UNITED STATES DEPARTMENT OF THE INTERIOR
MARINE MINERALS ADMINISTRATION
GULF OF AMERICA REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **17-MAY-2026** TIME: **1515** HOURS
2. OPERATOR: **Talos Energy Ventures, LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **White Fleet Abandonment, LLC**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [X] 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: **G03061**
   AREA: **MU** LATITUDE:
   BLOCK: **A 85** LONGITUDE:

5. PLATFORM: **A**
   RIG NAME:

6. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [ ] DEVELOPMENT/PRODUCTION(DOCD/POD)
   - [X] 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:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] OTHER
   - [ ] TEMP ABAND
   - [X] PERM ABAND
   - [ ] DECOM PIPELINE
   - [ ] DECOM FACILITY
   - [ ] SITE CLEARANCE

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

10. WATER DEPTH: **260** FT.
11. DISTANCE FROM SHORE: **43** MI.
12. WIND DIRECTION: **SE**
    SPEED: **20** M.P.H.
13. CURRENT DIRECTION:
    SPEED: M.P.H.
14. SEA STATE: **6** FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

On 5/17/2026 at approximately 1515 hours, during decommissioning operations located at Mustang Island 85, Lease G03061, operated by Talos Energy, the slot “C” 30-inch conductor which was secured by 30-inch stationary casing slips, unexpectedly dropped. This caused the temporary crane’s auxiliary line to part and the headache to fall into the work basket occupied by three White Fleet Abandonment decommissioning crew members. There were no injuries or pollution associated with the incident. Operations were suspended until equipment was assessed, the crane was repaired and a recovery plan approved by Talos was completed. At the time of the investigation, Marine Minerals Administration (MMA) personnel were operating under the former Bureau of Safety and Environmental Enforcement (BSEE). Therefore, all MMA personnel referenced in this report will be identified as BSEE personnel.

The slot “C” (CS6) 30-inch conductor was previously cut 15-feet below mudline. The slot “C” conductor was the only casing installed in this slot, so it has no cement grout or other casings associated with it.

The White Fleet Abandonment decommissioning crew was in the process of pulling the slot “C” conductor to remove it from the facility when the incident occurred. First, White Fleet Abandonment decommissioning crew members torch cut holes in the slot “C” conductor to pin it near the plus 10 deck. Talos Company Representative and White Fleet Abandonment Supervisor agreed to pin the slot “C” conductor at the plus ten deck opposed to near the top of the conductor due to corrosion degradation near the top of the conductor. Next, the White Fleet Abandonment decommissioning crew ran three joints of 5-inch work string with attached becket and bails inside the slot “C” conductor to a depth near the torch cut holes at the plus ten deck. The bails were then secured inside the conductor by a 3-inch diameter steel pin that ran through the previously torch cut holes in the conductor at the plus ten deck and secured with thru-bolts and washers.

With the 30-inch slot “C” conductor connected to the 5-inch work string, the White Fleet Abandonment decommissioning crew began to lift the conductor with casing jacks. During onsite interviews by BSEE with Talos Company Representative and White Fleet Abandonment Supervisor, the weight of the conductor was estimated to be 56,000 pounds. An initial estimate provided to BSEE by email stated the estimated weight to be 75,000 pounds. During the initial lift of the conductor off bottom both the casing jack’s stationary (lower assembly) and traveling head (upper assembly) were configured with 5-inch bowls and 5-inch slips to accommodate the 5-inch work string. Once the 30-inch conductor was lifted to a height just below the casing jack’s stationary, the 5-inch slips and bowl installed in the stationary were changed out to a 30-inch slips and bowl to accommodate the 30-inch conductor. The White Fleet Abandonment decommissioning crew continued jacking the 30-inch conductor upwards with the casing jack’s traveling head until full stroke was reached. The 30-inch slips were set in the stationary on the 30-inch conductor. The 30-inch slips secured the conductor and supported the conductor while the traveling head which still had 5-inch slips and bowl was lowered. The traveling head with the 5-inch slips were set and secured the work string again, and the casing jack’s traveling head made another stroke upwards. Upon full stroke of the casing jack’s traveling head, the 30-inch conductor slips were set in the stationary and again secured the conductor. The casing jack’s traveling head was lowered approximately 1-foot to ensure the stationary slips held and to allow the bails to be free of the 3-inch pin installed in the conductor. Note the bails have approximately 41-inches of travel. The temporary crane’s auxiliary line was then attached with single joint elevators to the 5-inch work string, becket and bails to allow for the removal of the 5-inch slips and bowl installed in the traveling head. This was in preparation for the 30-inch slips and bowl to be installed in the traveling head to handle the 30-inch conductor.

The Fluid Crane Operator began to lift the 5-inch work with the temporary crane’s

auxiliary line just enough to allow the 5-inch slips installed in the traveling head to be removed by White Fleet Abandonment decommissioning crew members in the work basket. Upon removing the 5-inch slips in the traveling head (15-30 seconds), the 30-inch slips in the stationary lost grip on the 30-inch conductor allowing the conductor to fall approximately 100-foot back to the seafloor while remaining in the bell guides. The pin in the conductor attached to the bails had not yet been removed. When the conductor dropped the temporary crane's auxiliary line took the conductor's weight of an estimated 56,000 pounds plus the shock load force. This weight and shock load parted the temporary crane's auxiliary line allowing the headache ball to drop and make impact on the West side of the work basket extremely close to White Fleet Abandonment decommissioning crew members who had to get out of the way. An all stop was initiated pending an investigation and further evaluation of recovery methods.

BSEE Investigators and Talos Representatives were unable to make it out to location until 5/22/2026 due to weather. No equipment had been moved since the day of the incident. When BSEE Investigators arrived on 5/22/2026, White Fleet Abandonment decommissioning crew members and Talos Company Representative who were on location the day of the incident had been sent in for a Talos investigation debrief. BSEE Investigators took photos of the area, equipment utilized, 30-inch conductor, and interviewed the Fluid Crane Operator who was still on the platform assisting the Fluid Crane Mechanic with repairs.

BSEE Investigators documented that all sides of slot "C" conductor had slip die marks and the pin which had been installed in the conductor to secure the 5-inch work string was missing. The drop likely caused the pin to break or deform enough that it came out. BSEE Investigators did note that the torch cut holes in the 30-inch conductor did not appear deformed from the pin impacting. 30-inch slip dies installed in the casing jack's stationary appeared in good condition and were free of debris which would have made the slips ineffective. The 30-inch slip dies did have casing material embedded in them. BSEE Investigators identified a chain hoist connected to the 30-inch slip handles still installed in the stationary bowl. Investigators sent questions to Talos questioning the manufacturer's guidance concerning the chain hoist being attached and the possibility of the chain hoist preventing the slips from seating evenly around conductor. Vendor owner of the 30-inch slips stated "The chain hoist should not be connected to the slips while slips are supporting pipe. They should only be used to lift slips out of bottom bowl." BSEE Investigators confirmed through multiple sources the chain hoist was connected to the 30-inch slips after the conductor slipped to secure the 30-inch slips from falling out the bowl.

The Fluid Crane Operator stated he did not take any weight beyond the 5-inch work string, becket, and bails which allowed the 5-inch slips installed in the traveling head to be removed. The weight indicator in the crane was analog with no recording capability. BSEE Investigators reviewed the daily report for day of the incident, weather report for the day of the incident, witness statements, JSA, White Fleet Abandonment Procedure for pulling casing with casing jacks, crane records, Talos photos, Talos initial report, Talos Procedure Hazard Review, and Talos Recovery Plan.

BSEE Investigators followed up with an onsite visit on 6/11/2026 to interview the White Fleet Abandonment decommissioning Supervisor in charge of running the casing jacks and a White Fleet Abandonment decommissioning crew member who was in basket at the time of the incident. The White Fleet Abandonment decommissioning crew reported the casing was moving due to weather conditions but not beyond normal conditions which would require stop work. Weather conditions at the time of the incident were a wind speed of 27 knots and sea state of 6-foot. BSEE Interviews aligned with witness statements and procedure questions were answered by Talos Company Representative and White Fleet Abandonment decommissioning Supervisor. The upper section of the slot "C" conductor and 30-inch stationary slips were sent in for a material evaluation to include dimensional, mechanical, chemistry and a bacterial

evaluation. The Drive Pipe Recovery Procedure was discussed, and the temporary crane was inspected. All critical crane parts were changed out, and an annual crane inspection was completed 6/9/2026. A load test was completed on the crane's main line, and a pull test was completed on the crane's auxiliary line before operations commenced following the incident.

The remaining conductors were removed successfully without incident. A spear was utilized after the top section of the slot "C" Conductor was removed. Due to the unknown failure mechanism of the drop, a two-retention method was utilized which incorporated the use of two sets of slips, or one set of slips and a pin inserted above the stationary slips. Note: A controlled cutter was used which expedited the cutting and pinning process.

The material evaluation report concluded the slot "C" 30-inch conductor showed extreme wall loss predominantly on a quarter section of the casing near the top. This reduced the casing's resistance against slip crushing forces and led to the slips losing grip as the compromised casing pipe elastically deflected out of shape. The 30-inch stationary slips had minimal wear and were in good overall condition. The material evaluation report recommends that the conductor pipe be inspected prior to pulling operations.

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

The slot "C" 30-inch conductor had poor structural integrity due to corrosion at the top of the casing where the 30-inch stationary slips were set. The slot "C" conductor's top section could not sustain the slip forces which allowed the slot "C" conductor to slip through the 30-inch stationary slips and fall back to the initial lift elevation.

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

Sea conditions impacted conductor movement, but sea conditions remained within the operational requirements set by the Operator.

20. LIST THE ADDITIONAL INFORMATION:

All well conductors and slot conductors other than the slot "C" conductor were removed before and after the incident without issue.

21. PROPERTY DAMAGED:	NATURE OF DAMAGE:
Temporary Crane's Auxillary line.	**Temporary Cran's Auxillary line parted due to overload condition.**

ESTIMATED AMOUNT (TOTAL): **$5,000**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

A safety alert is recommended to help prevent recurrence. All well casings and especially slot well casings should be evaluated for corrosion degradation and procedures put in place to handle the casing with additional risk mitigations to prevent drop hazards. This can include removing sections of casing instead of removing the entire casing string and/or using additional securing methods.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

None.

25. DATE OF ONSITE INVESTIGATION:

22-MAY-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:

Stephen Martinez

APPROVED
DATE: