



UNITED STATES COAST GUARD

**REPORT OF THE INVESTIGATION
INTO THE
LOSS OF LIFE ABOARD THE RED STAG (O.N.
1251769) IN PORT FOURCHON, LA
ON OCTOBER 14, 2023**



U.S. Department of
Homeland Security

United States
Coast Guard



Commandant
United States Coast Guard

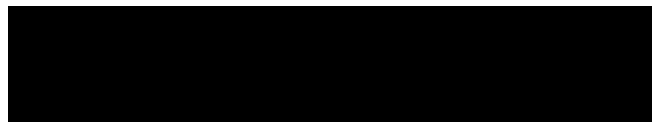
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16732/IIA #7874488
17 March 2025

**LOSS OF LIFE ONBOARD THE OFFSHORE SUPPLY VESSEL RED STAG
(O.N. 1251769) IN PORT FOURCHON, LOUISIANA ON OCTOBER 14, 2023**

ACTION BY THE COMMANDANT

The record and the report of investigation completed for this marine casualty have been reviewed by the Office of Investigations & Casualty Analysis. The record and the report, including the findings of fact, analyses, and conclusions are approved. This marine casualty investigation is closed.



E. B. SAMMS
Captain, U.S. Coast Guard
Chief, Office of Investigations & Casualty Analysis (CG-INV)



16732
FEB 14 2025

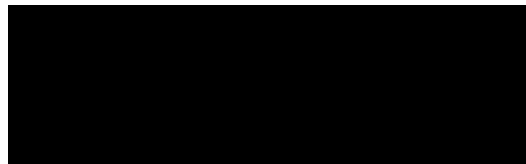
**LOSS OF LIFE ABOARD THE RED STAG (O.N. 1251769)
IN PORT FOURCHON, LA ON OCTOBER 14TH, 2023**

**ENDORSEMENT BY THE COMMANDER,
EIGHTH COAST GUARD DISTRICT**

The record and the report of the investigation convened for the subject casualty have been reviewed. The record and the report, including the findings of fact, analysis, conclusions, and recommendations are approved. It is recommended that this marine casualty investigation be closed.

COMMENTS ON THE REPORT

1. The loss of the mariner was a tragic and preventable accident. I offer my sincere condolences to the friends and family of the mariner who lost his life.
2. The investigation and report contain valuable information which can be used to address the factors that contributed to this marine casualty and prevent similar incidents from occurring in the future.



J. E. FOTHERGILL
Commander, U.S. Coast Guard
Chief of Prevention, Acting
Eighth Coast Guard District
By Direction



16732
05 June 2024

**LOSS OF LIFE ABOARD THE RED STAG (O.N. 1251769)
IN PORT FOURCHON, LA ON OCTOBER 14, 2023**

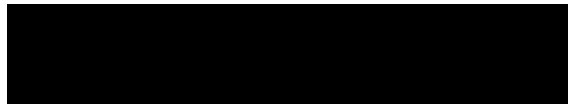
ENDORSEMENT BY THE OFFICER IN CHARGE, MARINE INSPECTION

The record and the report of the investigation convened for the subject casualty have been reviewed. The record and the report, including the findings of fact, analysis, conclusions, and recommendations are approved subject to the following comments. It is recommended that this marine casualty investigation be closed.

ENDORSEMENT ON RECOMMENDATIONS

Administrative Recommendation 1. Recommend this investigation be closed.

Endorsement: Concur; recommend this investigation be closed.



L. T. O'BRIEN
Captain, U.S. Coast Guard
Officer in Charge, Marine Inspection
Houma, Louisiana



16732
April 22, 2024

**LOSS OF LIFE ABOARD THE RED STAG (O.N. 1251769)
IN PORT FOURCHON, LA ON OCTOBER 14, 2023**

EXECUTIVE SUMMARY

On October 13, 2023, at approximately 1630, the RED STAG (O.N. 1107980), a 184 - foot offshore supply vessel (OSV) was moored at the Adriatic Marine dock located in Port Fourchon, Louisiana. The vessel's crew consisted of a Master, Relief Captain and three crewmembers. The vessel had been in dry dock and had recently moved to the Adriatic Marine Dock to prepare for an upcoming work assignment, which was scheduled for the next day. At approximately 2330, the crewmembers conducted watch relief; the oncoming watch consisted of the Relief Captain, Unqualified Engineer (UE), and Deckhand (DH). As common practice during the watch relief, the off-going and oncoming personnel conduct a pass down, to include work completed by the previous watch and work to be completed by the oncoming watch. The off going 1st Engineer passed to the UE that the vessel was leveled off via the mud pump system. The work assigned to the oncoming watch included cleaning the engine room, cleaning the interior spaces, and preparing for mooring stations. A Job Safety Analysis (JSA) was completed by the UE for the engine room cleaning, the DH completed a JSA for the interior space task, and both the UE and DH completed a JSA for the mooring stations task. Once the watch relief was completed the crewmembers set off to complete their assigned task.

At approximately 0530, the next day on October 14, 2023, the UE asked the DH the location of the voltage meter. The DH did not know the location of the tool. At approximately 0640, the vessel's Master found the UE unresponsive on the engine room floor next to the open mud pump high voltage panel. The Master of the vessel immediately notified the crew and emergency medical services (EMS), then the crew started administering first aid. The Port Fourchon Harbor Police and EMS arrived and continued first aid until the UE was pronounced deceased at 0740.

Through this investigation, the Coast Guard determined the initiating event was the presumed material failure of the mud pump system. This was followed by the death of UE. The causal factors that contributed to this casualty included: (1) Failure to follow company policy and procedures, (2) Lack of engineering experience, (3) Missing visual or audible indicator of emergency stop activation, and (4) Missing locking device on high voltage panel.



16732
April 22, 2024

LOSS OF LIFE ABOARD THE RED STAG (O.N. 1251769) IN PORT FOURCHON, LA ON OCTOBER 14, 2023

INVESTIGATING OFFICER'S REPORT

1. Preliminary Statement

1.1. This investigation involving the death of the crewmember onboard the RED STAG while moored at the Adriatic Marine Dock, in Port Fourchon, LA, on October 14, 2023, and submission of this report were conducted in accordance with Title 46, Code of Federal Regulations (CFR), Part 4, Subsection 4.07, and under the authority of Title 46, United States Code (USC) Chapter 63.

1.2. [REDACTED], the father of the deceased crewmember was designated a party-in-interest in accordance with 46 CFR Subsection 4.03-10. No other individuals, organizations, or parties were designated a party-in-interest.

1.3. The Coast Guard was the lead agency for all evidence collection activities involving this investigation. No other persons or organizations assisted in this investigation.

1.4. All times listed in this report are in Central Standard Time using a 24-hour format and are approximate. The Incident Investigation Activity Number for this investigation is 7874488.

2. Vessel Involved in the Incident



Figure 1. Photograph of RED STAG, date unknown. Source: Marine Traffic

Official Name:	RED STAG
Identification Number:	1251769
Flag:	United States
Vessel Class/Type/Sub-Type	Offshore Supply Vessel
Build Year:	2014
Gross Tonnage:	99 GT
Length:	184 feet
Beam/Width:	48 feet
Draft/Depth:	16 feet
Main/Primary Propulsion: (Configuration/System Type, Ahead Horsepower)	Inboard Diesel, 1500 Ahead Horsepower
Owner:	Adriatic Marine LLC Raceland, LA/United States
Operator:	Adriatic Marine LLC Raceland, LA/United States

3. **Deceased, Missing, and/or Injured Persons**

Relationship to Vessel	Sex	Age	Status
Unqualified Engineer	Male	30	Deceased

4. **Findings of Fact**

4.1. The Incident:

4.1.1. On October 13, 2023, at approximately 1630, the offshore supply vessel RED STAG (O.N. 1251769), was moored at the Adriatic Marine dock in Port Fourchon, LA, with a Master, Relief Captain and three crewmembers onboard. The vessel recently completed a dry dock period, and the crew was preparing the vessel for its upcoming work contract.



Figure 2. Aft deck emergency shut off. Taken on October 20, 2023.

4.1.2. At approximately 2000, the 1st Engineer leveled off the vessel using the mud pump system and secured the system by activating the emergency stop located on the aft deck. The system utilizes 480 volts for operation.

4.1.3. At approximately 2330, the oncoming and off-going watch conducted a watch relief pass down. The oncoming watch consisted of the Relief Captain, Unqualified Engineer, and Deck Hand.

4.1.4. During the pass down, three Job Safety Analyses (JSA) were completed for work to be conducted during the watch. The tasks were: cleaning of the engine room (JSA 1), cleaning the interior spaces of the vessel (JSA 2), and readying mooring stations (JSA 3). JSA 1 was assigned to the Unqualified Engineer, JSA 2 was assigned to the Deck Hand, and JSA 3 was assigned to both crewmembers.

4.1.5. During the pass down, the Unqualified Engineer was informed by the 1st Engineer, that water was transferred between the tanks to level out the vessel. This was also noted in the engineering rough log and engineer's log.

4.1.6. At approximately 0530 on October 14, 2023, the Unqualified Engineer asked the Deckhand for the location of the voltage meter. The Deckhand was unaware of the location of the voltage meter, nor did he know why the Unqualified Engineer needed the tool.



Figure 3. Inside of panel and high voltage conductor with fingerprints. Taken on October 14, 2023

4.1.7. The Unqualified Engineer opened the panel for the mud pump system and touched the high voltage conductors containing 480 volts.

4.1.8. At approximately 0640, the Master of the vessel started searching for the Unqualified Engineer and found him in the engine room unresponsive, laying on the deck beside the open high voltage panel.

4.1.9. At this time, The Master alerted the crew and notified emergency medical services via cell phone. The crew began conducting cardiopulmonary resuscitation (CPR) on the Unqualified Engineer.

4.1.10. At approximately 0704, the Port Fourchon Harbor Police arrived on scene and began assisting with first aid.

4.1.11. At approximately 0725, Lafourche Parish Emergency Services arrived and continued first aid. The Unqualified Engineer was pronounced deceased at approximately 0740.

4.1.12. On November 14, 2023, the Lafourche Parish Coroner's Office classified the manner of death as accidental, and the cause of death to be electrocution.

4.1.13. The postmortem toxicology report identified no presence of dangerous drugs or alcohol in the Unqualified Engineer's system. No other crewmembers onboard the RED STAG were identified as directly involved in this incident and therefore were not subject to post casualty drug or alcohol testing.

4.2. Additional/Supporting Information:

4.2 Lockout/Tagout Guidelines:

Lockout and tag-out procedures are used to prevent inadvertent use, start-up or energizing of any system that is in need of inspection, maintenance or repair.

This process is used to assure that any machine; energy, hydraulic or air source is isolated and completely free of any stored energy.

The process must be followed before any crewmember or service vendor performs inspections, maintenance or repair.

Note: Not all energy sources are lockable, due to design. In every case, the proper LOCK OR TAG should be used to warn of the pending danger.

Control of Hazardous energy

The Control of Hazardous Energy is the purpose of the Lockout- Tag out Program. This program establishes the requirements for isolation of energy sources prior to equipment repair, adjustment or removal. Precautions involve shutting *off* and placing a personal lock on all potential energy sources that need repair, plus securing a Danger- Do Not Operate' tag to the source switch.

Figure 4. Company Lockout/Tagout policy. Taken on October 28, 2023.

4.2.1. Company policy stated that for any work conducted on the vessel a JSA shall be completed and reviewed by the Captain on watch before the task is commenced. Additionally, the company policy stated, because of the hazards presented by the 480 volt panel, Lockout/tagout procedures should have been followed before opening the panel. There were no JSA's completed on or about October 14, 2023, for a task in which the 480 volt panel would need to be opened.



Figure 5. Mud Pump operation panel. Taken October 20, 2023

4.2.2. The mud pump system emergency stop was located on the aft deck. However, the system's only place of operation is located in the engine room, and lacked an audible or visual indicator to bring awareness when the emergency stop was activated.

4.2.3. Activation of the emergency stop cuts power to the mud pump but it does not cut power to the 480 volt panel. The emergency stop was still activated at the time of the incident with the Unqualified Engineer.

4.2.4. The Unqualified Engineer was training to become a licensed engineer but did not possess the qualifications to open and work in the 480-volt panel without oversight by someone with the appropriate qualification. The 1st Engineer was the only person onboard the vessel qualified to access the panel.

4.2.5. It is not known why the Unqualified Engineer accessed the inside of the mud pump 480 volt panel.

4.2.6. The Unqualified Engineer was utilizing all required personal protective equipment at the time of the casualty.

5. **Analysis**

5.1. *Lack of Engineering Experience.* The mud pump systems installed on board Offshore Supply Vessels are equipped with an emergency stop, which is normally located on the aft deck, so that the crewmember using the system can secure the operation remotely, instead of requiring the operator to go to the engine room to secure the system. The emergency stop is activated when the button is pulled, opening the circuit, stopping the flow of electricity to the pump. To re-energize the pump, the circuit must be closed by pushing in the button. It is common practice on OSV's to secure the system utilizing this method. The Unqualified Engineer's lack of engineering experience with the electrical system may have led to his belief that the mud pumps suffered an electrical failure due to the open circuit created by the activated emergency stop. It is reasonable to assume that if the Unqualified Engineer was more experienced with the operation of the mud pump system, he may have verified the status of the pump's emergency stop and de-activated it, preventing him from having to open the 480 volt panel and prevented the incident from occurring.

5.2. *Failure to Follow Company Policy and Procedures.* The Company's Safety Management System (SMS) was in place to prevent or lessen the number of injuries to personnel on board the vessels. The company's SMS stated that any time a task is to be performed, the work shall be approved by the vessel's Master. Once approved, a Job Safety Analysis (JSA) must be completed for all task prior to the work being conducted. The Master was neither aware of an issue with the mud pump system, nor was a JSA completed beforehand to conduct troubleshooting on the system. Furthermore, because of the high voltage used by the pump system, the Unqualified Engineer did not hold the qualifications needed to troubleshoot the issue without the 1st Engineer being present. It is reasonable to conclude that if the company's policy was followed the Master would have been made aware of the presumed issue with the mud pump and the correct procedures may have been followed before the Unqualified Engineer went to troubleshoot the panel.

5.3. *Missing Visual or Audible Indicator of Emergency Stop Activation.* It is common for machinery installed onboard vessels to have indicators, whether visual, audible, or both, incorporated in the systems to alert crew members when an emergency stop has been activated. The intended purpose of the indicators is, first and foremost, to alert crew members of an emergency and secondly to make personnel aware the stop is activated and needs to be deactivated prior to use. It is reasonable to assume that if the mud pump system had a method to alert personnel when the emergency stop was in an activated state, the Unqualified Engineer would have been aware of the need to deactivate the emergency stop and not accessed the energized panel.

5.4. *Missing Locking Device on High Voltage Panel.* It is common practice to restrict access to machinery that pose hazards to personnel or the environment. Normally, this is done by an installing a locking device which the Master or highest-ranking engineer has the key and are the only crewmembers who can grant access to the equipment. It is reasonable to conclude that if a locking device was installed on the high voltage panel, the Unqualified Engineer would have had to notify the Master or 1st Engineer for access to the panel, which may have prevented the Unqualified Engineer from entering the panel unsupervised.

6. **Conclusions**

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty was the presumed material failure of the mud pump system onboard the RED STAG. Casual factors contributing to this event were:

6.1.1.1. Lack of Engineering Experience.

6.1.1.2. Failure to Follow Company Policy and Procedures.

6.1.2. The Unqualified Engineer accessed an energized high voltage panel and contacted the electrical conductors which resulted in electrocution. Casual factors leading to this event were:

6.1.2.1. Missing Visual or Audible Indicator of Emergency Stop Activation

6.1.3. Missing Locking Device on High Voltage Panel

6.2. Evidence of Act(s) or Violation(s) of Law by Coast Guard Credentialed Mariner Subject to Action under 46 USC Chapter 77: There were no acts of misconduct, incompetence, negligence, unskillfulness, or violations of law by a credentialed mariner identified as part of this investigation.

6.3. Evidence of Act(s) or Violation(s) of Law by U.S. Coast Guard Personnel, or any other person: There were no acts of misconduct, incompetence, negligence, unskillfulness, or violations of law by Coast Guard employees or any other person that contributed to this casualty.

6.4. Evidence of Act(s) Subject to Civil Penalty: This investigation did not identify evidence of acts that would warrant civil penalty.

6.5. Evidence of Criminal Act(s): This investigation did not identify violations of criminal law.

6.6. Need for New or Amended U.S. Law or Regulation: No matters requiring new or amended laws or regulations were identified during this investigation.

6.7. Unsafe Actions or Conditions that Were Not Causal Factors: This investigation did not identify evidence of unsafe actions or conditions that were not causal factors.

7. **Actions Taken Since the Incident**

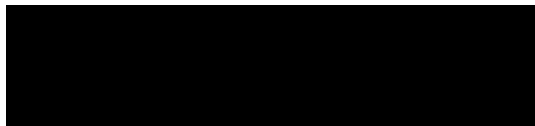
7.1. Since the incident, the company held a fleet wide Safety Stand – down and reinforced the importance of communication between Captains, crews, and following safety policies and procedures.

8. **Recommendations**

8.1. Safety Recommendation: There were no proposed actions to add new or amend existing U.S. laws or regulations, international requirements, industry standards, or U.S. Coast Guard policies and procedures as part of this investigation.

8.2. Administrative Recommendations:

8.2.1. Recommend this investigation be closed.



CWO3, U.S. Coast Guard
Investigating Officer