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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **12-SEP-2026** TIME: **1210** HOURS
2. OPERATOR: **Talos Energy Ventures, LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   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: **G07995**
   AREA: **GC** LATITUDE:
   BLOCK: **158** LONGITUDE:

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

6. ACTIVITY:
- [ ] EXPLORATION(POE)
- [ ] DEVELOPMENT/PRODUCTION(DOCD/POD)
- [X] 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
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER
- [X] 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: **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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On September 12, 2026, a lifting incident occurred on the Talos Developmental Driller 202 (DD 202) which was working for Talos Energy Ventures, LLC. Decommissioning activities were being conducted at Green Canyon, Block 158, OCS-G 07995. The DD 202 crew consisted of contract operators employed by Helmerich & Payne INC (H&P). A roustabout crew consisting of a Lead Roustabout/Crane Operator (CO), Banksman, and two roustabouts (RSTB1) and (RSTB2) were tasked with moving a 3" chiksan manifold (manifold) for upcoming well operations. The manifold was lifted about 8" above the deck using a four-part sling assembly. When the manifold was lifted one of the four sling legs became caught on a valve. The banksman, who is also the Injured Person (IP), attempted to signal the CO on the radio to stop, but the entangled sling released causing the manifold to shift and come to rest on his foot.

According to the H&P incident report the roustabout crew participated in the Pre-Tour meeting. The roustabout crew conducted shift relief with the night crew. Next, the roustabout crew reviewed the Job Safety Environmental Analysis (JSEA), permit, and compass card. Multiple lifts were made from the boat to the rig without incident. After completing the offloading of the boat, the roustabout crew performed a pre-lift plan and walk around to move the manifold for wireline operations.

According to the H&P incident report, the roustabout crew moved the manifold without incident but observed it was placed on top of a hydraulic hose on the skid beam. The roustabout crew attempted to reposition the manifold and the IP noticed one of the four sling legs became caught on a valve. The IP tried to signal the CO via radio, but the entangled sling released causing the manifold to shift and come to rest on the IP's foot.

According to witness statements, the IP gave the radio signal to cable up on the manifold and the CO complied. Once the IP got his foot free, RSTB1 and RSTB2 helped him to the Safety-Paramedic's (SP) office. The SP and supervisors were notified of the incident and the need for evaluation and medical treatment. The IP was evaluated by the SP and the Teledoc. Transport to shore was arranged and the IP was evacuated to the heliport where he would be picked up by a Safety Specialist (SS) and taken to a care facility. Following the incident, the IP was placed on Restricted Work at the H&P shop. Subsequent medical evaluations determined that surgery was needed. The IP had pins installed to repair two displaced metatarsal fractures in his right foot. H&P intends to continue working the IP on Restricted Work throughout his recovery period.

The Marine Minerals Administration (MMA) Houma District Office was notified and a written report was submitted on October 4, 2026, after multiple extensions were given due to the nature of the incident. The MMA Houma District Inspectors (Inspectors) were able to conduct an onsite investigation on September 18, 2026. The inspectors obtained witness statements, pre-job paperwork, pictures, and incident reports. MMA Houma District found that the roustabout crew followed the JSEA by identifying the banksman and establishing radio communications between the banksman and the CO. The JSEA did not note the hazard of the legs of the four-part sling becoming entangled in the manifold. The JSEA did not note the hazard of being struck by the manifold. H&P's incident report determined that the IP was positioned too close to the load and MMA Houma District agrees with H&P's findings. After reading the witness statements and conducting onsite interviews, it was determined that the IP lost situation awareness and was too close to the load. When asked if the IP was attempting to free the sling, all witnesses said he did not.

After reviewing the witness statements, pre-job paperwork, pictures, and incident reports, MMA Houma District agrees with Talos's findings. There were several probable causes of this incident. First was the IP being positioned too close to the manifold. The second probable cause was not identifying the hazard of the legs of the four-part

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sling becoming entangled in the manifold. The final probable cause was an inadequate JSEA. The contributing cause of this incident is the hazard of being struck by the manifold.

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

Human Performance Error – Not aware of hazards (sling hanging up and body positioning)
Management Systems – Inadequate hazard analysis and inadequate written job procedures

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

Management Systems – Inadequate hazard ID of being struck by the manifold

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

n/a

NATURE OF DAMAGE:

n/a

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The MMA Houma District does not have any recomendations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

n/a

25. DATE OF ONSITE INVESTIGATION:

18-SEP-2026

26. Investigation Team Members/Panel Members:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR:

Amy Gresham

APPROVED DATE: **09-NOV-2026**