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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **30-JUL-2026** TIME: **0845** HOURS
2. OPERATOR: **Hess Corporation**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Danos & Curole Marine Contracto**
   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: **G22897**
   AREA: **MC** LATITUDE: **28.23497328**
   BLOCK: **724** LONGITUDE: **-88.99536265**

5. PLATFORM: **A (Gulfstar 1)**
   RIG NAME:

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)		
[ ] 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:
- [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
- [X] OTHER **Miscommunication**

10. WATER DEPTH: **4600** FT.
11. DISTANCE FROM SHORE: **55** 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 SUMMARY:

On 30 July 2026, at approximately 0845 hours, a crane incident occurred at Mississippi Canyon (MC) 724 A (Gulfstar1) platform. Gulfstar 1 is a Single Point Anchor Reservoir (SPAR) platform that is owned by Williams Companies, Inc (Williams) and operated by Hess Corporation (Hess). Chevron Operates on Gulfstar as an affiliate of Hess and all operations on the platform are carried out under Chevron policy. During the crane incident, a Signalman (Injured Person - IP) and a Rigger were attempting to reposition a Vapor Recovery Unit (VRU) cooler (cooler), weighing approximately 1,500 pounds, in a cargo basket with the platform crane. While attempting to reposition the cooler, the cooler unexpectedly started to move. The IP attempted to move out the way of the moving load. While doing so, the IP's glove got caught on the rigging shackle's cotter pin. When this occurred, the IP's hand got caught between the shackle and the edge of the cargo basket and caused a laceration to the IP's right palm. Due to this incident, the IP received medical attention and sutures to the wound on the palm of his hand. There were no other injuries, equipment damage, or pollution associated with this incident.

SEQUENCE OF EVENTS:

On 30 July 2026, at approximately 0600 hours, a Job Safety Analysis (JSA), General Work Permit (GWP), and toolbox talk were conducted prior to platform operations for the day.

On 30 July 2026, at approximately 0630 hours, a GWP was approved and at 0635 hours, the GWP went live for general crane operations while backloading and offloading the Motor Vessel Odyssey Courage (MV) as well as moving equipment around the facility. Once the GWP was live, crane operations began on Gulfstar 1. These operations consisted of lifting and lowering various materials and equipment to and from the boat on site. The operations also included moving materials and equipment around the platform.

At approximately 0830 hours on 30 July 2026, the Danos lifting crew was tasked with placing a cooler in a cargo basket using the platform crane. After the crane successfully placed the cooler in the cargo basket, it was determined that the cooler was top-heavy and unbalanced. There was discussion as to whether the cooler could be laid on its side, but the IP stated that he was informed by the crane operator that it had to be standing upright. The IP and rigger observed the cooler was not stable in its current standing position at that time. The crew was concerned that if the cooler remained in its original position, it could fall over. The decision was made to reposition the cooler to provide better stability. The crew, with crane assistance, repositioned the cooler closer to the corner of the cargo basket to better stabilize the cooler.

At approximately 0845 hours on 30 July 2026, after repositioning the cooler, the IP decided to enter the cargo basket and manually attempt to adjust the cooler upright while still using the crane as support. Due to the rigging orientation of the slings, the cooler being top-heavy, and the load being uneven, the cooler could not be stood upright without some form of assistance. When this attempt was made, the cooler started to unexpectedly move. The IP recognized this and attempted to move out the way of the cooler. While the cooler was in movement, one of the rigging shackle's cotter pins caught the IP's right glove. This caused the IP's right hand to get caught between the shackle and the edge of the cargo basket. The result was a laceration to the right-hand palm of the IP.

After the IP was injured, he notified the Crane Operator (CO) by radio, informing him that an injury had occurred. An all-stop was called on the lifting operation. The IP

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reported the injury to appropriate platform supervision and safety personnel. The injury was evaluated and tended to by the platform medic. Shortly thereafter, the decision was made to send the IP into shore by helicopter for further evaluation and medical treatment. The IP was treated he received twenty-five sutures for the wound. The IP was released on the same day, on 30 July 2026, for full duty. However, his employer, Danos, assigned him tasks in the local office for precautionary measures.

MMA INVESTIGATIONS:

On 30 July 2026, The Marine Minerals Administration (MMA) received an electronically submitted incident report concerning the crane incident that occurred on 30 July 2026 at Tubular Bells. On 31 July 2026, the incident was assigned to an MMA Accident Investigator (AI). On 04 August 2026, the MMA AI flew to Gulfstar 1 and performed an on-site incident follow-up inspection along with collecting details concerning the incident. The AI took additional photographs, requested additional documents and investigated the incident area. The AI spoke with personnel that were on the platform when the incident occurred as well as the CO who was operating the crane when the incident occurred. Due to time restraints, the AI was unable to conduct any formal in-person interviews on 04 August 2026.

On 10 August 2026, the AI requested to conduct an interview with the IP. On 17 August 2026, the AI was able to conduct a phone interview with the IP. The interview with the IP was conducted over the phone due to scheduling conflicts with his job. The AI also conducted an in-person interview at Gulfstar 1 with the CO on 01 September 2026.

The information collected throughout the interviews and investigation identified that the lift that was being conducted at the time of the incident was considered a blind lift. The only view that the CO had of the lift was by the utilization of the crane boom tip camera, which the CO could view in the crane cab. The CO stated that when looking at the video screen in the cab, he did not have a clear view of the personnel handling the cooler. The CO stated that at that time of the day, there was a shadow cast over the area where the cooler was being repositioned. Due to this shadow, the CO could only see the Rigger and Signalman’s hard hats. He explained that the view from the camera at that time was very poor. The CO also explained that he was given the command to lower the load in the basket by the IP. When he lowered the load, he noticed that the weight indicator in the crane was reading zero. Just a few moments later, he was notified via radio that an injury had occurred. The crane operator also stated during the MMA interview that he was told over the radio that the IP was going to move the lift to the edge of the basket. The crane operator stated that he only found out about having to reposition the cooler from the IP right before he attempted to relocate the cooler. The CO explained that he heard no instructions prior to having to reposition the cooler in the basket.

The IP’s interview and witness statement also identified that there were instructions to stand the cooler up inside of the cargo basket for stabilization during transportation. The IP stated that he was attempting to relocate the cooler when the incident occurred. The IP stated that when the cooler was relocated near the edge of the cargo basket, he entered the cargo basket and attempted to manually adjust the position of the cooler. The IP said that he tugged on the rigging strap to ensure the load was stable. When he tugged on the rigging strap, the cooler began to move. At that point he attempted to move out of the way. When the cooler started to move and slide, a cotter pin on one of the rigging shackles caught his right-hand glove and pulled his hand in between the shackle and the edge of the cargo basket. He was able to get his hand dislodged from the pinch point and immediately contacted the CO by radio to inform him that an injury had occurred. There was an immediate all-stop called to the operation. The IP then reported his injury to platform supervision and to the platform Safety Representative.

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Throughout the MMA investigation, it was discovered that the IP, who was performing signalman duties, entered the cargo basket to secure the cooler. When reviewing the Chevron Lifting Policy, it notes that the signalman should have no other duties during the lifting operations other than giving hand signals and communicating with the crane operator.

The MMA investigation also noted that during the blind lift, the CO did not have a clear view of the Signalman. There was no additional Signalman present during the lift that the CO had visible sight of. Chevron Blind lift policy states “for a blind lift operation there must be a minimum of two qualified riggers. One shall be the designated signal person, who shall be positioned in a location continuously visible to the crane operator and shall have no other duties than to signal. If that signal person cannot directly see the load, another signal person (who is in direct view of the load) shall be utilized; therefore, allowing signals to be relayed to the crane operator. In cases where visible contact is unattainable, such as in diving and construction activities, a radio only process can be utilized, if the hazards have been properly mitigated utilizing a “hot microphone” or similar process.” The policy states that a radio can be used if visible contact is unattainable. However, the MMA on-site investigation suggests that there was the ability to have an extra signalman within visible sight of the CO.

The MMA investigation also identified the lack of risk assessment for repositioning the cooler in the cargo basket. The GWP created and signed by the Rigger and IP did state that “Hands Free” operations shall be conducted always and at no time shall the load be touched while suspended from the crane (use of taglines/Push-Pull poles will be used to guide the landing of the loads and “3-foot Rule’ used).”

During the MMA investigation, it was also noted that there was a Chevron Gulf of Mexico Business Unit (GOMBU) Blind Lift form filled out for blind lifts being made. However, the only blind lifts noted on the form were picking up from the boat and setting down on the deck. There was no mention of conducting a blind lift while repositioning the cooler into the cargo basket on the deck.

Chevron also indicated that the IP was a Short Service Employee (SSE) to Chevron and the IP was relatively new to offshore work.

IN CONCLUSION:

The MMA investigation revealed multiple process discrepancies that were noted to be probable causes of the incident. The first discrepancy that was determined to be a probable cause was the lack of recognition of the risk associated with the repositioning of the cooler inside the cargo basket. Due to the lack of recognition of the risk, there was no planning to mitigate the risk of repositioning the top-heavy cooler in the cargo basket.

The second probable cause was the lack of communication about whether there was a definitive need to reposition the cooler. Following the incident, it was discovered that the cooler was an older unit and did not have to be stood up and could have remained laying down in the cargo basket while being transported without causing damage. Had this information been known prior to the incident, the entire incident could have been prevented.

The third probable cause was identified as human error. The human error occurred when the IP entered the cargo basket in the attempt to manually assist the repositioning of the cooler. The IP was working as a signalman and deviated from his assigned duties. He also lacked judgement when assessing the risk of trying to manually assist a load that was still connected to a crane and was not stable.

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The MMA investigation also found multiple contributing factors that contributed to the incident. One of these contributing factors is not following proper company policies. According to Chevron policy, there should have been an additional signalman while conducting the blind lift due to the CO's limited view of the Signalman. The additional signalman should have had direct sight of the load, and the CO should have had direct line of sight of the signalman while the lift was being made.

The second contributing factor was not following the Work Permit/JSA as discussed prior to performing the crane lifts. The Signalman/IP should not have been performing any other duties other than his designated signalman responsibilities. Additionally, there should have been no handling of the load by hand while the load was still connected to the crane.

The crane incident that occurred at Gulfstar 1 on 30 July 2026 could have resulted in a much worse outcome. Due to lack of communication, lack of hazard recognition, and failure to follow company policies, the IP suffered a hand injury that could have had a far worse result. As a result of this incident, Chevron is taking steps to prevent these types of incidents from occurring in the future. These steps include consideration to updating their Lift Plan Template to check load stability and considering if SSE's should have limited responsibilities on crane crews with Lifting and Rigging (L&R) Steering Team.

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

Management systems: Inadequate hazard analysis- The crane crew failed to recognize the hazards associated with trying to reposition the unstable cooler into the cargo basket. Without recognizing the hazards, there was a failure to discuss and create steps to mitigate the hazards associated with the task as well.

Communication: Inadequate communication between the operator and contractor personnel- Lack of communication between the operator and contractor concerning the position the cooler should be in to be transported in the cargo basket.

Human performance error: Not aware of hazards- The IP lacked judgement when deciding to enter the cargo basket and trying to manually reposition the load.

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

Human performance error: Not following proper procedures- Crane crew did not follow proper blind lift procedures while conducting a blind lift.

Human performance error: Not following proper procedures- The IP did not follow proper procedures when deciding to deviate from his role as a signalman to perform additional functions by attempting to reposition the load with his hands.

20. LIST THE ADDITIONAL INFORMATION:

From item 25.DATES OF ONSITE INVESTIGATION: 04 Aug 2026, 01 Sep 2026

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21. PROPERTY DAMAGED:

NA

NATURE OF DAMAGE:

NA

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The MMA New Orleans District has no recommendations to the Office of Incident Investigations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110: Authority: 30 CFR 250.107 DOES THE LESSEE PERFORM ALL OPERATIONS IN A SAFE AND WORKMANLIKE MANNER AND PROVIDE FOR THE PRESERVATION AND CONSERVATION OF PROPERTY AND THE ENVIRONMENT?

On 30 July 2026, the crane crew failed to follow Chevron’s blind lift policy. While conducting a blind lift when lowering the VRU cooler into a cargo basket and then repositioning the VRU cooler in the cargo basket, the Crane Operator did not have clear view of the Signalman.

- The designated Signalman did not follow Chevron’s policy while performing other duties, such as entering the cargo basket and attempting to manually handle the load while the load was still attached to the crane.

Chevron’s Policy on Blind Lifts- Blind Lifts: for a blind lift operation there must be a minimum of two qualified riggers. One shall be the designated signal person, who shall be positioned in a location continuously visible to the crane operator and shall have no other duties than to signal. If that signal person cannot directly see the load, another signal person (who is in direct view of the load) shall be utilized; therefore,allowing signals to be relayed to the crane operator.

In cases where visible contact is unattainable, such as in diving and construction activities, a radio only process can be utilized, if the hazards have been properly mitigated utilizing a “hot microphone” or similar process.

25. DATE OF ONSITE INVESTIGATION:

01-SEP-2026

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:

Brody Vial

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