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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **14-OCT-2025** TIME: **0510** HOURS

2. OPERATOR: **Shell Offshore Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Stena Drilling**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **aerial lift**
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [X] INCIDENT >$25K **Damaged workman Basket**
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

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

4. LEASE: **G30876**
   AREA: **GB** LATITUDE:
   BLOCK: **959** LONGITUDE:

5. PLATFORM:
   RIG NAME: **STENA EVOLUTION**

6. ACTIVITY:
- [ ] EXPLORATION(POE)
- [X] DEVELOPMENT/PRODUCTION(DOCD/POD)
- [ ] 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
- [X] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER
- [ ] TEMP ABAND
- [ ] 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: **4273** FT.

11. DISTANCE FROM SHORE: **165** 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 14 October 2025, an Assistant Driller (AD) employed by Stena Drilling (Stena) sustained injuries while utilizing an aerial lift man-riding work basket during drilling operations for Shell Offshore, Inc. (Shell) on the Stena Evolution drillship located at Garden Banks Block 959. The aerial lift unit is a hydraulic telescopic crane mounted in the moonpool area on the drillship that can be utilized as a crane or man-riding work basket.

Sequence of Events:
On 14 October 2025, Stena was in the process of installing a subsea pump module (SPM) umbilical line counterbalance sheave to create the storm loop when a Stena AD, the Injured Party (IP), was ejected from an aerial lift man-riding work basket and fell 16 feet to the deck below. At the time of the incident, the IP was attempting to install the counterbalance sheave onto the SPM umbilical in the moonpool area. Slack between two sheaves was required to create the needed spacing for the counterweight installation. To accomplish this, the crew used an aerial lift man-riding work basket to pull down on the umbilical cable with a rope to create the necessary slack for installing the counterbalance. A 0.75-inch polypropylene rope was cradled over the umbilical by the IP while positioned inside the aerial lift man-basket. The rope was then tied to each side of the basket, forming a triangular configuration with the umbilical cable positioned overhead. The umbilical was pulled down to create slack between the overhead sheaves so the counterbalance sheave could be installed. As the aerial lift man-riding work basket was being lowered by the Operator, who was positioned at the walkaround master hydraulic controls, slack on the SPM umbilical spool was simultaneously paying out. The rope eventually parted when the umbilical ran out of slack and tension exceeded the rope's 9,810-pound breaking strength. As a result, the stored energy from the released tension was transferred to the aerial lift man-riding work basket, causing it to jolt downward violently. The IP who was positioned inside the aerial lift man-riding work basket was thrown out and fell approximately 16 feet, landing on the xmas tree cart deck below. At the time of the incident, the IP was wearing a life vest and a safety harness; however, the IP's harness was not properly secured adequately. The IP sustained a laceration to the head requiring numerous sutures and staples, bruising to the left leg and shoulder,and temporary loss of consciousness. First responders provided medical treatment, and a medevac flight was mobilized. The IP was transported and treated at University Medical Center New Orleans, Louisiana hospital.

BSEE Investigation:
On 17 October 2025 and 27 October 2025, the Bureau of Safety and Environmental Enforcement (BSEE) Lafayette District conducted onsite incident follow-up investigations. On each occasion, BSEE met with Shell and Stena representatives, inspected the incident scene and gathered all available incident-related documents.

Shell determined that the aerial lift man-riding work basket was operated beyond its approved design intent by functioning concurrently as a man-riding basket and a lifting device for loads. It was also discovered that the hydraulics, which would normally limit the crane to 280 kilograms (617 pounds) of force when the man-riding work basket is attached, had been placed in bypass. This allowed use of full hydraulic force which equated to 11,000 kilograms or approximately 24,250 pounds of force. This bypass also disabled the load indicator lights, alarms and the automatic basket leveling system. Moreover, the crew failed to recognize the hazards of the task of using the aerial lift man-riding work basket as a lifting device by pulling downward with rope. There was no lift plan in place for this type of operation.

In addition, it was found that prior to the aerial lift man-riding work basket going out of sight, the Managed Pressure Drilling (MPD) Toolpusher held a Toolbox Talk (TBT) meeting with a Floorman who was passing by so that the Floorman could act as a

Spotter. The MPD Toolpusher had three TBT meeting's forms on hand, but the Floorman who was going to act as a Spotter signed the incorrect TBT form, and the IP did not sign any TBT forms.

During the incident investigation it was also discovered that there was no Management of Change (MOC) performed when the radio remote controls failed to operate. Therefore, the operator control station became the primary means of control, thus exposing the bypass functions to misuse. Moreover, there was no physical method of control to prevent unauthorized use of bypasses or overrides. The Original Equipment Manufacturer (OEM) manual and control panel signage state that the deck control panel or operator station is for emergency use only.
Even though the AD was wearing a safety harness and was tied off to the aerial lift man-riding work basket, the Stena investigation team determined that the AD had connected the lanyard to the open-ended inner handrail near the gate, which was the wrong location to tie off. When the rope broke, the work basket jarred downward and the IP was thrown from the man-riding work basket and the lanyard hook was pulled off the open-ended section of the handrail. The man-riding work basket has two dedicated anchor points for safety harnesses, but the AD did not use either of these anchor points. The harness and lanyard were inspected, and it was confirmed that they were in good working condition and not subject to shock load.

The BSEE Incident Investigation Team reviewed all of the final findings of the Shell assessment report of the incident. According to the Shell report, the incident occurred because the aerial lift man-riding work basket was being used outside of its design as both a man-riding basket and as a crane to pull a load simultaneously. In addition, there was no lift plan in place for this type of operation.

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

Management System:
• Inadequate hazard analysis. Control measures for this operation involving the aerial lift man-riding work basket were ineffective or not implemented. The crew failed to recognize the hazards associated with using the aerial lift man-riding work basket as a lifting operation by pulling downward with rope. There was no lift plan in place for this operation.

Supervision:
• Inadequate Supervision. There was inadequate supervision during this operation which resulted in an incident since it was allowed to use the aerial lift man-riding work basket outside of its design for man-riding basket and for pulling a load, simultaneously.

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

Human Performance Error:
• Not aware of hazards. The AD confirmed that he was aware of designed anchor points but had no memory of the event. The AD tied off to an open-ended handrail instead of the designated anchor point inside the man-riding work basket.

Supervision:
• Inadequate Supervision. The MPD Toolpusher had three TBT meeting forms, but the Floorman signed the incorrect TBT form, and the IP did not sign any TBT forms.

Management System:
• Inadequate management of change procedures. There was no Management of Change (MOC) performed when the radio remote controls failed to operate, resulting in the operator control station becoming the primary means of control, thus exposing the bypass functions to misuse. Additionally, there was no physical method of control to prevent unauthorized use of bypasses or overrides. The OEM manual and control panel signage

state the deck control panel or operator station are for emergency use only.

20. LIST THE ADDITIONAL INFORMATION:

List of Appendices:

21. PROPERTY DAMAGED:

The man-riding Work Basket was damaged during this incident.

NATURE OF DAMAGE:

The man-riding Basket was damaged beyond repair and had to be replaced.

ESTIMATED AMOUNT (TOTAL): **$120,000**

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 G111 INC was issued to Shell on 17 October 2025 for an incident that occurred on 14 October 2025 where an employee fell from the port side Moon Pool aerial lift work basket to the deck below. BSEE was made aware there are active issues with the indicator lights, basket door proximity switch, a bent door, and an inoperable control panel in the work basket. BSEE is instructing the operator to shut in this component until the issues listed above are resolved. After repairs are made, contact the Well Operations Supervisor Inspector for Lafayette, or the Lafayette District After Hours Engineer to return the

component to service.

A G110 INC was issued to Shell on 10 December 2025 based on investigation findings to document that Shell failed to perform operations in a safe and workmanlike manner during drilling operations on the Stena Evolution drillship located at Garden Banks Block 959. On 14 October 2025, Shell informed BSEE that a Stena Assistant Driller (AD) and a managed pressure drilling (MPD) ToolPusher were attempting to install a gooseneck counterweight in the moonpool area. A loop of slack between two sheaves was required to create the necessary spacing for the counterweight installation. The crew utilized the aerial lift in personnel basket mode as a crane device to create downward force on the rope to obtain the necessary slack for counterbalance installation. A rope was positioned over the controlled mud level cable and tied to each side of the workman basket, creating a triangular configuration with the cable positioned overhead. As the workman basket was scoped down and outward by the MPD ToolPusher from the emergency hydraulic controls, the rope parted as tension increased. Subsequently, the stored energy was released, and tension was transferred to the workman basket. The Stena Drilling AD positioned inside the workman basket was thrown out of the basket and fell approximately 16 feet, landing on the blowout preventor deck below.

25. DATE OF ONSITE INVESTIGATION:

17-OCT-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: **16-MAR-2026**