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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **19-JUL-2026** TIME: **0730** HOURS
2. OPERATOR: **GOM Shelf LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **White Fleet Abandonment, LLC**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [X] CRANE
- [X] OTHER LIFTING **Rigging 3" lifting pin/bar**
- [ ] 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: **G04232**
   AREA: **SS** LATITUDE:
   BLOCK: **189** LONGITUDE:

5. PLATFORM: **A**
   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)		
[ ] 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
   - [X] 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: **78** FT.
11. DISTANCE FROM SHORE: **32** 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:

On July 19, 2026, an incident requiring evacuation occurred at Ship Shoal 189 A platform, at OCS-G 04232, owned by GOM Shelf LLC. White Fleet Abandonment (WFA) was contracted to perform plug & abandon (P&A) operations for Well A-04. A P&A crew consisting of a supervisor (SP), an assistant (A1), another assistant/the injured person (IP), and a crane operator (CO). SP, A1, and the IP are employed by WFA and the CO is employed by a third party contractor. The P&A crew was tasked with pulling 7" casing out of the wellbore. The rigging for pulling the casing consisted of a 3" diameter casing lifting pin (installed through holes cut in casing), a 2-legged wire rope hoisting sling (connected to the 3" casing lifting pin), 2 retainer plates (installed on the outside of the slings to hold them in place), and 2 keeper bolts with nuts (bolted on the 3" casing lifting pin to hold the retainer plates in place). Holes were cut in the 7" casing, the 3" casing lifting pin was installed, and the pin was lowered onto the landing beams, supporting the weight of the casing string, so the top joint of 7" casing could be laid down. The IP was securing the hoisting sling to one side of the 3" casing lifting pin when the CO was directed to boom down to center the rigging over the casing and allow the opposite sling to be rigged up on the other side of the lifting pin. The CO boomed down while simultaneously hoisting up inadvertently causing the retainer plate to pivot against the landing beams resulting in the retainer plate's top moving towards the casing and the retainer plate's bottom towards the keeper bolt and nuts. The IP's left thumb was pinched between the retainer plate and the keeper bolt while he was installing the bolt nuts.

A daily pre-tour meeting was attended by the P&A crew. According to the meeting log they discussed hand placement, hydration, compliance checks, and stop work authority. A Behavioral Job Safety & Environmental Analysis (BJSEA) was reviewed and signed by the P&A crew. The BJSEA included 10 job steps, associated hazards with each step and ways to reduce the identified hazards. The P&A crew successfully pulled 4 joints of 7" casing before the incident occurred. While securing the rigging (sling, D-ring, retainer plate, keeper bolt, and nuts) to pull the next joint of 7" casing from the wellbore, A1 directed the CO to boom down via radio. The CO boomed down while simultaneously hoisting up the load line.

The rigging accidentally lifted upwards forcing the retainer plate to pivot against the landing wood (two wooden beams the 3" pin rests on to support the weight of the casing string) resulting in the casing plate pinching the IP's left thumb between the plate and the keeper bolt.

The job was stopped and first aid was rendered to the IP. The crew conducted a safety stand down meeting to discuss and gather information about the incident. The IP was flown to Eugene Island Block 346 to be evaluated by the field paramedic (FP). The FP recommended the IP be evaluated by onshore doctors. The IP was evacuated. The IP suffered a left-thumb bone fracture (tip) with nail dislodgement requiring stitches. He was also given prescription medication for pain. The IP was given a full-duty release with no restrictions. GOM Shelf's investigation revealed the following findings:

- JSA did not reference the procedural steps of installing hoist rigging to the 7" casing with identified potential hazards and/or mitigation of same.
- The rigging retainer plate is secured to the lifting pin by a threaded bolt with no head, non-use of split-ring or locking washer to prevent the keeper nuts from backing off.
- The space between the retainer plate and threaded bolt does not have a guard of any type to eliminate the potential pinch point.
- Movement of the rigging upwards by lifting the load-line to a point that the lifting pin raised upwards without the opposite hoisting sling attached caused the bottom of the retainer plate to move outward pressing against at least one of the keeper bolt's nuts.

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• Casing hoisting slings 1 ¼ inch were appropriate in length and strength for hoisting a 42’ joint of 7” casing.
• The ability of the crane to lift the weight of the casing joint was well within the radius, angle, load weight per the cranes’ load chart.
• Vertical length in height (3 plus feet) of the casing stub above the lift pin did not hamper the ability of the cranes’ hoisting/rigging to be positioned directly above the load.
• Four previous casing lifts were accomplished with no adverse events, but did utilize the same procedure of attaching one hoisting sling to one end of the lifting pin, requesting the crane operator to lower the boom to enable the opposite hoisting sling to be attached to the opposite lifting pin end as well as center the load.
a. Day crew - Crane would lay down the joint of casing come back to the casing in the well and would have the fast line centered over the well to remove the saw. Then boom down to hook up the rigging to the pulling pin.
b. Night crew - Crane would lay down the joint of casing come back to the casing in the well and would have the big block centered over the well pull the fast line to them to remove the saw. Then just lower the rigging down to the pulling pin.
• Both sling ends could be attached to the lift pin without movement of the crane if the load-line is appropriately positioned at the top of the casing stub.
• While one worker was attaching nuts to the keeper bolt his co-worker (the signal person) gave via radio the command to boom down without verifying co-worker was clear of rigging.
• The crane operator had clear view of the workers and the work area, but the IP had his back to the crane so the crane operator could not see that the IP still had his hands placed in the rigging area.
• The crane operator followed the signal person’s instruction to lower the boom. While doing so, he simultaneously raised his load line rigging without instruction in attempt to ensure the two hoisting slings attached to a D-ring would be above the casing stub in centering the rigging.
• Different procedural processes were being utilized between the day and night crews. Night crew requires visual worker clearance of rigging prior to instructing movement with the crane. Day Crew did not require visual worker clearance of rigging prior to movement with the crane.

Marine Minerals Administration (MMA) Houma District office was notified and a written report was submitted in 15 days. The MMA Houma District Inspectors (Inspectors) did not conduct an onsite investigation due to operations ending on July 20, 2026. Although an onsite investigation was not performed, MMA was able to obtain photos, witness statements, BJSEA, and incident reports from the office. MMA concurs with GOM Shelf’s incident findings. The largest factor in this incident was the lack of hazard identification and mitigations. The BJSEA did not have the procedural steps of installing the hoist rigging to the 7” casing with hazards and mitigations. The banksman gave the command to boom down to the CO while the IP’s hands were in a potential pinch point. The CO boomed down as directed but also hoisted up to keep the load centered. He was not instructed to hoist up.

After reviewing the BJSEA, MMA discovered that it did not include steps of installing the hoist rigging to the 7” casing. Also, the hazards and mitigations for installing the hoist rigging for the 7” casing were not included. WFA did update the BJSEA to include the steps, hazards, and mitigations for installing the hoist rigging for the 7” casing. WFA also updated the BJSEA to include that communications between the CO and banksman must be clear and precise with the stated intent and understanding by both parties before moving the crane. These updates will be instrumental in ensuring this incident can be prevented in the future.

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

Human error performance – Not aware of the hazards. Not following proper procedures.

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Supervision – Inadequate pre-job safety meeting (BJSEA).
Communication – Instructions between banksman and CO not understood.
Management system – Inadequate hazard analysis. Inadequate written job procedures.

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

N/A

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

n/a

NATURE OF DAMAGE:

n/a

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

MMA Houma District does not have any recommendations 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:

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:

Amy Gresham

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