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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **09-FEB-2026** TIME: **0608** HOURS
2. OPERATOR: **W & T Offshore, Inc.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [ ] OTHER LIFTING
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [X] INCIDENT >$25K **51,917.75**
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

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

4. LEASE: **G13079**
   AREA: **EW** LATITUDE:
   BLOCK: **910** LONGITUDE:

5. PLATFORM: **A**
   RIG NAME:

6. ACTIVITY:
- [ ] EXPLORATION(POE)
- [X] 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
- [X] FIRE
- [ ] EXPLOSION

LWC
- [ ] HISTORIC BLOWOUT
- [ ] UNDERGROUND
- [ ] SURFACE
- [ ] DEVERTER
- [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

8. OPERATION:
- [X] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [X] PIPELINE SEGMENT NO.
- [ ] OTHER
- [ ] 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: **557** FT.
11. DISTANCE FROM SHORE: **66** 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:

On February 9, 2026, W & T Offshore, Inc. (W & T) notified the Bureau of Safety and Environmental Enforcement (BSEE) Houma District Office that a fire incident occurred at Platform "A," located within Block 910 of the Ewing Banks Area (EW 910 A), Lease OCS-G13079, approximately 70 miles offshore in the Gulf of America. The incident occurred during production operations and resulted in activation of the Emergency Shutdown (ESD) system after Temperature Safety Elements (TSEs) in the immediate vicinity of the glycol regeneration skid melted due to elevated temperatures. The Platform Person in Charge (PIC) identified the location of the fire and notified personnel onboard the facility. Platform personnel responded utilizing firewater hoses and extinguished the fire without injury to personnel. W & T estimated fire related damages and repair costs at approximately $51,917.75.

Sequence of Key Events:

Prior to the incident, the glycol dehydration system at EW 910 A was in operation as part of normal production activities. Operational records and trend data later reviewed during the investigation reflected that on February 8, 2026, approximately twenty-one hours prior to the fire, the glycol circulation pumps had been switched from glycol pump PBA-3350 "Inboard Pump" to the PBA-3340 "Outboard Pump". Following the glycol pump swap, the lean glycol suction inlet valve associated with the active, outboard pump remained in the closed position.

At approximately 0600 hours on February 9, 2026, elevated temperatures in the vicinity of the glycol regeneration skid caused nearby TSEs to melt, initiating the facility ESD system. The PIC identified the location of the fire near the glycol regeneration skid and notified the platform crew. Platform personnel responded to the scene utilizing firewater hoses and directed water at the base of the flames until the fire was extinguished. The estimated duration of the fire was five minutes.

BSEE Investigation:

On February 9, 2026, W & T notified the BSEE Houma District Office of a fire that occurred on the EW 910 A facility. BSEE Investigators subsequently initiated two Incident Follow-Up (IF) investigations. On February 10, 2026, BSEE personnel flew offshore to EW 910 A. During the investigation, BSEE Investigators reviewed operator statements, conducted interviews, reviewed trend data, maintenance records, and operational history, and took photographs of the area of the fire in the glycol regeneration skid.

Personnel reported observing flames and burning liquid in the vicinity of the glycol reboiler still-column drip pot and pressure safety valve (PSV) discharge area. Post-incident inspection identified the heaviest soot accumulation, burn patterns, and thermal damage in the area near the outlet of PSV-3201 located on Glycol Reboiler (BBC-3200). Fire damage was sustained to instrumentation and control devices associated with the glycol regeneration skid, insulation surrounding the Glycol/Glycol Heat Exchanger (HBG-3310), the still-column vent piping, still-column drip pot, underside of the Glycol Reboiler (BBC-3200), and portions of the Glycol Hydrocarbon Separator (MBD-3400).

During the post-incident inspection, the lean glycol inlet suction valve on glycol pump PBA-3340 (the Outboard Pump) was found in the closed position. The valve handle was missing, making valve position verification difficult through visual observation alone. BSEE Investigators reviewed trend data and operational records associated with the glycol regeneration system. The records reflected that the glycol pumps had been swapped from the inboard to the outboard pump approximately twenty-one hours prior to the incident. Based on physical inspection and operational analysis, investigators determined that normal lean glycol circulation would not have been possible with the lean glycol suction inlet valve in the closed position.

Following the IF, BSEE Investigators reviewed the findings documented by a service contractor regarding the glycol regeneration system. The service contractor identified the area of origin near the outlet of PSV-3201 and concluded that the reboiler stack temperature was the probable ignition source which ignited either a released gas plume or liquid carryover event associated with the glycol regeneration system. The service contractor further documented that no single definitive root cause could be identified and concluded the

incident resulted from a combination of contributing operational and system conditions.

The service contractor investigation documented historical operational issues involving vapor loading and liquid carryover within the glycol dehydration system. Records reviewed during the investigation reflected that in December 2022, the dehydration unit experienced liquid carryover or "burping" from the exhaust head and PSV during startup with water-saturated glycol. Additionally, a glycol analysis report dated December 10, 2025, identified entrained hydrocarbons within the glycol system and recommended replacement of charcoal filter elements.

The service contractor also documented a possible design flaw, noting in their report that the still-column exhaust configuration reduced a 3-inch vent line to a 2-inch outlet, which could introduce flow restriction and contribute to pressure buildup within the reboiler system. The service contractor reported to BSEE Investigators during the IF on February 10, 2026, that the configuration was installed as designed.

It was also noted in the contractors report that the reflux coil associated with the glycol regeneration skid had been bypassed utilizing blind skillets due to a pre-existing leak.

During the investigation, BSEE Investigators reviewed W & T procedures and investigation findings related to glycol pump changeover operations. W & T documented that at the time of the incident no formal written procedure or checklist existed requiring verification of valve alignment following glycol pump changeover activities. W & T further documented that the missing valve handle made valve position difficult to verify visually and that no documented process existed to ensure valve lineup verification during glycol pump changeover operations.

BSEE Investigators also reviewed field observations documented during the investigation, which reflected that soot accumulation and thermal damage were concentrated near the PSV discharge and skid drain areas. Operator statements referenced observations of burning liquid and flames in the vicinity of the still-column vent and drip pot area. Burn patterns observed near the still-column piping and flange areas were also documented during the investigation.

W & T sent the damaged still column to a contractor facility for teardown and analysis. On March 11, 2026, BSEE investigators traveled to the facility to conduct a final IF. BSEE Investigators witnessed the teardown inspection of the still that had been removed from the reboiler.

The still was caked in a thick emulsion that had solidified to a gum like consistency. Contractor personnel simply concluded the damage sustained during the incident warranted replacement and rendered the still beyond repair. No evidence of fire was observed within the still. Saddles were heavily coated in hydrocarbons, as exhibited by pictures taken at the facility that day. Following the final IF, BSEE Investigators reviewed the W & T internal investigation report and the third-party technical investigation conducted. To close out the investigation, BSEE Investigators corresponded with W & T via email regarding clarification of documents submitted by W & T.

W & T / Third-Party Investigation:

W & T conducted an internal investigation into the incident and a service contractor to conduct a third-party technical investigation of the glycol regeneration system and associated fire damage. W & T and the contractor concluded that the incident likely involved disruption of normal glycol circulation following glycol pump changeover operations. Both investigations determined that the lean glycol suction inlet valve associated with the active, outboard glycol pump remained closed following the pump swap, preventing circulation of lean glycol to the Glycol Contactor Tower (MAF-3100) and through the regeneration system.

According to W & T and the service contractor, the closed suction valve condition likely allowed the glycol pump to operate in a dry-stroking condition, which could facilitate movement of pressurized gas through portions of the glycol system rather than circulating glycol normally. Investigators concluded that disruption of glycol circulation, accumulation of entrained hydrocarbons within the regeneration system, and pressure buildup within the reboiler system likely contributed to activation of PSV-3201 and/or venting through the reboiler vent system.

The investigations further concluded that heated hydrocarbon-containing liquid and/or vapor released from the reboiler or PSV discharge area likely encountered an ignition source in the vicinity of the glycol reboiler stack or fired components, resulting in the fire.

As part of corrective actions following the incident, W & T initiated development of operator training associated with valve lineup verification and pump changeover activities, installation of valve handles and identification tags on glycol pump valves, and reinforcement of valve alignment verification practices during glycol pump changeover operations.

BSEE Conclusion:

Based on the information obtained through witness statements, physical inspection, review of trend data, review of historical operational records, and evaluation of the W & T and service contractor investigations, BSEE Investigators determined that the fire originated in the vicinity of the glycol regeneration skid near PSV-3201 associated with the Glycol Reboiler (BBC-3200).

The evidence indicates that disruption of normal glycol circulation following glycol pump changeover operations, combined with hydrocarbon accumulation and pressure buildup within the glycol regeneration system, likely contributed to release of hydrocarbon-containing liquid and/or vapor from the reboiler or PSV discharge system. The released hydrocarbons subsequently encountered an ignition source in the vicinity of the glycol reboiler stack or fired components resulting in the fire.

BSEE Investigators further determined that operational and management system deficiencies contributed to the incident, including failure to verify valve lineup following pump changeover activities, lack of formal documented valve lineup verification procedures, and the missing valve handle associated with the lean glycol suction valve. Historical operational issues involving vapor loading, entrained hydrocarbons, and venting restrictions within the glycol regeneration system were also identified during the investigation as conditions which may have contributed to pressure buildup and hydrocarbon release within the system.

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

Human Performance Error – Failure to follow proper procedures

The lean glycol suction valve associated with the active, outboard glycol pump remained in the closed position following pump changeover operations, preventing normal glycol circulation through the glycol regeneration system. Failure to verify valve lineup and restore normal circulation conditions following pump changeover activities contributed to upset conditions within the glycol regeneration system and subsequent hydrocarbon release in the vicinity of the glycol reboiler.

Management Systems – Inadequate written procedures

At the time of the incident, no formal documented procedure or checklist existed requiring valve lineup verification following glycol pump changeover operations. The absence of documented valve alignment verification procedures allowed critical valve positioning activities to rely solely upon individual operator actions and informal practices.

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

Equipment Failure – Inadequate equipment condition

The lean glycol suction valve associated with the active, outboard glycol pump was missing its valve handle at the time of the incident, making valve position difficult to verify visually during pump changeover operations. This equipment condition contributed to improper valve alignment remaining undetected.

Management Systems – Inadequate hazard analysis / failure to identify system vulnerabilities

Historical operational issues involving vapor loading, liquid carryover, entrained hydrocarbons within the glycol system, and possible vent restrictions associated with the still-column exhaust configuration had previously been identified within the glycol regeneration system. These conditions contributed to increased susceptibility

for pressure buildup and hydrocarbon release within the glycol regeneration process.

20. LIST THE ADDITIONAL INFORMATION:

n/a

21. PROPERTY DAMAGED:

Glycol regeneration skid-associated tubing, piping, and ancillary equipment. W & T estimated repair costs associated with the incident at approximately $51,917.75.

NATURE OF DAMAGE:

Insulation surrounding the Glycol/Glycol Heat Exchanger (HBG-3310), portions of the Glycol Reboiler (BBC-3200), the Glycol Hydrocarbon Separator (MBD-3400), associated tubing, piping, and ancillary equipment.

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE Houma District has no recommendations for the Office of Incident Investigations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

None

25. DATE OF ONSITE INVESTIGATION:

10-FEB-2026

28. ACCIDENT CLASSIFICATION:

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: **22-JUN-2026**