW worker measured the diameter of both. Using a "pi tape", the worker measured the casing hanger's circumference and found the diameter to be approximately 10.88 inches. He then used the "pi tape" to measure the seal ring's circumference, finding the diameter to be approximately 11.44 inches. Therefore, the seal ring, which was approximately .44 inches larger than the 11-inch 3M by 11-inch 5M riser spool, could not drift through the spool riser at the time of the incident.

Conclusion:

Supreme and NNW workers removed part of the wellhead exposing the seal ring sitting on top of the casing hanger. They installed a spool riser onto the wellhead, which had an inside diameter of 11.00 inches, on top of the exposed seal ring, which had a diameter of 11.44 inches. When the crane operator was retrieving the first cut of the 7-inch

casing with the auxiliary hoist, the casing collar pushed the casing hanger and the seal ring. The casing then became stuck because the seal ring could not pass through the spool riser.

The crane operator attempted to lift the second section of stuck casing with the main hoist, which was not free to be lifted. The casing pin bent into a U-shape striking the IP. It is believed the pin bent with a lifting force of over 102,000 pounds, based on the independent third party pull test.

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

Human Performance Error: Inattention to task - A spool riser, which had an inside diameter of 11.00 inches, was installed onto the wellhead on top of the exposed seal ring, which had a diameter of 11.44 inches.

Human Performance Error: Inattention to task - The crane operator exceeded the safe working load limit of the casing lifting pin while attempting to lift the second section of stuck casing with the main hoist, which was not free to be lifted.

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

Human Performance Error: Inattention to task - The two-part sling was not installed correctly onto the casing lifting pin. The D-rings were not placed directly adjacent to the casing.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

Crane Main Hoist Wire Rope, Casing Lifting Pin, Two Part Sling

Damaged (unrepairable)

ESTIMATED AMOUNT (TOTAL): **\$38,841**

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The BSEE Lake Charles District recommends the Office of Incident Investigations issue a Safety Alert/Bulletin regarding this incident.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 Does the lessee perform all operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment?

After investigation, the combination of the following actions demonstrates the operator failed to perform in a safe and workmanlike manner during casing removal operations on Well 003, which resulted in a casing pin failure and a subsequent injury to an employee:

- **On July 12, 2025, the operator installed a spool riser with an inside diameter of 11.00 inches above a wellhead seal ring with an outside diameter of 11.44 inches. This dimensional incompatibility caused the seal ring to become stuck inside the spool riser during an attempted lift and retrieval of the casing.**

- **According to the operator's approved safe lifting plan, the operator exceeded the plan's**

maximum weight capacity of 24,255 pounds. In addition, the operator exceeded ~~For~~ **Public Release** manufacturer's safe working load limit of the casing lifting pin of 60,000 pounds. These actions demonstrate a failure to verify component compatibility and the safety of personnel.

25. DATE OF ONSITE INVESTIGATION:

14-JUL-2025

28. ACCIDENT CLASSIFICATION:

26. Investigation Team Members/Panel Members: 29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR:

Beau Boudreaux

APPROVED

DATE:

15-OCT-2025