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: **16-JAN-2020** TIME: **0530** HOURS

2. OPERATOR: **Arena Offshore, LP**
   REPRESENTATIVE:

- [ ] STRUCTURAL DAMAGE
- [X] 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:
   AREA: **EI**
   BLOCK: **252**

5. PLATFORM: **I**
   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)		
[ ] LTA (>3 days)		
[ ] RW/JT (1-3 days)		
[X] **RW/JT (>3 days)**	**0**	**1**
[ ] FATALITY		
[ ] Other Injury		

- [ ] POLLUTION
- [ ] FIRE
- [ ] EXPLOSION

LWC
- [ ] HISTORIC BLOWOUT
- [ ] UNDERGROUND
- [ ] SURFACE
- [ ] DIVERTER
- [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

8. OPERATION:
- [ ] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [X] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] 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: **150** FT.

11. DISTANCE FROM SHORE: **51** MI.

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

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

14. SEA STATE:

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

On January 16, 2020, at approximately 0530 hours, a deckhand sustained injuries on the M/V Mr. Lloyd while attempting to retrieve a Job Safety Analysis from a personnel basket for Arena Offshore, LP at Eugene Island 252-I. The deckhand suffered two fractured ribs due to this incident.

Once the motor vessel arrived at the facility, the crane operator lowered the personnel basket containing a Job Safety Analysis (JSA) that was requiring a signature by all employees involved with the crane lifting operations. Personnel placed the JSA, located inside a zipped plastic bag, in the middle section of the personnel basket.

The deckhand stated he boarded the personnel basket placing both feet inside to retrieve the JSA. The crane operator stated, he could not see the personnel basket or the deckhand at time he began to lift due to the design of the platform deck blocking his view of the boat. The crane operator stated he heard the command to "come up" on the radio prior to lifting but could not determine who was speaking. As the crane operator began lifting the basket, the deckhand began to exit the basket, stepping on the opening of the basket between deck cover and the foam padding causing him to twist his left leg and back. As the deckhand departed the personnel basket, he lost his balance causing him to strike the midship bitt of the vessel.

The boat captain asked the deckhand if he was injured and the deckhand responded that he was okay. Once the motor vessel arrived at the dock, Arena was notified that the deckhand was sent to a physician due to his injuries. The deckhand suffered two fractured ribs due to this incident.

The BSEE Lafayette District conducted an onsite investigation on January 21, 2020. During the investigation, BSEE investigators found the following information:
The Job Safety Analysis indicated the crane operator was to follow hand signals from the deckhand. The deckhand who was injured was listed as the designated signal person. However, the crane operator stated he could not see the deckhand or the personnel basket at the time of the lift. There was no listing on the Job Safety Analysis for verbal communication.

According to the boat personnel, there was no verbal communication given by anyone on the boat to lift the personnel basket. The crane operator stated he received the signal by radio to "come up" with the personnel basket but could not determine who gave the command. At the time of the incident, the radios were set on an open marine channel allowing the crane operator to receive communication from other facilities.

The crane operator failed to follow Arena's Safe Practices Manual* concerning crane operations. According to the lift planning section, the crane operator should have revised the original lift plan.

***As per Arena's Safe Practices Manual:**
"Section 28.28 (A) (1) Signals between the Crane Operator and the designated signal person should be discernible, audibly or visually, at all times. The Crane Operator should not respond unless signals are clearly understood.

Section 28.28 (c) (2) When operations are required to be controlled by signals, a designated signal person should be assigned to work with the crane. The designated person should: Be in clear view of the Crane Operator to ensure that their signals may be seen. Their position should give them clear view of the load, crane, personnel, and area operation. If the Crane Operator's view of the primary signal person is obstructed, a secondary signal person should be provided.

Section 28.31 (B.)(1) A lift plan should be created before each crane operation and adhered to during the entire operation. If the lift plan cannot be followed, it must be revised."

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

The crane operator did not follow the Job Safety Analysis procedures while lifting the personnel basket. According to the Job Safety Analysis, the crane operator was to follow hand signals from the deckhand. The deckhand, who was injured as a result of this incident, was listed as the designated signal person. The crane operator stated he could not see the deckhand or the personnel basket at the time of the lift. There was no listing on the Job Safety Analysis for verbal communication

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

The BSEE investigation concludes the possible contributing causes of the accident were the following:
1). The crane operator failed to follow Arena's Safe Practices Manual* concerning crane operations. According to the lift planning section, the crane operator should have revised the original lift plan.

2). Incorrect communication received by crane operator. According to the boat personnel, there was no verbal communication given by anyone on the boat to lift the personnel basket. The crane operator stated he received the signal by radio to "come up" with the personnel basket but could not determine who gave the command. At the time of the incident, the radios were set on an open marine channel allowing the crane operator to receive communication from other facilities.

***As per Arena's Safe Practices Manual:**
"Section 28.28 (A) (1) Signals between the Crane Operator and the designated signal person should be discernible, audibly or visually, at all times. The Crane Operator should not respond unless signals are clearly understood.

Section 28.28 (c) (2) When operations are required to be controlled by signals, a designated signal person should be assigned to work with the crane. The designated person should: Be in clear view of the Crane Operator to ensure that their signals may be seen. Their position should give them clear view of the load, crane, personnel, and area operation. If the Crane Operator's view of the primary signal person is obstructed, a secondary signal person should be provided.

Section 28.31 (B.)(1) A lift plan should be created before each crane operation and adhered to during the entire operation. If the lift plan cannot be followed, it must be revised. "

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: N/A

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District office makes no recommendations to the Regional Office of Incident Investigations (OII).

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

On January 16, 2020, Arena Offshore, LP failed to perform operations in a safe and workmanlike manner as follows: A crane operator lowered a personnel basket containing a JSA requiring signature prior to work activity. The deckhand entered the personnel basket to retrieve the JSA. While the deckhand was in the basket, the crane operator stated he heard the command to "come up" on the radio and began lifting the personnel basket causing the deckhand to fall from the basket and hit the bit on the deck of the boat. According to personnel on the boat, there was no signal communicated by anyone from the boat to the crane operator to begin lifting the personnel basket. Also, during the BSEE onsite investigation, the crane operator stated he could not see the personnel basket or the deckhand prior to lifting the personnel basket. The deckhand sustained injuries that resulted in a lost time accident.

As per the Job Safety Analysis, the deckhand was designated to give the hand signals to the crane operator. There was no mention of verbal communication on the Job Safety Analysis. At the time of the incident, the radios were set on an open marine channel.

25. DATE OF ONSITE INVESTIGATION:

21-JAN-2020

26. INVESTIGATION TEAM MEMBERS:

Mark Woods / Jeremy LeMieux / Wade Guillotte / Jason Manuel /

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Robert Ranney

APPROVED DATE: **08-JUN-2020**