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

ACCIDENT INVESTIGATION REPORT

For Public Release

1.	OCCURRED STRUCTURAL DAMAGE
	DATE: 09-JAN-2021 TIME: 0830 HOURS CRANE
2	OPERATOR: Cox Operating, L.L.C. OTHER LIFTING OPERATOR: Cox Operating, L.L.C.
- •	OPERATOR: Cox Operating, L.L.C. REPRESENTATIVE: DAMAGED/DISABLED SAFETY SYS. INCIDENT >\$25K
	TELEPHONE: H2S/15MIN./20PPM
	CONTRACTOR: REQUIRED MUSTER
	REPRESENTATIVE: X SHUTDOWN FROM GAS RELEASE
	TELEPHONE:
3.	OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR 8. OPERATION:
	ON SITE AT TIME OF INCIDENT:
4.	LEASE: UUU26
	DIOCK. 30 LONGITUDE: -89 61394
	HELICOPTER MOTOR VESSEL
5.	PLATFORM: P PIPELINE SEGMENT NO.
	RIG NAME: OTHER
6	ACTIVITY: EXPLORATION(POE)
ο.	x DEVELOPMENT/PRODUCTION 9. CAUSE:
	(DOCD/POD)
7.	TYPE: INTIDIES. X EQUIPMENT FAILURE
	INJURIES: HUMAN ERROR HISTORIC INJURY
	L EXTERNAL DAMAGE
	OPERATOR CONTRACTOR SLIP/TRIP/FALL REQUIRED EVACUATION WEATHER RELATED
	LTA (1-3 days)
	LTA (>3 days) UPSET H2O TREATING
	RW/JT (1-3 days) OVERBOARD DRILLING FLUID
	RW/JT (>3 days) OTHER
	Other Injury 10. WATER DEPTH: 43 FT.
	11. DISTANCE FROM SHORE: 8 MI.
	POLLUTION
	FIRE 12. WIND DIRECTION: EXPLOSION SPEED: M.P.H.
	LWC HISTORIC BLOWOUT 13. CURRENT DIRECTION:
	UNDERGROUND SPEED: M.P.H.
	U SURFACE □ DEVERTER 14. SEA STATE: FT.
	SURFACE EQUIPMENT FAILURE OR PROCEDURES 15. PICTURES TAKEN:
	COLLISION THISTORIC To >\$25K To <=\$25K 16. STATEMENT TAKEN:
	COLLISION IHISTORIC 1 > S25K 1 < = \$25K 10 · STATEMENT TAKEN:

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INCIDENT SUMMARY:

On 09 January 2021 at approximately 0600 hours, a gas release that resulted in a process automated shutdown occurred on West Delta (WD) 30 Platform P, Lease OCS 026. WD 30 P is an unmanned platform monitored and operated by personnel located at WD 31 E. The Operator on record is Cox Operating, LLC (Cox).

SEQUENCE OF EVENTS:

According to Cox, on 09 January 2021 at 0600 hours, the control room operators monitoring the Supervisory Control and Data Acquisition (SCADA) System located at WD 31 E, noticed a loss of production at WD 30 P. The Person In Charge (PIC) sent personnel by field boat to investigate the loss of production. Upon arrival, personnel found the fuel gas scrubber, gas generator, and the Emergency Shut Down (ESD) System were still in service. The gas compressor's inlet and discharge Shut Down Valves (SDV) were closed, and the Low Pressure (LP) Separator and all nine LP wells were shut in. The operator investigated the Pressure Safety Low (PSL) on the suction inlet that the tripped on the panel. He heard the gas leak and found a pin hole in the inlet suction piping to the compressor. This leak likely caused the PSL to activate the shut-in. There was no loss of containment and no pollution observed. The operator did not attempt to restart production. The operator notified Cox management.

At 0830 hours, Cox requested a variance from the Bureau of Safety and Environmental Enforcement (BSEE) to install a 6 inch (in), 2000 psi clamp on the 6 in ANSI 150 series piping to bring the facility back online. Also, Cox requested to use the clamp for 14 days until permanent repairs could be made. Approval was granted at 0920 hours by the BSEE New Orleans District (NOD). The clamp was installed at 1000 hours and the platform was returned to production.

BSEE INVESTIGATION:

The BSEE Accident Investigator (AI) reviewed the incident in BSEE's eWell reporting system on 11 January 2021. The AI requested the Safety Analysis Function Evaluation (SAFE) charts required by 30 CFR 250.842 which indicate what functions are caused by the PSL on the MBF-PC11 compressor suction scrubber. According to the SAFE charts, the PSL would have only shut down the compressor. However, the loss of the pressure on the gas lift system caused the LP separator's PSL to shut down the wells. The AI also requested photos of the pin hole leak location. The photos indicated corrosion and a failure of the piping coating system in the place where the leak occurred. The AI confirmed the loss of production at WD 30 P from Cox's WD 30 Area Morning Report.

CONCLUSIONS:

The pin hole leak in the inlet suction piping of the gas compressor activated the PSL which shut in the Gas Compressor, LP Separator, and the 9 LP production wells. The pin hole was likely caused due to excessive corrosion. The corrosion was a result of Cox's failure to maintain coatings on the process piping. However, the platform safety system performed as designed in accordance with the regulations.

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

Equipment Failure - Inadequate preventive maintenance - Cox failed to maintain pipe coatings which caused corrosion. The corrosion caused enough wall loss such that the piping lost integrity.

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- 19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:
- 20. LIST THE ADDITIONAL INFORMATION:
- 21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

The affected piping is a 6 in diameter, 150 class rating capable for 285 psi and measured to be approximately 19 feet in length.

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

N/A

- 23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO
- 24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G111 - Cox failed to maintain piping coatings which caused corrosion. The corrosion caused enough wall loss such that the piping lost integrity and leaked.

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

26. INVESTIGATION TEAM MEMBERS:

Gerald Taylor /

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR:

David Trocquet

APPROVED

DATE: 17-JUN-2021