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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **28-MAY-2026** TIME: **0746** HOURS
2. OPERATOR: **Walter Oil & Gas Corporation**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Baleen Process Solutions**
   REPRESENTATIVE:
   TELEPHONE:

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

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

4. LEASE: **G31481**
   AREA: **ST** LATITUDE:
   BLOCK: **311** 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
   - [ ] FIRE
   - [X] 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.
   - [ ] TEMP ABAND
   - [ ] PERM ABAND
   - [ ] DECOM PIPELINE
   - [ ] DECOM FACILITY
   - [ ] SITE CLEARANCE
   - [X] OTHER **Pipeline Cleanout**

9. CAUSE:
   - [X] EQUIPMENT FAILURE
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER _____

10. WATER DEPTH: **391** FT.
11. DISTANCE FROM SHORE: **64** 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 May 28, 2026, a fire incident occurred at the South Timbalier Block 311 Megalodon facility (ST-311) operated by Walter Oil and Gas Corporation (Walter) in the Gulf of America. Walter contracted a remediation contractor for pipeline clean out operations using a specialized coil tubing system and a shaker system owned by an equipment rental contractor and rented out to Walter by Baleen Process Solutions (Baleen). Also on location were two field management consultants for the operation (consultants). On May 28 at approximately 7:30 A.M., a loud bang was heard by multiple personnel throughout the facility, including inside the living quarters. Personnel on the job site noticed a flash followed by smoke coming from the shaker box cover. The pressure from the flash fire blew out one of the shaker door windows which fell approximately 10 feet to the deck below. Personnel immediately responded by initiating a facility Emergency Shutdown (ESD) and activating the general alarm. Two personnel involved in the operation proceeded to the incident location and discharged a single 30lb fire extinguisher into the shaker tank located below the shaker box. Remediation contractor personnel shut down the operation, leaving the coil tubing system in the pipeline. Once the scene was secure, all personnel on the facility mustered to their designated lifeboats until all clear was announced.

Sequence of Events:

The ST-311 facility was in process of pipeline cleanout operations involving the remediation contractor using a coil tubing system, operating by breaking up built up material inside the pipeline and pushing it back up through the line to the surface to be properly disposed of. On May 28, at approximately 7:30 A.M., daytime production operations were having a morning shift change meeting when a loud bang was heard throughout the facility. The pipeline cleanout is a 24 hour operation, and was currently underway during this time. Personnel in the living quarters as well as personnel located outside immediately proceeded to the area and noticed smoke coming from the door of the shaker box used for the clean out operations and debris on the deck surrounding the shaker. It was determined that an explosion occurred inside the shaker box which was the source of the loud bang.

Two remediation contractor operators were at the operations panel for the coil tubing system located approximately 50 feet away from the shaker. Once the explosion occurred, one remediation contractor operator immediately shut the process down and locked out the system, while the other ran around to the front of the scene to inspect for visible flames. A consultant employee and the crane operator were also on scene when the incident occurred. They reported witnessing a window on the shaker door blow out followed by smoke, and saw flashes and smoke coming from the shaker tank which is located below the shaker box. The two workers responded to the area and discharged a full fire extinguisher into the tank. They then reported to muster once the flashes were extinguished.

A full facility muster was successfully achieved and the all clear was given to stand down. Further investigation into the incident revealed a poorly repaired damaged cable connection located on the vibration motor inside the shaker box. It appeared that the cable was damaged, causing wire to be exposed. The cable was improperly repaired with electrical tape only. The damaged cable was discovered to have sparked inside the shaker box which is a hydrocarbon containing area. The spark ignited inside the shaker box resulting in the explosion. No actual flame was witnessed. The blast migrated from the shaker box into the tank via hose and had ignited the residual gas inside of the tank. The operation was shut down until further notice pending investigation by Walter and MMA.

MMA Investigation:

At approximately 12:00 P.M. on May 28, 2026, the Marine Minerals Administration (MMA) Houma District received an initial notification via phone call regarding a flash fire that occurred on the ST-311 facility. Pictures of the scene were included in the email communication chain after the follow-up email. MMA investigators were included in the communication chain, and the decision was made to conduct a follow-up investigation the following morning.

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On May 29, 2026, MMA investigators flew offshore to conduct a follow-up investigation. Upon arrival, MMA investigators met with Walter personnel as well as third-party contract personnel. Interviews were conducted with all personnel involved as well as a walkthrough assessment of the area and pictures were taken. The investigation revealed that the shaker box had sporadically been experiencing problems since the beginning of the clean out operation. On May 25, operations personnel had to replace the control panel due to the breaker panel constantly tripping. Also, the operation supervisor for Baleen explained to MMA that one of the bolts holding the shaker motor inside the shaker box had sheered, which caused shaking and imbalance of the motor. The operation was shut down and promptly repaired. Operations continued once the bolt was replaced and the motor was secured.

MMA also discovered during the investigation that on the night of May 27, at approximately 10:20 P.M., operations personnel observed flashes from inside the shaker box through the shaker door windows. The remediation contractor operators were notified, and the operation was temporarily shut down. However, with regards to the specific tool used to clean out the pipeline, there is a high probability of the coil getting stuck in the pipeline. So, the remediation contractor operators elected to pull the coil tool out of the hole prior to troubleshooting and inspection into the flashes. Despite the flashes, the operation continued for approximately 45 extra minutes after the flashes were observed until the remaining 400 feet of coil was successfully pulled from the pipeline.

It was explained to MMA that once the coil was out of the pipeline, investigation into the flashes began. A Baleen operator discovered a damaged cable connection for the vibration motor inside the shaker box. The conduit for the cable had become loose and the sealing compound inside the conduit was missing, along with damaged wires. It was determined that sparks had originated from the damaged cable, causing the observed flashes. The Baleen operator repaired the connection by wrapping it in electrical tape. At approximately 12:45 A.M., the remediation contractor continued the cleanout operations.

The Baleen supervisor reported that he went to inspect the job site in the morning before shift and noticed the taped-up wire connection. It was discussed with the crew that operations could not continue with the improper cable repair, and it was decided to properly repair the cable connection as per manufacturer. The remediation contractor was in process of retrieving the coil from the pipeline when the explosion occurred. All personnel reported hearing a loud bang throughout the facility, and smoke was witnessed coming from the shaker box blown out window.

The consultant and crane operator were outside when the incident occurred. They reported that they grabbed a fire extinguisher and immediately proceeded to the shaker tank to investigate if any fire had migrated into the tank from the shaker above. They witnessed small flashes inside the tank and discharged the entire fire extinguisher into the tank hatch. The consultant reported that he also experienced minor burns on his arms during this process but was not severe enough to be evacuated.

Two remediation contractor operators were at the control panel for the coil tubing system when the incident occurred, located approximately 50 feet away. They reported that they heard the explosion and witnessed the shaker door window blowing out and smoke coming from the window hole. One of the remediation contractor operators went around the scene to investigate if any fire was present, while the other operator shut down the process, leaving approximately 400 feet of coil still in the pipeline. They immediately reported to their muster stations once they secured the control panel.

Once the muster was complete and the situation was under control, all clear was called and all personnel stood down. Inspection into the incident began immediately and revealed that there were no other damaged electrical parts inside the shaker box, and was determined that the damaged cable connecting sparked once again, igniting flash gas inside the shaker box. It was also discovered that the vibration motors inside the shaker were not properly grounded to the shaker skid and the shaker skid was not properly grounded to the deck. Walter contacted MMA later on May 28 at approximately 1:00 P.M. after the initial notification, requesting approval to retrieve the coil tubing system from the pipeline, without the shaker being used. Approval was granted to

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retrieve the coil without the shaker, under the condition of the operation being shut down immediately after retrieval and remaining shut down pending MMA investigation.
Conclusion:
Walter Oil and Gas conducted their own investigation into this incident and concluded that the direct cause of the incident that occurred on May 28 was equipment failure, which was the improperly repaired cable connection inside a class 1 division 1 area, along with improper grounding. Resulting in a spark that ignited present hydrocarbons inside the shaker box causing the explosion.
With all of the information gathered during the follow-up investigation as well as phone calls and emails, MMA agrees with Walter on their findings that the direct cause of the incident was the improperly repaired damaged cable connection for the vibration motor in the shaker box. Had the connection been properly repaired as per manufacturer's recommendations when discovered, the potential for sparks moving forward would have been eliminated.
A contributing cause to this incident would be human error, with inexperience of tasks related to the incident. The Baleen operator that put tape on the cable connection was not aware of the procedures to properly repair the connection as per the manufacturer's recommendations, and failed to seal the conduit containing the damaged wiring, contributing to the spark that caused the explosion.

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

Equipment Failure (Inadequate Equipment Repair) - The cable connection inside the shaker was not properly repaired as per the manufacturer specifications.

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

Human Error (Inexperience of tasks related to incident) - The employee that taped the cable connection was not aware of the specific method needed to repair the connection based on the area classification the cable was located in.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:	NATURE OF DAMAGE:
***Window for shaker box cover**	***Cracked window**
***Vibration cable connection**	***Frayed wire**

ESTIMATED AMOUNT (TOTAL): **$1,200**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

N/A

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

Unworkman-like unsafe practice - Continuing to operate the equipment after sparks were witnessed.

25. DATE OF ONSITE INVESTIGATION:

29-MAY-2026

28. ACCIDENT CLASSIFICATION:

26. Investigation Team Members/Panel Members:

27. OPERATOR REPORT ON FILE:

29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

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OCS REPORT:

30. DISTRICT SUPERVISOR:
Amy Gresham

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