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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **18-APR-2026** TIME: **0640** HOURS

2. OPERATOR: **W & T Offshore, Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Danos & Curole Marine Contractors, Inc.**
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **00830**
   AREA: **SS** LATITUDE:
   BLOCK: **229** LONGITUDE:

5. PLATFORM: **C**
   RIG NAME:

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

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	**0**	**3**
[ ] LTA (1-3 days)		
[ ] LTA (>3 days)		
[ ] RW/JT (1-3 days)		
[ ] RW/JT (>3 days)		
[ ] FATALITY		
[X] Other Injury	**0**	**3**

First Aid

- [ ] POLLUTION
- [ ] FIRE
- [ ] EXPLOSION

LWC
- [ ] HISTORIC BLOWOUT
- [ ] UNDERGROUND
- [ ] SURFACE
- [ ] DEVERTER
- [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

- [ ] STRUCTURAL DAMAGE
- [X] 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
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER _____

10. WATER DEPTH: **130** FT.

11. DISTANCE FROM SHORE: **62** MI.

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

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

14. SEA STATE: **3** FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

Incident Summary:
On April 18, 2026, W & T Offshore, Inc. (W & T) notified the Bureau of Safety and Environmental Enforcement (BSEE) Houma District Office that three injured persons (IPs) had been evacuated from platform "C," located within Block 229 of the Ship Shoal Area (SS 229 C), Lease OCS-00830, approximately 62 miles offshore in the Gulf of America. W & T reported that during transfer of personnel from platform "C" to the motor vessel "GOL Lightning" (MV), the personnel basket suddenly dropped 6-7 feet before making a hard landing on the deck of the MV. The three contractors that were positioned within the personnel basket during the uncontrolled descent sustained injuries to their neck, back, and lower extremities. The IPs were evacuated via helicopter to Galliano, LA, and transported to Houma and Youngsville, LA, to undergo diagnostic procedures and treatment. The crane and the scene of the incident were secured following a BSEE-issued Preservation Order.

Sequence of Key Events:
At approximately 6:40 a.m. on the morning of April 18, 2026, contractors were being lowered onto the back deck of the attending MV using the SS 229 C platform crane's auxiliary (aux) line. After swinging the personnel basket over the handrail into position over the water, the Crane Operator (CO) began to lower the basket, and it unexpectedly fell approximately 1 foot. Personnel inside the basket observed the abnormal movement, and one of them almost fell out of the basket when he lost his footing and they attempted to communicate concern to the CO through the use of visual signals.

The CO acknowledged the initial 1 foot slippage by pointing and laughing at the startled contractor within the basket. The CO then continued to lower the personnel basket down to the back deck of the MV. As the contractors were approximately 6-7 feet above the deck, the aux line did not stop despite the CO disengaging the hydraulics. The aux brake was not holding with the aux line lever in a neutral position, resulting in loss of controlled lowering. The Boat Captain of the MV reported that the personnel basket slammed the deck as a 3-4 foot ground swell caused the vessel to come up and jar the basket as it was landing.

Upon landing, the contractors retrieved their work bags from the inside of the personnel basket and moved away toward the front of the MV as they contacted the CO via radio. Radio communication between the CO and contractors included expressions of dissatisfaction in the manner in which the basket had been landed. The MV departed SS 229 C in route to SS 218 B (approximate fifteen-minute travel time) where paraffin cutting operations had been planned for the day's activities. By approximately 7:15 a.m., the three contractors had transferred from the MV to SS 218 B via swing rope and had ambulated up the stairs of the facility. Once on-board SS 218 B, all three contractors contacted their respective leadership to report they had begun to experience symptoms, such as soreness and stiffness.

The decision was made to evacuate the IPs, and a helicopter arrived at SS 218 B at approximately 8:40 a.m. After stopping at SS 229 C to be evaluated, compose witness statements, and pack their belongings, the IPs were evacuated via helicopter from SS 229 C at approximately 10:40 a.m. The helicopter reached Galliano, LA, at approximately 11:15 a.m., and the IPs departed to be seen by their company doctors.

Following the hard landing onto the deck of the MV, the crane was not taken out of service. The crane boom was not cradled, and the CO, with the assistance from two certified riggers onboard SS 229 C, immediately transitioned into diesel filling operations. As the MV departed SS 229 C for SS 218 B, the personnel basket was landed and disconnected, a stinger was installed on the aux ball, and a tote tank of diesel was connected. When diesel filling operations began, while lifting a 550-gallon tote tank of diesel, the tote tank began to lower despite the CO pulling up on the aux

lever to hoist upward. Following this observation of aux brake slippage, the CO decided to have the tote tank disconnected by the riggers and cradled the boom before placing the crane out of service (OOS). Observations of aux brake slippage were reported to W & T leadership and the Field Crane Mechanic (CM).

BSEE Investigation:
On April 18, 2026, at 8:31 a.m., verbal notification was made by W & T via telephone to the BSEE Houma District regarding the evacuation of three contractors who had sustained injuries during a crane incident that morning at SS 229 C. W & T emailed witness statements and preliminary incident reports to BSEE by 12:31 p.m. on April 18, 2026. BSEE issued a Preservation Order to W & T at 1:24 p.m. on April 18, 2026. By the end of the day on April 18, 2026, W & T reported that all three IPs had been cleared to full duty with no restrictions by their respective company doctor offices.

At 9:15 a.m. on April 19, 2026, BSEE Houma District Accident Investigators (AIs) flew offshore to begin their Incident Follow-Up (IF) Investigation. BSEE AIs reviewed incident details with the group involved in the incident that were present at the facility: the PIC, acting PIC at the time of the incident, CO at the time of the incident, one of the three IPs (a Danos Production Operator who returned to the facility minutes prior to BSEE's arrival that morning), and the Field CM. The two personnel who were not present at the facility at the time of the BSEE IF were the two Acculine Well Services (Acculine) Wireline Operators. W & T and Acculine informed BSEE that the other two IPs (Acculine Wireline Operators) had not been flown back offshore due to their hitch being scheduled to end that day, Sunday, April 19, 2026.

After interviewing the group collectively, BSEE conducted one-on-one interviews with the Danos IP, CO, acting PIC at the time of the incident, PIC, and CM. Following the interviews, BSEE conducted a physical inspection of the crane alongside the CM. BSEE took pictures as the CM and BSEE engaged in discussion regarding the SS 229 C platform crane's braking system. The CM explained that as hydraulic pressure is applied, the brake releases and the brake engages upon loss of hydraulic pressure. It was noted by BSEE AI's that at the time of the incident, both the crane boom and MV were facing northwest and the boom angle was approximately 50-55 degrees. Per the Load Chart, the Safe Working Load (SWL) at that boom angle is 2,280 lbs., and the personnel basket and contractors weighed approximately 1,030 lbs.

A Pre-Use Inspection was conducted by the CM prior to beginning Dynamic Brake Testing, and all safety devices were found to be functioning as designed. After the test weight was determined to be 11,060 lbs. by utilizing the Crane Load Chart, the CM hooked the aux line to a dynamometer (dyno) and a pull-test padeye. Five-minute holding checks were performed at intervals including 2,000 lbs., 4,400 lbs., 10, 400 lbs., and 11,400 lbs. At 10,400 lbs. the brake slipped one-time dropping to 10,000 lbs. and at 11,400 lbs. the aux brake slipped to 10,000 lbs. where it held.

BSEE AIs noted that the CO was running the crane at full throttle throughout the extent of the Dynamic Brake Testing. BSEE AIs recalled that during interviews with the CO, the CO reported to BSEE that he typically ran the crane at half to three-quarter throttle and that he typically eased into crane control levers steadily, referring to this style of actuation as "feathering". As a result, BSEE asked for testing variables to be altered to match those during the incident, feathering actuation at half to three-quarter throttle. As theorized, brake slippage increased in frequency in the repeated tests following the adjustments.

Consistent with the CO's observations during and following the incident, increased load slippage was exhibited (fell in a controlled manner until bringing the aux control back to neutral) when the throttle was decreased and the controls were "feathered". However, when the CO actuated the aux control in a more forceful motion,

slippage decreased notably. No visual indications of damage or degradation were observed during the physical inspection of the crane.

BSEE AIs reviewed crane inspection records and discussed the maintenance history of the SS 229 C crane. The PIC and CM reported that following observations of load slippage, the aux brake had been tightened and a successful pull test was found to be documented on April 19, 2025. W & T provided information to BSEE reflecting the last brake change on the SS 229 C as being February 10, 2021. The hydraulic crane was installed on SS 229 C in 1986. Prior to the incident on April 18, 2026, the last Annual Inspection was completed on February 3, 2026, and the most recent crane maintenance had been performed on March 28, 2026 (issues unrelated to the incident-radial thrust bearing replacement on king post). Deficiencies identified during the February 3, 2026, Annual Inspection were corrected in a timely fashion, and none were related to the subject crane incident. Prior to departure from the SS 229 C facility on April 19, 2026, BSEE granted W & T permission for repairs to be conducted on the SS 229 C Crane following the failures exhibited during the Dynamic Brake Test.

BSEE requested further information (RFI) from W & T via email on April 20, 2026. That same day, W & T provided BSEE with contact information for the two Wireline Operators (IPs not present at BSEE IF) with Acculine. On April 20, 2026, BSEE conducted phone interviews with the Acculine Wireline Operators at 11:09 a.m. (25-minute duration) and at 1:52 p.m. (22-minute duration). Nothing was reported to BSEE by either of the Acculine Wireline Operators that was not already reported to BSEE during interviews at SS 229 C on April 19, 2026. One of the Acculine IPs reported to BSEE that he heard the CO increase the throttle and the crane engine revved just before the final 6-7 foot uncontrolled descent. The Danos IP reported the same details to BSEE on April 19, 2026 and described the CO's "gunning it" just before the fall. During the interview with the acting PIC at the time of the incident, he reported to BSEE that he had instructed the CO on more than one occasion to stop operating the crane at half-throttle and to operate the crane at full throttle because he explained to the CO that "more throttle meant more hydraulic pressure".

On April 28, 2026, BSEE reviewed information provided by W & T per BSEE's RFI, including the following: W & T Crane and "Stop Work Authority" (SWA) Policies, shipping manifests from the day of the incident dating back to March 12, 2026, CO certifications, all Daily Work Tickets associated with the previous brake slippage resolution (April 19, 2025), the previous year of Oil Sample Analysis records, all 2025 and 2026 Service Reports, Return to Work documentation, and the Job Safety Analysis (JSAs) for the work being done at the time of the incident.

BSEE determined that on the date of the incident, contractors failed to follow W & T's SWA policy when the crane was not immediately put out of service upon the occurrence of the initial 1 foot drop. During the BSEE IF on April 19, 2026, the CO at the time of the incident reported to BSEE that, "as I was getting close to boat I felt like the fastline did not want to stop and that's when the basket slammed on the boat! When I disengaged the hydraulics at that time it seemed it did not want stop". After the personnel basket fell 6-7 feet during a second exhibition of crane brake slippage, the crane was still not removed from service and diesel filling operations were undertaken. During diesel filling operations, further exhibition of crane brake slippage prompted the CO to put the crane out of service. However, the incident and injuries would have been prevented had W & T SWA Policy been followed as written. W & T policy states: "All W&T employees, contractors and visitors have the responsibility and authority to stop work or decline to perform an assigned task when an imminent risk or danger exists, without fear of reprisal. Imminent risk or danger means any condition, activity, or practice in the workplace that could reasonably be expected to cause death or serious physical harm."

W & T Investigation:
W & T conducted an internal investigation following the incident at SS 229 C on April 18, 2026, which included a review of witness statements, crane maintenance records, JSA documentation, and post-incident inspection, testing, and repair. The investigation determined that the incident resulted from a combination of mechanical equipment failure and operational factors that together led to the uncontrolled descent of the personnel basket. W & T identified that the two root causes included 1. mechanical failure of the crane auxiliary winch braking system and 2. failure to immediately halt crane operations after abnormal basket movement was observed.

In their final investigation report, W & T acknowledged that witness statements indicated the personnel basket suddenly dropped in an uncontrolled downward movement rather than lowering in a controlled manner. W & T pointed out that during the post-incident investigation on April 19, 2026, issues with the crane braking system were exhibited that required repair. On April 20, 2026, the CM noted repair and testing of the SS 229 C crane in his Crane Repair Ticket. The CM documented that he tightened the aux brake band and cleaned both it and the winch drum with vinegar while the brake was locked on the aux winch. After he unlocked the brake on aux winch, he noticed the brake actuator engaging and winch drum spinning at the same time (pressures to release brake and drum spinning at same time). The CM then hooked the aux line to the dyno and pull test padeye and pulled 11,000 lbs. The CM concluded at the end of the pull test that the aux winch held the 11,000 lbs. shown on the dyno for 5 minutes with 0% loss and that the aux winch was successfully holding the maximum capacity load as per load chart. BSEE granted permission for the SS 229 C crane to be put back into service on April 24, 2026, after W & T submitted records of successful post-repair testing.

W & T's final investigation report further identified that despite personnel observing abnormal basket movement during the transfer, crane operations were not immediately halted. According to their investigation, visual signals and body language were used to communicate concern to the CO, but the lift operation continued instead of utilizing SWA to intervene and reassess the situation. W & T's review of their procedural controls also determined that existing crane operation and personnel transfer procedures were adequate when properly followed; however, gaps were identified in the execution of pre-job safety processes, including incomplete verification of Job Safety and Environmental Analysis (JSEA) requirements and hazard control confirmations.

As part of their corrective actions, by April 26, 2026, W & T developed a detailed JSEA specifically for crane operations and created a Safety Alert- Lessons Learned. The two documents were distributed throughout W & T's full complement of facilities on the OCS. W & T's Safety Alert provided a summary of the crane incident on April 18, 2026 at SS 229 C and warned: "Personnel basket transfers are high-risk lifting operations that require precise equipment control and strong communication between all parties involved. Any abnormal equipment behavior should result in immediate stop work and reassessment of the operation. Safety depends on both reliable equipment and decisive operational response. If you see something unsafe- Stop Work and notify supervision immediately."

BSEE Conclusion:
Based on the information obtained through witness interviews, physical inspection of the crane, witnessing of dynamic brake testing, and review of maintenance, operational, and procedural documentation, BSEE determined that the uncontrolled descent of the personnel basket occurred as a result of reduced braking effectiveness within the crane aux winch system in conjunction with continued crane operations after abnormal equipment behavior was observed. The evidence indicates that degradation in braking performance allowed unintended movement of the hoist drum under load, while the failure to discontinue operations following the initial abnormal descent prevented

reassessment of the lifting operation prior to the subsequent hard landing. The combination of mechanical performance deficiencies and operational decision-making during the personnel transfer resulted in loss of controlled lowering of the load and contributed to the injuries sustained by personnel.

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

1) Equipment Failure – Inadequate preventative maintenance/Inadequate equipment repair

The crane auxiliary winch braking system exhibited reduced braking effectiveness under load conditions, as demonstrated during BSEE-observed dynamic brake testing where slippage occurred at multiple load intervals. The degradation in braking performance allowed unintended rotation of the hoist drum, resulting in loss of controlled lowering of the personnel basket. This condition directly contributed to the uncontrolled descent event.

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

1) Human Performance Error- Not following directions of supervisor (or) proper procedures

Crane operations continued after the initial abnormal descent of approximately one foot, despite clear indications of unsafe equipment behavior. Personnel failed to exercise Stop Work Authority (SWA) as required by company policy, and the crane was not removed from service prior to continuation of lifting operations. This failure to discontinue operations prevented reassessment of the lift and directly contributed to the subsequent uncontrolled descent, hard landing, and evacuation of injured personnel.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

Cost of inspection and crane repair is estimated at $2772.00.

NATURE OF DAMAGE:

labor- post-incident inspection, testing, tightening and cleaning brakes- repair, and re-testing and verification prior to return to service.

ESTIMATED AMOUNT (TOTAL): **$2,772**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE---District has no recommendations for Office of Incident Investigations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

None

25. DATE OF ONSITE INVESTIGATION:

19-APR-2026

28. ACCIDENT CLASSIFICATION:

26. Investigation Team Members/Panel Members:

29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR:

Amy Gresham

APPROVED DATE: **23-JUN-2026**