OCS Report
MMS 2009−008

Investigation of Fatal Accident
North Padre Island Block 969, Platform JA
OCS-G 5953
19 January 2008

Gulf of Mexico
Off the Texas Coast

U.S. Department of the Interior
Minerals Management Service
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Lance Labiche – Chair
Sid Falk
Stephen Martinez

U.S. Department of the Interior
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Contents

Abbreviations and Acronyms

ESD	Emergency Shut Down
JSA	Job Safety Analysis
Lead Operator	The WGPS Lead Operator on board Platform A, PN 975 at time of accident
MMS	Minerals Management Service
OCS	Outer Continental Shelf
OSW	The lone Prosafe Technologies on scene witness
Peregrine	Peregrine Oil & Gas II L.L.C.
PFD	Personal Floatation Device
Pilot	The pilot of the Rotorcraft contract helicopter (tail number N518RL)
PN	North Padre Island
USCG	United States Coast Guard
WGPS	Wood Group Production Services
WGPS Employee	The deceased WGPS employee

Executive Summary

An accident that resulted in one fatality occurred on Lease OCS-G 05953, Platform JA, PN Block 969, leased by Peregrine in the Gulf of Mexico, offshore the State of Texas on January 19, 2008, at approximately 0930 hours. Peregrine had hired WGPS as the production contract operator.

On Saturday, January 19, 2008, at approximately 0849 hours, two production hands were flown by helicopter from Lease OCS-G 05953, Platform A, PN Block 975 to Lease OSC-G 05963, Platform JA, PN Block 969 to perform maintenance to the facility. PN 969 had been shut in for five days due to what was suspected to be a tripped ESD station near the boat landing. Weather conditions had previously prevented WGPS personnel from boarding the facility.

The WGPS Employee began working on the ESD station at a level approximately 10 feet above the boat landing. At approximately 0930 hours the OSW felt a large wave hit the platform and looked to see if the WGPS Employee was okay. He noticed that the WGPS Employee was missing but soon spotted him in the water on the south side of the platform. The OSW threw a life ring and life vest, which landed within 5 to 15 feet of the WGPS Employee. Neither was reached by the WGPS Employee. After several minutes the WGPS Employee was motionless and face down in the water. The USCG was notified of a person in the water and launched a helicopter to assist in the rescue. At approximately 1046 hours the WGPS Employee was retrieved from the water and was transported to Spohn Memorial Hospital in Corpus Christi, where he was pronounced dead.

This investigative panel has concluded that the decision to attempt to repair/replace the boat landing ESD in rough weather conditions resulted in the WGPS Employee being washed overboard by a large wave. It is also a conclusion of this panel that the WGPS Employee was not wearing a PFD when he was washed overboard. Furthermore, this panel has also concluded that other contributing causes of this fatality include the lack of guidance on when a JSA is required when working in rough weather conditions, and the decision of the OSW to not exercise his Stop Work Authority for this unsafe operation.

Introduction

Authority

An accident that resulted in one fatality occurred on Lease OCS-G 05953, Platform JA, PN Block 969, leased by Peregrine in the Gulf of Mexico, offshore the State of Texas, on January 19, 2008, at approximately 0930 hours. Pursuant to Section 208, Subsection 22 (d), (e), and (f) of the OCS Lands Act, as amended in 1978, and U.S. Department of the Interior Regulations 30 CFR 250, MMS is required to investigate and prepare a public report of this accident. By memorandum dated January 31, 2008, the following personnel were named to the investigative panel:

Lance Labiche, Chairman – Office of Safety Management, Field Operations, GOM OCS Region;
Sid Falk – Office of Structural and Technical Support, Field Operations, GOM OCS Region;
Stephen Martinez – Lake Jackson District, Field Operations, GOM OCS Region

Procedures

On March 13, 2008, the three panel members from the U. S. Department of the Interior, Minerals Management Service, met with representatives of Peregrine, WGPS, and Rotorcraft to take statements and gather information pertinent to the accident. On March 13, 2008, panel members met and reviewed documents, pictures, and written accounts of the accident. Other data acquired by the panel, and used in the course of the investigation, include the "Report of Postmortem Examination" from the Nueces County Medical Examiners Office, the USCG Investigation Report, and the Peregrine Investigation Report.

The panel met numerous times throughout the investigation and, after having considered all of the information available, produced this report.

Background

Lease OCS-G 05953, Platform JA, PN Block 969 is located in the Gulf of Mexico, off the Texas coast approximately 60 miles south southeast of Corpus Christi *(for photo of platform see Figure 1; for lease location see Figure 2).* The lease was originally awarded to Shell Offshore, Inc., as majority interest owner and designated operator, on October 1, 1983.
Platform JA was installed on January 1, 1989. Peregrine acquired the lease from Shell Offshore, Inc. and was approved as majority interest owner effective July 1, 2007. Peregrine was

designated Operator on October 3, 2007. The platform is an unmanned facility that is operated on behalf of Peregrine by WGPS' personnel quartered at Platform A, PN 975.

Figure 1: Photo of PN 969, Platform JA.

Figure 2: Location of Lease OCS G-5953, North Padre Island 969, Platform JA

Findings

The Accident

At approximately 0849 hours, on the morning of January 19, 2008, the WGPS Employee and the OSW were delivered to Platform JA, PN 969 by Rotorcraft contract helicopter (tail number N518RL). The two men were sent to PN 969 to perform repairs, maintenance, and testing. The WGPS Employee was installing an ESD on the stairway between the main deck and its boat landing. The OSW had completed his testing of Navaids and electronics. The OSW stated that a heavy wave struck the platform causing it to shake. The OSW attempted to locate the WGPS Employee on the platform but was unsuccessful. He then located the WGPS Employee in the water, on the south side of the platform. The OSW deployed a ring buoy within approximately 15 feet of the WGPS Employee which he attempted to swim toward. The OSW then hailed the host Platform A, PN 975 via handheld radio to give notice of "man overboard". The contract Rotorcraft helicopter immediately deployed with the Pilot and the Lead Operator onboard. The OSW then deployed a PFD into the water. The WGPS Employee was not able to reach either floatation device. The OSW indicated that after no more than two minutes the WGPS Employee was floating "facedown" in the water. The Pilot indicated in the interview that, upon arrival at the location, the WGPS Employee's body was motionless and there was a life ring with beacon floating nearby. The crew of a USCG HH-65C rescue helicopter from Air Station Corpus Christi recovered the body of the WGPS Employee at approximately 1045 hours on January 19, 2008. His body was taken to Corpus Christi Spohn Memorial Hospital where he was reported to have no vitals. Exact cause of death was later determined to be "drowning". The weather on scene was reported as 35-knot winds, 8-foot seas, and overcast clouds at 1,200 feet by the USCG.

Post Accident Discoveries

At the time of the accident the WGPS Employee had been employed for approximately the last 17 years in various capacities with WGPS. The OSW, an electronics technician for Prosafe Incorporated (subsidiary of WGPS), had been employed by that firm in that capacity for approximately the last two years. He had never been previously deployed to the PN 969 field nor had he previously encountered either the WGPS Employee or the Lead Operator. The Lead Operator had been employed by WGPS in that capacity for approximately the last nine years. The Lead Operator remained on the host Platform PN 975 on the morning of January 19, 2008.

The Lead Operator approximated production for PN 969 at the time of the incident at 0.5 thousand cubic feet of gas per day. It is reported that PN 969 was frequently shut in due to washed out ESD, and in fact PN 969 was shut in on January 15, 2008, and remained shut in on the morning of January 19, 2008.

Wood Group Production Services' personnel had been waiting since Tuesday, January 15, 2008 to go to PN 969 to bring the platform back online. Due to excessive wind speeds on the previous days, Saturday morning, January 19, 2008, was the first opportunity for flight since shut in of PN 969. During the interview the Pilot reported that, on the morning of January 19, 2008, "Thirty-five- to forty-knot winds prevented shut down of rotors on PN 969. PN 975 had a sheltered helideck, which is shielded from wind, allowing shut down of rotors". Therefore, the WGPS Employee and the OSW were dropped off on PN 969 by helicopter which then returned to PN 975 to await a call for pick-up. Rotorcraft policy, with regard to flight in high winds, is ". . . to not fly, start or shut-down in 40 knots of wind or greater, below 40 knots is left to the pilot's discretion".

The OSW was tasked to perform regularly scheduled navigation aid inspections or "Quarterly Inspections". The WGPS Employee volunteered to go to PN 969 on the morning of January 19, 2008 with the task of assessing the reason for shut in and to bring the platform back online. It was assumed that the ESD was the likely cause of the shut in. If the ESD was determined to be the cause of shut in, the plan was to affect permanent repair if feasible (temporary if needed) in order to bring the platform back online. The WGPS Employee (presumably) determined that the permanent fix was feasible and descended the stairways to an elevation of approximately +10 to +12 feet above the boat landing.

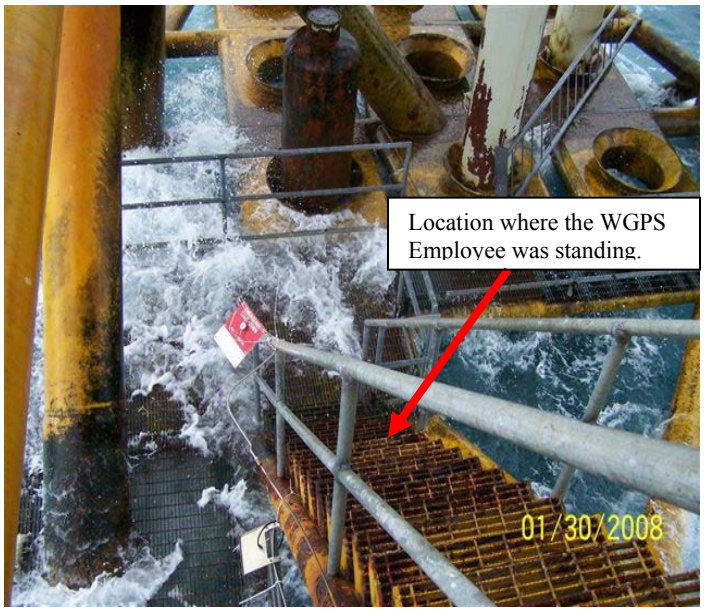

Figure 3: Photo of the WGPS Employee's location on stairs leading to boat landing.

At the time of the incident the OSW had completed his work on the Navaids and was standing on the top deck by the master control panel in position to assist and monitor the WGPS Employee. During the interview the OSW indicated that the WGPS Employee's lower extremities were wet from "spray" hitting his legs during his work on the stairway. Apparently the WGPS Employee had completed the repairs to the ESD prior to being washed overboard and was in the process of "zip-tying" the line to the stair rail. During the interview the OSW reported feeling a shock from a "large" wave, then locating the WGPS Employee in the water "swimming away from the platform". The OSW deployed the life ring "to within 15 feet" of the WGPS Employee, hailed the host platform with a distress call "man overboard", then deployed a life vest to "within five feet" of the WGPS Employee. The OSW indicated that the WGPS Employee struggled to swim toward the floatation devices then ceased movement within approximately two minutes of immersion in water. Initial response time for the Rotorcraft aircraft was approximately five minutes.

At approximately 0925 hours PN 975 received a distress call from PN 969 indicating "man overboard". The Pilot immediately launched the helicopter with the Lead Operator on board. Once airborne a radio call was placed to notify the USCG of incident. Upon arrival at the scene (0930 hours), the Pilot noted that the WGPS Employee was motionless and face down in the water, approximately 30 yards downwind of the platform. The Pilot also noticed a life ring with flashing strobe about 20 to 30 yards from the WGPS Employee which facilitated him being located. The Pilot and the Lead Operator hovered over the WGPS Employee until there was approximately 200 pounds of fuel remaining on the helicopter. At that time they set down on PN 969 to recover the OSW then left for PN 975. They delivered the OSW to PN 975 and refueled a total of 650 pounds of fuel. After refueling, the Pilot returned to hover over the WGPS Employee's body. He remained on location until the USCG arrived and released him from the scene. He then returned to PN 975, landing at approximately 1100 hours.

Records indicate that there was no JSA performed prior to performing this task as it was considered "routine". Furthermore, no concrete definition of "routine" tasks can be identified in either the policy of Peregrine or WGPS. There was no policy to specifically include weather conditions in the decision making process as to whether to conduct a JSA. There has been a previous Safety Alert issued by MMS instructing operators to consider "all hazards" when conducting a JSA. However, this Safety Alert did not specifically identify inclement weather as a potential hazard.

Despite his reputation as an experienced, safe, and conscientious worker, the WGPS Employee was not wearing a life jacket at the time of the incident. There were three to four Type 1 life jackets, in serviceable condition, available at the top of the stairs leading to the incident site (*see Figure 4*). There was a policy in place, including signage, at the top of stairs explicitly stating "PFD's Required Beyond This Point" (*see Figure 5*). The Lead Operator indicated that the WGPS Employee had been made aware of the life jacket policy. There were no other safeguards regarding life vests and descent to the boat landing area known to this investigative panel.

There was a WGPS policy granting all individuals "stop work authority" for reasons of safety at the time of the incident. Interviews indicate that the WGPS Employee, the OSW, and the Lead Operator were aware of the policy. No employee exercised this authority to stop work.

Figure 4: Photo of life jacket box at the top of the stairs.

Figure 5: Photo of sign stating "PFD'S REQUIRED BEYOND THIS POINT".

Conclusions

Cause of Fatality

Based on the information obtained during this investigation, it is the conclusion of this panel that on the morning of January 19, 2008, the WGPS Employee was washed overboard as he attempted to replace the boat landing ESD station in high winds and rough seas. The WGPS Employee was not wearing a life jacket, and it was determined by the Nueces County Medical Examiner's Office that the cause of death was drowning. This panel further concludes that the decision of the WGPS Employee to work on the stairs leading to the boat landing during inclement weather, and the decision to not follow company policy and work at that location without wearing a life jacket, are causes of his drowning.

Contributing Causes of Fatality

1. Records indicate that there was no JSA performed for the repair/replacement of the boat landing ESD. Had a JSA been conducted, the rough weather conditions probably would have been discussed, as well as the policy requiring persons to wear a PFD when working at that level. Failure to conduct a JSA for this operation is considered to be a contributing cause of the fatality

2. The OSW did not object to the WGPS Employee working on the stairs leading to the boat landing without wearing a PFD. The OSW stated that he was aware of the Stop Work Authority Policy. The OSW's failure to exercise his "stop work authority" is considered to be a contributing cause of the fatality.

Recommendations

Safety Alert

Minerals Management Service has issued Safety Alert Number 203 entitled *Job Safety Analysis (JSA),* which recommends to operators when and how they should conduct a JSA. This Safety Alert does not specifically state that inclement weather should be considered as a potential hazard to an operation. Therefore, this investigative panel recommends that the MMS revise and re-issue Safety Alert Number 203 to recommend that operators consider inclement weather as a potential hazard to operations to determine if a JSA is required.