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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **07-MAR-2026** TIME: **2200** HOURS

2. OPERATOR: **W & T Offshore, Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Accu-Line Wireline Services**
   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: **G11573**
   AREA: **GB** LATITUDE:
   BLOCK: **783** LONGITUDE:

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

6. ACTIVITY:
- [ ] EXPLORATION(POE)
- [X] DEVELOPMENT/PRODUCTION(DOCD/POD)
- [ ] DECOMMISSIONING

7. TYPE:
   INJURIES:
- [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	**0**	**1**
[ ] LTA (1-3 days)		
[X] LTA (>3 days)	**0**	**1**
[ ] 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:
- [ ] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [X] 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
- [ ] OTHER _____

10. WATER DEPTH: **4670** FT.

11. DISTANCE FROM SHORE: **148** 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 7 March 2026, an Accu-Line Well Services (Accu-Line) employee sustained a head injury while conducting workover operations on Well A008 on the W&T Offshore, Inc. (W&T) Magnolia platform, located at Garden Banks Block 783A. The Accu-Line employee's injury required evacuation from the platform for medical treatment.

Sequence of Events:
On 7 March 2026, an Accu-Line wireline crew was removing a wireline ram preventor valve from the top of the coil tubing unit (CTU) blow out preventor (BOP). A connection lift cap was installed on top of the wireline ram preventor above the tool trap, and the crane hook was attached to the shackle on the lift cap. The crane lifted the wireline ram preventor valve off the CTU BOP and placed it on the deck near several pipe flanges protruding approximately twelve inches above the deck.

An Accu-Line Supervisor, the Injured Party (IP), climbed onto the frame of the wireline ram preventor valve, which was approximately three feet two inches high, to disconnect the crane hook from shackle on the lift cap. As the IP stepped down from the wireline ram preventor onto a protruding pipe flange, he lost his footing and fell, wedging his head between two of the pipe flanges. The incident was witnessed by another crew member, who provided immediate assistance. The IP lost consciousness for around two or three minutes and upon regaining consciousness, he appeared confused and lethargic. The IP sustained a six-inch and a two-inch laceration on the back and top of his head, a quarter-inch laceration near his left eye, and an abrasion on his left cheek. According to the operator, there are no videos of the incident. The medic was contacted, and the IP was transported to the medic's station using a stair chair litter where he was able to transfer from the litter to the cot without assistance.

At 2300 hours on 7 March 2026, an on-call physician was consulted, and the wounds were cleaned and dressed. At this time the IP was able to get up and use the restroom without assistance. A decision was made not to medivac the injured person, and the IP was monitored by the medic overnight. At 0600 hours on 8 March 2026, the IP got dressed and ate breakfast, and the medic continued to monitor the IP until he departed the facility at 1050 hours on 8 March 2026. The IP's supervisor met him at the heliport and escorted him to the Hospital. He was diagnosed with laceration of scalp without foreign body, subarachnoid bleed, and open occipital bone fracture. The IP was treated and released on 17 March 2026 with no restrictions.

BSEE Investigation:
On 17 March 2026, the Bureau of Safety and Environmental Enforcement (BSEE) Lafayette District conducted an onsite Incident Follow-up (IF)Investigation. BSEE met with W&T and Accu-Line representatives and collected all available incident-related documentation. At the time of the IF Investigation, BSEE verified the area had been secured with caution tape and was no longer in use for crane operations. BSEE also interviewed an onsite witness. The crane operator and medic were no longer on location at the time of the investigation and were unable to be interviewed. BSEE reviewed Accu-Line's job safety and environmental analysis (JSEA) and found that a designated flagman was not assigned during the crane operation as required.
The BSEE Incident Investigation Team also determined that the incident resulted from the IP failing to identify hazards, either visually or within the JSEA, including the need for a step ladder or equivalent tool to safely access and remove the D-ring from the lift cap during the crane operation.

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

Human Performance Error:

• Not aware of hazards. The IP climbed up onto the wireline ram preventor to unlatch the D-ring from crane hook without identifying associated hazards.

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

Management Systems:
• Inadequate hazard analysis. The JSEA was insufficient. Accu-Line's JSEA required a designated signal man and to maintaining communications verbal or radio with the crane operator however, these measures were not implemented by Accu-Line.

20. LIST THE ADDITIONAL INFORMATION:

None.

21. PROPERTY DAMAGED:

There was no property damaged during this incident.

NATURE OF DAMAGE:

Not applicable.

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

None.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

On 26 March 2026, W&T Offshore Inc. was issued a G-110 Incident of Noncompliance for failure to conducted well operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment. Operator reported to BSEE on March 7, 2026, Garden Banks 783A, at approximately 2200hrs, Injured Person (IP), was working on the main deck assisting with rigging operations after making a run into Well# A008. The Crane Operator set the Wireline Ram Preventor onto the deck, and the IP climbed onto the Ram Preventor approximately three (3) feet and two (2) inches to unhook the cranes hook from the bridal D-ring on the Wireline Ram Preventor. After disconnecting the crane hook, IP stepped down onto a deck flange and as he attempted to pivot and step off the deck flange, he lost his footing. This caused him to slip and fall, striking his head and face on adjacent pipe flanges located on the deck. IP was monitored overnight and medically evacuated to shore the next morning.

BSEE requested all documentation from Operator's Regulatory and reviewed the following: witness statements, Job Safety and Environmental Analysis (JSEA), photographs and Incident Reports. BSEE observed Operator did not follow the following procedures on the JSEA:
1.(Step #1) Assigning a designated signal man for crane operations,
2.(Step #15) Good communication with crane operator, one flagman.
3.The (Site Specific Hazard Section) According to JSEA Note: Site Specific Hazards must be handwritten on JSA, Every JSA must include handwritten hazards, specific to the location. BSEE determined the Operator failed to follow the above-mentioned procedures.

25. DATE OF ONSITE INVESTIGATION:

17-MAR-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:

Mark Malbrue

APPROVED DATE: **16-APR-2026**