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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **08-JAN-2026** TIME: **0845** HOURS

2. OPERATOR: **Talos Petroleum LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Danos & Curole Marine Contracto**
   REPRESENTATIVE:
   TELEPHONE:

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

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

4. LEASE: **G06898**
   AREA: **VK** LATITUDE: **28.97303233**
   BLOCK: **989** LONGITUDE: **-88.62598209**

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
- [X] 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:
- [ ] EQUIPMENT FAILURE
- [X] HUMAN ERROR
- [ ] EXTERNAL DAMAGE
- [ ] SLIP/TRIP/FALL
- [ ] WEATHER RELATED
- [ ] LEAK
- [ ] UPSET H2O TREATING
- [ ] OVERBOARD DRILLING FLUID
- [X] OTHER **MANAGEMENT SYSTEMS**

10. WATER DEPTH: **1290** FT.

11. DISTANCE FROM SHORE: **26** 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 08 January 2026, at 0845 hours, an incident occurred at Viosca Knoll (VK) 989 A (Pompano) platform. Pompano is a fixed leg platform located in the Gulf of America and is owned and operated by Talos Petroleum LLC (Talos). During the incident, Danos & Curole Marine Contractors, Inc. (Danos) contractor crew was in the process of replacing 480-volt cable (CLX) for a vapor recovery unit (VRU). While replacing the cables, the crew determined that an old cable needed to be removed from the cable tray to have room to install the new cables. A Danos crew member began cutting the identified cable with an electric bandsaw when an arch flash occurred due to cutting the wrong cable. There were no injuries or pollution associated with the incident. There was damage to the bandsaw blade and the energized cable that was cut.

SEQUENCE OF EVENTS:

Per the Talos investigation report, on 07 January 2026, at 1400 hours, the Danos electrical crew that was tasked with work to replace the CLX cables arrived on Pompano. At 1500 hours, the Danos crew and the Talos electrician walked down the jobsite and performed the required Lock Out Tag Out (LOTO) procedures on the CBA-4010 (VRU #1 1st stage) compressor motor. At 1530 hours, the junction box for the VRU #1 1st stage was prepped for work. During this timeframe, the Talos electrician identified the VRU #1 cable to be cut and removed. The Talos electrician showed it to the Danos crew. Work then concluded for the day.

On 08 January 2026, at 0600 hours, Danos electrical crew members took part in a pre-tour safety meeting, JSEA, and Permits to Work (PTW) for the VRU #1 1st stage cable replacement. At 0700 hours, a cable spool was set up on the drill deck and prepared for the cable replacement. At 0800 hours, the crew began running new cable for the VRU #1 1st stage from the drill deck through the deck penetration location. At 0840 hours, the new cable was routed to the cable tray below drill deck. At this point, the crew determined that the old cable needed to be removed from the cable tray to accommodate the new cable installation. At 0845 hours, a Danos crew member electrician used a portable bandsaw to cut what was believed to be the old cable. When the Danos crew member cut into the cable, an arch flash occurred when the bandsaw blade contacted the energized cable during the cut. All work was immediately stopped, and the incident was reported to the Talos Offshore Installation Manager (OIM). The energized cable that was mistakenly cut and was the source of the arc flash was servicing CBA-4060 B (VRU #1 2nd stage) which was in service at the time of the incident. The energized cable was locked out by Talos electrician after the incident.

BSEE INVESTIGATIONS:

On 13 January 2026, Talos submitted an electronic report to the Bureau of Safety and Environmental Enforcement (BSEE). The electronic report included a description of the incident, investigation reports, photographs and other related documentation. After the report was submitted, the incident was assigned to a BSEE Accident Investigator (AI) on 14 January 2026.

Once assigned to the incident, the AI requested additional documents from the operator pertaining to the incident. The AI then performed an on-site investigation at Pompano where additional photographs were taken and additional documentation was requested. Before the AI arrived at the location to perform the on-site investigation, the cable that was mistakenly cut had already removed from the area to avoid any further hazards. Through the review of the Talos investigation report, Danos investigation report, and witness statements, the AI was able to verify the details that took place leading up to and during the incident.

Per the Talos and Danos investigation reports, the Talos electrician identified the wrong cable that needed to be cut and removed. The Talos electrician then proceeded to point out the wrong cable to the Danos personnel during the pre-job walkthrough. The cable that needed to be removed was locked out and energy isolation was performed. Unfortunately, the Talos electrician identifying the wrong cable during the pre-job walkthrough led to the incorrect (energized) cable being cut. Additionally, the Danos crew member did not independently verify the correct cable to be cut and removed. This allowed the wrong (energized) cable to be cut and the arc flash to occur. The VRU #1 2nd Stage breaker did trip as designed once the cable was cut into. After realizing the breaker was tripped and the wrong cable was cut, energy isolation was performed along with LOTO on the VRU #1 2nd Stage breaker.

Upon further review of the incident and documentation, the Job Safety Environmental Analysis (JSEA) that was performed for the task did not have the hazards listed for cutting the wrong cables. Additionally, there were no controls or mitigation methods implemented to verify the correct cable to be cut before cutting the cable. By not verifying the correct cable to be cut, the Danos crew did not follow their company's procedure (Cable Removal-Demolition Procedure ES-P-300-002). Per the Danos policy, the demolition crew is required to use the Cable Removal-Demolition Procedure checklist in conjunction with the JSEA. The checklist was not performed as per Danos policy. The investigation also exposed a breakdown in communication between the Danos management and the electrical crew. Danos admitted that the policy was not distributed to the Danos work crew that was replacing the cable prior to the job and the Danos work crew replacing the cables were not familiar with the cable demo procedures as this type of task was not usually in their scope of work.

Danos stated that the crew did not follow the Danos Work Safe Oath Element- Energy Isolation which states to verify isolation and zero energy before work begins. The investigation found that as the job scope changed and it was determined that the old cable would need to be removed to install the new cable, the JSEA was never updated to account for the new tasks and the hazards that were involved with the new task.

On 11 March 2026, the New Orleans District forwarded Safety Alert No.506, "Arc Flash Incident Highlights Critical Need for Voltage Verification During Offshore Electrical Maintenance," previously issued by the Office of Incident Investigations, to Talos Petroleum LLC for awareness.

IN CONCLUSION:

The incident that occurred on 08 January 2026 at Pompano was a direct result of poor communication, management not providing crew members with proper procedures prior to performing a task, and personnel not following company policies set in place for personnel safety. The incident could have had a far worse outcome. Fortunately, the breaker for the CBA-4060B tripped as intended when the band-saw cut into the cable. As a result of this incident, a Safety Alert was distributed throughout Talos that focused on proper energy isolation and verification prior to work being performed.

Danos management distributed their Work Safe Oath Element training to employees through the Danos dashboard to reinforce safety around life-saving rules. Danos also conducted a Safety Stand Down with the Power Gen field team including the Ops Manager and Project manager to discuss the incident and the path forward. The Cable Removal-Demolition Procedure that was not distributed prior to the incident, will be distributed through Computer-Based training to all work groups to become familiar with the process/procedure. Lastly, Danos created an Early Learning Bulletin and distributed it to work groups to review the learnings and prevent similar incidents in the future.

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

Human Performance Error: Not following proper procedures- Danos crew members did not follow their company Work Safe Oath Element-Energy isolation which calls to verify energy isolation before work begins.

Human Performance Error: Inexperience doing task related to incident- Danos stated in their investigation report that the "Crew was not familiar with cable demo procedure due to this type of task not usually in their scope of work."

Communication: Inadequate communication between the operator and contract personnel- The Talos electrician pointed out the wrong cable to be cut. Danos personnel never verified the energy isolation and never verified that the cable pointed out during the pre-job walkthrough was the correct cable to cut.

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

Management Systems: No written job procedures- Danos management failed to provide the crew on location with the Cable Removal-Demolition Procedure prior to performing the work.

Communication: Inadequate job instructions provided- Danos failed to provide the crew with the proper training to perform the task. Due to the crew not being familiar with the task, training should have been provided prior to the crew performing the task.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: **CLX cable**

NATURE OF DAMAGE: **Cut/ damaged**

ESTIMATED AMOUNT (TOTAL): **$2,600**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans District recommended the Office of Incident Investigations consider a Safety alert regarding the incident (if a safety alert has not been previously issued on this topic), with focus directed towards verifying energy isolation and following company policies.

Since a similar Safety Alert had already been published, the Office of Incident Investigations shared Safety Alert No 506 "Arc Flash Incident Highlights Critical Need for Voltage Verification During Offshore Electrical Maintenance," which was then forwarded to Operator for awareness.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

06-FEB-2026

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-MAR-2026**