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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **16-AUG-2025** TIME: **0530** HOURS

2. OPERATOR: **High Point Gas Gathering, L.L.C.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

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

4. LEASE: **G09743**
   AREA: **VK** LATITUDE: **29.16740033**
   BLOCK: **817** LONGITUDE: **-88.45586715**

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

10. WATER DEPTH: **673** FT.

11. DISTANCE FROM SHORE: **34** MI.

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

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

14. SEA STATE: **0** FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

INCIDENT SUMMARY:

On the morning of 16 August 2025, the Motor Vessel (MV) Dry Tortugas struck the production platform Viosca Knoll 817 A (VK 817), on Lease G09743, and operated by High Point Gas Gathering, LLC. The impact of the allision was located near the SW corner of the platform, which resulted in damage to the platform from the +10 level to the +50 level. The MV was owned and operated by Romero Papa LLC. The vessel had been previously operating in the field as a support vessel. The allision resulted in a few minor non-recordable first aid injuries. No serious injuries were reported and no pollution.

The allision resulted in extensive damage to the platform support structures, piping, and walkways, which resulted in an immediate platform Emergency Shut Down (ESD). The M/V sustained damage to its bow, pilothouse, mast and other areas, but the crew did not report any injuries. Damage to the platform was estimated to be $4.45 million, and damage to the M/V was estimated to be $500,000.

SEQUENCE OF EVENTS:

On 16 August 2025 at 0500 hours, personnel on board VK 817 were preparing for their morning safety meeting. At the same time, the captain of the M/V, a 143-foot work boat tending to the field, set the autopilot to navigate toward VK 817 at a speed of approximately 6 knots, prior to departing the field to head to its next destination Main Pass (MP 260 P).

At 0530 hours, the M/V violently struck the VK 817 platform on the Southwest corner. Immediately after the allision, the Control Room Operators (CRO) rushed to the eastern-side handrail and observed the M/V Dry under the platform and beginning to back away from the structure. The platform was immediately ESD'd. Once the severity of the damage to the platform was assessed, the decision was made to begin de-manning.

On 27 August 2025, two representatives from the Bureau of Safety and Environmental Enforcement (BSEE) arrived on location to begin an incident investigation. BSEE personnel questioned the personnel on board (POB) and requested documentation consisting of the POB list and morning reports from the platform. They also took photos and requested additional photos of the damage to the platform and vessel to be sent via email.

BSEE INVESTIGATIONS:

The BSEE investigation revealed that on the morning of the allision, the 17 POB were preparing for the morning safety briefing as the M/V was headed towards VK 817 to acknowledge its departure to MP 260 P approximately 4 miles away. According to statements provided in the United States Coast Guard (USCG) Investigation Report, the M/V Master admitted to setting the autopilot and then subsequently falling asleep. The CRO's at VK 817 were unaware of the M/V's fast approach to the platform.There was no radio call made from the MV to the platform, and no external surveillance monitors or warning alerts were triggered on the MV or platform to alert personnel of the approaching MV.

The sudden impact of the MV's allision with the platform shook the entire facility. After the allision, platform personnel ran to the eastern handrail and observed the M/V under the platform just to the right of the High-Pressure Gas Pipeline. Extensive damage to the lower levels of the platform was observed.

IN CONCLUSION:

In conclusion, the USCG investigation found that the M/V allided with VK 817 because the captain fell asleep at the controls, while the vessel was navigating toward the platform on autopilot.

From the USCG investigation, the master failed to adhere to International Navigational Rule #5 which requires maintaining a proper lookout by sight, hearing and all available means to assess the situation and avoid collisions. Additionally, the Master failed to adhere to International Navigation Rule #8 which requires taking timely and effective action to avoid collisions. The M/V failed to have a Bridge Navigational Watch Alarm System installed which is designed to continuously monitor the bridge and alert the crew in the event of inactivity or lack of response from the operator. The absence of this system allowed the Master to fall asleep at the helm without any alerts to notify other crew members of the situation.

Additionally, the Master did not adhere to the work-hour limitations. The Master was on a two-week rotation, working the midnight-to-noon 12-hour watch schedule. On the previous day, during their off-duty hours, the Master engaged in manual labor cleaning bilges. This additional work exceeded the limitations set forth in Coast Guard regulation 47USC8104(b), which restricts crew members from working more than 12 hours in a 24-hour period, except in emergencies. This fatigue resulting from his excessive workload likely contributed to the Master's inability to remain awake during their watch.

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

• Human Performance Error: International Navigational Rule #5 and #8. The captain failed to safely operate the M/V Dry Tortugus. He admitted to falling asleep at the controls while the vessel was on autopilot.

• Human Performance Error: Work-hour limitations exceeded. The captain's excessive workload on the day prior to the incident may have contributed to his inability to stay awake and alert while at the helm.

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

• Equipment failure: At the time of the incident there was no Bridge Navigational Watch Alarm System installed on the M/V. There were no safety devices, monitors or alarms in use, either on the platform or the M/V, to detect the collision course of the vessel with the platform.

• Supervision- Inadequate Training in Fatigue Management. The crew, including the Master, did not receive training on recognizing and managing fatigue as part of their safety protocols. The crew lacked the knowledge and tools necessary to identify and mitigate fatigue-related risks during operations.

• Supervision- Failure of Management to Implement fatigue Monitoring Systems.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

Cost estimate: platform $4.45 million and the M/V $500,000.

NATURE OF DAMAGE:

Caused by allision by the M/V Dry Tortugas

ESTIMATED AMOUNT (TOTAL): **$4,950,000**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE New Orleans District has no recommendations for the Office of Incident Investigations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

27-AUG-2025

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: **26-FEB-2026**