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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **21-APR-2025** TIME: **1930** HOURS

2. OPERATOR: **Apache Corporation**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Crescent Energy Services**
   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: **G01089**
   AREA: **WD** LATITUDE:
   BLOCK: **90** LONGITUDE:

5. PLATFORM: **B**
   RIG NAME: *** WIRELINE UNIT**

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		

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

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

10. WATER DEPTH: **183** FT.

11. DISTANCE FROM SHORE: **14** MI.

12. WIND DIRECTION: **SSW**
    SPEED: **3** M.P.H.

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

14. SEA STATE: FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

INCIDENT SUMMARY:

On April 21, 2025, at approximately 19:30hrs Central Daylight Time, the West Delta (WD) 90 “B” platform experienced a loss of well control incident. An uncontrolled release of well fluids estimated to be 20bbls from a leak at the well head during Plug and Abandonment (P&A) operations occurred. The P&A crew was working on the B020 well (API#177190135901). The event led to a full platform evacuation and shut down as the crew was unable to contain the gas release. Apache reported the incident to the Bureau of Safety and Environmental Enforcement (BSEE) New Orleans District (NOD). The release of pollutants (produced well bore fluids) was reported to the National Response Center NRC#1429098.

SEQUENCE OF EVENTS:

On April 21, 2025, around 15:00hrs CDT, the Crescent Energy Services (CES) crew contracted by the well owner, Apache, finished moving from well B018 to B020 on the WD 90 B platform. After rigging up to the well head and testing the pump lines, the CES crew began to fill the 7-5/8” x 2 7/8” annulus with seawater. A leak of seawater was observed just below the starter head base plate. With the annulus full, the CES crew continued rigging up and pressure testing the Slickline (SLK) lubricator. The CES Crew then locked open the Surface-Controlled Subsurface Safety Valve (SCSSV) and ran SLK in the well with a 2.25” Outer Diameter Gauge Ring to tag the Back Pressure Valve (BPV) at 506’ Measured Depth (MD) per the BSEE approved procedure in the original APM dated 24-FEB-2025.

The BPV was not found at 506’ (MD). The CES crew then continued running slickline in the well unobstructed until eventually tagging what was believed to be the Type D equalizing slickline deployable (DS) plug at 7046’ (MD). After tagging, the slickline was pulled to surface and the tools were swapped from the Gauge Ring to an RS pulling tool, jar up release, medium core RS pulling tool with a 21” prong. The SLK was then run back in the well to the same depth. The SLK operator tagged and latched the DS plug.

After latching onto the DS plug, tension was held on the slickline to allow pressure equalization through the plug ports before attempting to loosen by “jarring” the plug out. After approximately 15 minutes of waiting, due to the small equalization ports on the plug, the decision was made by the CES supervisor and SLK operator to pump fluid down the tubing to help with the equalization process. From the Apache partner report, 19:00-1930:
Pump rate was 1 BPM @ 950 psi (tubing pressure). After 5 bbl's pumped the tubing pressure slowly began falling to 475 psi. Pumped approx. 20 Bbl.’s total. S/D pump and oil coming out of between the Starter Head Flange and 10-3/4" X 20" Surface Casing Annulus.

As stated above, at some point during the pumping operation, approximately 17:30hrs CDT, oil from the wellbore was noticed coming out between the well starter head flange and 10 3/4” x 20” surface casing annulus, leaking onto the platform and into the Gulf of America waters below. Upon observation of this leak, the CES supervisor called an all stop over the radio, and the pump operator shut down the pump. Oil and gas continued to flow underneath the well head base plate. The CES supervisor and Apache representative attempted to bleed the pressure off by opening the choke manifold to the return tank. After an estimated 5 to 10 minutes the fluid flowing from the well reduced and stopped. Once the flow of fluid ceased, uncontrolled gas was observed coming from the starter head prompting a full site evacuation. All personnel from the “B” platform were evacuated to the “E” platform, where a full muster was announced. They then waited for the Motor Vessel (MV) “GO Discovery” to arrive and embark all personnel. During this time two persons, an Apache representative and a CES crew member, traversed via gangway from the E platform to the B platform, de energized all

equipment, and closed the crown valve on the B20 surface tree which attempted to shut the well in and cut the wire. Once these personnel arrived back at the E platform and transited to the MV “GO Discovery”, the boat disembarked the platform and stayed approximately 1 mile away.

On April 24, 2025, after discussions between Apache and BSEE, the platform was reboarded and P&A operations on the well continued with no further detection of hydrocarbon. The process of plugging and abandonment of the well after the incident are captured in the (12) RPMs from 23-APR-25 to 30-May-25.

The following narrative was provided by Apache to the BSEE New Orleans After Hours cellphone at 20:49 CDT April 21, 2025:
“The P&A crew arrived at WD90 B to begin P&A work, they ran wireline into the hole and latched to the tubing plug. When the pressure equalized, but before they were able to pull the plug, there was a “burp” of production fluid (oil and gas mixture) at ~1945 hrs. The muster alarm was sounded, and the 22 POB moved across the gangway from the “B” structure to the “E” structure where the temporary quarters are set. Two members of the team crossed back to the “B” structure, cut the wire, closed the lower master valve, and then closed the crown valve. Closure of the two valves slowed the flow “substantially” but not completely. Status of the well is still flowing gas with occasional “sputter” of oil. The leak appears to be at the starter head and there are known holes in the tubing, casing, and outer casing. The plug that was latched onto was at 7,001’ TVD. All POB are currently back on the “E” structure, and no injuries have been reported. The MV Go Discovery is en-route to the structure from Fourchon, LA and should arrive at ~0000 hrs. to evacuate all 22 POB until we can develop a path forward. The wind is blowing from south to north, which is moving the gas away from where the crew is mustered. Apache estimates the volume of oil spilled to be ~20bbls. All wells at WD 90 (“A”, “B”, and “E”) are shut in. Apache has stood up an emergency response team and next steps are to evacuate everyone by boat. In the morning, Apache will assess next steps, but preliminary thought is for Apache to visit the structure in the daylight with a small crew to see if gas is still flowing. Apache's next meeting is at 0500 at the Apache office.”

BSEE INVESTIGATIONS:

The BSEE assigned Accident Investigator (AI) received and reviewed information submitted through emails, phone communications, and witness statements from Apache concerning the uncontrolled release of wellbore fluids. Due to the potential for continued hydrocarbon release to the environment , a flight was performed by the BSEE investigation team over the platform and in a 5-mile, 15-mile, and 25-mile search arc to look for a sheen. No visible sheen was observed. The investigation team boarded the platform on May 16th, 2025 for the onsite investigation. The team requested relevant paperwork and conducted interviews with individuals that were present during the incident. A physical inspection of the facility was conducted. No observable evidence of hydrocarbon release was identified. The CES crew had implemented secondary containment measures, including the installation of a purpose-built acyclic berm secured to the wellhead, to mitigate potential future discharges. A follow up visit was conducted on May 30th, 2025, and the safety representative onsite during the incident was interviewed two individuals, the Apache night contractor representative and CES pump operator, were unable to be interviewed.

IN CONCLUSION:

Once the starter head spool was found to be leaking, there was no stopping point by the crew to discuss what potential hazards may exists and how to prevent/mitigate this risk before continuing with the abandon procedure. The well control equipment (SLK Lubricator) only controls pressure in the tubing, but is not effective if a leak in the casing strings is present. The actions after the release of the fluid show the CES

Crew was not aware of why the leak was occurring or well control contingencies for this event. This is also shown by the two-hour gap it took to make the decision of closing the crown valve, cutting the wire, and shutting in the tubing side of the well.

Although the CES Crew possessed extensive cumulative experience in Plug and Abandonment operations, the lack of detailed knowledge regarding the specific well history limited their ability to anticipate and mitigate risk. The environmental release and associated personnel hazards were likely preventable through: more rigorous pre-job planning, inclusion of complete and accurate wellbore history in the procedure, and a structured hazard assessment process. One example of a mitigative action, application of a rubberized sealant at the spooling head after leak identification, illustrates the earlier implementation of engineering controls could have reduced the severity of the incident. This highlights the importance of systematic contingency planning and information sharing in ensuring regulatory compliance and operational safety.

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

Well control was compromised due to a breach at the spooling head. Concurrently, a failure within the tubing string enabled unintended hydraulic communication between the tubing and the annulus, resulting in an uncontrolled release of well fluids. Based on the available data and post-incident analysis, it is not possible to conclusively determine whether the act of pumping fluid into the wellbore induced a failure in the tubing above the isolation plug, or whether the breach originated from a malfunctioning completion component located below the plug. The loss of isolation became evident after the Slickline tool engaged and equalized pressure across the downhole plug.

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

A breakdown in communication between successive work crews operating on the platform contributed to critical procedural oversights. The operational procedure in use was deficient as it failed to account for prior well activity conducted on 06-Apr-2019 and 17-Aug-2021. Review of historical well reports from these dates indicates the spooling head had a documented history of leakage, and that the DS plug had been installed in response to operators detecting gas emissions at the surface-specifically from the drive pip beneath the tree. This prior information was not integrated into the current operational planning. In the Apache procedure it directed the crew to remove the back pressure valve, an action that was not applicable, as the valve was no longer present in the well having been extracted during the well work previously mentioned. This inconsistency underscores a failure to reconcile historical well data with the current procedural framework, increasing the likelihood of operational error.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

Slickline reel

NATURE OF DAMAGE:

Cut at surface due to closure of tree valve.

ESTIMATED AMOUNT (TOTAL): **$4,350**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans District has no recommendations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

1) E-100 – 30 CFR 250.300(a) (W)
With the release of ~20bbls of produced well fluids and an unknown quantity of hydrocarbon gas, The operator failed to prevent unauthorized discharge of pollutants into offshore waters creating conditions that pose unreasonable risk to public health, life, property, aquatic life, wildlife, recreation, navigation, commercial fishing or other uses of the ocean.

2) G 131- 30 CFR 250.188 (W)
The District Manager was not provided with a written follow-up report within 15 days of the incident that resulted in loss of well control, "uncontrolled flow resulting from a failure of surface equipment or procedures"

3) G 115 - 30 CFR 250.107 (W)
The operations were not conducted in accordance with approved permit terms and conditions. Step two and three of the procedure attached to the approved permit states:
"2. Conduct a pre-job safety meeting with all personnel to be involved with the project on-site and ensure everyone is aware that they have a work-stop responsibility if conditions pose a threat to anyone and or the environment"
"3. Document meeting agenda and attendance"
No documentation could be provided showing the safety meeting agenda and attendees for the crew on shift during the event.

25. DATE OF ONSITE INVESTIGATION:

15-MAY-2025

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:

Michael J. Saucier

APPROVED DATE: **16-DEC-2025**