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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **21-SEP-2024** TIME: **1630** HOURS

2. OPERATOR: **Talos Third Coast LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: 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:
   AREA: **SM** LATITUDE:
   BLOCK: **160** LONGITUDE:

5. PLATFORM: **A**
   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
- [ ] OTHER _____

10. WATER DEPTH: **285** FT.

11. DISTANCE FROM SHORE: **84** 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 September 21, 2024, at approximately 1630 hours, a contract construction supervisor (CCS) injured his eye while learning how to use banding material on the Talos ERT LLC (Talos) RUE-G30388 South Marsh Island (SM) 160 A Facility. The CCS was holding the spool of banding material when the band clamp buckle slipped off the end and struck the CCS in the right eye. The CCS was transported to an onshore medical facility where it was determined the cornea in the right eye had been lacerated.

Sequence of Events:

On September 21, 2024, at approximately 1630 hours, a CCS was attempting to familiarize himself with using a banding tool to conduct repairs on the fencing of the heliport skirting. The CCS had used a banding tool in the past but felt the need to familiarize himself with using the banding tool prior to making repairs to the heliport skirting. While the CCS was holding the housing containing the banding material, approximately 2 feet of the banding material was extending from the spool. The CCS was attempting to place a band clamp buckle on the end of the extended banding material when the band clamp buckle slipped off the banding material. The 2-foot section of banding material sprung forward knocking off the CCS's safety glasses. The sharp edge of the banding material struck the CCS in his right eye. The CCS was evacuated and transported to a medical facility where it was determined the cornea in the right eye had been lacerated. The CCS required surgery due to this incident.

BSEE INVESTIGATION:
On September 21, 2024, the Bureau of Safety & Environmental Enforcement (BSEE) Lafayette District (LD) Accident Investigator (AI) received a phone call notification of an employee that injured his right eye that occurred on Talos's SM 160 A Facility. The AI requested additional information pertaining to the incident such as photos, statements, and other relevant documents from Talos.
The BSEE LD AIs conducted an onsite investigation at SM 160 A on September 26, 2024. BSEE conducted interviews and a reenactment with the personnel that witnessed the incident. According to the witness, while attempting to attach a band clamp buckle to the end of the banding material, the buckle slipped off causing the extending end of the banding material to strike the CCS in his right eye. The witness stated there was at least 2 foot of banding material extending from the housing.

The CCS arrived at the facility on the afternoon of September 21, 2024. There were no construction operations conducted that afternoon and a Job Safety Analysis was not created.

CONCLUSION:
The CCS failed to recognize the potential recoil from the spool of banding material when the band clamp buckle detached from the banding material. Also, the excess amount of banding material extending from housing was enough to make contact with the CCS's eye.

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

Human Performance Error:
• The CCS failed to recognize the potential hazard regarding the recoil of the banding material.

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

NA

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

NA

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District office makes no recommendations to the Regional Office of Incident Investigations (OII).

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

NA

25. DATE OF ONSITE INVESTIGATION:

26-SEP-2024

26. Investigation Team Members/Panel Members:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

27. OPERATOR REPORT ON FILE:

OCS REPORT:

30. DISTRICT SUPERVISOR:

Mark Malbrue

APPROVED DATE: **11-FEB-2025**