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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **30-APR-2026** TIME: **0700** HOURS
2. OPERATOR: **Nugulf Operating, L.L.C.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   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: **00694**
   AREA: **SP** LATITUDE: **28.966156**
   BLOCK: **28** LONGITUDE: **-89.229344**

5. PLATFORM: **99**
   RIG NAME: *** LIFT BOAT**

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

7. TYPE:
   INJURIES:
- [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	**0**	**1**
[ ] LTA (1-3 days)		
[X] LTA (>3 days)	**0**	**1**
[ ] 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.
- [X] OTHER **Construction**
- [ ] TEMP ABAND
- [ ] PERM ABAND
- [ ] DECOM PIPELINE
- [ ] DECOM FACILITY
- [X] SITE CLEARANCE

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

10. WATER DEPTH: **35** FT.
11. DISTANCE FROM SHORE: **4** 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:

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INCIDENT SUMMARY:

On Thursday, 30 April 2026, at 0700 hours, while the Lift Boat (L/B) Jimmie Holmes was performing diving support operations at South Pass 28 platform # 99 on OCS Lease No. 00694, operated by NuGulf Operating, L.L.C. (NuGulf), a contract worker (IP) was injured as he was installing and testing a new Oxygen (O2) manifold. While the IP was checking a newly received Oxygen rack, the manifold unexpectedly burst and injured the IP. After first aid was provided on the L/B by a Medic in the field, the IP was then transferred to a nearby facility via crew boat and then medevac'd onshore via helicopter to a medical facility for further treatment. There were no other injuries, damage to the platform, or environmental impact associated with this incident.

At the time of the investigation, Marine Minerals Administration (MMA) personnel were operating under the former Bureau of Safety and Environmental Enforcement (BSEE). Therefore, all MMA personnel referenced in this report will be identified as BSEE personnel.

SEQUENCE OF EVENTS:

On Thursday morning, 30 April 2026, at approximately 0700 hours, the L/B was in the process of performing diving support operations at SP 28 #99. A contract diver for Gulf Stream Diving and Salvage, LLC (Gulf Stream), was working on installing high pressure hoses and fittings (whips) to a newly designed O2 manifold/regulator for the diver's chamber breathing system. This newly designed O2 system allowed the use of multiple O2 bottles to supply the Diver's Chamber via a manifold, instead of a single tank setup. Immediately after opening the manifold valve on the oxygen bottle which had 2600 psi on it to test the system, the manifold failed. As a result of the manifold failing, metal fragments from the manifold struck the IP's right hand, arms, chest, and face.

Once the incident scene was secured, the IP received first aid on the lift boat, was transferred to a nearby facility (WD 106 A) via crew boat and then medevac'd via helicopter to New Orleans further evaluation and treatment.

BSEE INVESTIGATIONS:

On 4 June 2026, the Bureau of Safety and Environmental Enforcement (BSEE) accident investigation team arrived on the L/B to perform their investigation. Due to challenging logistics, weather concerns, and the remote location of the incident, it took a few weeks for the investigation team to make it out to the L/B, which was no longer at the location where the incident occurred. The investigation team consisted of an Accident Investigator (AI) and the Production Supervisory Inspector (SI). Additionally, a NuGulf Supervisor accompanied the investigation team on their visit.

On the morning of 4 June 2026, the team arrived at the EPS Dock in Venice, Louisiana and traveled to the East Bay Field aboard the Motor Vessel (M/V) Warrier. The L/B was no longer at the incident location, but was still present in the East Bay field, at a different platform nearby. Once aboard the L/B, the investigation team met with Gulf Stream personnel that were on location when the incident occurred. The investigation team requested the following documents concerning the incident: Job Safety Analysis (JSA), Initial Report of accident/ Injury to BSEE, Preliminary Incident Investigation Report, Root Cause Analysis (RCA) Report, witness statements, Photos of the damaged equipment, and the Equipment Inspection Report.

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NuGulf's investigation revealed that, prior to the incident, the newly designed manifold was hydrotested to 7000 psi in a controlled environment, with no failures. The investigation also revealed that the IP followed normal installation procedures while installing and testing the multi bottle manifold, confirming that there were no installation issues. At the time of the BSEE investigation, the damaged O2 manifold was no longer on location, as it had already been sent to a laboratory for analysis. The IP was back on the job and on location, after full medical clearance and back in the diving rotation. An interview with the Gulf Stream diving foreman stated that because of the incident, Gulf Stream went back to using their typical single O2 bottle system to provide O2 to the diver's chamber.

IN CONCLUSION:

In conclusion, Gulf Stream's RCA revealed that, when the IP connected the O2 bottles to the manifold and subsequently opened the valve to test the system with Oxygen, the manifold failed at 2500 psi. The failure was determined to be oxygen-service specific and driven by contamination in the "non-O2 clean" components (ball valves) combined with rapid pressurization of the manifold. In other words, the manifold was able to withstand 7000 psi during pressure testing in a controlled environment with inert gases. However, once in Oxygen service in the field, the same manifold failed at 2600 psi of O2, due to suspected hydrocarbon contamination of the manifold components, and the rapid pressurization that occurred via use of quick opening ball valves.

The O2 bottle rack on location at the time of the incident was set up as a multiple bottle system to supply the divers chamber with O2. The lab analysis of the manifold revealed that, while the manifold held 7000 psi without failure in a controlled environment, the conditions offshore at the time of the incident are what caused the failure. Specifically, the ball valves that were utilized were not "O2 clean" valves, which caused contamination in the system and contributed to the failure. Additionally, the utilization of quick opening "ball valves" instead of slow opening "needle valves" allowed for rapid pressurization and led to failure of the manifold.

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

Equipment Failure: Flawed equipment designed or construction:
• The manifold ball valves were not O2-clean (possibly contained with hydrocarbons/ grease), which ignited in the presence of high-pressure oxygen.
• Quick-opening ball valves (instead of slow-opening needle valves) were used, creating an adiabatic compression heat spike that led to the ignition of the contaminants.

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

Management Systems: No or inadequate hazard analysis/ written job procedures:
• Absence of a detailed written Safe Work Procedure (SWP) for oxygen systems requiring O2-clean components, needle valves instead of ball valves, and controlled pressurization.

20. LIST THE ADDITIONAL INFORMATION:

Immediate action taken by Gulf Stream D & S: As a result of the incident, Gulf Stream required all company diving operations to stop using multi bottle manifolds to supply air to the divers chamber, and instead use a single O2 tank setup, until further notice.

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21. PROPERTY DAMAGED:

High pressure manifold setup

NATURE OF DAMAGE:

Sudden release of pressure, rupture, burst.

ESTIMATED AMOUNT (TOTAL): **$750**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

• The BSEE New Orleans District recommends the Office of Incident Investigations look into developing a safety alert specific to Oxygen systems in the Gulf. Specifically, we recommend ensuring that O2 systems in diving operations are using components/equipment that are specifically designed for O2 use, as opposed to other types of valves/equipment commonly used offshore

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

25-JUN-2026

26. Investigation Team Members/Panel Members:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR:
Brody Vial

APPROVED DATE: **09-SEP-2026**