

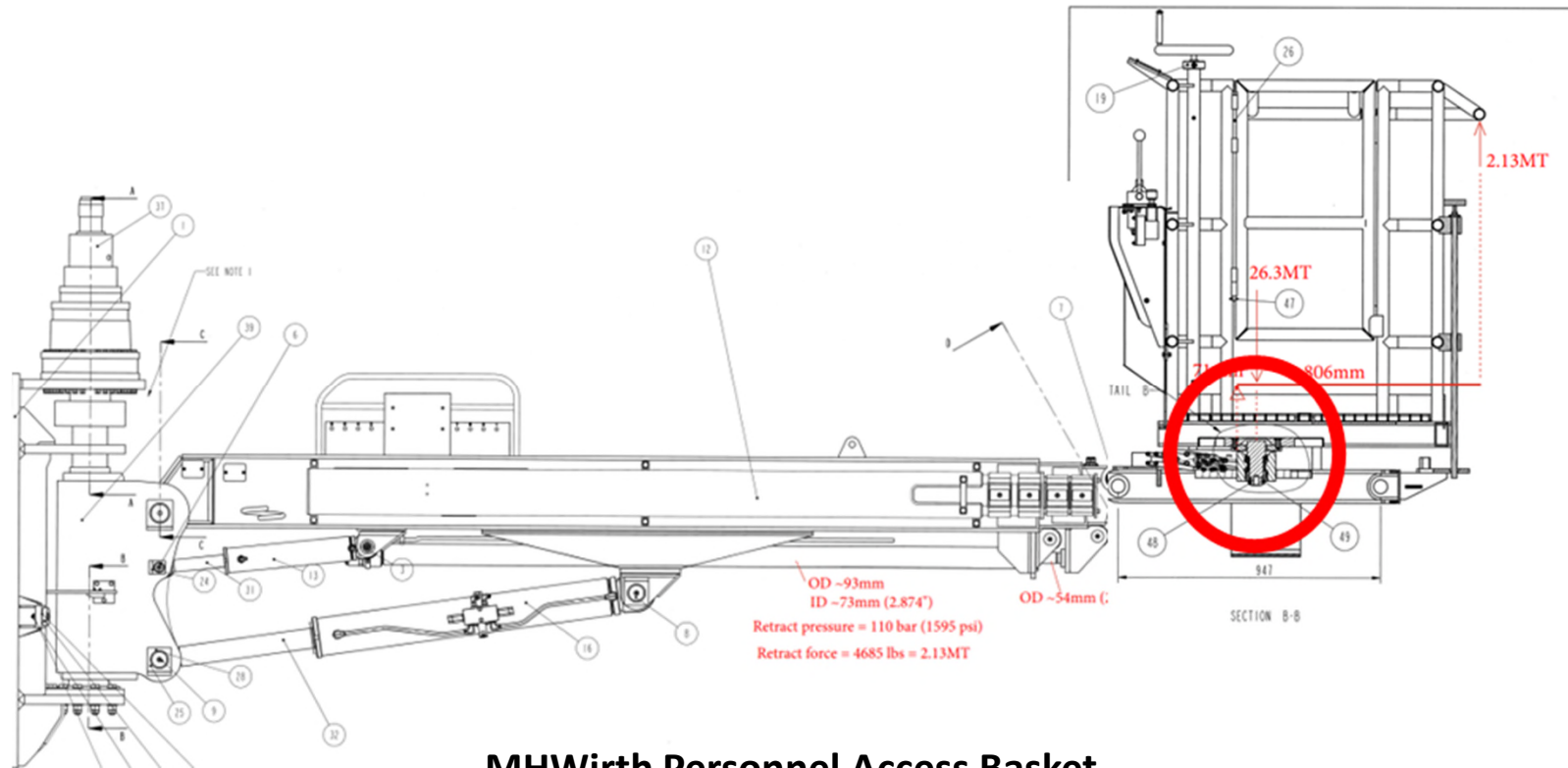
# INCIDENT INVESTIGATION OVERVIEW

Transocean Equinox / Moonpool Basket Pulled from Telescopic Arm

23 Jan 2026



# EQU – WORK BASKET INCIDENT INVESTIGATION



**MHWirth Personnel Access Basket**

# INCIDENT SUMMARY

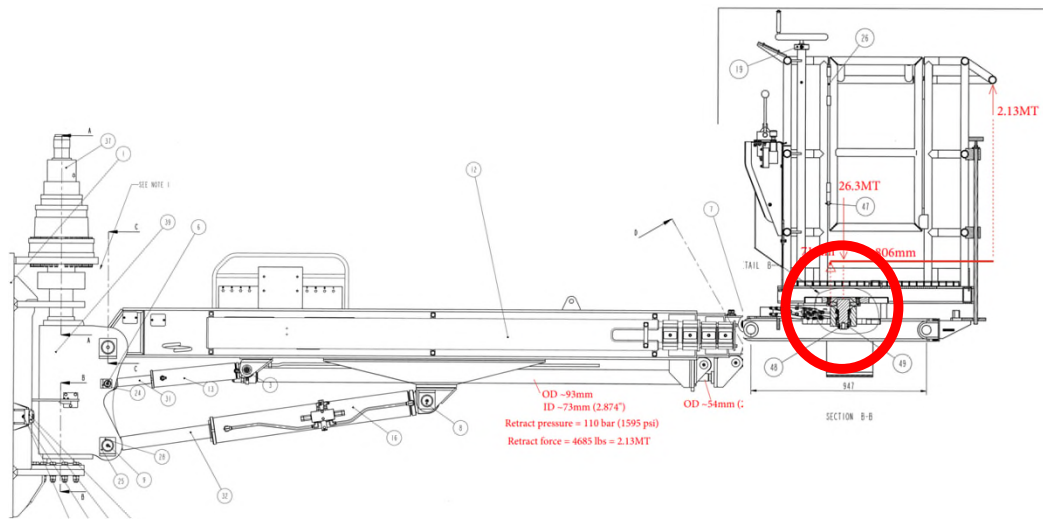
- In-between well maintenance was ongoing.
- A work basket had been positioned below the rotary as DROPS mitigation.
- In preparation to run the diverter the work basket had to be moved clear.
- An MRT wire had been caught within the basket through the open gate.
- The operator did not see the caught wire.
- As the basket was moved, tension increased until the basket axle failed.
- The basket rotated sideways and was left suspended by the hydraulic hoses.



# INVESTIGATION FINDINGS



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**Basket rotation axle  
vulnerable to overloading**



# INVESTIGATION FINDINGS

- Risk of positioning the basket close to the MRT wires was not assessed.
- Basket gate had been left open.
- Basket handrail had been modified.
- The hazard of the caught wire was not identified prior to repositioning the basket.
- Operators view was restricted.
- No spotter or banksman was assigned.
- Operator was a contract worker and not fully familiar with the operation of the basket.
- OJT did not include a demonstration or assessment of competency.
- No procedure or checklist exist for using the basket unmanned.
- Vulnerability of the basket axle design highlighted.

# INVESTIGATION FINDINGS



# ROOT CAUSES

Root causes included:

- Inadequate procedure relating to post use checks and safe stowage
- Inappropriate use of work basket
- Inadequate procedure when operating the basket from static control station (unmanned)
- Inadequate On the Job Training (OJT), competence verification and authorization