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: **25-MAR-2026** TIME: **1550** HOURS

2. OPERATOR: **White Fleet Operating, LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **White Fleet Abandonment, 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: **G01870**
   AREA: **ST** LATITUDE:
   BLOCK: **26** LONGITUDE:

5. PLATFORM: **F**
   RIG NAME:

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)		
[ ] LTA (>3 days)		
[ ] RW/JT (1-3 days)		
[x] RW/JT (>3 days)	0	1
[ ] 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
- [ ] HUMAN ERROR
- [ ] EXTERNAL DAMAGE
- [ ] SLIP/TRIP/FALL
- [ ] WEATHER RELATED
- [ ] LEAK
- [ ] UPSET H2O TREATING
- [ ] OVERBOARD DRILLING FLUID
- [ ] OTHER ______

10. WATER DEPTH: **53** FT.

11. DISTANCE FROM SHORE: **7** 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:

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On March 25, 2026, a lifting incident occurred on the Platform F located at South Timbalier (ST) Block 26, OCS-G01870. White Fleet Operating, LLC (WFO) was conducting decommissioning activities at ST-26F when the lifting incident occurred. The Plug & Abandonment (P&A) consisting of four personnel and lift boat (LB) crew consisting of one crane operator (CO) was in the process of pulling 7 5/8" casing out of the F-2 well, using the crane, when the injured person (IP) sustained an injury to his right hand. This operation required a hole cut in each side of the casing, so a pin could be placed through the casing to hold the casing weight when it is set down on the work deck. The IP inserted a 2" pin through a hole in the casing, then the crane operator lowered the casing to the deck. This caused the IP's right hand to become caught between the pin and the work deck. The IP was evaluated by the Emergency Medic Responder on location and the decision was made to evacuate the IP. The IP was evacuated via motor vessel to a shore based medical facility for evaluation. The IP sustained fractures and lacerations to the middle finger and ring finger on his right hand.

The P&A crew and CO were tasked with pulling the 7 5/8" casing from the well. A Job Safety Analysis (JSA) from the P&A crew and the LB crew were reviewed along with a JSA Worksheet from the LB crew. Thirteen joints of casing were pulled before the incident took place.

The IP was kneeling on the work deck while installing the pin in precut holes approximately 18" above the work deck. While the IP was installing the pin, the CO thought he saw the IP give the signal to lower the casing to the work deck. The IP unsuccessfully attempted to move his right hand from under the pin as the CO lowered the casing to the deck. The IP's right hand became caught between the pin and the work deck.

Members of the P&A crew signaled the CO to raise the casing and the IP removed his hand, but not before cutting and fracturing his middle and ring fingers. The job was immediately shut down, a meeting was held with the crew to discuss the event, the crew established a designated banksman, and the stop-if-unsure rule was reinforced with the CO. The IP was evaluated by the safety tech and then transported to the shore based medical facility for evaluation. It was determined that the IP sustained a fracture of the distal phalanx of the right ring finger, open displaced fracture of distal phalanx of right middle finger, and open displaced fracture of distal phalanx of middle finger. IP was released to light duty, land based with limited use of right hand.

The Bureau of Safety and Environmental Enforcement (BSEE) Houma District was notified orally and a written report was submitted in 15 days. The BSEE Houma District inspectors (Inspectors) did not perform an onsite investigation as this incident was underreported as lacerations to the fingers. Inspectors were able to receive reports, witness statements, pictures, and get follow up questions answered through WFO personnel. After reviewing WFO's JSA, it was found that pinch points were identified, but it wasn't specific in pointing out where the pinch points existed. It is also noted that the JSA does not contain signaling the CO or designate the banksman. After reviewing the LB crew's JSA, it was noted that the JSA was not specific to the job of pulling casing from a well. It does point out that the CO and rigger will use clear, concise, and visible hand signals, but it fails to designate a banksman for the operation.

After reviewing pictures, documents, and investigation reports, BSEE agrees with WFO's findings. The largest factors in the incident were the failure to designate a banksman and not specifically identifying pinch points. Also, normal procedure for the person to insert the pin was not followed at the time of the incident. The IP's body position created unintended hand movement that was misinterpreted by the CO. Finally, the hole locations for the pinning bar were estimated which potentially

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affected the ergonomics and body position of the IP.

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

Inadequate written job procedure - specific pinch points not identified. Banksman not designated before starting task.

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

Inattention to task - IP did not maintain body position as per procedure.
Communication - CO lowered casing without a proper signal.
Not aware of the hazards - Crew estimated the height to cut the holes to pin the casing.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Houma District does not have any recommendations for the Office of Incident Investigations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

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:

Amy Gresham

APPROVED DATE: **27-MAY-2026**