Safety Alert

MMS U.S. Department of the Interior
Minerals Management Service
Gulf of Mexico OCS Region

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Motor Vessel to Platform Boat Landing Transfer Fatality

A platform construction crew had been working in the East Cameron/West Cameron area for approximately three weeks. The Construction Crew Foreman (CCF) and Captain of the Motor Vessel (CMV) making the personnel transfer agreed to use a platform's "condemned" Southeast boat landing, since the active Southwest boat landing was too high to make a safe personnel transfer. Sea states at the time of the accident ranged from 7 to 10 feet. The CCF reached out to place his hand on the platform and his foot on the platform's three foot diameter support pipe, but fell approximately four feet into the water. The M/V crewman and a construction crewman threw the CCF a rope, which the CCF placed around himself. Within five minutes the CCF was standing on the M/V's deck while speaking/mumbling. Within the next three minutes the CCF collapsed and the M/V crew members began CPR. A medivac helicopter was dispatched and the CCF was flown to the nearest hospital, where the CCF was pronounced deceased.

A Minerals Management Service (MMS) investigation into this accident revealed the following findings:

- There was no company/operator representative present on the boat during this activity.
- Testimony indicated that the CCF exhibited a sense of urgency to complete the job in order to meet a personal deadline.
- A Stop Work Authority (SWA) was not utilized by all parties present;
- Neither the CCF or CMV made any attempt to involve the Operator's Platform Field Foreman in their decision to make the transfer.
- The autopsy report indicated the cause of death to be hypertensive heart disease;
- The autopsy report revealed that the CCF had two different prescription pain medications in his system at the time of the incident.
- Contributing causes were reported from the autopsy report as blunt injuries, including abrasions, contusions and lacerations to the head and extremities, with a fracture of the left ninth rib.
- Testimony from a construction crew welder indicated that he was not aware of the operating company offering the crew members the opportunity to travel via helicopter from platform to platform. The welder also indicated that if the CCF had successfully boarded the platform, the remaining construction crew members would have also attempted the boarding.

Therefore, the MMS makes the following recommendations:

- Operators should maintain adequate oversight of contract personnel working on their locations.
- Operators should perform an assessment of their facilities, for the purpose of identifying hazardous areas and safe means of access and egress, and communicate their policy prior to visitors arriving on location.
- Operators should provide site specific orientations, for the purpose of revealing areas of concern, to all visitors arriving on their facilities. These orientations should be used to familiarize all with emergency procedures including, but not limited to, alarm location, activation, and recognition, fire fighting and lifesaving equipment's location and use, and facility evacuation procedures, including muster locations and areas marked as hazardous or off limits.
- Operators should remind all workers of the Operator's Policy with respect to Stop Work Authority.
- Operators should consider removing swing ropes from condemned boat landings;
- Operators are reminded that when personnel transfer by M/V to and from platforms, all personnel must utilize the assistance of a swing rope as well as a Coast Guard approved Personal Flotation Device (PFD).
- Operators are reminded that pre-job planning and communications are crucial tools for the successful outcome of all job tasks.

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