UNITED STATES DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **13-APR-2008** TIME: **0730** HOURS

2. OPERATOR: **ATP Oil & Gas Corporation**
   REPRESENTATIVE: **Wilkins, Clay**
   TELEPHONE: **(713) 403-7007**
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:

4. LEASE: **G04427**
   AREA: **VR** LATITUDE: **28.304045**
   BLOCK: **318** LONGITUDE: **-92.441133**

5. PLATFORM: **A**
   RIG NAME:

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

7. TYPE:
- [ ] HISTORIC INJURY
  - [ ] REQUIRED EVACUATION
  - [ ] LTA (1-3 days)
  - [ ] LTA (>3 days
  - [ ] RW/JT (1-3 days)
  - [ ] RW/JT (>3 days)
  - [ ] Other Injury
- [X] FATALITY **1**
- [ ] POLLUTION
- [ ] FIRE
- [ ] EXPLOSION
- LWC
  - [ ] HISTORIC BLOWOUT
  - [ ] UNDERGROUND
  - [ ] SURFACE
  - [ ] DEVERTER
  - [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES
- COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K
- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [ ] OTHER LIFTING DEVICE
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

6. OPERATION:
- [ ] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [X] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [X] OTHER **Construction-Related**

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

9. WATER DEPTH: **209** FT.

10. DISTANCE FROM SHORE: **86** MI.

11. WIND DIRECTION: **N**
    SPEED: **17** M.P.H.

12. CURRENT DIRECTION:
    SPEED: M.P.H.

13. SEA STATE: **5** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

The MMS investigation revealed that the construction crew had been working in the EC/WC area for ATP approximately three weeks. On April 11, 2008, the construction crew performed repairs on WC 557C, then proceeded to EC 299A platform where they remained on the platform overnight due to rough seas. On April 12, 2008, the construction crew spent the day on EC 299A platform until the seas calmed in order to board the Motor Vessel (M/V) Miss Debbie. The crew boarded the M/V Miss Debbie on April 12, 2008 at approximately 1800 hours en route to VR 318A platform in order to remove two plastic water tanks from the platform. On April 13, 2008 at approximately 2430 hours, the construction crew arrived at VR 318A platform, where they spent the remainder of the night on board the M/V.

The following sequence of events leading to this incident was gathered from the operator's data coupled with testimony gathered during an interview with one of the construction crew members. On April 13, 2008 at approximately 0600 hours, the Construction Crew Foreman (CCF) and the 2nd Captain ate breakfast together. The CCF expressed his urgency to complete the job so he could return home to celebrate his 40th anniversary. At approximately 0700 hours the Captain of the Miss Debbie (CMD) and the CCF decided that it would be better to use the boat landing on the Southeast side of the platform due to the Southwest boat landing being too high. At approximately 0730 hours the CMD repositioned the vessel and approached the Southeast boat landing stern first. At this time, one of the vessel's crewman attempted to retrieve a swing rope with a seven foot hook pole. The CCF notices that the crewman was having a difficult time retrieving the swing rope, because it was wrapped around a pipe on the platform (not an uncommon situation given the design and location of the swing ropes on most platforms). At approximately 0725 hours, the CCF motioned to the CMD to reposition the boat to gain better access to the swing rope. At approximately 0730 hours, the CCF climbed onto the jump deck from the cargo deck (said "getting rope"), and reached out and placed his hand on the platform with his foot on a three foot diameter support pipe. Before the crewman finished saying "No, not a good idea", the CCF fell approximately four feet into the water. The CMD immediately disengaged the boat's engine upon losing sight of the CCF, and announced man overboard while ordering the cook to alert all other crew members that were not on the deck. The crewman threw the CCF a rope, which the CCF placed around himself. At approximately 0735 hours the M/V crewman and a construction crewman pull the CCF back on board the M/V. At this time, the CCF was standing andspeaking/mumbling.Atapproximately 0738 hours, the CCF collapsed and the M/V crewmembers began CPR. The CMD attempted unsuccessfully to contact the Coast Guard via radio. At approximately 0755 hours the ATP Foreman (ATPF) was contacted via satellite telephone. The ATPF then immediately contacted the Medivac helicopter. At approximately 0850 hours the Medivac helicopter contacted the ATPF to notify him that the helicopter was en route. At approximately 0930 hours, the CCF is lifted by crane onto the helideck of the VR 318A platform. At approximately 1015 hours the Medivac helicopter contacted the ATPF to inform him that the CCF was en route to the Abbeville General Hospital. According to the autopsy report, the CCF was pronounced deceased at 1345 hours.

The autopsy report indicated the cause of death to be hypertensive heart disease. The contributing causes were reported as blunt injuries (abrasions, contusions and lacerations to the head and extremities and fracture of the left ninth rib).

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

The CCF attempted to transfer from the M/V Miss Debbie to the boat landing on VR 318A platform without the assistance of a swing rope.

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

*** Testimony displayed in the operator's data revealed that the CCF's sense of urgency to complete the job in order to meet a personal deadline caused the CCF to demonstrate poor judgment and attempt the transfer without a swing rope.**
*** The failure to utilize Stop Work Authority (SWA) by all parties enabled the CCF to jeopardize his safety by attempting the unsafe transfer.**
*** The autopsy report revealed that the CCF had two different prescription pain medications in his system at the time of the incident, but since blood levels were not identified, it can only be assumed that this could have been a possible contributing cause.**

20. LIST THE ADDITIONAL INFORMATION:

The following testimony was revealed during an interview with one of the construction crew members on July 29, 2008. For the purpose of this report, the individual interviewed will be referred to as CCM1. CCM1 stated that their crew consisted of only four members and that he had been working as a welder with the deceased CCF for seven years and for this company for three years. The CCM1 stated that they had spent most of the day of April 12, 2008 at EC 299A platform with the operators due to rough seas, but they departed the EC 299A platform the same day as soon as seas began to calm at approximately 1800 hours. At approximately 2430 hours the M/V Miss Debbie arrived at VR 318A platform and the construction crew spent the remainder of the night on board the M/V. At approximately 0530 hours on April 13, 2008, the construction crew woke up, and ate breakfast. They waited until day light to board the platform due to the poor visibility at the plus 10 level. At approximately 0700 hours the CCM1 stated that they made several attempts to board the platform from all corners but were unable due to high seas and the height of the SW boat landing on the SW corner. The CCM1 stated that the seas were 7 to 10 foot. At approximately 0730 hours the CCF asked the CMD to reposition the boat to the Southeast boat landing. Once in position, one of the M/V crew members took notice that the swing rope was not accessible. At this point the CCF made an effort to board the platform without the use of a swing rope and slipped into the water.

The CCM1 stated that they had planned to use the crane to offload the water tanks. The CCM1 also stated that he does not have a fear of flying in helicopters, but was not aware of anyone with the operating company offering the crew members the opportunity to travel via helicopter to VR 318A platform. The CCM1 also stated that had the CCF successfully boarded the platform, the rest of the crew members would have also boarded.

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

None

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Charles District recommends that MMS Office of Safety Management (OSM) issue a safety alert which includes the following:

*** Operators should perform an assessment of their facilities prior to construction crews arriving on location, for the purpose of identifying hazardous areas and safe means of access and egress.**
*** Operators should provide site specific orientations to all visitors arriving on their facilities, for the purpose of revealing areas of concern, and familiarizing them with emergency procedures including, but not limited to, alarm recognition, location, and activation; fire fighting and lifesaving equipment location and use; and facility evacuation procedures, including muster locations.**
*** Operators should remind all workers of the Operator's philosophy with respect to Stop Work Authority.**
*** Operators should consider removing all swing ropes from condemned boat landings.**
*** Operators are reminded that when personnel transfer by boat to and from platforms with a Coast Guard approved personal flotation device (PFD), all personnel must utilize the assistance of a swing rope.**
*** Operators are reminded that pre-job planning and communications are crucial tools for the successful outcome of all job tasks.**

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 C 107(a) (1) - An unsuccessful personnel transfer was attempted from the M/V Miss Debbie to the "condemned" Southeast boat landing at VR 318A. At the time of the incident, the Southeast boat landing had missing grating and was barricaded off from the plus 10 level. The CCF attempted to transfer from the vessel to the platform without the assistance of a swing rope and fell into the Gulf of Mexico. At the time of the incident, the only active boat landing was on the Southwest (SW) corner of the platform, but was not utilized because it was determined that the SW boat landing was too high to gain safe access to the platform. At this point, the decision should have been made by all crew members to stop operations and communicate their findings to the ATPF at EC 299A platform.

25. DATE OF ONSITE INVESTIGATION:

08-JUL-2008

26. ONSITE TEAM MEMBERS:

Scott Mouton / Marco DeLeon /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Williamson

APPROVED

DATE: **06-OCT-2008**

INJURY/FATALITY/WITNESS ATTACHMENT

☐	OPERATOR REPRESENTATIVE	☐	INJURY
☐	CONTRACTOR REPRESENTATIVE	☒	FATALITY
☒	OTHER **Construction Representative**	☐	WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: **35** YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE: