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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **22-MAY-2026** TIME: **1455** HOURS
2. OPERATOR: **Talos Energy Ventures, LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Magnolia Torque and Testing, In**
   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: **G07995**
   AREA: **GC** LATITUDE:
   BLOCK: **158** LONGITUDE:

5. PLATFORM: **A (Brutus)**
   RIG NAME: **DD 202**

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)		
[ ] LTA (>3 days)		
[ ] RW/JT (1-3 days)		
[X] RW/JT (>3 days)	**0**	**1**
[ ] 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
- [ ] TEMP ABAND
- [ ] PERM ABAND
- [ ] DECOM PIPELINE
- [ ] DECOM FACILITY
- [ ] SITE CLEARANCE
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [X] OTHER **Construction - Rig Refurbish**

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

10. WATER DEPTH: **2900** FT.
11. DISTANCE FROM SHORE: **125** 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:

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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.

On May 22, 2026, a dropped object incident occurred on the Talos Developmental Driller 202 which was working for Talos Energy Ventures, LLC. Construction operations were being conducted at Green Canyon Block 158, OCS-G 07995. Several different crews were working in the same area. The rig crane crew, scaffold builders from Magnolia Torque and Testing Inc (MTT), and a contract welding crew (CWC) from Acadian Contractors Inc (ACI) consisting of a welder, fitter and a rigger (R1). The rig crane crew delivered material to the CWC. The CWC was performing work from atop, in, and around a scaffold, that was approximately 45' above the deck, to repair the gumbo box (solids removal equipment used to filter out highly reactive clays known as "gumbo"). The scaffold builders were working below the CWC dismantling unused scaffold sections. R1 placed a 4 ft x 2 ft section of ¼" steel flat plate upright on the scaffold deck. While repositioning the flat plate and adjusting hand placement, the plate shifted and fell through a ¼" gap between the scaffold boards, hitting a scaffold builder, the Injured Person (IP) from MTT. The 82 lbs plate fell from 30' going between a gap in the planking of two sets of scaffold boards positioned at 15' intervals. After striking the IP, the plate fell another 15 ft before coming to rest on the deck. The IP was escorted to the medic then evacuated via field helicopter to RLC heliport. The IP was escorted to South Star Urgent Care in Youngsville, LA. The IP sustained deep contusions and a fractured rib on the right side of his body.

The CWC and R1 were assigned the task of repairing the gumbo box. The IP was located on scaffolding 30' below. The IP was working with his supervisor, who was positioned on the deck 15' below the IP, dismantling and moving scaffolding. A Permit to Work (PTW) and Job Safety Analysis (JSA) was completed for hot work/repairing the gumbo box and to erect, modify, and dismantle scaffolding around the drilling rig. A simultaneous operations (SIMOPS) meeting, construction pre-tour safety meeting and a pre-job walk through were performed. The CWC worked for approximately 1.5 hours before taking a 15-minute break. The CWC continued working for 2 more hours before taking a 30 min lunch. The CWC returned from lunch and the scaffold crew started demo of the scaffold. The crane delivered material to the gumbo box deck. The CWC and R1 started moving the flat plate to the upper scaffolding and the incident occurred.

The CWC and R1 were moving the unsecured flat plate by hand to the upper scaffolding. R1 lost his balance and had to sit the flat plate on the scaffolding. When R1 went to grab the flat plate again it fell and went through the crack of the scaffolding boards striking the IP in the hard hat and back. The IP, who was working 30' below, was knocked off the scaffold. He was tied off with a lanyard and harness and was able to perform self-rescue. The plate came to rest on the deck 15' below where the IP was working.

All work in the area was stopped and the job sites were secured. A safety stand down was held with all crews. The IP was escorted to the rig medic for evaluation and then evacuated via field helicopter to RLC heliport. He was escorted to South Star Urgent Care in Youngsville, LA. Talos investigated and had multiple findings. The gumbo box was worked on for multiple days. Plating and materials were delivered via rig crane to a nearby landing area. Materials were then walked over and placed onto nearby scaffolding then manually to crew one level of scaffolding higher for installation. The dropped plate was manually handled by one crew member rather than team lifting or utilizing a mechanical means of lifting. Leather gloves used by CWC were unfit for the task. These gloves are designed for welding and do not have the proper grips for moving heavy objects. The CWC used an outdated JSA template which did not address required hold points.

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There was reduced supervisory coverage for the CWC due to one supervisor having to leave the platform for personal reasons. Barrier tape was used but there was insufficient communication between the CWC and scaffolding crew. The CWC and R1 were not aware of the potential dropped flat plate, therefore they did not alert the workers below when moving the plate into position. Also, the lack of tagging of the barrier resulted in personnel being exposed to dropped objects. The **final finding of the Talos investigation was lack of effective coordination during SIMOPS. This was evident by having people exposed to potential dropped objects by the CWC.**

The Bureau of Safety and Environmental Enforcement (BSEE) Houma District office was notified and a written report was submitted in 15 days. The BSEE Houma District Inspectors (Inspectors) were able to conduct an onsite investigation on May 26, 2026, and photos, witness statements, PTW, and JSA's were obtained. BSEE concurs with the findings of the Talos investigation. BSEE also found the Working at Heights permit to be inadequate. It did not reference specific tools to prevent drops or tying off the flat plate. After reviewing the JSA to erect, dismantle or modify scaffolding, BSEE found that it was inadequate. While it did have the SIMOPS blocked checked, the JSA didn't state the hazard of overhead work being conducted. BSEE also noted that the JSA was not updated after the CWC supervisor departed the rig.

After reviewing pictures, documents, and the Talos investigation, BSEE agrees with Talos's findings. The largest factor in this incident was the insufficient communication between the CWC and scaffolding crew. Also, the lack of overhead hazard being mentioned in the JSA was a major factor. The CWC failed to properly secure the flat plate while the IP failed to recognize the hazard of the work being performed above him. BSEE believes that proper communication and hazard ID would have possibly prevented this incident.

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

Equipment failure – improper tools used. CWC did not properly tie off flat plate when handling at heights. Did not consider mechanical lifting devices. CWC used leather gloves that were inadequate for handling materials.
Human performance error – Not aware of hazards. CWC was unaware of the hazards of dropping the plate.
Management systems – CWC used an outdated JSA template.
Communication – Instructions misunderstood. Although a SIMOPS meeting was held, the IP was working under the CWC while they were moving unsecured materials above.

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

Supervision – Inadequate supervision. There was lack of supervision due to a supervisor having to go in for personal reasons.

20. LIST THE ADDITIONAL INFORMATION:

N/A

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21. PROPERTY DAMAGED: NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Houma District does not have any recommendations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

26-MAY-2026

26. Investigation Team Members/Panel Members:

27. OPERATOR REPORT ON FILE: **NO**

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Amy Gresham

APPROVED DATE: **08-OCT-2026**