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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **18-JUL-2025** TIME: **0730** HOURS

2. OPERATOR: **Nugulf Operating, L.L.C.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **ISLAND OPERATORS CO. INC.**
   REPRESENTATIVE:
   TELEPHONE:

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:

4. LEASE: **00693**
   AREA: **SP** LATITUDE:
   BLOCK: **27** LONGITUDE:

5. PLATFORM: **5**
   RIG NAME:

6. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [ ] DEVELOPMENT/PRODUCTION (DOCD/POD)
   - [X] 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 [X] <=$25K

- [X] STRUCTURAL DAMAGE
- [ ] CRANE
- [ ] OTHER LIFTING
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

8. OPERATION:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [X] OTHER **Platform Survey**
   - [ ] 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: **60** FT.

11. DISTANCE FROM SHORE: **4** MI.

12. WIND DIRECTION:
    SPEED: **12** M.P.H.

13. CURRENT DIRECTION:
    SPEED: M.P.H.

14. SEA STATE: **5** FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

INCIDENT SUMMARY:

On 18 July 2025, at 0730 hours, an incident occurred at South Pass 27 #5 platform (SP 27 #5). SP 27 #5 platform is owned and operated by Nugulf Operating L.L.C. (Nugulf). During platform surveying operations for the East Bay field, the Motor Vessel Marc C (MV) allided with the SP 27 #5 platform. The allision that occurred resulted in damage to the SP 27 #5 platform and the starboard bow of the MV. Once the MV crew assessed the damage, the MV was able to drop off two Island Operator workers that were onboard to a neighboring platform in West Delta (WD) 106 area and continue traveling to the Allied Shipyard (shipyard) in Golden Meadow, Louisiana for vessel repairs. There were no injuries or pollution associated with the incident.

SEQUENCE OF EVENTS:

On 18 July 2025, the MV was providing transportation for Island Operators to conduct platform surveys in the East Bay field for decommissioning operations. At approximately 0730 hours, the Island Operators crew had completed platform surveys and were beginning to travel to the WD field. Approximately 3 minutes after leaving the East Bay field and heading to the WD field, the MV contacted the SP 27 #5 platform.

After the MV contacted the platform, the MV crew began assessing the damage on the MV as well as the SP 27 #5 platform. During the assessment, the crew confirmed damage to the platform, as well as the starboard bow of MV. There were no injuries to personnel on the MV. The MV immediately notified the United States Coast Guard (USCG) of the incident that had occurred. The USCG then gave the MV permission to proceed to drop off the Island Operators at WD 106 platform and travel to the shipyard for repairs. Upon arrival at the dock the MV crew was drug tested and provided statements to Gulf Offshore Logistics, L.L.C. (GOL) representatives. The results of all drug tests performed came back negative.

BSEE INVESTIGATIONS:

On 18 July 2025, at 1002 hours, Nugulf notified the Bureau of Safety and Environmental Enforcement (BSEE) of an incident that occurred at SP 27 #5 platform. During this incident, an MV contacted SP 27 #5 platform which caused damage to both the platform and the MV. On 31 July 2025, Nugulf submitted an electronic incident report to BSEE. The incident report consisted of photographs of the damage to the platform and MV, a brief description of the incident, and other relevant information concerning the incident.

On 31 July 2025, the incident was assigned to a BSEE Accident Investigator (AI). Once the incident was assigned, the AI requested additional information pertaining to the incident and performed an on-site investigation on 07 August 2025. During the on-site investigation, additional photographs were taken, and verification of the platform coordinates were performed.

During the incident investigation, witness statements, USCG form CG-2692, and the internal investigation report from GOL were reviewed. Per witnesses that were onboard the MV at the time of the incident and the investigation report completed by GOL, the MV struck the SP 27 # 5 platform shortly after completion of platform surveys in the East Bay field. Multiple witnesses stated that they felt the MV hit the platform but no witnesses on board the MV at the time of the incident saw the MV contact the platform. One witness stated that they were in the wheelhouse with the captain at the time of the incident but had their back turned away from the bow of the MV at the time of the incident.

As per the USCG report and the GOL investigation report, after the platform surveys were completed on 18 July 2025, the captain stated that after leaving the East Bay field, he looked out the wheelhouse and did not see any structures in his view. He then set his course to the WD field and was traveling at approximately 8 knots. The captain then turned around to do paperwork on his computer. The impact with SP 27 #5 was approximately 3 minutes after he set his course. The MV then notified USCG of the incident and proceeded to drop off Island Operators personnel at WD 106 platform and traveled to the shipyard for vessel repairs. After the vessel arrived at the shipyard, GOL management met the vessel there where they gathered statements from all the MV crew.

The GOL internal investigation concluded that multiple factors could have contributed to the incident. Some of these factors include the failure to account for the proximity of navigational hazards, the platform's low profile which could have caused limited visibility, and the captain allowing himself to become distracted by working on the computer and not designating proper look-out personnel while he did his computer work. The GOL investigation also concluded that the captain violated company safe navigations/voyage planning policy by setting his course to the WD field prior to clearing all structures in the East Bay field. It was determined by GOL that the captain did not use his electronic navigation chart system that has the structures in the field clearly identified.

IN CONCLUSION:

The incident that occurred on 18 July 2025 could have resulted in a far worse outcome. Due to the lack of awareness by the boat captain and the failure to use the proper electronic navigation chart system, the MV contacted the SP 27 #5 platform causing damage to both the platform and the MV. Specifically, the captains disregard for GOL's navigation policy, and focusing his attention on his computer rather than navigating the vessel while underway, caused the allision. Although there were no injuries or pollution as a result of the incident, there was the potential for both. Due to the allision, GOL has stated that they will take multiple steps to prevent this type of incident from occurring in the future. Some of these steps include a safety alert being shared with the GOL fleet for maneuvering close to platforms/ structures and safe navigation of the vessel. GOL will also hold a review of the navigation policy with each vessel of the entire GOL fleet.

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

HUMAN ERROR: Inattention to task- The boat captain was not paying attention to the MV's heading once he set course to the WD field and turned his attention to performing computer tasks

HUMAN ERROR: Not aware of hazards- The captain of the MV failed to identify the hazards of nearby structures before setting the MV's course to his next location.

HUMAN ERROR: Not following proper procedures- The MV captain did not use his electronic navigation chart system that has the structures clearly identified. This is a violation of the company safe navigation/voyage planning policy.

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

WORK ENVIRONMENT: Poor visibility- The boat captain could have experienced platform visibility issues due to the MV wheelhouse area sitting much higher than the low-lying structure.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

Damage to SP 27 #5 structure

NATURE OF DAMAGE:

Bent, Broken

Etimated Amount (Total):Less than $25,000.00. The platform is not in consideration for repair due to future decommissioning plans.

ESTIMATED AMOUNT (TOTAL): **$**

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:

07-AUG-2025

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:

Michael Saucier

APPROVED DATE: **08-SEP-2025**