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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **16-APR-2025** TIME: **1500** HOURS
2. OPERATOR: **Murphy Exploration & Production (**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Sparrows Offshore, LLC**
   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: **G16623**
   AREA: **MC** LATITUDE: **28.39240104**
   BLOCK: **582** LONGITUDE: **-89.45346089**
5. PLATFORM: **A (Medusa)**
   RIG NAME:
6. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [X] DEVELOPMENT/PRODUCTION (DOCD/POD)
   - [ ] DECOMMISSIONING

8. OPERATION:
   - [X] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] OTHER
   - [ ] TEMP ABAND
   - [ ] PERM ABAND
   - [ ] DECOM PIPELINE
   - [ ] DECOM FACILITY
   - [ ] SITE CLEARANCE

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

9. CAUSE:
   - [X] EQUIPMENT FAILURE
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER _____

10. WATER DEPTH: **2223** FT.
11. DISTANCE FROM SHORE: **36** 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:

INCIDENT SUMMARY:

On 16 April 2025, an incident occurred on Mississippi Canyon 582 A (Medusa) platform. Medusa is Single Point Anchor Reservoir (SPAR) platform owned and operated by Murphy Exploration & Production Company-USA (Murphy). During the incident, a cable roller that was mounted on a crane boom broke off from the boom and fell approximately 50 feet to the deck below. The cable roller struck a hydraulic hose as it landed. There were no injuries or significant damages associated with this event.

SEQUENCE OF EVENTS:

On 16 April 2025, at approximately 1500 hours, a Murphy crane operator was in the process of repositioning a 700L-140 crane (East Crane) so the Sparrows crane mechanics could remove the main hoist and auxiliary hoist from the East crane by utilizing another crane on the platform. While in the process of repositioning the East crane, a 15-pound cable roller, measuring 66 inches long and one inch in diameter, broke off and fell 50 feet to the deck below. The cable roller struck a hydraulic hose that was on the deck below the crane. Due to the hydraulic hose being struck and damaged, the hydraulic hose had to be replaced.

BSEE INVESTIGATIONS:

On 28 April 2025 at 1103 hours, Murphy submitted an incident report to the Bureau of Safety and Environmental Enforcement (BSEE) of an incident that occurred on 16 April 2025. The report that was submitted by Murphy included a brief description of the incident, the Job Safety Analysis (JSA) for the work being performed, photographs documenting the incident, damages, worksite photographs, as well as the most recent annual inspection of the crane which was performed on 05 October 2022. After receiving the incident report, a BSEE Accident Investigator (AI) began collecting evidence and performing an office-based investigation of the incident.

During the BSEE investigation, evidence for the work being performed during the incident was reviewed. Both Murphy’s cold work permit and Sparrows’ JSA mentioned the potential danger of dropped objects while performing work on the crane. However, it was noted by the operator that there were no barricades to block off the area underneath the crane to prevent personnel from traveling under the crane while the work was being performed. As per Murphy’s Working at Heights Permit, the only barricades that were installed on the platform were those that were protecting open hole locations. By not having the barricades installed around the working area under the crane, it allowed personnel to be within 20 feet of the cable roller when it fell to the deck.

Upon review of the East crane annual inspection performed on 05 October 2022, it was noted that the boom had major corrosion on two of the boom mid-sections and major corrosion on the boom tip section along with storm damage. The inspection also identified that the cable rollers on the boom had major corrosion and were unable to move as designed. The crane inspector recommended that the cable rollers be replaced or repaired within one to three months on the annual crane inspection deficiency report. However, the parts were never ordered by Murphy to repair or replace the cable rollers.

Per Murphy, the East Crane was placed out of service on 12 January 2022 and was still out of service at the time of the incident. The crane mechanics were in the process of removing the main winch and the auxiliary winch to have them refurbished and use as spares on other facilities. Murphy also stated that the East Crane was not intended to be placed back in service.

IN CONCLUSION:

The incident that occurred on Medusa on 16 April 2025 could have resulted in a far worse outcome. Due to the extensive corrosion that was found on the boom sections and cable rollers during the annual crane inspection on 05 October 2022, more attention should have been directed towards addressing these areas of concern. By failing to address the corrosion issues discovered during the annual crane inspection, an on-going safety concern remained with the possibility of components becoming detached from the crane and falling on personnel or equipment below.

Additionally, extra attention should have been directed towards securing the area below the crane before starting any type of work on the crane where the potential for dropped objects was identified. Due to the size and weight of the cable roller that fell 50 feet to the deck below, the possibility of a serious injury or fatality occurring was present. In the future, in the area where work is being performed, the immediate surroundings and drop zone areas should have barricades installed or other means of preventing personnel from entering the potentially hazardous areas. Murphy has stated that in the future, JSAs will provide a more thorough description of possible dropped objects and will require barricading the work area prior to performing work on the cranes. Additionally, Murphy has obtained quotes from vendors to remove the crane boom from the facility. This will eliminate the possibility of additional components falling from the crane boom and mitigating risk to personnel and equipment.

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

- Equipment failure: Inadequate preventive maintenance- The operator did not perform the recommended repairs that were noted on the annual crane inspection that specifically identified the major corrosion of the cable rollers.

- Equipment failure: Inadequate preventive maintenance- Due to the major corrosion on the cable roller, the cable roller was able to break off and fall to the deck below.

- Human Performance Error: Not aware of hazards- Failure to secure the area underneath the crane prior to starting operations and preventing personnel from entering the hazard areas.

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

- Supervision: Inadequate pre-job safety and operation planning- Failure to properly identify the need to secure the area where the potential for dropped object were present on the Sparrows' JSA, Murphy's Cold Work Permit, and Murphy's Working at Heights Permit.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

Crane boom cable roller and Hydraulic hose

NATURE OF DAMAGE:

Cable roller broken; Hydraulic hose damaged beyond use due to impact of cable roller.

ESTIMATED AMOUNT (TOTAL): **$500**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE New Orleans District recommends the Office of Incident Investigations should consider issuing a Safety Alert regarding the incident.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

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:

Michael J Saucier

APPROVED DATE: **12-JUN-2025**