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

ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED
DATE: 26-JUL-2018 TIME: 0130 HOURS

2. OPERATOR: Chevron U.S.A. Inc.
    REPRESENTATIVE:
    TELEPHONE:
    CONTRACTOR:
    REPRESENTATIVE:
    TELEPHONE:

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

4. LEASE: G16942
    AREA:  WR   LATITUDE:
    BLOCK: 29   LONGITUDE:

5. PLATFORM: A-Big Foot
    RIG NAME:

6. ACTIVITY: ☑ EXPLORATION (POE)
    ☑ DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
   ☑ HISTORIC INJURY
     ☑ REQUIRED EVACUATION
     ☑ LTA (1-3 days)
     ☑ LTA (>3 days)
     ☑ RW/JT (1-3 days)
     ☑ RW/JT (>3 days)
     ☑ Other Injury
   ☑ FATALITY
   ☑ POLLUTION
   ☑ FIRE
   ☑ EXPLOSION
   ☑ HISTORIC BLOWOUT
   ☑ UNDERGROUND
   ☑ SURFACE
   ☑ DEVERTER
   ☑ SURFACE EQUIPMENT FAILURE OR PROCEDURES
   ☑ HISTORIC
   ☑ >$25K
   ☑ <=$25K

8. OPERATION:
   ☑ PRODUCTION
   ☑ DRILLING
   ☑ WORKOVER
   ☑ COMPLETION
   ☑ HELICOPTER
   ☑ MOTOR VESSEL
   ☑ PIPELINE SEGMENT NO.
   ☑ OTHER

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

10. WATER DEPTH: 5185 FT.
11. DISTANCE FROM SHORE: 120 MI.

12. WIND DIRECTION:
    ☑ SPEED: M.P.H.

13. CURRENT DIRECTION:
    ☑ SPEED: M.P.H.

14. SEA STATE: 15 FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:
At approximately 0130 hours on July 26, 2018, an incident occurred on the OCS-G 16942, Walker Ridge 29A facility (Big Foot). The operator of record is Chevron U.S.A. Inc. The facility is located 120 miles from shore in 5185 feet of water.

In the early morning hours of July 26th, a worker witnessed a fire ignite in the skid of a rental oil filtration unit on the North side of the production deck. According to the witness, the fire was approximately 10 feet high by 10 feet wide with heavy black smoke. The witness alerted everyone in the area of the fire as another employee announced the fire to the entire platform on the Gai-Tronics system. Another worker manned a handheld fire extinguisher, simultaneously, two other employees utilized an Aqueous Film Forming Foam (AFFF) unit and attempted to extinguish the flames. According to multiple witnesses, "the fire was put out temporarily" but "lit back up" after a few seconds. The flames were again extinguished by the worker with the AFFF unit. After the fire was extinguished, a worker continued to spray the area with the firewater hose for approximately 30 minutes. According to witness statements, the fire lasted only a few minutes. During the incident, the General Alarm was sounded and all personnel mustered to their assigned stations until the all clear signal was given. No injuries to personnel were reported during the incident.

BSEE inspectors arrived at the platform later that morning to begin the incident investigation. Pictures and witness statements were taken as well as a survey of the damages at the site of the incident.

Based on the information obtained during the BSEE investigation, the rental units' purpose was to dehydrate lube oil in a tote tank before adding the oil to the compressors. The filtration unit was in service at the time of the fire. Records indicate that approximately five weeks prior to the incident, the unit operators were having difficulties keeping the unit running. After contacting the manufacturer, the operators were instructed to disable the low flow and high temperature safety devices to enable the unit to remain running. The manufacturer also instructed the operators that the unit must be continuously manned while in service due to the disabled safety devices. Around midnight prior to the incident, the unit was shut down and the inlet and outlet valves were closed. The operators then took a supper break. After returning from his meal, one of the operators, a short service employee, restarted the unit but failed to reopen the inlet and outlet valves. At that time, the operator left the unit unattended (approximately 14 minutes) to retrieve some equipment. While the operator was away, the temperature in the unit rose high enough to degrade the integrity of the hose causing it to burst, releasing hot lube oil to the surrounding area. This event caused the lube oil to ignite resulting in the fire.

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

The temperature in the unit rose high enough to degrade the integrity of the hose causing it to burst, releasing hot lube oil to the surrounding area. This event caused the lube oil to ignite resulting in the fire.

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

1. The disabled low flow and high temperature safety devices.
2. The inlet and outlet valves left in the closed positions after unit restart.
3. The employees leaving the unit unattended against the manufacturer's instructions.

20. LIST THE ADDITIONAL INFORMATION: n/a
21. PROPERTY DAMAGED:
   1. Cables and trays in the immediate area of the fire.
   2. The rental oil filtration unit in the GlyTech skid.

   NATURE OF DAMAGE: Fire, smoke, and water damages.

   ESTIMATED AMOUNT (TOTAL): $3,275,000

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:
   The Houma District has no recommendations for the Office of Incident Investigations.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

   On 10-19-2018 an Incident of Non-Compliance (INC-G-110(W)) was issued from the Houma District Office for an incident occurring on 07-26-2018. The INC states as follows: "On July 26, 2018 a fire incident occurred on the Chevron Big Foot facility located at Walker Ridge 29. At approximately 0130 hours a fire was discovered in the Gly-Tech skid located on the North side production deck. The fire was extinguished in a few minutes. During the investigation it was determined three areas of concern led to the fire: 1. The low flow and high temperature safety devices were disabled on the rental oil filtration unit located in the Gly-Tech skid. 2. The inlet and outlet valves were left in the closed positions after unit restart. 3. The employee leaving the running unit unattended against manufacturers instruction."

25. DATE OF ONSITE INVESTIGATION: 26-JUL-2018

26. INVESTIGATION TEAM MEMBERS:
   Clinton Campo / James Hamilton / Terry Hollier - Author /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

30. DISTRICT SUPERVISOR:
   Bryan A. Domangue

APPROVED DATE: 19-FEB-2019