OCS Report
MMS 2004-004

Investigation of Fall with Fatality
High Island Block A-368
OCS-G 02433
June 5, 2003

Gulf of Mexico
Off the Texas Coast

U.S. Department of the Interior
Minerals Management Service
Gulf of Mexico OCS Regional Office

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Frank Pausina – Chairman
James Hail
Kathleen Wysocki

U.S. Department of the Interior
Minerals Management Service
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New Orleans
January 2004

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Investigation and Report

Authority

An accident that resulted in one fatality occurred on Devon Energy Production Company LP's (Devon) Platform A, High Island Block A 368, Lease OCS-G 02433, in the Gulf of Mexico, offshore the State of Texas, on June 5, 2003, at approximately 0630 hours. Pursuant to Section 208, Subsection 22 (d), (e), and (f), of the Outer Continental Shelf (OCS) Lands Act, as amended in 1978, and Department of the Interior Regulations 30 CFR 250, Minerals Management Service (MMS) is required to investigate and prepare a public report of this accident. By memorandum dated June 26, 2003, the following personnel were named to the investigative panel:

Frank Pausina, Chairman – Office of Safety Management, GOM OCS Region
James Hail – Lake Jackson District, Field Operations, GOM OCS Region
Kathleen Wysocki – Lake Jackson District, Field Operations, GOM OCS Region

Procedures

A panel member visited the scene of the accident on June 7, 2003.

The panel received

1. Statements from various contractor employees and the Devon representative,
2. Devon's accident investigation summary report of the accident,
3. Devon's post-accident company safety alert, and
4. Various documents related to pre- and post-accident activities.

The panel chairman spoke with representatives of Devon and the contractor.

After having considered all of the information available, the panel produced this report.

Introduction

Background

Lease OCS-G 02433 covers approximately 5,760 acres and is located in High Island Block A 368, Gulf of Mexico, off the Texas Coast. *For lease location, see Attachment 1.* The lease was issued effective August 1, 1973. Devon Energy Production Company (Devon) became Designated Operator of the lease on November 2, 2000.

Brief Description of Accident

On the morning of June 5, 2003, a contractor employee was on the landing of a stairway to the platform's skimmer deck level for the purpose of wrapping a light fixture in preparation for sandblasting operations. The landing was approximately 25 feet above the plus 10 deck. The light fixture extended approximately 2 feet from the landing. When the contractor employee leaned out through the landing guardrails in an attempt to wrap the light fixture with plastic, the light fixture broke off its pedestal, resulting in the employee falling and striking his head on a plus 12 level beam before entering the water. The employee was retrieved from the water; however, resuscitation attempts were unsuccessful.

Findings

Preliminary activities – Pre-job Safety Meeting

On June 5, 2003, at approximately 0600 hours, a safety meeting was held during which pre-painting sandblasting operations were discussed. The meeting was led by a Meaux Surface Protection (MSP) supervisor and attended by various MSP personnel, including the MSP employee who was later fatally injured.

According to a statement given by the MSP supervisor, that employee was told by the supervisor to wrap a lighting fixture in preparation for sandblasting operations. Further, according to the statement, the MSP supervisor told the employee to use a spider in the performance of the task. Documentation of interviews with two other MSP employees present at the meeting supports the supervisor's statement. A company representative for Devon was present at the meeting.

On the Job Safety Analysis (JSA) sheet signed by those present at the safety meeting, including the MSP supervisor and the MSP employee, a paragraph that generally addresses blasting makes reference to personnel protection equipment (PPE) and uses the phrase "P.P.E. at all times." *For a copy of the JSA, see Attachment 2.*

The Platform

The fixture in question extended approximately 2-1/2 feet from the landing of a stairway that leads to the skimmer deck. The stairway landing is approximately 35 feet above the water level, and therefore approximately 25 feet above a 24-inch beam at the plus 12 level. *For a photograph of the landing, see Attachment 3.*

The Accident

According to the statement given by the MSP supervisor, as he was making his rounds after the safety meeting checking on sand blasters, he saw the MSP employee stretching out through the guardrail and attempting to wrap the light fixture. He called to the employee for the purpose of informing him to put on his PPE, "full body harness and work vest." He states that the employee looked up at him and pushed out farther to wrap the light. He states that at that moment the light fixture broke and that the employee fell through the guardrail. He states that the employee held on for "a few seconds" before falling, hitting the plus ten deck, and falling into the water. Records indicate that these events occurred at approximately 0630. *For a photograph depicting a simulation of the employee's position at the time of the accident, see Attachment 4. For a photograph showing the various pertinent levels of the platform, see Attachment 5.*

One other MSP employee stated that he saw the victim fall and hit his head "on water line." Another MSP employee said that he last saw the employee leaning through the guardrail.

Post-Accident Activities

Immediately after the employee fell, the supervisor stated that he threw liferings into the water, sounded the alarm, and attempted to keep the employee in sight. Various MSP employees stated that they saw the employee floating face down with no apparent movement.

An escape capsule was immediately deployed to retrieve the employee. A helicopter and marine vessel were likewise deployed to assist in the recovery. With the aid of the helicopter, the capsule reached the employee at a location approximately one mile from the platform. The employee was held by the capsule, brought aboard a motor vessel, and transported to the platform at approximately 0745 hours. The boat crew stated that the employee had no pulse when brought up on the boat. Medics arrived at the platform at approximately 0845 hours and declared the employee deceased 10 minutes later. MMS was shortly thereafter notified of the accident.

Post-Accident Scene

An examination of the accident scene revealed that the deceased employee's PPE was located approximately 5 feet from the location on the landing from which the deceased fell. *For a photograph of the post-accident scene, see Attachment 6.*

Employee History

MSP records indicate that the MSP employee had been employed by MSP for 11 months prior to the accident and had worked offshore for approximately 13 years. Records also indicate that the employee, while with MSP, had received training in PPE, spider usage, and fall protection, among other topics. MSP management indicated no problems with the employee's job performance prior to the accident.

Regulatory Noncompliance

With respect to the accident, MMS inspectors issued to Devon, on June 7, 2003, two incidents of noncompliance (INC) for violations of Federal regulations. INC Z-106 was issued for the employee not utilizing the required fall protection equipment, a violation of Federal regulation 33 CFR 142.4 and 142.42. INC Z-190 was issued for the failure of the employee to have worn a buoyant work vest, a violation of 33 CFR 146.20 and 146.135(e).

Conclusions

The Accident

It is concluded that, when the contractor employee leaned out through the walkway handrails in an attempt to wrap the light fixture with plastic, his center of gravity extended beyond the walkway, with most of his weight being supported by the light fixture. Consequently, when the light fixture gave way, the employee fell through the guardrails for a distance of approximately 23 feet before striking his head on a plus 12 level beam and subsequently falling into the water. It is further concluded that the employee was instructed by his supervisor to use the spider and PPE in performing his task.

Causes

The panel has concluded that the major cause of the accident was the contractor employee's apparent decision to ignore his supervisor's instructions regarding the use of PPE in the performance of the task during which the accident occurred. Given the employee's experience, training, and performance appraisal, as well as the proximity of his PPE to the site from which he fell, the panel is unable to conclude the reason for his decision to ignore his supervisor's directives.

The panel concluded that a nominally contributing cause of the accident is the informality of the Job Safety Analysis sheet. The only reference to PPE is "P.P.E. at all times." The JSA sheet for that day does not state the conditions or steps of the task for which the PPE is required. Even though the employee was verbally given instructions regarding the use of PPE in the performance of the task, the formality of written directives clearly listing those task steps for which the PPE is required arguably would have had a reinforcing influence on the recognition of the importance of following those instructions.

Recommendations

The MMS should issue a Safety Alert to all lessees and operators containing the following:

1. A brief description of the accident,
2. A summary of the causes, and
3. The following recommendations:
    a) That the importance of following procedures formulated in pre-job safety meetings, especially those resulting from JSA's, be stressed, and
    b) That the documentation of JSA's be formalized to the extent that the specific task step(s) for which procedures have been formulated are clearly stated and associated with those procedures.

The Department of the Interior Mission

As the Nation's principal conservation agency, the Department of the Interior has responsibility for most of our nationally owned public lands and natural resources. This includes fostering sound use of our land and water resources; protecting our fish, wildlife, and biological diversity; preserving the environmental and cultural values of our national parks and historical places; and providing for the enjoyment of life through outdoor recreation. The Department assesses our energy and mineral resources and works to ensure that their development is in the best interests of all our people by encouraging stewardship and citizen participation in their care. The Department also has a major responsibility for American Indian reservation communities and for people who live in island territories under U.S. administration.

The Minerals Management Service Mission

As a bureau of the Department of the Interior, the Minerals Management Service's (MMS) primary responsibilities are to manage the mineral resources located on the Nation's Outer Continental Shelf (OCS), collect revenue from the Federal OCS and onshore Federal and Indian lands, and distribute those revenues.

Moreover, in working to meet its responsibilities, the **Offshore Minerals Management Program** administers the OCS competitive leasing program and oversees the safe and environmentally sound exploration and production of our Nation's offshore natural gas, oil and other mineral resources. The MMS **Minerals Revenue Management** meets its responsibilities by ensuring the efficient, timely and accurate collection and disbursement of revenue from mineral leasing and production due to Indian tribes and allottees, States and the U.S. Treasury.

The MMS strives to fulfill its responsibilities through the general guiding principles of: (1) being responsive to the public's concerns and interests by maintaining a dialogue with all potentially affected parties and (2) carrying out its programs with an emphasis on working to enhance the quality of life for all Americans by lending MMS assistance and expertise to economic development and environmental protection.

Location of Lease OCS-G 02433, High Island BlockA-368

Attachment 1

Attachment 2

WORK ACTIVITY (JOB)	House keeping
DATE:	6-5-03
LOCATION:	HI 368-A
APPROVED BY:	
LEADERMAN:	
FOREMAN:	Linus Valley
SUPERVISOR:	

SAFETY EQUIPMENT REQUIRED FOR THIS JOB

Hard Hats X	Work Vests X	Fire Extinguishers ____
Safety Shoes X	Safety Harness X	Lock-Out/Tag-Out
Safety Glasses X	Face Shield	Work Permit Required
Cotton Gloves X	Goggles	
Leather Gloves ____	Barricades ____	

Sequence of Basic Job Steps	Potential Accidents or Hazards	*Probability of Accident	Recommendations to Eliminate or Reduce Potential Hazards
Keep work area job site free of flying Debris			Pick up all Trash even if you did not put it down, Duck Tape, Rope Plastic, Shield paper.
Clean work area after Task is complete			When job is completed clean work area so you don't have to go all over location cleaning up
House keeping in living quarters, pick up behind, clean vest[?] when finish, Towel out of shower + off floor mom don't work here			Be careful climbing in + out of bunks during nite turn night light on.

Continue blasting in cellar area, set up + press washed East & West other hang, blow dry, continue blasting, Check safe equip, P.P.E. at all times, stay focus, have good communication

HDeaton[?]

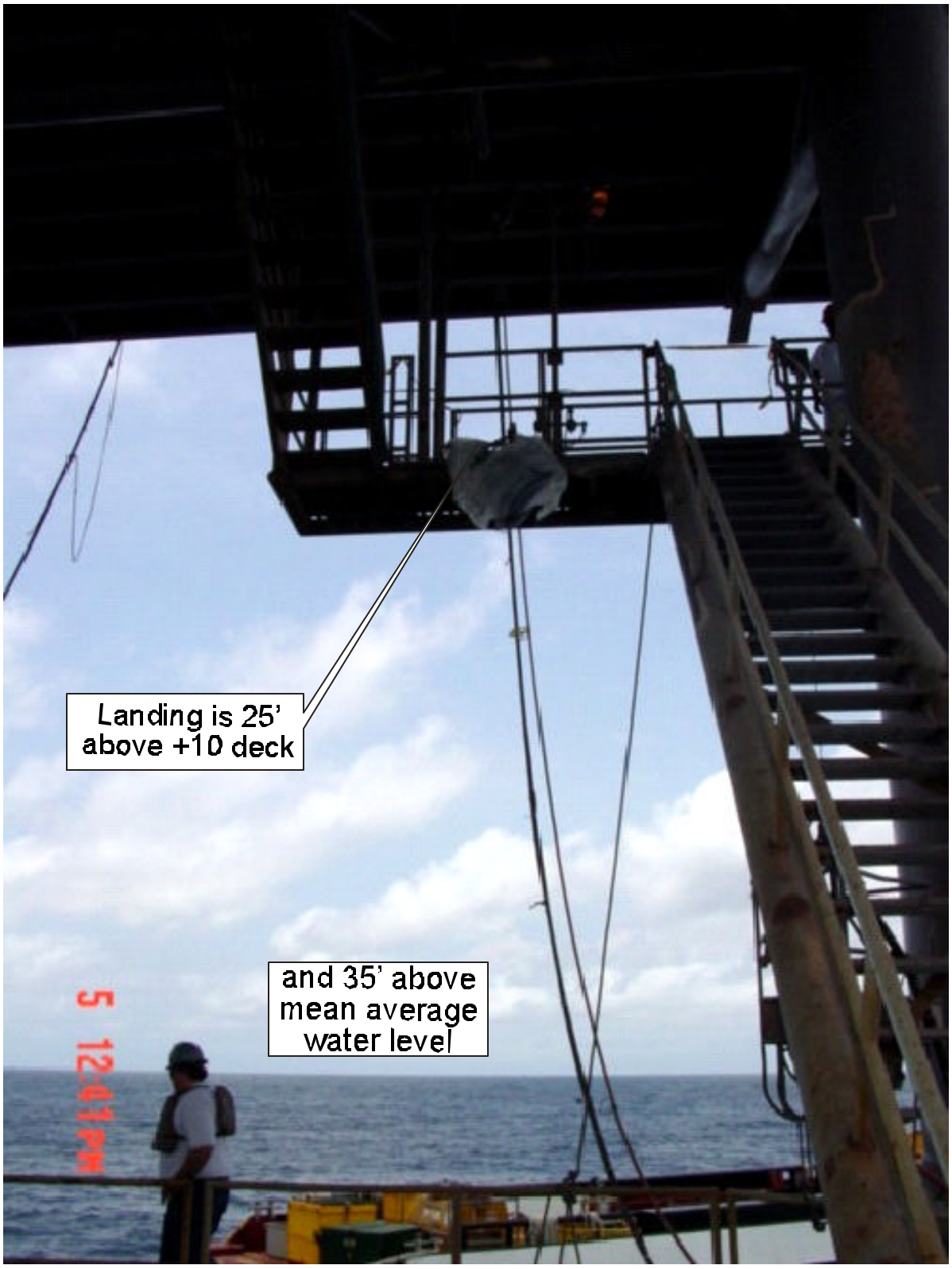
Ashton Joseph
Larry Provost
Coty Theriot
Kenneth Woods
Paul Hanes[?]
Arthur Campbell
Ernest Hebert-View
Chavana[?] [illegible]

* H = HIGH, M = MEDIUM, L = LOW

Copy of Pre-Job Safety Meeting JSA

Copy of pre-job safety meeting JSA

Attachment 3

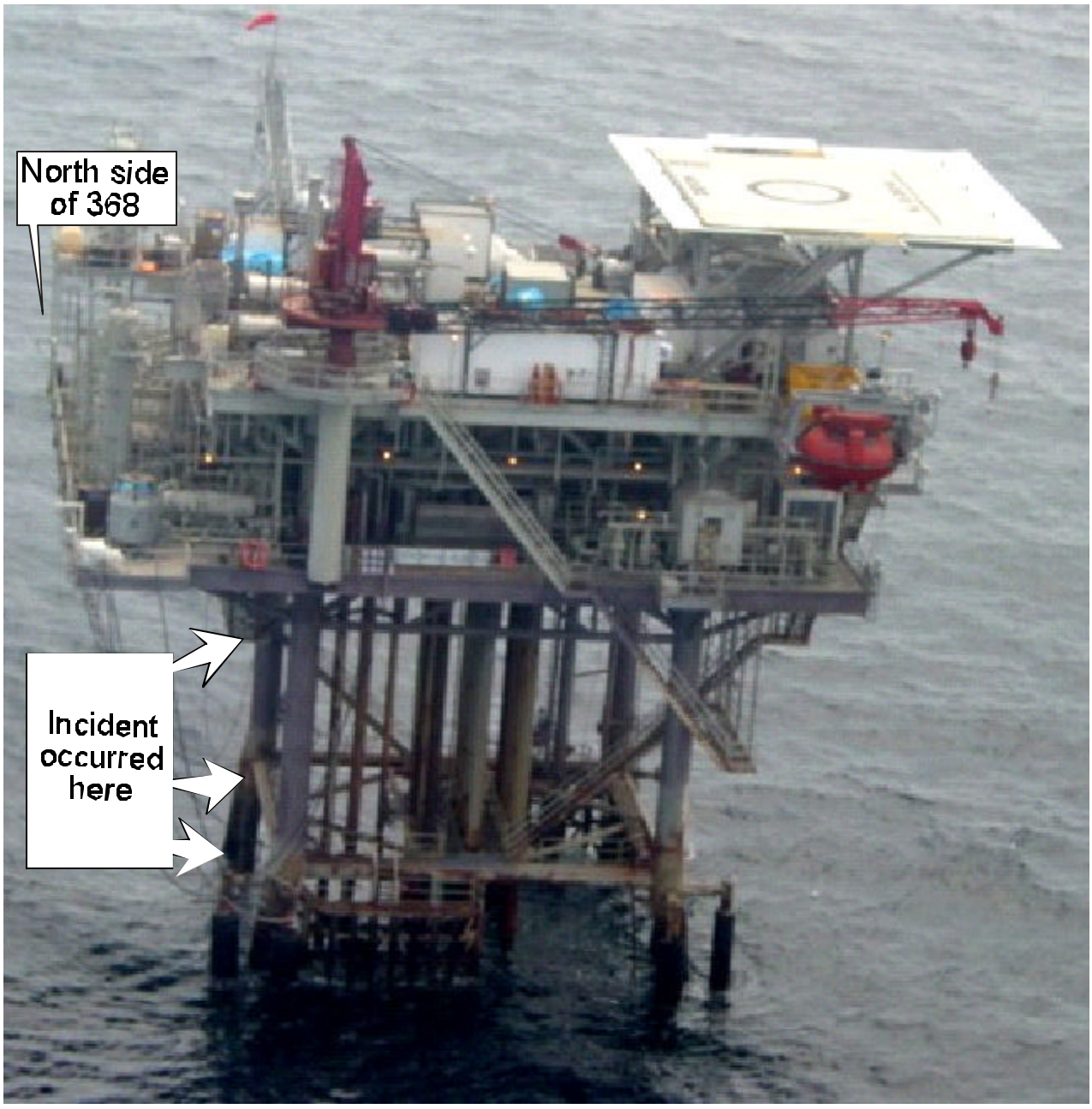


Photograph of stairway landing

Photograph of employeeposition simulation

Attachment 4

Attachment 5



Photograph of platform

Photograph of post accident scene