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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **04-APR-2024** TIME: **2230** HOURS
2. OPERATOR: **Renaissance Offshore, LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Cajun Cutters**
   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: **G02274**
   AREA: **VR** LATITUDE:
   BLOCK: **369** LONGITUDE:

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

6. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [X] DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	**0**	**1**
[ ] LTA (1-3 days)		
[X] LTA (>3 days)		**1**
[ ] 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:
   - [X] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] DECOMMISSIONING
     - [ ] PA [ ] PIPELINE [ ] SITE CLEARANCE
     - [ ] TA [ ] PLATFORM
   - [ ] OTHER

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: **316** FT.
11. DISTANCE FROM SHORE: **100** 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:

17. INVESTIGATION FINDINGS:

On April 5, 2024, at 8:43 AM, Renaissance Offshore LLC. (Renaissance) reported an injury that required evacuation from the Vermilion 369 Alpha platform (VR-369A), lease G02274. Renaissance reported," The incident occurred when the Injured Person (IP) was reconfiguring a tree cap connection for temporary equipment when trapped pressure from the valve cavity was released." An employee of Cajun Cutters Inc. (Cajun Cutters), hereafter referred to as the injured person (IP), was impacted by the release of gas pressure from the open top of the tree of well A-15.

On April 4, 2024, at approximately 6:00 AM, a platform safety meeting was held to discuss the temporary production piping and equipment for the depressurization of Stingray Pipeline, LLC 20-inch pipeline (Segment No. 10875) through KAH-20275 (Segment No. 20275), a 4-inch departing pipeline at VR-369A. The VR-369A platform wells were to be shut in, while still receiving incoming production from the VR-408A platform. Persons on board were a field supervisor employed by Renaissance, a lead operator (Platform PIC) and a C-operator employed by Danos, a Mechanic and an A-operator employed by Dynamic Production Services (Dynamic), an A-operator and a scaffold builder employed by Gulf South Services Inc. (GSSI), a specialist tech employed by River Rental Tools, a welder and rigger employed by Cajun Cutters, and a cook employed by Premier Catering. The A-operator employed by Dynamic was informed that he would be working nights upon arrival that day and was instructed to rest before the overnight shift.

On April 4, 2024, at approximately 2:27 PM the platform was shut in by the platform operators and pressure from the tie-in points was bled to zero. After verifying the pressure was removed, Cajun Cutters removed a section of pipeline piping and installed a flange connected with a 2" high-pressure hose. After the installation at the pipeline, work began on the production deck at the Test Separator (MBD-1000). The Test Separator outlet was connected to the Blowdown Header with 2" high pressure hose. At approximately 10:00 PM, Cajun Cutters took a break, discussed what was next and how they would proceed. They agreed to proceed and began removing the tree cap adapter flange above the crown valve on well A-15. At approximately 10:30 PM, while installing a new flange to accept the high-pressure hose, an unexpected release of pressure from the top of the well tree contacted the IP's left eye and the left side of the IP's face. The IP was provided first aid with eye wash bottles, clean bandages and Advil. After first aid, the decision was made to request a medevac flight. On April 5, 2024, at approximately 12:20 AM, the platform was notified that the medevac flight would arrive at 1:20 AM. The Medevac departed VR-369A with the IP at 1:34 AM and was flown to Lafayette General Hospital to receive emergency treatment. The IP has received treatments to remove foreign substances from the eye, incurred partial permanent hearing loss, and has been evaluated for future eye surgeries following the incident. As of June 26, 2024, the IP has not been released to full duty.

On April 12, 2024, the Bureau of Safety of Environmental Enforcement (BSEE) Lake Charles District investigators (investigators) conducted an onsite incident investigation. The BSEE investigators met with the Renaissance representatives at VR-369A and received a briefing of the incident. The investigators collected all prepared witness statements, collected pictures taken by Renaissance, collected job safety analysis (JSA), collected Lockout/Tagout paperwork, and the persons on board (POB) paperwork. While on-board, BSEE investigators also took photos of the well bay, interviewed personnel that were involved during or after the incident, and completed a physical inspection of well A-15. A recent Surface Controlled Sub-Surface Safety Valve (SCSSV) test was collected indicating the A-15 well had a shut-in tubing pressure of 1195 psig. Witnesses stated that the A-15 well had 800 psig of pressure at the top of the well tree before the pressure was bled to zero above the Surface Safety Valve (SSV). Investigators also requested a copy of procedures outlining the job steps used to complete the task. Renaissance was not able to provide such documents.

On April 17, 2024, investigators traveled to Cajun Cutters office in Houma, LA to conduct interviews with the IP (welder) and his helper (rigger). Recorded interviews were conducted with both Cajun Cutters employees. The IP presented pictures of his injuries to investigators and provided copies. Cajun Cutters provided copies of the employees written statements with investigators.

The BSEE investigators reviewed written statements received from Renaissance, as well as interviews with persons on duty at the time of the incident. In more than one statement, personnel claimed to have heard a process alarm moments before the pressure release. Statements included such comments as" 'The tree blew up with pressure,' 'It was so loud,' and 'I heard what sounded like a gas release @~10:30 PM. I got out of bed and got dressed.' "Witnesses estimated the release of gas, from the open crown valve, lasting from 2 to 5 seconds.

The BSEE investigators reviewed photographs taken during the investigation as well as photographs provided to the BSEE by Renaissance. These photographs included reenactments of the IP and helper's body positions with a movable access platform with stairs measuring approximately 36 inches by 36 inches wide and 48 inches high, positioned next to the well. The IP and helper exited the access platform to obtain the body positioning and strength needed to unbolt and replace the tree cap adapter at the top of the A-15 well. The IP was standing with one foot on the SSV the other on the moveable platform and the helper was standing on flowline wing valve of the A-15 well. This position placed the top of the well tree at the IP and helper's midsection with them looking down at the tree cap.

While conducting interviews, it was noted that the operator on duty (Dynamic), during the night shift, had arrived at the platform earlier that day and had never worked at VR-369A previously. The night shift operator's duties included routine production operations of the platform, including maintaining the incoming production from VR-408A. The IP stated in his interview that he had a conversation with the PIC before removing the tree cap adapter to verify that they would continue working to complete the work before the boat's scheduled arrival at 3:00 AM.

The BSEE investigators reviewed the JSAs and Lockout/Tagout paperwork for removing and installing gas pipeline piping. Cajun Cutters' JSA discussed "not following procedure and stored energy as potential hazards" and "100% containment and checking for pressure" as steps to eliminate hazards, or "reduce risks to an acceptable level." The scaffold builder (GSSI), who was assisting with the job, was not listed on the JSA. No site specific JSA was prepared discussing job steps or body positioning. According to the paperwork provided, Lockout/Tagout of the A-15 lower manual master valve was not installed until after the incident occurred. No record of Lockout/Tagout was provided to the BSEE investigators for the automatic surface safety valve. Likewise, no Lockout/Tagout paperwork was provided for any other valves associated with the A-15 well.

The BSEE investigators have determined Renaissance did not implement their Lockout/Tagout to ensure positive isolation of all A-15 well tree valves thus preventing accidental release of pressure from the wellbore and escape of pressure from a valve cavity. Renaissance reported that trapped gas pressure was released from a valve cavity but did not identify which valve the pressure was released from. However, during the investigation, witnesses stated that no manual valves on the A-15 well tree were manipulated at the time of the incident. Renaissance designated an operator with no previous platform specific experience as the sole operator on duty of the overnight shift. The night operator arrived at VR-369A the morning of the incident. There were no written procedures provided to the BSEE investigators, nor written instructions provided to personnel that would specify which valves had been isolated and ensure all pressure had been removed. The IP was on duty for 15.5 hours, from 6:00 AM until the time of the incident at approximately 10:30 PM. No safe working surfaces were provided around the entire A-15 well which contributed to the poor body positioning of the IP and helper.

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

Work Environment:
Lockout/Tagout was not implemented to ensure positive isolation of all A-15 well tree valves thus preventing accidental release of pressure from the wellbore and escape of pressure from a valve cavity.

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

Supervision/Personnel training:
Renaissance designated an operator with no previous platform specific experience as the sole operator on duty of the overnight shift.
Management systems:
There were no written procedures provided or instructions provided to personnel that would specify which valves had been isolated and ensure all pressure had been removed.
No safe working surfaces were provided around the entire A-15 well which contributed to the poor body positioning of the IP and helper.
Human performance error:
The IP was on duty for 15.5 hours, from 6:00 AM until the time of the incident at approximately 10:30 PM.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

N/A
ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lake Charles District has no recommendations for the Office of Incidents at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 DOES THE LESSEE PERFORM ALL OPERATIONS IN A SAFE AND WORKMANLIKE MANNER AND PROVIDE FOR THE PRESERVATION AND CONSERVATION OF PROPERTY AND THE ENVIRONMENT?
1. Lockout/Tagout was not implemented to ensure positive isolation of all A-15 well tree valves thus preventing accidental release of pressure from the wellbore and escape of pressure from a valve cavity.
2. Renaissance designated an operator with no previous platform specific experience as the sole operator on duty of the overnight shift.
3. There were no written procedures provided to the BSEE, nor written instructions provided to personnel that would specify which valves had been isolated and ensure all pressure had been removed.
4. No safe working surfaces were provided around the entire A-15 well which contributed to the poor body positioning of the IP and helper.

25. DATE OF ONSITE INVESTIGATION:

12-APR-2024

26. Investigation Team Members/Panel Members:

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

MINOR

29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Beau Boudreaux

APPROVED DATE: **22-JUL-2024**