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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **11-JUL-2024** TIME: **0730** HOURS

2. OPERATOR: **Manta Ray Gathering Company, L.L.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Quality Process Services, L.L.C**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **Lifeboat Manual Winch**
- [ ] 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: **HI** LATITUDE:
   BLOCK: **A 5** LONGITUDE:

5. PLATFORM: **C**
   RIG NAME:

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

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	**1**	**1**
[ ] LTA (1-3 days)		
[X] LTA (>3 days)	**0**	**1**
[ ] RW/JT (1-3 days)		
[ ] RW/JT (>3 days)		
[ ] FATALITY		
[X] Other Injury	**1**	

First Aid

- [ ] 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: **59** FT.
11. DISTANCE FROM SHORE: **35** 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:

Incident Summary:
On July 11, 2024, at approximately 0730 hours, Genesis Energy LP evacuated two individuals to Galveston UTMB due to injuries sustained during a routine life capsule inspection at the High Island (HI) A-5 Manta Ray Gathering Facility.
The Genesis Operations Manager reported the incident to the Bureau of Safety and Environmental Enforcement (BSEE) Lake Charles District (LCD) Office at 1138 hours on the same day and forwarded the information to the Lake Jackson District (LJD) who then began and completed the investigation. A contract pipeline operator from Quality Process Services (QPS) suffered a serious head injury, which required a medivac to UTMB in Galveston. The second individual, a Genesis employee, did not sustain any injuries but sought evaluation due to trauma experienced during the incident. Sequence of Key Events:
On July 11, 2024, the Genesis Person in Charge (PIC) and QPS pipeline operator, injured person (IP) conducted the weekly capsule inspection. As part of this inspection, the PIC and IP lowered the capsule 4 to 6 feet to verify the winch's operations. The IP used the winch assist to lower the capsule from the upper deck near the winch. The winch assist features a handle designed to be removed and stored when not in use, and it should be removed before operating the electric winch. After the IP lowered the capsule and inspected the davits, the PIC informed him that he would raise the capsule back up. The PIC engaged the electric winch from the lower section using the push button. As the winch operated, the PIC heard a banging noise and immediately stopped to investigate. The PIC saw the IP fall after struck in the head by the winch assist handle, which remained in the socket. The IP was unconscious and bleeding from the head. The PIC called for assistance via handheld radio and began administering first aid to the IP. At 0756 hours, Genesis Health, Safety, Security, and Environment (HSSE) contacted a medivac service company out of Lake Charles for a medivac. However, medivac company could not make it to the location due to surrounding thunderstorms in the area and subsequently called the United States Coast Guard (USCG). The USCG arrived at the facility at 0957 hours. After an initial assessment, the USCG departed at 1033 hours, transporting both the injured IP and the PIC to University of Texas Medical Branch (UTMB) in Galveston for evaluation and treatment. The PIC was released that afternoon, the injured IP diagnosed with a fractured skull required surgery. As of July 11th, at approximately 15:30 hours, the IP completed surgery and was in stable condition.
BSEE Investigation:
On July 11, 2024, the BSEE Inspector initiated contact with the Genesis Health, Safety, Security, and Environment (HSSE) manager to gather information regarding an incident that had occurred. The BSEE Inspector requested a series of documents and evidence, including witness statements, photographs of the relevant area, the inspection checklist, and a physical inspection of the site. However, due to weather conditions, the BSEE LJD Inspector was unable to conduct an onsite visit the entire week following the incident report. The platform visited by LJD 7-27-24 to examine the scene of incident. The IP sustained a skull fracture from impact and significant blood loss, requiring surgery at UTMB Galveston. The PIC experienced trauma from the incident and was advised by the doctor on scene to seek evaluation and was released the same day. According to the witness statements gathered, the capsule was lowered 4 to 6 feet. When the capsule was raised using the powered winch, the manual assist handle remained in place and struck the IP on the head. The IP was positioned on the upper section of the davit where the winch is located, which is unnecessary during winch operation. The winch assist handle should have been removed before engaging the powered winch. The BSEE Inspector concluded that the incident occurred because the winch was engaged while the winch assist handle was still in place. The winch assist is a removable metal handle designed for manual cranking of the vessel to the stops and should only be inserted after the powered winch is disengaged and stored when not in use. A safety to override the handle in place and power the winch was later found to be bypassed. The IP and the PIC opted to use a weekly inspection checklist for this task instead of preparing a Job Safety Analysis (JSA) together with the checklist.

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

Human Performance Error- Inadequate knowledge of equipment operation:
Engagement of Winch with Handle in Place: The primary cause of the incident was the engagement of the powered winch while the winch assist handle was still inserted and in bypass to allow winch to operate.
Failure to Follow Safety Protocols: The failure to remove the winch assist handle before engaging the powered winch directly led to the incident. It was learned after the initial investigation that a safety device was bypassed allowing winch to operate.

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

Human Performance Error- Not aware of Hazards:
Lack of Job Safety Analysis (JSA): The task was considered routine, and no JSA or Job Safety and Health Analysis (JSHA) was conducted. The weekly checklist did not include the actual operation of the winch.
Improper Equipment Handling: The winch assist handle was not removed prior to engaging the powered winch in bypass, leading to the incident.

20. LIST THE ADDITIONAL INFORMATION:

Training and Awareness: Genesis has scheduled a contract survival craft specialists to inspect the area and conduct onsite training for all operators.
Development of JSHA: Genesis is currently developing a JSHA to address safety concerns related to routine tasks, including winch operations.
Review of Procedures: A thorough review of operational procedures and checklists should be conducted to ensure that all necessary safety measures are included.

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE Lake Jackson District has no recommendations for Office of Incident Investigations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

No Violations

25. DATE OF ONSITE INVESTIGATION:

27-JUL-2024

26. Investigation Team Members/Panel Members:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED:

NO

27. OPERATOR REPORT ON FILE:

OCS REPORT:

30. DISTRICT SUPERVISOR:

Stephen Martinez

APPROVED DATE: **17-SEP-2024**