

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **05-NOV-2025** TIME: **1623** HOURS

2. OPERATOR: **Chevron U.S.A. Inc.**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **BrandSafway**

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K **\$54,881.07**
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR
ON SITE AT TIME OF INCIDENT:

4. LEASE: **G32703**

AREA: **WR** LATITUDE:

BLOCK: **718** LONGITUDE:

5. PLATFORM: **A(Jack St. Malo**

RIG NAME:

6. ACTIVITY: EXPLORATION(POE)

DEVELOPMENT/PRODUCTION(DOCD/POD)

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
 - PERM ABAND
 - DECOM PIPELINE
 - DECOM FACILITY
 - SITE CLEARANCE

9. CAUSE:

- EQUIPMENT FAILURE
- HUMAN ERROR
- EXTERNAL DAMAGE
- SLIP/TRIP/FALL
- WEATHER RELATED
- LEAK
- UPSET H2O TREATING
- OVERBOARD DRILLING FLUID
- OTHER _____

10. WATER DEPTH: **6950** FT.

11. DISTANCE FROM SHORE: **149** 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:

Incident:

On November 5, 2025, at a approximately 16:23 hrs., a fire and muster incident occurred on the Jack St. Malo semi-submersible floating production unit operated by Chevron USA Inc. in the Walker Ridge (WR) Area Block 718 in the Gulf of America. Diesel fueling operations were ongoing on an air compressor used for blasting and painting on the south side of the facility when a large flame erupted on the adjacent air compressor and engulfed a large area of the surrounding deck. The fueling operations were immediately stopped and nearby personnel notified the control room. The facility was shut in with a full facility muster following. The fire team responded to the scene and extinguished the fire via two firewater hoses. Water was applied to the area approximately ten minutes after the flames were extinguished.

Sequence of events:

Two contract painters (WP#1 and WP#2) employed by Waveland Services (Waveland) were tasked with refueling one of two rental diesel air compressors stationed on the facility's main deck. The compressors were designated for sandblasting and painting operations. Waveland would alternate use of the compressors, and refueling would take place when a compressor was not in use. At approximately 16:22, WP#1 and WP#2 began manually refueling the compressor currently not in use. WP#1 was stationed at the refuel port of the compressor and manning the nozzle while WP#2 was manning the fuel hose. During the refueling, a fire ignited on the second air compressor. A notification of the incident was made to the control room, and the running compressor was immediately shutdown, and the fuel supply was shut off. Two Grand Isle Shipyard (GIS) personnel were in the vicinity of the scene when the incident occurred. They attempted to extinguish with fire extinguishers but made the call to report to primary muster when the fire engulfed the surrounding area. The facility was immediately shut in and the general alarm sounded, prompting a full facility muster.

Once the control room was notified and the alarm sounded, a Fast Response Team (FRT) deployed to the area. Upon arrival, the FRT began suppressing the fire with a fire hose station on a nearby compressor module and another hose reel on the second deck of the Water Injection Module (WIM) next to the scene. The fire was extinguished approximately 30 seconds after suppression began. The fire team then arrived and kept suppressing the area with water for ten minutes to ensure a proper cool down. The FRT then proceeded to the hull deck below the affected area to verify the flames had not spread. The On-Scene Commander (OSC) of the FRT reported over radio that the fire was extinguished when confirmation was made that the fire had not spread, and the incident scene was properly cooled down. A stand down was called and a debrief was held with the crew.

BSEE Investigation:

At approximately 18:20 on November 5, 2025, the BSEE Houma District After Hours received an initial notification via phone call of a fire and muster event that occurred on WR-718 Jack St. Malo semi-submersible floating production unit. Pictures of the scene were included in the email communication chain after the follow-up email.

BSEE investigators were made aware of the situation, and the decision was made to conduct a follow-up investigation the following morning.

On November 6, 2025, BSEE investigators flew offshore to conduct a follow-up investigation. Upon arrival, BSEE investigators met with Chevron management as well as third party representatives. They prepared to conduct interviews with all personnel involved, conduct a walkthrough assessment of the incident scene, and take pictures. The investigation revealed that Waveland Services had been sandblasting and painting throughout the facility for the past few weeks. Two air compressors are used to be able to conduct these operations, rotating between the compressors during operations using only one at a time. It is a safe work practice among the Waveland personnel to refuel the air compressor that is not running with diesel when they rotate compressors. Neither Chevron nor Waveland have a formal policy for refueling the air compressors. On November 5, 2025, Waveland switched air compressors during blasting and painting operations and two Waveland painters (WP#1 and WP#2) were tasked with filling the offline compressor with diesel. The compressor is filled with a

diesel hose that is located approximately 150 feet away around a building towards the south side of the facility. WP #1 held the nozzle and filled up the compressor while WP #2 manned the hose and observed the area approximately 30 feet away from the compressor. WP #1 reported that at 16:22, the fuel hose lost pressure. When that occurred, WP#1 looked up and noticed that flames had ignited on the exhaust of the online air compressor, then quickly increased in size and spread to the surrounding area. WP #1 also noticed diesel spraying from the hose fueling the fire, which caused the fire to grow in size. Once WP# 1 noticed the flames, he immediately went to the control panel on the running compressor and hit the emergency stop button, shutting the compressor down instantly. Once the air compressor was shutdown, WP #1 called the control room to notify them that a fire had occurred on the North end of the facility.

Once the call was made, he reported to his designated muster station. WP #2 reported to BSEE that he was on stand-by with the fuel hose when he noticed the hose lost pressure and the hose moved slightly. WP #2 then looked towards the area and noticed the flames on the exhaust of the compressor and the flames began to grow in size. WP #2 immediately ran around the quarters building to the diesel hose reel and shut off the inlet valve, stopping the fuel source of the fire.

It was reported to BSEE that additional to the Waveland painters, two Grand Isle Shipyard (GIS) employees, a crane operator and the deck foreman, were on the deck in the vicinity to where the incident occurred. The GIS crane operator reported that he and the GIS deck foreman were involved in crane operations in the area at the time, dumping used blasting sand into a waste basket. The crane operator was at a cooling station, and the deck foreman was walking to a GIS tool house when the incident occurred. The deck foreman reported that he was in the tool house when he noticed a flash reflect on the wall. At the same time, another worker ran out of the building towards the compressor area. The deck foreman followed the worker out of the building and saw the flames significantly increasing in size. He reported that he ran to retrieve a portable fire extinguisher and attempted to fight the fire, but it had grown out of control. After deciding not to fight the fire, the deck foreman reported to his designated muster location.

The GIS crane operator reported that he was taking a break at a cooling station located approximately sixty feet away from the incident location. The crane operator reported noticing a flash coming from the air compressor area, dying off and then reigniting again with a flame. The crane operator was aware of WP #1 fueling the air compressor and was concerned for his safety following the ignition. The crane operator ran over to the nearby WIM and climbed up onto the module platform. The crane operator noticed that the flames were growing in size as time progressed, so he pushed the Emergency Shutdown (ESD) button located on the WIM. After pushing the ESD, the crane operator grabbed the nearest fire extinguisher and ran up to the fire to attempt to fight it. However, the fire had grown past the point of fire extinguishers, so the crane operator made the decision to head to his primary muster station.

At approximately 16:23, the control room was notified of the situation from WP #1 and the facility ESD had already been initiated by the GIS crane operator. The control room operator initiated the facility fire alarm via the Human-Machine Interface (HMI), which then initiated a full facility muster. An FRT and the Fire Team were deployed to the area upon initial activation of the fire alarm. At approximately 16:25, the OSC for the FRT was first to arrive on scene, with the remaining FRT arriving shortly after. They first manned a fire hose reel located on the upper Compressor Module and began applying water to the incident location. The fire had spread to the surrounding area around the air compressors reaching out to about twenty feet away engulfing other Waveland equipment such as a fire hose box, hoses, and other miscellaneous equipment.

Another FRT arrived on scene and began applying water from another hose reel located on the lower west side of the WIM. After a few minutes of suppression, the fire was eventually extinguished. The facility's designated Fire Team arrived on scene at this time and relieved the two FRTs and continued to apply water to the area for approximately ten minutes, verifying a proper cool down. The FRT then made their way to the Hull Deck area below the incident scene to verify no fire had spread to that

deck. At approximately 16:29, the OSC reported over the facility's designated radio channel confirming that the fire was extinguished, and the fire team continued to apply water to the area. The FRT confirmed that no fire had spread to the Hull Deck, and the fire team ceased water application to the area at approximately 16:36. Barricades were posted up around the area, and a designated fire watch was also posted to observe the scene for an extra thirty minutes. A full facility muster was successfully achieved after approximately nine minutes. A debrief was held by the Facility Security Officer and Person in Charge with all personnel on the facility. After the briefing, the call was made to stand down.

During the BSEE investigation, Chevron, Waveland, and GIS reported that personnel involved in the incident had witnessed a mist like spray emitting from the diesel hose before and during the fire until the supply valve was closed. The exact source of the fuel leak was not evident during the initial investigation, but evidence suggested that a leak of some sort developed allowing diesel fuel to spray from the hose and onto the exhaust of the running compressor. On November 7, 2026, during cleanup of the area, Chevron reported to BSEE with photographic evidence that a hole was discovered in the hose once an oil containment drum was removed from on top of it. Further investigation into the matter proved that the max output pressure of the pump is lower than the max pressure rating for the fuel hose. Additionally, Waveland reported that the fuel hose was visually inspected prior to work, and no abnormalities were found.

BSEE Conclusion:

After all the evidence gathered during the onsite follow-up, reviewing witness statements and taking pictures, BSEE concludes that the direct cause of this incident was the rupture of the fuel hose during the refueling operations. A visual inspection of the hose was all that was required before use. A formal procedure identifying proper inspection processes could have identified a defect in the hose that a visual inspection could not. Another probable cause of the incident would be an inadequate hazard analysis. A proper hazard analysis would have brought attention to the ignition source on the compressor adjacent to the operation. Shutting both compressors down with a proper cool down would have prevented ignition. A possible contributing factor to the incident would be a proximity of the air compressors to each other. Had the compressors been placed further away from each other, it is likely the spray of diesel would not have contacted the running compressor exhaust, preventing ignition.

Following the incident, Chevron replaced all fueling hoses on the facility, as well as initiating a Gulf wide hazard hunt involving fuel hoses for all their facilities. Engineering methods are currently being developed for additional fueling stations around the facility, given the distance of the fuel hose being used during the incident. Additionally, replacing fuel hoses annually has been implemented and will be tracked in Chevron's compliant system. Chevron will also collaborate with Waveland to implement a formal procedure for refueling, including refueling when both compressors are shut down and cool.

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

Equipment Failure (Inadequate Equipment Testing/Calibration/Inspection) - Even though the hose was not over pressured during the operation, some degradation was happening on the hose. At the time, only a visual inspection on fuel hoses was required prior to use. There was no formal inspection procedure or maintenance plan in place. It is probable that an in-depth inspection process as well as a proper preventative maintenance plan would have identified defects that a visual inspection cannot.

Management Systems (Inadequate Hazard Analysis) - Proper hazard analysis would have brought awareness to the running air compressor next to the operation. A proper hazard analysis would have identified this as a heat source and possible ignition hazard. Shutting down both compressors prior to fueling would have allowed the exhaust to cool down and remove the ignition source.

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

Work Environment (Poor Layout or Design of Work Area) - The air compressors were stationed relatively close together during the equipment layout process. Had the compressors been placed further away, the diesel spray may not have reached the exhaust of the compressor.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

**Enclosure of air compressor
Fiberglass fire hose box
Hoses
Oil containment drum**

Charred/Melted

ESTIMATED AMOUNT (TOTAL): **\$54,881**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Houma District recommends inspection for procedures and/or maintenance plans on hoses throughout the facility.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

06-NOV-2025

26. Investigation Team Members/Panel Members:

29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

27. OPERATOR REPORT ON FILE:

OCS REPORT:

30. DISTRICT SUPERVISOR:

Amy Gresham

APPROVED

DATE: **13-APR-2026**