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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: **03-JUL-2026** TIME: **0700** HOURS
2. OPERATOR: **Walter Oil & Gas Corporation**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Seadrill Americas**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **Tubing Hanger Running Tool**
- [ ] 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: **G19001**
   AREA: **EB** LATITUDE:
   BLOCK: **430** LONGITUDE:

5. PLATFORM:
   RIG NAME: **SEADRILL SEVAN LOUISIANA**

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

7. TYPE:
   INJURIES:
- [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[ ] REQUIRED EVACUATION		
[ ] 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	[X] TEMP ABAND
[ ] DRILLING	[ ] PERM ABAND
[ ] WORKOVER	[ ] DECOM PIPELINE
[ ] COMPLETION	[ ] DECOM FACILITY
[ ] HELICOPTER	[ ] SITE CLEARANCE

- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER

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: **2285** FT.
11. DISTANCE FROM SHORE: **96** MI.
12. WIND DIRECTION: **S**
    SPEED: **10** M.P.H.
13. CURRENT DIRECTION:
    SPEED: M.P.H.
14. SEA STATE: **2** FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

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Incident Summary

On 7/3/2026 at approximately 0700 hours, during decommissioning operations located at East Breaks (EB) 430, Lease G19001, well SS001, API 608044019202 operated by Walter oil and Gas Corporation (WOG), onboard the Seadrill SEVAN LOUISIANA Rig ID 49565, the (manual setting) tubing hanger emergency running tool (THERT) disconnected from the tubing hanger. This caused the tubing hanger and 3.5-inch diameter approximate 20-foot section of production tubing to drop vertically and impact the rig floor.

The upper part of the tubing hanger and production tubing then fell over and came to rest against the top drive dolly (DDM) tracks on the motor shed side of the draw works adjacent the rotary table. Before and during the incident there were personnel on the rig floor in the red zone.

Rig floor operations were suspended, and the scene was evaluated for safety hazards to allow for an investigation by Seadrill and third-party vendor Trendsetter who is the owner of the (THERT). Following the investigation, the Seadrill Offshore Installation Manager (OIM) authorized operations to resume on the rig floor. There were no injuries or pollution associated with the incident.

WOG regulatory was not made aware of the incident until the rig had been released from contract from WOG to another Operator. BSEE was notified of the incident 7/7/2026, at 1556 hours.

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:

During the initial recovery of the tubing hanger and 3.5-inch production tubing from well SS001, the (hydraulic setting) open water tubing hanger running tool (OWTHRT) was utilized without incident. Once the tubing hanger and 3.5-inch production tubing were clear of the rotary, the slips were set on the 3.5-inch production tubing. A discussion between WOG, Seadrill, and Trendsetter Supervisor on location was conducted to determine how to handle the tubing hanger and the 3.5-inch production tubing on deck because OWTHRT is not designed to lay out tubulars horizontally. The tubing hanger handling and test tool (THHTT) specifically designed for the task of laying out the tubing hanger and 3.5-inch production tubing needed repairs. The Trendsetter Supervisor suggested using THERT due to the tool being able to handle the weight of the tubing hanger and 3.5-inch production tubing with the capability to lay out tubulars horizontally.

The OWTHRT was removed and replaced with THERT. The THERT was brought to the rig floor and landed in the tubing hanger by the Seadrill Driller. The Driller made 5.5 clockwise revolutions to lock the THERT in the tubing hanger. The Driller then picked up THERT, but the tubing hanger was not connected. The Driller came back down and landed the THERT in the tubing hanger. The Driller aligned the tubing and made 5.5 counterclockwise rotations to reset THERT. The Trendsetter Technician then requested 1000 psi hydraulic pressure to be applied to retract THERT hanger release piston to the “up” position. The pressure was bled off and again pressured up to 1000 psi with a second bleed off. The Driller made a second attempt to lock THERT with 5.5 clockwise revolutions. The Driller picked up the tubing hanger and 3.5-inch production tubing out of the rotary letting it float while holding the weight.

Trendsetter employees did not witness the second attempt to lift the tubing hanger and 3.5-inch production tubing which had the hanger release piston stroking “downward” indicating the split lock ring did not have the weight. Steps to ensure the THERT was fully landed were not completed. The THERT was picked up by the Actuator Latch Ring engaged with the TH Latch Ring. The Split Lock Ring, which is designed to pick up the load, was never properly engaged.

The Seadrill crew members cut control tubing and severed 3.5-inch production tubing at the first tubing pup joint below the tubing hanger with a portable bandsaw. When the 3.5-inch production tubing was nearly severed the portable bandsaw’s blade became pinched and stuck in the 3.5-inch production tubing. The portable bandsaw blade was

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removed from the bandsaw and the Seadrill Assistant Derrick hand hit the tubing with a sledgehammer allowing the blade to become free and clear of the tubing.

Next, the Seadrill Assistant Derrick hand let the Seadrill Driller know the tubing was ready to be picked up by the top drive to be laid out on deck. As soon as the Driller picked up on the top drive the tubing hanger and 3.5-inch severed production tubing section released from the THERT falling over onto the rig floor adjacent to the rotary table coming to rest against the DDM tracks on the motor shed side of the draw works. Before and during the incident there were personnel on the rig floor in the red zone.

BSEE Investigation:
BSEE Investigators reviewed video footage of the incident, photos, witness statements, WOG's initial report, Seadrill's initial report, Trendsetter's root cause analysis report, and Dril-Quip Tubing Hanger with Tubing Hanger Emergency Retrieving Tool Procedure.
The Decommissioning operations were being conducted during the day under favorable weather conditions.
Trendsetter's root cause analysis report and witness statements illustrate a plan was not in place to handle the tubing hanger and cut tubing once on the rig floor due to the THHTT not being operational. The THERT is not designed to be used as the primary topside handling tool. A meeting with the onshore Trendsetter support team/Trendsetter engineering was not held to ensure the decision to use THERT was the safest path forward. An MOC was not completed. The steps to ensure THERT was properly secured to the tubing hanger were not followed by onsite personnel.

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

The THERT is a backup tool and was not installed correctly. The THERT split lock ring was never engaged during the attempt to lock into the tubing hanger, therefore the hanger released after the control tubing was cut and struck once by sledgehammer. Procedures or work instructions were not available or followed to utilize the THERT topside in this manner allowing the tubing hanger and cut section of production tubing to fall.

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

Plan was not in place to handle tubing hanger and cut tubing once on the rig floor. The THERT is not designed to be used as the primary topside handling tool. A meeting with the onshore Trendsetter support team/Trendsetter engineering was not held to ensure the decision to use THERT was the safest path forward. An MOC was not completed.

20. LIST THE ADDITIONAL INFORMATION:

None.

21. PROPERTY DAMAGED: **None.**

NATURE OF DAMAGE: **None.**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

None.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

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On 7/3/2026, onboard the SEVAN LOUISIANA, the tubing hanger emergency running tool (THERT) disconnected from the tubing hanger allowing the tubing hanger and 3.5-inch section of tubing cut just above the rig floor to fall to the rig floor adjacent the rotary table coming to rest against the top drive dolly (DDM) tracks on the motor shed side of the draw works. Before and during the incident there were personnel on the rig floor in the red zone whose safety was compromised due to the threat of falling object hazard.
1) The installation procedure for the topside use of the THERT was not available or followed; therefore, the correct sequence of installation steps, and steps to ensure the THERT was fully landed out were not completed.
2) A risk analysis meeting was not completed with the appropriate personnel when the decision was made to run the THERT instead of the tubing hanger handling and test tool (THHTT). The THHTT is the designed tool to be used for topside tubular handling.
3) A lack of pre-job planning and not using the correct tool for the job contributed to the incident.

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The Lake Jackson District was not notified of the lifting incident which occurred onboard the SEVAN LOUISIANA 7/3/2026 until 7/7/2026 at 1556 hours. At that time, the rig was already working for another Operator. Incident notifications must meet the requirements of 30 CFR 250.188 and 189.

25. DATE OF ONSITE INVESTIGATION:

07-JUL-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:
Jarvis Outlaw

APPROVED DATE: **28-OCT-2026**