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UNITED STATES DEPARTMENT OF THE INTERIOR
MARINE MINERALS ADMINISTRATION
GULF OF AMERICA REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **17-JUL-2026** TIME: **1100** HOURS
2. OPERATOR: **Anadarko Petroleum Corporation**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **Chain Fall**
- [ ] 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: **G22987**
   AREA: **GC** LATITUDE:
   BLOCK: **680** LONGITUDE:

5. PLATFORM: **A(Constitution)**
   RIG NAME:

6. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [X] DEVELOPMENT/PRODUCTION(DOCD/POD)
   - [ ] DECOMMISSIONING

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	**1**	
[ ] LTA (1-3 days)		
[X] LTA (>3 days)	**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:
   - [X] 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
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER _____

10. WATER DEPTH: **4970** FT.
11. DISTANCE FROM SHORE: **134** 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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Incident:
On July 17, 2026, a lifting incident and evacuation of an injured person occurred on the Constitution Spar operated by Anadarko Petroleum Corporation in the Green Canyon Block 680 (GC 680) in the Gulf of America. On July 17, Anadarko operators were in process of replacing an isolation valve for a pressure safety valve (PSV) with a chain fall when the valve got stuck between the two pipe flanges. One Anadarko operator (IP) went around the valve to investigate what the valve was stuck on, while instructing another Anadarko operator (Rigger) to pull up on the chain fall. In doing so, the valve dislodged from its position forcefully, resulting in an amputation of the tip of the IP's pinky finger. The job was immediately stopped and the IP reported to the medic. The IP was promptly evacuated from the facility via search and rescue (SARS) flight to a hospital onshore.

Sequence of Events:
On July 17, 2026, Anadarko operators prepared to replace an 8 inch isolation valve for PSV-1232 on the HP Oil Exchanger #2. Prior to this operation, the lifting authority onboard drafted a proper lift plan, involving two chain falls. One chain fall was rigged to pull tension on the discharge piping while the other chain fall was rigged up to the valve. The valve was in a vertical run, so the lift plan was drafted to have a strap wrapped around the topmost flange of the valve to minimize motion.
At approximately 11:00 a.m., the crew was working to change out the valve when it got pinched between its two connector flanges. Four operators were involved in the operation, including the IP, the rigger, and two Anadarko operators. When the valve pinched, the IP instructed the rigger to pull up on the chain fall applying tension while the IP inspected the valve to see where it was stuck. As the rigger pulled up on the chain fall, the valve suddenly dislodged from the flanges and forcefully rotated downward, still suspended by the chain fall. When the valve was dislodged, the IP instinctively reached out to grab the valve. In doing so, his pinky finger was caught between the valve and the pipe flange, causing an amputation to the tip of his finger. The operation was immediately shut down following the incident, and the valve was lowered to the deck.
The IP reported to the medic while the rigger and operators notified the Offshore Installation Manager (OIM) as well as Anadarko Regulatory. Once evaluated by the medic, the IP was promptly evacuated to shore via SARS flight to a hospital where he was assessed. The IP was seen by an orthopedic surgeon on July 20th and underwent surgery on July 21st. The IP was cleared to regular duty by his physician on August 24th but has not returned offshore pending a fit for duty assessment scheduled for September 28th.

MMA Investigation:
MMA Houma District After Hours received an initial incident notification via phone call regarding the lifting incident and the evacuation notification on Constitution. However, the initial notification did not give a full description of the incident. There was no mention to MMA from the initial report that the IP had suffered an amputation. The report simply stated a pinched finger. The severity of this incident was not determined until the Houma accident investigator reviewed the report in the MMA incident reporting database (eWell) on August 3, 2026. The investigator reported the situation to Houma District supervisors, and the decision was made to conduct a follow-up investigation offshore the following day.
On August 4, 2026, MMA investigators flew offshore to conduct a follow-up investigation. MMA investigators met with Anadarko personnel, interviews were conducted with all personnel involved and a walkthrough assessment of the area was conducted and pictures were taken. The investigator mentioned that the initial report from Anadarko did not specify that the IP suffered an amputation, there was only mention of a pinched finger. Anadarko personnel claimed that they reported the amputation to the Anadarko regulatory team. It was determined to be a misunderstanding between the facility report and the regulatory report to MMA.

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Upon investigation into the incident, MMA learned that Anadarko has a dedicated lifting authority on board who is responsible for drafting a specific lift plan for all lifting operations on the facility. The lift plan includes the permit for the operation, as well as diagrams and drawings of the plan layout, rigging instruction, lifting device placement, landing area, etc. The lift plans are also posted at the job site. The operation involved with this incident did have a proper lift plan drafted including all the previously stated requirements. All four Anadarko operators signed off on the permit and lift plan prior to work commencing.

The investigation revealed that the valve was not rigged up the proper way according to the lift plan. The lift plan drafted the rigging set up with two chain falls secured to a support beam overhead. One chain fall was attached to the PSV discharge piping via strap to pull tension, and the other chain fall was attached to the valve with a strap wrapped around the top side flange. The operators involved in this operation did not rig up the strap to the valve as described in the lift plan. Instead, they used a pad eye located on the middle section of the valve and secured the strap to the pad eye with a shackle. This rigging practice was not recommended because this anchor point would cause the valve to swing in a downward motion once free from the pipe.

MMA investigators then walked down the incident scene to further investigate the lift plan and personnel placement. Anadarko informed MMA that the IP did not have impact gloves on at the time of the incident, which were required as per the work permit. However, Anadarko expressed that they don’t believe impact gloves would have made a difference given the size and weight of the valve.

The rigger that was involved in the incident was onboard at the time of the follow-up investigation, and informed MMA on the positioning of the personnel involved in the operation when the incident occurred. The rigger also described how the valve was rigged up using the valve pad eye and shackle. When the valve got stuck, the operators realized that the valve would be difficult to control once it was free given how it was rigged up. They theorized another chain fall could possibly assist but determined that attaching more rigging to the valve would be risky given the valve’s current position. They continued the lift anticipating the motion of the valve once it was released, and in doing so, the IP reached for the valve and pinched his finger between the valve flange and pipe flange, resulting in amputation. A safety stand down was held following the incident, and all lifting operations facility wide were postponed until further notice.

After a thorough assessment of the area following the incident, and lifting operations were approved to resume, the rigger explained that they were able to safely remove the old valve without issue. They also added a second chain fall to assist with the installation of the new valve. The rigger reported this correction added a lot more stability and control to the valve, and they were able to install it without issue.

Conclusion:

After all the evidence gathered during initial communications made following the incident and the onsite investigation, MMA concludes that the direct cause of the incident that occurred on July 17th was the improper rigging that was situated on the valve. Had the lift plan been followed and the valve been properly rigged up, the motion of the valve would have been greatly minimized and would have also allowed more clearance for the valve to be removed out of the pipe flanges with minimal issue. One contributing cause that also led to this incident was the improper gloves being worn by the IP. Had the IP selected the proper impact gloves to wear, it is possible that the injury could have been minimized, regardless of the size and weight of the valve. Anadarko implemented corrective actions in several areas following this incident, including an immediate facility wide safety stand down and a postponement of all lifting operations. The safety stand down resulted in an audit of all other active lift plans at the time of the incident. The safety stand down also covered pinch point awareness as well as other Anadarko lifting policies.

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

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Human Performance Error (Not following proper procedures): The personnel included in the operation did not follow the proper rig up procedure as stated in the lift plan. Personnel rigged up the valve incorrectly which resulted in the violent motion once loose.

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

Human Performance Error (Not following proper procedures): The work permit for the operation stated impact gloves as required PPE. The IP was not wearing impact gloves when the incident occurred.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

N/A

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

The direct contributing violation is the lift plan rig up procedures not being followed, resulting in an improper rig up and incident occurring.

An indirect violation is the work permit not being followed when the IP did not wear impact gloves, which were required as per the work permit.

25. DATE OF ONSITE INVESTIGATION:

04-AUG-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:

Amy Gresham

APPROVED DATE: **19-OCT-2026**