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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **30-JUL-2025** TIME: **1310** HOURS

2. OPERATOR: **W & T Offshore, Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Supreme Services, Inc.**
   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: **G02177**
   AREA: **SP** LATITUDE:
   BLOCK: **49** LONGITUDE:

5. PLATFORM: **C**
   RIG NAME: *** WIRELINE UNIT**

6. ACTIVITY:
- [ ] EXPLORATION(POE)
- [ ] DEVELOPMENT/PRODUCTION (DOCD/POD)
- [X] 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
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER
- [ ] TEMP ABAND
- [X] PERM ABAND
- [ ] DECOM PIPELINE
- [ ] DECOM FACILITY
- [X] 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: **400** FT.

11. DISTANCE FROM SHORE: **65** 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 30 July 2025, a Supreme Services, Inc. (Supreme) crew contracted by W & T Offshore, Inc. (W&T) was laying down a mechanical casing cutter in a shipping basket on the South Pass (SP) 49 "C" platform (Lease Number G02177) after performing work on Well C005. While handling the cutter, the outermost casing jack bowl separated unexpectedly and slid down the tool. An operator's left hand was trapped, resulting in serious injuries to the left hand, including a severed finger. Immediate first aid was provided, and the Injured Person (IP) was evacuated via Motor Vessel (M/V) to the "A" platform before being airlifted to shore and transported by ambulance to University Medical Center New Orleans. There, the IP underwent medical treatment that resulted in the permanent dismemberment of three fingers. W&T reported the incident to the Bureau of Safety and Environmental Enforcement (BSEE) New Orleans District (NOD).

SEQUENCE OF EVENTS:
On 30 July 2025, at 13:10 Central Daylight Time, a plug and abandonment crew from Supreme was engaged in removing a 12-inch mechanical casing cutter from Well C005 and placing it into a designated shipping basket for storage. The cutter was previously secured in the well by means of a casing jack and two slip bowls, one inner bowl and one outer bowl, with inserts designed to hold the Bottom Hole Assembly (BHA) during the cutting process. Upon completion of the cutting operation, a crane was connected to the top of the BHA to facilitate removal of the slip bowl inserts. The crew proceeded to lift the mechanical casing cutter in a near-vertical position, raising it just high enough for the bottom edge of the tool to clear the slip bowl inserts inside the casing jack. As the cutter was lifted, the inner bowl, which remained engaged below the outer bowl, was allowed to rest on the horizontal stabilizer fins for temporary support while the tool was still suspended by the crane. At this point, the outer bowl remained attached to the inner bowl, and both components were generally upright as the crew prepared to relocate to the shipping basket. The mechanical casing cutter was then lifted via crane and moved approximately 20 feet to the shipping basket on the deck. The bottom of the mechanical casing cutter was placed into the basket first, with the top portion hanging over the front edge, suspended by the crane.

Once the bottom of the mechanical casing cutter was in the basket, a Supreme operator and the 3rd party service technician approached the basket placing their hands on the lower portion of the cutter near the cutting knives to help guide the tool down. During this process, the outermost bowl (approximately 250 pounds) unexpectedly dislodged and slid down the length of the tool, traveling past the stabilizer fins. Subsequent inspection determined that the two bowls had been bonded together by a heavy buildup of grease and debris from prior cutting operations. This created what is commonly referred to as a "grease lock", in which the downward force applied during cutting causes a vacuum-like seal between surfaces. When the mechanical casing cutter was repositioned horizontally, the internal pressure differential was released abruptly, allowing the outermost bowl to separate and slide freely.

The service technician was able to remove their hands before the bowl passed; however, the Supreme operator's left hand was caught between the bowl and the tool, resulting in an amputation of one finger and traumatic crush injuries to two others. The crew immediately halted operations, administered first aid to control the bleeding and retrieved the severed finger for possible reattachment. The attending vessel was notified and moved into position alongside the platform to facilitate medical evacuation. The IP was transferred to the "A" platform, where a medic stabilized the injury and prepared the severed finger and other dismembered tissue for perseveration. The IP was subsequently airlifted via field helicopter to the RLC base in Venice, LA, and then transported by ground ambulance to University Medical Center New Orleans. Medical evaluation confirmed that the index, middle, and ring fingers on

the left hand sustained irreparable damage, and they were permanently amputated. A safety standdown was conducted on the platform after the IP was evacuated, and all operations were halted for the day.

BSEE INVESTIGATIONS:
The BSEE-assigned investigator received and reviewed information submitted through emails, phone communications, and witness statements from the operator after the incident occurred. An investigation team boarded the platform on 14 August 2025. The team requested relevant paperwork and conducted interviews with individuals that were present during the incident or who arrived shortly after the incident occurred. The IP was not on location at the time of the investigation and was unable to be interviewed.

IN CONCLUSION:
The investigation determined that while Supreme maintained a formal “no hands” policy (Dated: 11/30/2022), the policy was not effectively communicated to or enforced among the crew. Apart from one recently hired employee whose knowledge was derived solely from the employee handbook during onboarding, crew members interviewed on location were either unaware of the policy or unfamiliar with its requirements. Furthermore, hands-free tools were not provided until after the incident, and the permit process authorizing manual tool handling was not implemented. The cutter was placed in a confined basket with other tools, creating restricted access. The absence of push poles or other approved hands-free safety devices increased the likelihood of manual handling. The crew relied on an unsupported assumption that the bowls would remain attached while being lifted from the casing jack to the shipping basket, with the potential hazard not identified due to the absence of a task-specific pre-job safety meeting or risk assessment. These deficiencies collectively demonstrated a failure to implement and enforce established safety policies and hazard controls.

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

- Uncontrolled release of mechanical energy: The ability for the bowls to slip past the centralizer with the “grease lock” keeping them together was not recognized or mitigated prior to movement, resulting in unexpected separation.

- Improper hand placement: The Supreme operator positioned their hands in a pinch point during lifting operations.

- Inadequate securing of heavy components: The outermost bowl was not mechanically restrained prior to changing the cutter’s orientation (moving it from the vertical position to the horizontal position in the basket), allowing it to slide under gravity when separation occurred. While there is no specific procedural requirement to mechanically restrain the bowls, this incident demonstrated the need to implement such restraints, and the crew subsequently procured slings for use in future operations.

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

- Insufficient hazard recognition during rig down: The potential for stored mechanical energy and the ability for the bowls to separate was not identified during pre-task hazard analysis or communicated in the Job Safety Analysis (JSA).

- Lack of engineered or procedural controls: No barriers, restraining devices or mechanical handling aids were utilized to protect personnel during transfer of the cutter.

- Crew familiarity and procedural drift: Routine handling of similar assemblies and lack of training may have contributed to complacency and deviation from the service company's "no hands" policy.

- No stop work intervention: The hazardous hand positioning was not corrected prior to movement, indicating an opportunity for improved hazard oversight.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

No damage to equipment.

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans 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:

G110 – 30 CFR 250.107 (C)
The operator failed to implement and enforce its service providers established "no-hands" policy. Crew members were not trained or made aware of the policy requirements, and hands-free tools were not provided until after the incident. The required permit process for manual tool handling was not followed. The operator allowed the cutter to be placed in a confined basket with other tools, creating restricted access and increasing the likely hood of manual handling in the absence of an approved device. The operator failed to conduct a task-specific pre-job safety meeting and risk assessment to identify the hazard of the bowls slipping past the centralizer. These deficiencies, culminating with the injury and dismemberment of a contract employee, constitute a violation of recognized safe work practices and demonstrate noncompliance with the code of federal regulation.

25. DATE OF ONSITE INVESTIGATION: 28. ACCIDENT CLASSIFICATION:

14-AUG-2025

26. Investigation Team Members/Panel Members: 29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

27. OPERATOR REPORT ON FILE: OCS REPORT:

30. DISTRICT SUPERVISOR:

Michael J. Saucier

APPROVED DATE: **01-DEC-2025**