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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **02-MAY-2026** TIME: **0215** HOURS

2. OPERATOR: **White Fleet Operating, LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **SDS Petroleum Consultants L.L.C**
   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: **G03520**
   AREA: **WC** LATITUDE:
   BLOCK: **498** LONGITUDE:

5. PLATFORM: **B**
   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)		
[X] RW/JT (1-3 days)	**0**	**1**
[ ] 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
- [ ] 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: **159** FT.

11. DISTANCE FROM SHORE: **87** MI.

12. WIND DIRECTION:
    SPEED: **24** M.P.H.

13. CURRENT DIRECTION:
    SPEED: M.P.H.

14. SEA STATE: FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

Introduction:

On Saturday, May 2, 2026, at approximately 5:00 AM, White Fleet Operating (WFO) reported an incident that occurred at the West Cameron 498B (WC498B) platform, lease G03520, while conducting abandonment operations from the liftboat Miami. WFO contracted the liftboat Miami from Helix Energy Solutions as a support vessel for the abandonment operations. An SDS Petroleum Consultant employee, hereafter referred to as the injured person (IP), injured his right hand, requiring evacuation to shore for medical treatment.

At the time of the investigation, Marine Minerals Administration (MMA) personnel were operating under the former Bureau of Safety and Environmental Enforcement (BSEE). Therefore, all MMA personnel referenced in this report will be identified as BSEE personnel.

Sequence of Events:

At approximately 2:15 AM on Saturday, May 2, 2026, the White Fleet Abandonment crew boarded the platform and were assembling on the top deck. The crew was in the process of setting up the casing jack to verify the abrasive cut on the B5 well casing fifteen feet below the mudline. When the IP did not show up on the top deck, the crew assumed he had returned to the liftboat.

The White Fleet Abandonment crew lowered a casing spear into the B5 well casing and lifted the well, proving the well was successfully cut. The White Fleet Abandonment crew Supervisor left the platform and walked over to the liftboat’s living quarters to give the results of the lift to the IP. The supervisor observed the IP being treated for injuries by the Medical Emergency Responder (MER) in the liftboat's living quarters.

At approximately 2:25 AM MER treated the IP for a completely severed middle finger at the distal interphalangeal joint and a partially severed ring finger on his right hand. At 3:00 AM the Ultimate Work Authority (UWA) called for a helicopter to bring the IP to shore for medical treatment. The helicopter arrived at 7:45 AM, and the IP was flown to Santa Fe heliport where his company representative picked him up and drove him to UTMB of Galveston (UTMB). The IP arrived at approximately 10:45 AM and he was released from medical care at approximately 2:00 PM.

BSEE Investigation:

On May 5, 2026, Bureau of Safety and Environmental Enforcement (BSEE) investigators from the Lake Charles District (LCD) conducted an onsite incident investigation at WC498B. During the investigation, LCD investigators requested statements, all Job Safety Analyses (JSA), and a list of Persons on Board. Personnel were interviewed as part of the process. Interviewees reported that the support gussets, used to prevent movement of the well casings, had been removed for abrasive cutting. LCD investigators learned that the wells were being abrasively cut 15 feet below the mudline, then lifted using a casing spear and casing jack to confirm the cut. LCD investigators were also informed that prior to the incident, work on the platform had been suspended due to high winds. Once the winds dropped below 25 mph, the White Fleet Abandonment crew returned to the top deck of the platform to continue abrasive cutting and verifying the cuts.

The IP stopped on the well bay deck when he saw what he believed to be a hazard, an open hole in the grating at the B10 well. He observed that the half-moon plate covering the opening around the well casing had been shifted by the movement of the casing. The IP reached with his right hand and grabbed the half-moon plate. As he was

repositioning the plate, a wave pushed the casing and pinched his fingers between the plate and the casing. The IP immediately returned to the liftboat and reported the incident to MER.

The MER treated the injured person, and the UWA notified his office and requested a helicopter to transport the IP to shore for medical treatment. The IP arrived at UTMB at 10:45 AM and underwent an amputation procedure of the middle finger at the distal interphalangeal joint on his right hand.

The MER informed the LCD investigators that the IP was wearing gloves at the time of the incident and treated him for a completely severed middle finger at the distal interphalangeal joint and a partially severed tip of the ring finger on his right hand.

LCD investigators reviewed the JSA completed at the pre-tour meeting, which discussed pinch points for cutting and lifting casings, but did not address the movement of the wells. LCD investigators were informed that there were no barricades around the cut moving wells at the time; however, barricades were installed after the hand injury incident. LCD investigators reviewed pictures taken by WFO after the incident and confirmed there were no barricades around the moving wells.

When LCD investigators boarded the platform, they verified that WFO had subsequently installed safety barricades around the wells in the danger zones to prevent personnel exposure to open holes and wave-induced well movement. Investigators observed the hole around the B10 well casing, which measured approximately 24 inches long and 5 to 6 inches at its widest point. They were also informed that the half-moon plates around the B10 well had fallen through the hole. The previously removed gussets had supported these plates. LCD investigators documented the area around well B10 with photos, noting that other well half-moon plates were also at risk of falling; those plates were subsequently removed by WFO personnel.

Conclusion:

White Fleet abandonment personnel removed the gussets from the B10 well, allowing the well casing to shift as waves passed under the platform. As the casing moved, it pushed the half-moon plate away, creating an open hole in the platform deck. Hard barricades had not been installed to prevent personnel from entering this danger zone. The IP noticed the displaced half-moon plate and attempted to reposition it. In doing so, the IP failed to recognize the pinch point created by the moving casing and placed his hand between the plate and the casing, resulting in a severe hand injury.

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

The IP noticed the half-moon plate was out of place and attempted to reposition it. While doing so, the IP failed to recognize the pinch point created by the moving casing and placed his hand between the plate and the casing, resulting in a severe hand injury.

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

Hard barricades were not installed to prevent personnel from entering the danger zone around the moving wells.

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 Lake Charles 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:

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 the Lake Charles District investigation, the combination of the following actions demonstrates the operator failed to perform in a safe and workmanlike manner during casing cutting and removal operations which resulted a subsequent injury to an employee:

On Saturday, May 2, 2026, hard barricades were not installed to prevent personnel from entering the danger zone around moving wells. The injured person noticed the half-moon plate was out of place and attempted to reposition it. While doing so, the IP failed to recognize the pinch point and placed his hand between the plate and the casing, resulting in a severe hand injury.

25. DATE OF ONSITE INVESTIGATION:

05-MAY-2026

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:

Beau Boudreaux

APPROVED DATE: **28-JUL-2026**