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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **04-MAY-2025** TIME: **0445** HOURS

2. OPERATOR: **Anadarko Petroleum Corporation**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Adriatic Marine LLC**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [ ] OTHER LIFTING
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [X] INCIDENT >$25K **Greater than $10,000,000**
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [X] OTHER **Allison**

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

4. LEASE: **G06894**
   AREA: **VK** LATITUDE: **29.10755646**
   BLOCK: **915** LONGITUDE: **-87.94362203**

5. PLATFORM: **A (Marlin)**
   RIG NAME:

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 [X] >$25K [ ] <=$25K

8. OPERATION:
- [X] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [X] 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: **3236** FT.

11. DISTANCE FROM SHORE: **64** 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 04 May 2025, at 0445 hours, an allision incident occurred to Viosca Knoll (VK) 915 A, Marlin Tension Leg Platform (Marlin), operated by Anadarko Petroleum Corporation (Anadarko). A 178-foot supply boat, motor vessel Adriatic, (M/V) owned by Adriatic Marine LLC struck the platform. The allision impact was felt throughout the platform, which resulted in a manual Emergency Shut Down (ESD) and bleed down of the platform by nighttime control room operators (CRO).

Immediately following the allision, the CROs performed a quick assessment of the platform and surrounding areas and discovered that the M/V Adriatic had impacted the Northwest and Southwest side of the hull columns, which resulted in damage to the platform as well as the M/V. There were no reported injuries to personnel, no environmental pollution observed, and no stability issues reported on the platform or vessel. Anadarko personnel contacted their management and notified the United States Coast Guard (USCG), the National Response Center (NRC) via NRC# 1430144, and the Bureau of Safety and Environmental Enforcement (BSEE), to inform them of the allision incident.

SEQUENCE OF EVENTS:

On 04 May 2025, at 0430 hours, the M/V Adriatic was 22 minutes away from the Marlin Platform when they contacted the control room by radio and informed them that the boat would be in the field soon to pick up a passenger. The CRO directed the M/V's captain to remain outside of the 500-meter zone until the Anadarko Balast Control Operator (BCO) was on tower. The M/V captain asked the CRO if he could perform a drift test. The CRO advised that the captain could perform his drift test as requested.

At 0445 hours, Marlin was struck by the M/V Adriatic. The bow contacted the Northwest pontoon and then the right stern of the vessel contacted the Southwest pontoon shortly thereafter.

At 0446 hours, the CROs quickly went to the handrails and observed the M/V backing away from the platform, with damage to the bow of the vessel. The vessel appeared to have made contact with two production risers (Dorado and Crown and Anchor), a gas lift line that was internal to the Dorado Riser, and firewater piping on the hull column , the CRO ESD'd the platform. Personnel mustered while production personnel began shutting in wells, making the facility safe, and isolating a small section of firewater piping. The M/V Adriatic then positioned itself outside the 500-meter zone.

At 0830 hours, M/V Adriatic departed from the facility, heading to the Adriatic Dock located in Port Fourchon, Louisiana. A meeting was held with Adriatic Marine management personnel and Anadarko personnel. The USCG was fully engaged with the Adriatic Marine company representatives as they performed their own investigation. A completed report was filed by the USCG.

BSEE INVESTIGATIONS:

On 06 May 2025, a BSEE New Orleans District investigation team consisting of a Supervisory Inspector (SI) and an Accident Investigator (AI) arrived on location. The team met with Anadarko's Health Safety and Environment (HSE) Coordinator, Director of Regulatory Affairs, the Offshore Installation Manager (OIM) and the nighttime CRO's. Witness statements were gathered, and an inspection of the damaged areas was performed. Photos were taken by the BSEE investigation team and additional photos were provided by Anadarko representatives to the BSEE Investigation team. In addition, a

video from a platform surveillance camera capturing the moments leading up to the allision, as well as when the M/V Adriatic allided with the platform was also provided to the investigators. A copy of the USCG Report of Marine Casualty was provided and a Final Incident Summary Report was received from Anadarko with their findings. All documents were reviewed by the BSEE investigation team.

Based off the reports and statements taken, the investigation revealed that the M/V Captain was not paying attention to navigating the vessel as he should have been at the time of the incident. After requesting and receiving approval to perform the drift test, the captain focused his attention on administrative tasks instead of navigation of the vessel. Due to the lack of attention given to navigating the vessel, the captain wasn't aware of his surroundings at the time of the incident, which led to the vessel allision with the platform.

Based off documents received, it was determined that the captain was preparing paperwork for the upcoming dynamic positioning "drift test" and turned his attention away from captaining the vessel. Additionally, the "2nd captain on the bridge was given permission by the captain to step away from the bridge to meet with the vessel's unlicensed engineer in the galley, which took his attention away from the helm as well with no one steering the motor vessel at the time of the allision.

The video of the allision clearly shows the vessel approaching the facility "at speed". As such, either personnel thought the vessel was drifting, while it was actually underway, or the vessel wasn't performing the drift test at the time of the incident. The video does not indicate a change in direction or speed as the boat approaches the platform. Seconds before the allision, the vessel disappears beneath the camera's view. A few seconds later, the allision is indicated as the surveillance camera and platform structure shake. Unfortunately, the video could not verify whether the wheelhouse was occupied or unoccupied at the time of the incident due to darkness in the wheelhouse.

IN CONCLUSION :

After reviewing all the submitted documents, photos, surveillance video and statements, the investigation team determined the allision occurred because of the captain not being aware of his surroundings, and the captain not having his full attention on navigating the vessel near the platform.

The captain focused his attention on administrative tasks to prepare paperwork for the upcoming drift test, instead of navigation of the vessel. Typically, there is a 2nd Captain on the bridge at all times to ensure there is always somebody at the helm. In this case, the Ccaptain had already granted permission to the 2nd Captain to leave the bridge to meet with the vessel's unlicensed engineer. As a result, neither of the captains were focused on navigating the vessel at the time of the incident, which led to the vessel allision with the platform.

Since the allision, repairs have been made to the facility. The Dorado flowline and internal gas lift has been repaired and returned to production. The Crown and Anchor flowline was already out of service at the time of the allision, and is in the process of being decommissioned. The platform firewater piping has been repaired and returned to service as well.

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

Human Performance Error: Inattention to the task. - Reports received indicate that the captain was not focused on captaining the vessel at the time of the incident. Instead, he was focusing on preparing paperwork for the upcoming "drift test."

Human Performance Error: Not following proper procedures. – Multiple procedures were not adhered to, which contributed to the incident. Specifically, the requirement there will always be a minimum of one other watch stander in the bridge during periods when the vessel is underway. The captain should not have allowed the 2nd captain to leave the bridge while underway, especially since the captain was focusing on other administrative tasks, taking his attention away from captaining the vessel.

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

Human Performance Error – Rushing to get the job completed and trying to do to many tasks at once. - The captain should have assigned the task of performing paperwork for the upcoming drift test, or captaining the vessel to the 2nd Captain. Additionally, the 2nd captain should not have been allowed to leave the bridge, while the captain was multi-tasking, and not fully focused at the helm.

20. LIST THE ADDITIONAL INFORMATION:

BSEE NOD recommends the Office of Incident Investigation (OII) issue a Safety Alert on this incident. It should be noted that BSEE Recommends finding a way to ensure this Safety Alert gets to the personnel who work on the boats/vessels that tend to the facilities, not just to the operators on the facility.

21. PROPERTY DAMAGED:

Damages the 8" Dorado Steel Catenary Riser (SCR) and the gas lift tubing internal to the Dorado Riser. Additionally, damage was identified on the Beacon operated Crown and Anchor SCR. Also, damages to a section of piping for the firewater system.

NATURE OF DAMAGE:

Allision

ESTIMATED AMOUNT (TOTAL): **$10,000,000**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE NOD recommends the Office of Incident Investigation (OII) 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:

06-MAY-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 J. Saucier

APPROVED DATE: **22-SEP-2025**