

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

ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED

DATE: 03-OCT-2025 TIME: 1230 HOURS

2. OPERATOR: White Fleet Operating, LLC

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: United Production & Constructio

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: G00985

AREA: EI LATITUDE:

BLOCK: 259 LONGITUDE:

5. PLATFORM: C

RIG NAME:

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

1

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: 160 FT.

11. DISTANCE FROM SHORE: 49 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

17. INVESTIGATION FINDINGS:

On October 3, 2025, at approximately 1230 hours, a contract fitter (CF) sustained a severe injury to his right leg during decommissioning operations. The incident occurred on the White Fleet Operating, LLC OCS-G00985 Eugene Island (EI) 259 C **For Public Release** Facility. While attempting to install stabilizing brackets to support piping during platform removal operations, a section of pipe was cut that was next to the CF's right leg. Once the section was cut, the remaining pipe shifted making contact with the CF's right leg. The CF suffered a severe injury due to this incident.

Sequence of Events:

On October 3, 2025, a welder and CF were attempting to install stabilizing brackets to support piping during platform removal operations. The CF was sitting on a piece of pipe with his right leg draped across a different section of pipe. The CF was working at a height that required a fall protection harness with no scaffolding or other work platforms available. Due to working on the piping in a harness, the CF had limited mobility and positioning. A welder was next to the CF welding the stabilizing brackets. Approximately 20 ft. away from where the CF and welder were located, a crew of three construction employees were cutting a section of 8-inch pipe that was located next to the CF. Once the pipe passed the CF's leg, it took a 90-degree turn then rested in a P-trap. Once the pipe was cut, it began to slide towards the CF pinning his right leg between a flange on the cut pipe and the piping the CF's leg was draped across. The welder and the three construction employees were able to move the pipe and lower the CF to the deck. The CF was evacuated via medivac helicopter to an onshore medical facility where he was treated for multiple fractures of the right femur.

BSEE INVESTIGATION:

On October 3, 2025, the Bureau of Safety & Environmental Enforcement (BSEE) Lafayette District (LD) Accident Investigator (AI) received a phone call notification regarding an injury that occurred during decommissioning operations on White Fleet's EI-259-C Facility. The AI requested additional information pertaining to the incident such as the Job Safety Analysis (JSA), photos, statements and other relevant documents from White Fleet.

The BSEE LD AI conducted an onsite investigation at EI-259-C on October 6, 2025. BSEE conducted interviews with the personnel involved in the decommissioning operations.

CONCLUSION:

During the morning Job Planning meeting, there was discussion of cutting pipe for future decommissioning of the facility however, there was no discussion of what areas other crews would be located. The CF and the crew cutting pipe were only 20 feet away from each other but there was no communication of what pipe the crews were cutting. Also, the JSA identified "pinch points by material shifting" with the hazard mitigation being "keep body parts away from hazardous areas before moving." However, the JSA does not identify the hazard that piping being cut needs to be secured so that it doesn't shift once the cut is made (pipe movement due to stored energy).

As a result of the EI-259-C incident, White Fleet has implemented the following actions:

- White Fleet developed a Lessons Learned Report that was reviewed with all offshore employees.
- A coaching session with the contract superintendent was developed and a formalized version of the session will be developed and presented to all contract superintendents and foreman.

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

No or inadequate job instructions provided: The lessee conducted a pre-job safety meeting with the operators and the construction crew but failed to review the locations of where the crews would be located during the decommissioning operations. Having knowledge of where the crews were located would have prevented the contractors from cutting the pipe that caused the injury.

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

Management Systems, no or inadequate hazard analysis/written job procedures. The Job Safety Analysis (JSA) failed to address the hazards of the potential for pipe movement due to stored energy.

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20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

None

NA

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECCURANCE NARRATIVE:

The BSEE Lafayette District office makes no recommendations to the Regional Office of Incident Investigations (OII).

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 C 107 (a)

On October 3, 2025, White Fleet Operating, LLC failed to perform operations in a safe and workmanlike manner as follows: A construction crew was engaged in the removal of a section of 8" of piping and the installation of bracing in preparation for platform removal. As the pipe was cut on one end, the remaining 8-inch pipe shifted approximately 2 feet within the P-trap on the opposite end. The sudden shift resulted in a contractor's right leg getting caught between a flange on the shifting pipe and the P-trap. The injured contractor suffered a fractured right femur.

The following itemized bullets include, but do not limit, contributing/causal factors of the incident:

- No or inadequate job instructions provided: The lessee conducted a pre-job safety meeting with the operators and the construction crew but failed to review the locations of where the crews would be located during the decommissioning operations. Having knowledge of where the crews were located would have prevented the contractors from cutting the pipe that caused the injury.
- Management Systems, no or inadequate hazard analysis/written job procedures. The Job Safety Analysis (JSA) failed to address the hazards of the potential for pipe movement due to stored energy.

White Fleet Operating, LLC is directed to submit a letter of explanation addressing the hazard associated with the aforementioned INC., and its plans for eliminating future incidents of this nature, to the BSEE Lafayette District.

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25. DATE OF ONSITE INVESTIGATION:

06-OCT-2025

28. ACCIDENT CLASSIFICATION:

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

NO

27. OPERATOR REPORT ON FILE:

OCS REPORT:

30. DISTRICT SUPERVISOR:

Mark Malbrue

APPROVED

DATE:

22-JAN-2026