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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **24-AUG-2025** TIME: **1530** HOURS
2. OPERATOR: **W & T Energy VI, LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Phoenix Offshore Solution**
   REPRESENTATIVE:
   TELEPHONE:

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

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

4. LEASE: **G07824**
   AREA: **MP** LATITUDE:
   BLOCK: **252** LONGITUDE:

5. PLATFORM: **B**
   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

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: **277** FT.
11. DISTANCE FROM SHORE: **59** 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 24 August 2025 at 1530 hours, a crane incident occurred at Main Pass (MP) 252 B, operated by W&T Offshore VI, LLC (W&T). After the platform crane was utilized to offload the Motor Vessel (MV) Captain Rudy, the crane boom unexpectedly collapsed onto the cradle while the boom was being lowered. There were injuries and no pollution reported. Estimated repair costs were greater than $400,000.

SEQUENCE OF EVENTS:

Prior to the incident, from 22 August 2025 to 23 August 2025, the crane's pre use inspection and documentation from the platforms daily operations safety meeting indicated that the load block and wire rope on the crane were replaced by Phoenix Offshore Solutions (Phoenix) personnel before the incident that occurred on 24 August 2025. The load block and wire rope replacement were able to be verified from both the crane pre-use and the platforms daily operations safety meeting documentation from 08/24/2025.

On Sunday, 24 August 2025, at 0600 hours, W&T personnel discussed the daily activities during the Operations Safety Meeting. They discussed the offloading and backloading of the M/V Captain Rudy, taking on diesel and water from the MV, and securing inbound cargo. Additionally, they discussed the status of the recently replaced crane load block and wire rope on the boom winch load block.

At 1525 hours, the crane offloading/backloading operation was completed. The Phoenix crane mechanic took over crane operations from the designated Danos crane operator. There is no indication or documentation of the Phoenix Crane Mechanic performing a pre-use inspection before taking over the crane. The Crane Mechanic began lowering the boom down into the cradle to allow maintenance personnel access for measurements of replacement parts. At 1530 hours, without a load on the crane, approximately 3 feet from the boom cradle, the boom free-fell into the cradle, causing the lattice boom to buckle and bend downward at a 90-degree angle over the side of the platform. As the boom fell, the broken boom cable hit and shattered the glass of the crane cab windshield. Some of the shattered glass struck the crane mechanic in the face. All crane operations were immediately stopped. Stop Work Authority initiated. Personnel went to the aid of the crane mechanic. Notifications were made shortly thereafter.

On Monday, 25 August 2025, W&T dispatched their safety and compliance technician and a Phoenix Contract Crane Supervisor to MP 252 B to meet with the platform Person in Charge (PIC) and to evaluate and secure the scene. The W&T construction foreman also arrived on location to discuss a plan to secure the boom.

On 26 August 2025, W&T's Construction Foreman and a Fluid Crane Supervisor met on location and developed a plan of action for securing the crane bridle. With the bridle secured, the pre-use inspection was retrieved from the crane cab.

W&T's initial determination for the cause of the crane incident was due to boom cable failure. As such, W&T focused their efforts on removing sections of damaged cable to send them in for analysis. Third-party Engineering report determined that something sharp likely encountered the wire rope, causing the failure.

BSEE INVESTIGATIONS:

The day after the incident, on 25 August 2025, two (2) Bureau of Safety and Environmental Enforcement (BSEE) inspectors arrived on location to assess the

situation. At the time of their arrival, the crane boom had not yet been safely secured or stabilized. The inspectors requested reports and documents from the PIC, Maintenance Technician, Compliance personnel and Contract Crane Supervisor. The inspectors took photos of the scene and gathered information from platform personnel.

On the morning of, 27 August 2025, Fluid crane personnel and equipment and third-party scaffolding company personnel and scaffolding arrived on location via the Motor Vessel (M/V) Eveready to secure and remove the boom. On the same day, the BSEE Accident Investigator (AI) and one Inspector also arrived on location. BSEE personnel Interviewed the PIC, Crane Mechanic, Platform Operators and witnesses. The BSEE AI gathered information, reports, documents, photos and witness statements needed to assess the incident. Documents that were not readily available offshore were emailed to the assigned AI.

IN CONCLUSION:

The results of third-party Engineering's cable analysis indicated the failure to be a combination of shear and tensile breaks in the cable wire ends, with the majority being shear breaks. The report mentions it is likely that that something sharp encountered the rope causing failure, such as the rope jumping a sheave. The third-party report found no manufacturing anomalies, and the rope failure was attributed to the result of operating conditions.

In conclusion, the third-party Engineering report determined that something sharp likely encountered the wire rope, causing the failure. It was unable to be determined what specific sharp object may have caused this cable failure.

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

Equipment failure – Inadequate preventative maintenance/inadequate equipment repair.

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

Equipment Failure – Inadequate equipment testing/calibration/inspection

20. LIST THE ADDITIONAL INFORMATION:

DATES OF ONSITE INVESTIGATIONS: August 24, and August 27, 2025

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

American Aero OM-450B-100 crane boom.

ESTIMATED AMOUNT (TOTAL): **$400,000**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans District recommends that a safety alert regarding the incident should be considered.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

27-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 J. Saucier

APPROVED DATE: **26-FEB-2026**