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# UNITED STATES DEPARTMENT OF THE INTERIOR
## MARINE MINERALS ADMINISTRATION
## GULF OF AMERICA REGION
# ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **05-SEP-2026** TIME: **2000** HOURS
2. OPERATOR: **Arena Offshore, LP**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Enterprise Offshore Drilling**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **man rider**
- [ ] 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: **G36211**
   AREA: **EI** LATITUDE:
   BLOCK: **320** LONGITUDE:

5. PLATFORM: **B**
   RIG NAME: **WFD 450**

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

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

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

8. OPERATION:
- [ ] PRODUCTION
- [X] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER
- [ ] TEMP ABAND
- [ ] PERM ABAND
- [ ] DECOM PIPELINE
- [ ] DECOM FACILITY
- [ ] SITE CLEARANCE

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

10. WATER DEPTH: **252** FT.
11. DISTANCE FROM SHORE: **62** 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 5 September 2026, an Enterprise Offshore Drilling (Enterprise) Floorhand, the Injured Party (IP), sustained injuries while connecting a chiksan line while seated in a man rider belt during drilling operations for Arena Offshore, LP (Arena) on the White Fleet Drilling Rig 450 (WFD 450) located at Eugene Island Block 320B. Due to the severity of the injuries, the IP required evacuation from the WFD 450 for medical treatment.**

**Sequence of Events:**
**On 05 September 2026, an Enterprise Floorhand, the IP, was installing a 3-inch chiksan loop connection to a lo-torque valve on a drill pipe stump approximately 28 feet above the rig floor deck while secured with a man rider belt. Initially, Crew A lifted the chiksan from the rack on the rig floor. However, the crew did not follow the standard practice of lifting the chiksan to be connected. Then there was a shift change from Crew A to Crew B. Crew B continued the operation without reassessing the lift or repositioning the sling to the lower connection point as required by standard practice. Instead, Crew B used the same sling connection point to make up the hammer union. After the connection was installed and tightened, the air hoist was slacked off, the IP proceeded to remove the air hoist sling. At this point, the energy stored in the 3-inch chiksan line and the lead-off connection swivel caused the chiksan assembly to roll, pinning the IP between the lo-torque valve and the 3-inch chiksan loop. The crew used the air hoist to lift the chiksan line to free the IP. The IP was lowered to the rig floor and was found to be unconscious. The rig medic applied a cervical collar, secured the IP in a Stokes basket, and transported him to the rig medic's office for treatment. The IP was subsequently evacuated by a United States Coast Guard helicopter to University Medical Center in New Orleans, Louisiana for further medical evaluation and treatment. X-rays revealed that the IP sustained fractures to the left scapula and the first through third ribs, both anteriorly and posteriorly. The IP was discharged from the hospital on 7 September 2026.**

**MMA Investigation:**
**On 9 September 2026, the Marine Minerals Administration (MMA) Lafayette District conducted an onsite Incident Follow-up (IF)Investigation. MMA investigators met with Arena and Enterprise representatives and collected all available incident-related documentation. As part of the IF Investigation, MMA reviewed Enterprise's job safety analysis (JSA)for Man Riding Operations and Rigging Up Gravel Pack Equipment, Enterprise's Permit to Work for Man Riding and Enterprise's Man Riding Operations Checklist.**

**The MMA Incident Investigation Team determined that the incident resulted from an inadequate planning system, including the JSA, procedures, and supervisory verification that did not address the common practice for connecting the chiksan line. The chiksan line was not lifted using a common method for making the connection. This method involves attaching the sling several loops down the line so that the line hangs freely while the connection is made. The air-hoist brake is then set to hold the line in position. This arrangement allows the chiksan line to move as the pipe is worked up or down, without requiring the entire line to be lifted. Additionally, there was no designated Signalman/Flagger as stated on the Enterprise Manriding Operations Checklist. Moreover, the Lift Plan was not updated when the lift purpose had changed. Crew A used an attachment point to lift the chiksan line for removal from the rack. Following the shift change, Crew B continued the lift from the same attachment point, but the purpose had changed to connecting the assembly, which required a different attachment point under standard practice. The handover did not reset or reassess the task. Finally, the Hoist Operator failed to recognize that there was stored energy in chiksan swivel that resulted in the IP to be pinned against the chiksan loop and lo-torque valve.**

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

**Management Systems:**
**• Inadequate hazard analysis. The IP's injury was a result of an inadequate planning system, including the JSA, procedures, and supervisory verification that did not address the standard practice for connecting the chiksan line.**

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

**Human Performance Error:**
**• Not following proper procedures. The crew did not follow the Enterprise's Man Riding Operation Procedure/Checklist, which required the assignment of a designated Signalman/Flagger during man-riding operation, No Signalman/Flagger was assigned to the operation.**
**• The Air Hoist Operator failed to recognize that there was stored energy in chiksan swivel.**

**Management Systems:**
**• Inadequate management of change procedures. The Lift Plan was not updated when the lift purpose had changed. Crew A used an attachment point to lift the Chiksan line for removal from the rack. Following the shift change, Crew B continued the lift from the same attachment point, but the purpose had changed to connecting the assembly, which required a different attachment point under standard practice. The handover did not reset or reassess the task.**

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

**There was no property damaged during this incident.**

NATURE OF DAMAGE:

**Not applicable.**

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

**The MMA Lafayette District makes no recommendations to the Office of Incident**

**Investigations regarding this incident.**

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

**A G110 Incident of Noncompliance was issued to Arena Offshore, LP (Arena) for its failure to perform operations in a safe and workman like manner. On 5 September 2026, an Enterprise Offshore Drilling (Enterprise) Floorhand, sustained injuries while connecting a chiksan line in a man riding belt during drilling operations for Arena on the White Fleet Drilling Rig 450 (WFD 450) located at Eugene Island Block 320B. The severity of the Floorhand's injuries required evacuation from the WFD 450 for medical treatment.**

**On 8 September 2026, MMA conducted an onsite Incident Follow up investigation and reviewed all incident-related documents. MMA determined the Arena failed to comply with the approved policies implemented in their SEMS plan that listed below which allowed for an unsafe and/or un-workman like practice:**
**• Job Safety Analysis Rigging up Gravel Pack Equipment; Step (No 2) Specific Hazards column; Stored Energy. *Tugger Operator failed to recognize stored energy in chiksan Swivel.**
**• Job Safety Analysis Man Riding Ops; Step (No 2) Risk Reduction Measures 3) Have designated flagger and/or radio. *No Signalman/Flagger was designated on the JSA.**
**• Enterprise Offshore Drilling LLC Human Resources Manual; Post-Accident/Incident Testing 4.6, & 5.2. *No post-accident Drug or Alcohol screens were performed.**
**• Safety Manual Mechanical/Hoisting Operations; (8.1.6) Man riding tugger operations shall only be performed under the PTW and compliance with Policy SAF 300, Man Riding Operations.**
**• Enterprise Offshore Drilling; Man Riding Operations Checklist; SAF 300, Rev 0 Feb 2017, Item (No. 6) Signalman/Flagger assigned as required and signals reviewed. *No Signalman/ Flagger was assigned or signals reviewed as required on the Man Riding Operations Checklist.**

25. DATE OF ONSITE INVESTIGATION:

**09-SEP-2026**

26. Investigation Team Members/Panel Members:

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

**Mark Malbrue**

APPROVED DATE: **19-NOV-2026**