Investigation of Fatality
Grand Isle Block 37 Platform Z
OCS 00392
February 28, 2006

Gulf of Mexico
Off the Louisiana Coast
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Randall Josey – Chair
Perry Jennings
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Attachment 5 – Additional Hole #2 Missing Grating.

Attachment 6 – Additional Hole #3 Missing Grating.
Investigation and Report

Authority

An accident that resulted in one fatality occurred on Chevron U.S.A.’s (Chevron) Platform Z, Grand Isle Block 37, Lease OCS 00392, in the Gulf of Mexico, offshore the State of Louisiana, on February 28, 2006, at approximately 12:55 p.m. 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 March 06, 2006, the following personnel were named to the investigative panel (panel):

Randall Josey, Chairman—Office of Safety Management, GOM OCS Region
Perry Jennings—New Orleans District, Field Operations, GOM OCS Region

Procedures

Two MMS representatives visited the accident scene on March 01, 2006, took photographs of the accident scene, and obtained Chevron’s statement.

On May 25, 2006, two MMS representatives from the Office of Safety Management visited the accident scene to interview Chevron personnel and review training records. Various documents from Chevron pertinent to the investigation were collected by the panel.

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

Background

Lease OCS 0392 is located in Grand Isle Block 37 (GI 37), Gulf of Mexico, off the Louisiana Coast. Chevron U.S.A. was the designated Operator of the lease at the time of the accident. For lease location, see attachment 1.

Brief Description of Accident

Field personnel were in the process of determining the cause of a failed pipeline hydro-test, performed the previous day, by inspecting the outlying platforms connected to the pipeline.

A contract diver representative (CD rep.) set out for the GI 37 W platform; however, the boat was redirected by the CD rep. for an unplanned visit to the GI 37 Z platform for the apparent purpose of troubleshooting. He boarded Platform Z, which is unmanned and contains no producing wells or active pipelines.

The CD rep. went up to the cellar deck (see attachment 2) and, after about ten minutes, fell approximately 20 feet to the plus-10 deck (see attachment 3), striking the grating, and subsequently falling into the water. After recovery from the water, he was given emergency treatment, flown to Our Lady of the Sea Hospital in Galliano, Louisiana, but was pronounced deceased early that afternoon.
Findings

The Accident

Platform Z, located in GI 37, was damaged by the storm surge and winds associated with Hurricane Katrina in August of 2005, with some of the gratings torn away, leaving holes of various sizes in the deck (see attachments 4, 5, and 6). The platform repair needs had been previously identified, with that work pending a commencement schedule.

On February 28, 2006, Chevron and Qualitech Services personnel were in the process of locating the cause of a failed pipeline hydro-test that occurred the day before. The contract diver representative (CD rep.) boarded the motor vessel Mr. Clint and set out for the GI 37 W platform, but for reasons that are unclear, the CD rep. redirected the boat to the GI 37 Z platform. Upon arrival, the CD rep. boarded the Z platform, which had no warnings signs, barricades, or warning tape to alert personnel the structure was unsafe for boarding because of holes in the deck created by the missing grating. The CD rep. was on the platform approximately 10 minutes prior to falling.

The boat captain was alone and remained on the boat. In interviews, the boat captain stated that he saw the CD rep. on the cellar deck. After looking away briefly, the captain looked back and saw the CD rep. falling approximately 20 feet from the cellar deck, striking his head on the plus-10 deck, and entering the water. The boat captain was unable to determine if the victim was deceased or unconscious. Being unable to retrieve the victim by himself, the boat captain traveled to a neighboring structure for help. The CD rep. was retrieved from the water and brought to the Bay Marchand shore base, from where the CD rep. was flown to Our Lady of the Sea Hospital in Galliano, Louisiana, where he was pronounced deceased early that afternoon. The CD rep. was wearing a personal flotation device (PFD) and was seen by the captain only in a face-up position while in the water.
Post-Accident Discoveries

A list of damaged/closed platforms was not prepared until after February 28, 2006, indicating which structures were “OFF LIMITS TO ALL PERSONNEL.” There was no written plan or process by Chevron to secure or restrict access to the damaged platforms following the major weather event. Deck openings created by damaged and missing grating had not been barricaded. The stairs and swing ropes were available to permit boarding of the Z platform.

Chevron stated that, prior to this incident, Qualitech was highly rated in the Chevron contractor’s safety database and no separate safety plan to mitigate hazards was required. The Job Safety Analysis (JSA) meeting, held at the Bay Marchand field office the morning of the accident, did not include visiting or boarding the Z platform.

United States Coast Guard (USCG) requirements state that, except when moving from one location to another, personnel engaged in an activity where there is a hazard of falling 10 feet or more shall wear a safety harness that meets ANSI A10.14 specifications secured by a lanyard to a lifeline, drop line, or fixed anchorage. However, if there is a hazard of falling 6 feet or more, ChevronTexaco requires the use of a double lanyard when moving from one location to another. When the deceased boarded the Z platform, he failed to follow Chevron’s “Fall Hazard Management Plan” by not wearing the required fall protection equipment or using the buddy system (more than one person) when open holes were present. The “Fall Hazard Management Plan” also states floor holes shall be guarded with a guardrail, covered with a floor hole cover of standard strength and construction, or constantly attended by someone.
Conclusions

The Accident

The CD rep. deviated from the original plan of action, which was to go by boat to the GI 37 W platform. Once he reached the GI 37 Z platform, he boarded the platform and walked around for approximately ten minutes before falling to his death. Judging from the point of impact, and the missing grating directly above the impact, the panel concluded that the CD rep. fell through the open hole created by the missing grating.

Causes

Whether he redirected the boat captain to the Z platform in an effort to troubleshoot a failed hydro-test that occurred the day before is not known; however, the employee’s decision to deviate from the original plan was a contributing factor in the accident. He made a conscious decision to board the platform. We have no way of knowing if he was aware of the condition of the structure.

The panel concludes that Chevron’s failure to follow their “Fall Hazard Management Plan” is a contributing cause. Further, Chevron did not require Qualitech to have a safety plan in place prior to commencing work. Chevron did not have signs posted stating the platform was closed, and Chevron authorization was required prior to entry. Stairwells were not barricaded to prevent entry and deck holes were not covered or protected with guardrails.
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) Lessees and Operators should review their policies regarding access and boarding damaged platforms.
   b) Lessees and Operators should communicate clearly and in writing what is expected of their field representatives with respect to boarding damaged, unrepaired structures or platforms in the Gulf of Mexico.
   c) Prior to boarding a closed structure or platform, a hazard mitigation plan must be prepared that addresses all issues concerning damage.
   d) Signs should be posted on platform access points advising that the platform is “closed.”
   e) Metal bars should be installed across all stairwell entry points.
   f) Helicopter landing decks should have the stairways leading to the platform barricaded.
Location of Lease OCS 00392, Grand Isle Block 37.
Missing Grating; Employee Fell Through Consequent Hole.
Walkway Employee Struck Prior to Entering Water.
Additional Hole #1 Missing Grating
Additional Hole #2 Missing Grating
Additional Hole #3 Missing Grating
Facility Inspection Summary Checklist

Facility Name: Zulu

Name of Person Conducting Inspection: RP, RT, MM
Date of Inspection: 9/9/05

<table>
<thead>
<tr>
<th>Inspection Items</th>
<th>Y</th>
<th>N</th>
<th>NA</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Well Deck</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Is grating in need of repair?</td>
<td>X</td>
<td></td>
<td></td>
<td>Cellar deck, top deck</td>
</tr>
<tr>
<td>B. Are stairs to other decks in need of repair?</td>
<td>X</td>
<td></td>
<td></td>
<td>To landing bent</td>
</tr>
<tr>
<td>C. Are handrails in need of repair?</td>
<td>X</td>
<td></td>
<td></td>
<td>Cellar deck</td>
</tr>
<tr>
<td>D. Are Well signs needed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Are flowline repairs needed?</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Are pipeline repairs needed?</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>G. Are gaslift repairs needed?</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>H. Are swing rope poles/davit repairs needed?</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.</td>
<td></td>
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</tr>
<tr>
<td>2. Heliport</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Is Heliport Deck in need of repair?</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Are stairs to heliport in need of repair?</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Is skirting in need of repair?</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Boatlanding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Do we need to repair the grating?</td>
<td>X</td>
<td></td>
<td></td>
<td>damaged</td>
</tr>
<tr>
<td>B. Do we need to repair handrails. Poles, cable, or chain?</td>
<td>X</td>
<td></td>
<td></td>
<td>Handrails, cable damaged &amp; riser bent</td>
</tr>
<tr>
<td>4. Wireline Enclosure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Is the enclosure walls, deck, or any structure repairs needed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Is any piping repairs needed?</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Risers bent and pulled
- Anodes
- Well deck around single well gone
- Tubing and trays damaged
- Lighting & elect damage
- Battery box cover gone
- PFD box damaged
- Gaugers shack window broken
- Panel blown off
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.