Memorandum

To: Andrew Black, Panel Chair
   Lars Herbst, BSEE Gulf of Mexico Region Director
   Douglas Morris, Chief, Office of Offshore Regulatory Programs

From: Margaret N. Schneider, Acting Director

Subject: Review of Panel Report for Green Canyon Block 18

I have reviewed the Panel report entitled Investigation of March 16, 2016 Fatality, Lease OCS-04940, Green Canyon Area – Block 18. The report presented a number of findings and conclusions arising from the work being done to remove material from the drilling rig’s vertical mud/gas separator that resulted in the death of an Assistant Driller for Nabors Offshore Corporation. I thank the Panel for its work, accept the report and am directing that follow-up actions be taken in response to the Panel findings.

The Assistant Driller died after sustaining traumatic injuries while performing assigned work to remove material from the vertical mud/gas separator. The Panel report identifies a number of failures in the application of basic safety management practices that may have contributed to the death. In particular, the Panel found documentation of non-conformances related to task-level hazard analysis. In addition, the Panel found that after a third-party Safety and Environmental Management Systems audit in August of 2015, the operator, Whistler Energy II, LLC, self-verified that corrective actions had been taken in December of 2015, however the Panel found numerous inconsistencies after the corrective action completion date. Another tragic part of this incident was the emergency response after the incident occurred. The injured worker remained on the facility for approximately three hours after sustaining the traumatic injuries waiting for the emergency services provider to arrive.

The Panel’s recommendations underscore the importance of placing safety first in every job being undertaken on a facility. The report also draws attention to the importance of having meaningful and updated hazard analyses and associate work permits to ensure they reflect all changes in the task conditions and/or the work environment. Finally, the report underscored the need for having medical evacuation procedures pre-approved to allow for timely response.
I am directing the Office of Offshore Regulatory Programs, working with the Regional Directors and appropriate staff to:

- Issue a safety bulletin to inform industry regarding the most significant findings of the Panel investigation and provide recommendations for preventing a similar incident.

- Undertake a review of mud/gas separators design and maintenance requirements to identify best practices. Following appropriate review of the best practices findings, share the results with all stakeholders.

I request that a work plan for these directed actions be provided to me within 30 days of this memorandum. The Panel members should be consulted as necessary.

Please contact me if you have any questions regarding what actions need to be taken based on the report. I would again like to thank the Panel for its efforts in investigating this fatal incident and developing the Panel report.