

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **31-JAN-2023** TIME: **1045** HOURS

2. OPERATOR: **Talos ERT LLC**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **Alliance Offshore, LLC**

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: **G01023**

AREA: **SS** LATITUDE:

BLOCK: **224** LONGITUDE:

5. PLATFORM: **E**

RIG NAME:

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

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.
- DECOMMISSIONING
- PA PIPELINE SITE CLEARANCE
- TA PLATFORM
- OTHER **Plug and abandonment**

9. CAUSE:

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

10. WATER DEPTH: **147** FT.

11. DISTANCE FROM SHORE: **44** MI.

12. WIND DIRECTION: **E**
SPEED: **13** M.P.H.

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

14. SEA STATE: **3** FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

On January 31, 2023, a wireline incident occurred during operations for the operator, Talos Energy, located at Ship Shoal 224 "E" OCS-G-01023. Personnel were in the process of temporarily abandoning (T&A) the E-4 well, using electric line (E-line) with a casing cutter. During the procedure, a release of energy occurred, causing the tool string to be ejected out of the well, damaging some grating. No injuries reported, and an onsite investigation was initiated.

On the morning of January 31, 2023, the crew held a pre-job safety meeting to discuss the safety of using E-line for the T&A procedure of the E-4 well on the platform. The crew proceeded to erect barricades on the cellar and wellbay decks before installing the work plate on the top deck. A pipe rack was then set up to lay out and measure the 2-3/8" work string before going into the well. The well has a subsea wellhead tieback system (subsea wellhead) near the mudline with all casing cut off 12 feet above the water line. The crew made up a 7-5/8" casing scraper assembly and went in the well to 30 feet below the water line before rigging up a pump line to circulate 8.6-pound seawater. After circulating, the assembly was pulled out of the hole (POOH) and a 6.35" gauge ring and junk basket was run in the well and tagged the cement plug at 123 feet below mud line (BML). The crew POOH with the gauge ring and junk basket to rig up an E-line cutter to cut the 7-5/8" casing at 120 feet BML. Once in place, the E-line operator fired the casing cutter and the fluid and tool string were ejected from the well, damaging the grating on the cellar and well bay decks. A safety stand down was called and an onsite investigation was initiated.

Investigation:

The Bureau of Safety and Environmental Enforcement (BSEE) inspectors conducted an onsite investigation on February 3, 2023. The BSEE investigation team consisting of Well Operations Inspectors were able to collect incident documentation and photos from the operator and contractor at the team's request. The BSEE investigation team reviewed all the provided documentation and found that in 2004 the E-4 well at Ship Shoal 224-E was abandoned with a cement plug set in the 7-5/8" production casing from 123 feet to 375 feet below the mud line (BML). In 2007, the well head was removed from the well and all casings were cut off 12 feet above the water line and a subsea tieback wellhead was in the well near the mudline.

According to the approved procedure, contractor's crew was instructed to cut and remove the 7-5/8" casing above the surface cement plug. Following its removal, a cement retainer was going to be placed in the 10-3/4" casing so an attempt could be made to inject fluid to the 10-3/4" casing shoe. The 16" and 10-3/4" casing was tied back to surface but there was no communication with the wellbore below the subsea wellhead. This allowed trapped pressure to build up under the wellhead without being detected. All non-essential personnel were clear of the area, in the case of any unforeseen pressure event. When the casing cutter was fired below the subsea wellhead, the trapped pressure in the 10-3/4" and 7-5/8" annulus was released causing the tool string to be ejected from the wellbore. The tool string landed on the top deck, damaging the grating on the cellar and wellbay decks. The 2004 well files indicated a subsea tieback wellhead in the well near the mudline. All the casing strings were tied back into the system and run back to surface for the well to be completed. In 2007, the surface wellhead was removed from the well and all casings were cut off approximately 12 feet above the waterline. The operator or contractor were not aware that the well did not communicate above or below the subsea tieback system. The well had no history of pressure recordings and the surface wellhead had been removed, therefore no wireline pressure control equipment was used.

Since the incident, the contractor will install a slip-on surface wellhead on all wells that have a subsea wellhead system on this facility. The contractor will also update their standard operating procedure to include utilizing pressure control

equipment before perforating untested annuli to protect from the release of trapped pressure.

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

Project personnel were unaware that there was no communication above or below the subsea wellhead tieback system where there was trapped pressure.

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

No wireline pressure control equipment was used because the wellhead was removed.

20. LIST THE ADDITIONAL INFORMATION:

n/a

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

Damaged grating on cellar deck

Grating broke loose and bent

ESTIMATED AMOUNT (TOTAL):

\$4,000

22. RECOMMENDATIONS TO PREVENT RECURRENCE 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:

28. ACCIDENT CLASSIFICATION:

03-FEB-2023

26. Investigation Team Members/Panel Members:

29. ACCIDENT INVESTIGATION PANEL FORMED:

Tim Boudreaux / Tony Bass / Gabe Orellana / Paul Reeves - Author /

NO

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR:

Amy Pellegrin

APPROVED

DATE:

12-FEB-2024