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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **16-JUL-2025** TIME: **1810** HOURS

2. OPERATOR: **Eni US Operating Co. Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G19996**
   AREA: **MC** LATITUDE:
   BLOCK: **773** LONGITUDE:

5. PLATFORM: **A(Devils Tower)**
   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 [ ] >$25K [ ] <=$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:
   - [X] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] OTHER
   - [ ] TEMP ABAND
   - [ ] PERM ABAND
   - [ ] DECOM PIPELINE
   - [ ] DECOM FACILITY
   - [ ] SITE CLEARANCE

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

10. WATER DEPTH: **5610** FT.

11. DISTANCE FROM SHORE: **58** 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 July 2025, at 1810 hours, an incident occurred on Mississippi Canyon (MC) 773 A (Devils Tower) platform. Devils Tower is a Single Point Anchor Reservoir (SPAR) platform in the Gulf of America owned and operated by Eni US Operating Co. Inc. (Eni). During the incident, three Nabors employees were standing on a Northside external walkway platform on the third floor outside of Room 77 C of a Temporary Living Quarters (TLQ). While the employees were standing on the walkway platform, the platform unexpectedly detached from the TLQ structure by an estimated 12 to 18 inches. This created a visible gap between the walkway and the TLQ structure. The walkway platform was still held in place by stanchions that were bolted to the TLQ, and the stairway beneath the walkway was bolted to the 2nd level of the TLQ. The stairway and walkway were immediately secured to prevent any dropped objects and/or further separation of the walkway platform from the TLQ. Due to the immediate action taken to secure the walkway, there were no injuries or dropped objects associated with the incident.

SEQUENCE OF EVENTS:

On 16 July 2025, at approximately 1810, three Nabors employees were standing on an external walkway platform outside of Room 77 C located on the third floor of the platform's TLQ. While standing on the walkway, the walkway unexpectedly detached from the TLQ structure. Two of the Nabors employees were able to open the Room 77 C door and make their way back into the room. The third employee was able to move a safe distance from the detached area while still on the third-floor walkway. Immediately after all individuals were in safe locations, the stairway and walkway were secured with chain bindings to prevent any dropped objects or the walkway separating even further.

After the stairway and walkway had been secured, the affected area was cordoned off, and red danger tape was installed around the area to warn personnel of the hazards in the area. All personnel that were housed on the third floor living quarters were then relocated to alternative accommodations, using an alternative walkway. An immediate investigation was then initiated to determine what caused the walkway to separate and evaluate the structural condition of the TLQ and connections supporting the TLQ infrastructure.

BSEE INVESTIGATIONS:

On 17 July 2025, at 1220 hours, Eni notified the Bureau of Safety and Environmental Enforcement (BSEE) by email of an incident that occurred at Devils Tower on 16 July 2025. In the initial notification, Eni provided the time of the incident and a short description of the incident. On 30 July 2025, at 1339 hours, Eni submitted an electronic incident report to BSEE. The electronic report provided further details of the incident that occurred.

On 30 July 2025, the incident was assigned to a BSEE Accident Investigator (AI). After being assigned to the incident, the AI reviewed all the information provided by Eni concerning the incident. The AI requested additional information pertaining to the incident such as additional photographs, platform drawings, and the Eni internal investigation report.

The BSEE investigation and information provided by the Eni internal investigation report revealed that the TLQ was originally installed on the platform in 2002 and was only intended as temporary accommodations to house overflow construction and drilling contractors on the facility. The TLQ was then left on Devils Tower for twenty-three years and remains on location to the present date. According to the Eni internal

investigation report and the fact that the TLQ was originally intended to be temporary, it was found that the welded tabs securing the walkway to the TLQ structure were not sufficient to provide a long-term permanent attachment point. The tabs lacked welded surface area which would have provided additional support for the tabs. Eni's investigation report states that the method in which the tabs were welded was meant to simplify any future demolition or relocation of the TLQ. In addition, the investigation found that a lack of cross bracing on the south side of the walkway could have contributed to additional stress and structural vulnerability of the failed section.

Eni's investigation report also revealed that in May 2024, twenty-two years after initial installation, a visual inspection was performed on the TLQ. This visual inspection was deemed by Eni to be inadequate to detect welding defects. Because Eni only performed a visual inspection of the TLQ's structural components, the inspection was unable to identify the deteriorated condition of the welded tabs. These welded tabs suffered fatigue and material degradation due to progressive corrosion after years of being in a harsh marine environment.

In the past few years, Eni has implemented an Asset Integrity Management Strategy that required Level 1 surveys of all Eni platforms' structural components. The most recent Level 1 survey that was conducted in May 2024 did not indicate any discrepancies in the walkways or structures for the TLQ. This was most likely due to only visual inspections having been performed. In future Level 1 surveys, Eni has stated that they have created specific annual inspection requirements for the TLQ landings and tab welds that will be incorporated in the Eni Computerized Maintenance Management System (CMMS). Eni feels that these additional inspection requirements will help minimize the possibility of similar issues occurring in the future.

Per Eni, as of 09 September 2025, all tabs have been correctly welded to provide the correct amount of support for the walkways on the TLQ. Eni is still awaiting NDT inspections for those repairs to place the walkways back in full service. Projected timeframe for completion of the NDT is 15 October 2025.

IN CONCLUSION:

BSEE investigation findings revealed that the TLQ was lacking consistent structural support for the walkways on the TLQ. The tabs which connected the walkways to the TLQ structure lacked sufficient welds to provide the correct amount of support. Investigation findings also revealed that the TLQ was originally intended to be temporary and was designed to be easily removed or dismantled. As the TLQ was originally designed to be temporary, the inspections that were performed did not take the age of the TLQ into consideration. In addition, inspection criteria did not identify or consider the possible environmental effects and age-related degradation of the welds.

Eni has stated that they will ensure that future design and construction of temporary structures will account for potential long-term use. Eni will also be incorporating dedicated inspections and protocols for TLQs and other similar installations that will focus on marine corrosion, fatigue and weld conditions. Eni intends to use these newly implemented guidelines to prevent the possibility of similar incidents occurring in the future.

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

Equipment failure: Flawed equipment design or construction- The TLQ was designed and constructed to be used as temporary housing for overflow workers. The TLQ remained on site for twenty-three years after original installation, which it was not originally intended for.

Equipment failure: Inadequate equipment inspection- The TLQ inspections that were performed were visual inspections only. The visual-only inspections were inadequate for determining the integrity of the tab welds.

Equipment failure: Inadequate structural support- The welded tabs used for connection points to the TLQ lacked the proper welded surface to provide proper support. There was lack of support under the south side of the stairway which could have contributed to additional stress and structural vulnerability of the failed section.

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

Work environment: Environmental factors- Due to the age of the TLQ and the natural marine environments, corrosion had become present on the tab welds, along with age-related fatigue.

Management Systems: Improper management system for inspections- Due to the construction method and original intent of the TLQ being temporary, improper visual inspection criteria were used. Visual inspection failed to identify hazards associated with the structural support of the TLQ and walkways.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: **Walkways and support**

NATURE OF DAMAGE: **Broken/Repaired**

ESTIMATED AMOUNT (TOTAL): **$22,124**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE New Orleans District recommends that 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:

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: **21-OCT-2025**