



ATP OIL & GAS CORPORATION

178 IBLA 88

Decided August 5, 2009



United States Department of the Interior  
Office of Hearings and Appeals  
Interior Board of Land Appeals  
801 N. Quincy St., Suite 300  
Arlington, VA 22203

ATP OIL & GAS CORPORATION

IBLA 2009-92

Decided August 5, 2009

Appeal from an Incident of Noncompliance issued by the Minerals Management Service. OMM G-2008-005.

Affirmed.

1. Oil and Gas Leases: Generally--Oil and Gas Leases: Civil Assessments and Penalties--Outer Continental Shelf Lands Act: Oil and Gas Leases

Where the evidence of record confirms that an attempted personnel transfer did not occur at the only in-service landing on a fixed platform on Outer Continental Shelf lands, there is no need to determine which of the two out-of-service landings identified by witnesses was actually used. In such circumstances, no hearing is required, and it was not arbitrary or capricious for the Minerals Management Service to deny the request.

2. Oil and Gas Leases: Generally--Oil and Gas Leases: Civil Assessments and Penalties--Outer Continental Shelf Lands Act: Oil and Gas Leases

Lessees and operators on Outer Continental Shelf lands are responsible for ensuring safe and workmanlike operations and conditions. That responsibility includes contractors acting on their behalf, because lessees, operators, and the person actually performing the activity to which the requirement applies are jointly and severally responsible for compliance with safety provisions.

3. Oil and Gas Leases: Generally--Oil and Gas Leases: Civil Assessments and Penalties--Outer Continental Shelf Lands Act: Oil and Gas Leases

Where a contract crewman fell from a fixed platform on Outer Continental Shelf lands attempting to transfer from a motor vessel, an Incident of Noncompliance issued by the Minerals Management Service that states that the transfer was attempted at an out-of-service boat landing, that the transfer was attempted without a swing rope, and that the decision should have been made by all crew members to stop operations and communicate their findings to the operator's supervisory foreman adequately informs the recipient of the violation and of the action necessary to correct the violation.

APPEARANCES: Robert P. Thibault, Esq., Denver, Colorado, for appellant; Silvia Murphy, Esq., Office of the Solicitor, U.S. Department of the Interior, Washington, D.C., for the Minerals Management Service.

#### OPINION BY ADMINISTRATIVE JUDGE PRICE

ATP Oil & Gas Corporation (ATP) has appealed an Incident of Noncompliance (INC) issued by the Minerals Management Service (MMS) on October 2, 2008, for failure to ensure safe and workmanlike operations as a result of an accidental fatality at ATP's Vermillion 318A offshore platform in the Gulf of Mexico pursuant to its lease OCS-G-04427.

#### *Background*

At the time of the accident, the Vermillion 318A platform was unmanned and shut in, and was being dismantled because of past severe hurricane damage. ATP retained Top Coat, Inc., to perform the decommissioning of the platform. Top Coat provided a construction crew that had previously worked on the Vermillion 318A platform, including performing the work of taking three of its four boat landings out of service because they were no longer safe, and repairing the fourth landing at the southwest corner to provide the access needed to complete the decommissioning of platform 318A. The construction crew was supervised by Top Coat Foreman Modesto "Sal" Saldana. Tab 6 of the Administrative Record (AR) includes MMS' 6-page Accident Investigation and ATP's Root Cause Analysis; the two are largely consistent in their statements of the facts of the incident.

On April 12, 2008, the construction crew and Saldana boarded the offshore supply vessel *Miss Debbie* and went to the Vermillion platform for the purpose of removing two water tanks. The night before, on April 11, they had spent the night at the East Cameron Block 299 platform, approximately 35 miles away. The ATP foreman on duty at the East Cameron platform, Raymond George, had recommended that Saldana and his crew stay overnight and travel to the Vermillion platform by helicopter on April 12, with ATP supervisor Stacey Landreneaux. Instead, Saldana elected to travel aboard the *Miss Debbie* supply vessel. Statement of Reasons (SOR) at 7-8.<sup>1</sup> Landreneaux had not arrived at the East Cameron platform when the *Miss Debbie* departed for the Vermillion platform, and had not arrived when the accident occurred, because he had taken a “routine detour to another work site in the area.” SOR at 7, ¶¶ 15-16. The vessel arrived at the Vermillion platform the evening of April 12. The crew spent the night aboard the boat, and in the morning of April 13, 2008, began to prepare to board the platform. Several attempts at different corners of the platform failed because of the high seas and because the southwest corner landing, the only landing still in service, was too high to be reached from the boat.

Saldana and the senior captain of the vessel, Rogers Joseph Mayon, Jr., determined to use the southeast corner landing and repositioned the boat accordingly. The swing rope<sup>2</sup> was wrapped around a platform pipe. A crewman, Steve W. Bailey, attempted to free the swing rope using a 7-foot hook pole without success. Saldana was wearing his personal flotation device. He climbed onto the jump deck of the *Miss Debbie*. He made the statement “getting rope,” and put his foot on a pipe of the platform structure that was wet and covered by slime. As Saldana did so, Bailey began to speak, saying “No, not a good idea,” just as Saldana’s foot immediately slipped off the pipe. He fell approximately four feet into the water. Bailey threw Saldana a rope, which he secured around himself, and Bailey, with the help of another crewman, Juan Bazaldua, drew Saldana out of the water and back onto the boat deck. Saldana had been in the water less than five minutes. Saldana was mumbling or speaking when he reached the deck, but within minutes, he had collapsed.

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<sup>1</sup> That vessel is owned by K&K Offshore, LLC, and pursuant to a Master Time Charter Agreement with ATP, K&K Offshore provides transportation to ATP and its contractors. SOR, Ex. 16.

<sup>2</sup> The swing rope is a piece of safety equipment provided to assist personnel transfer between platforms and motor vessels. Personnel are required to use swing ropes in any transfer. See AR, Tab 9 (MMS Safety Alert dated Oct. 22, 2008) at 2; see also SOR, Ex. 17 (ATP Safety Handbook) at 38-39.

The captain tried to reach the U.S. Coast Guard by radio, but failed. Eventually George was reached by satellite telephone at East Cameron Block 299, and he called the medivac helicopter. The second captain, John “Jody” Cunningham, III, and Jason P. Simmons, the deck engineer, began administering cardio-pulmonary resuscitation, which they maintained for 2 hours. Both noted that Saldana had sustained cuts about the face and had a bump on his head. Saldana was lifted by a platform crane to the helideck on the platform, where he was airlifted and taken to Abbeville Hospital in Louisiana. He was pronounced dead at 1:45 p.m. on April 13, 2008. The cause of death was hypertensive heart disease, with a secondary cause of blunt force injuries sustained during the fall into the water (it was determined that Saldana had abrasions, lacerations, contusions, and a broken rib). Prescription pain killers were present in his body, and Saldana had been eager to complete the job so that he could celebrate his 40th wedding anniversary at home. The latter circumstances raise the question of whether Saldana’s judgment and/or motor skills may have been impaired.

In a meeting on August 21, 2008, ATP informed MMS that George, who had remained on the East Cameron Block 299A/B connected platforms, had redirected ATP’s onsite supervisor (also referred to as the contract operator) to start up the Garden Banks Block 142A platform instead of continuing on to the Vermillion 318A. George called a medivac helicopter as soon as he received the captain’s call, but that helicopter had to refuel on the way to the Vermillion platform, and it arrived approximately an hour and 45 minutes later. George also called ERA Helicopters, ATP’s contract transportation service, which rerouted a helicopter that arrived ahead of the medivac helicopter. SOR, George Affidavit, Ex. 5 ¶ 29. ERA could not transport Saldana because he required medical attention. When the medivac helicopter arrived, ERA vacated the platform so that it could land. SOR, Ex. 22 at 7.

MMS issued the INC to ATP on October 2, 2008, citing 30 C.F.R. § 250.107(a), which requires operators on the Outer Continental Shelf (defined by 30 C.F.R. § 250.105 to include lessees, operating rights holders, designated operators or agents of the lessee, pipeline rights-of-way holders, or State lessees) to “protect health, safety, property, and the environment by: (1) Performing all operations in a safe and workmanlike manner; and (2) Maintaining all equipment in a safe condition.” The INC identifies three actions that were not performed in a safe and workmanlike manner: (1) attempting a personnel transfer using a boat landing that was not in service; (2) attempting a personnel transfer without using a swing rope; and (3) ineffective use of ATP’s Stop Work Authority (SWA).<sup>3</sup> The enforcement code

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<sup>3</sup> The SWA may be exercised by any and all personnel when it is believed that behavior, conditions, or circumstances would cause death, injury, illness, or loss or damage to property or the environment. See SOR, Ex. 17 at 38 (ATP’s statement of  
(continued...)

of “C” for “component shut-in” is identified on the INC form.<sup>4</sup> ATP was to provide the date the violation was corrected, sign and date the green copy of the INC, and return it to MMS not later than 14 days after the issuance date.

On October 22, 2008, ATP requested that the Regional Director revoke the INC, challenging MMS’ jurisdiction by contending the incident had been investigated by the U.S. Coast Guard, and asserting that the INC was not supported by the facts and failed to give ATP notice of either the noncompliance or the corrective action that was required. ATP requested the appointment of a panel investigation and a fact-finding hearing. AR, Tab 8. On November 6, 2008, ATP returned the unsigned green copy of the INC with a photograph showing all the decks of the platform had been dismantled and removed. AR, Tab 11.

On November 14, 2008, MMS rejected the requested revocation of the INC, finding the INC to be valid. MMS rejected ATP’s request for a panel investigation and fact-finding hearing. AR, Tab 13. On November 20, 2008, MMS again informed ATP that the INC was valid, enclosed another copy of the INC, and directed ATP to sign the copy and implement corrective action within 14 days, although MMS also advised that an extension of time could be requested. This appeal followed. MMS granted an extension of time to respond to the INC during the pendency of the appeal. AR, Tab 17.

#### *The Parties’ Arguments*

On appeal, ATP renews its arguments that the INC is arbitrary and capricious because it is premised on numerous factual and legal errors; that it fails to provide any meaningful specification of the prohibited conduct or proposed corrective action (an argument that will be the last we consider); that the INC constitutes rulemaking; that the U.S. Coast Guard and not MMS has jurisdiction over the incident; that it was arbitrary and capricious to deny the requested panel investigation and hearing; that MMS improperly relies on documents prepared after the INC was issued; that MMS

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<sup>3</sup> (...continued)  
its SWA).

<sup>4</sup> MMS explains that, although the platform has since been removed and there is no component to shut in now, MMS considers the action it would have taken had it been on site and avers that code “C” is “the most appropriate code for an unsafe situation that posed an immediate danger to personnel when shutting in the affected area would not affect the overall safety of the facility.” Answer at 7, citing Attachment A, MMS National Potential Incident of Noncompliance (PINC) and Guideline List (Guideline) and entry G-110 (pertaining to performance of operations in a safe and workmanlike manner).

errs in concluding that ATP is responsible for Saldana's actions, where those actions constituted a violation of ATP's safety rules; and that MMS has wrongly failed to comply with a request for documents filed pursuant to the Freedom of Information Act (FOIA), 5 U.S.C. § 552 (2006).<sup>5</sup>

MMS responds that the INC is supported by a rational basis; that MMS properly has jurisdiction over the incident, since it was determined that Saldana fell from the platform and not the vessel; that the INC is not a rulemaking and does not establish any new regulatory requirements; that there are no material issues of fact that require a hearing, noting that most of the salient facts are confirmed in ATP's own analysis of the root causes of the accident; that the INC adequately apprises ATP of the violations and the corrective action that ATP must implement; and that MMS properly exercised its discretion to determine the kind of investigation warranted by the incident.

#### *Discussion*

The Outer Continental Shelf Lands Act states that

operations in the Outer Continental Shelf should be conducted in a safe manner by well-trained personnel using technology, precautions, and techniques sufficient to prevent or minimize the likelihood of blowouts, loss of well control, fires, spillages, physical obstruction to other users of the waters or subsoil and seabed, or other occurrences which may cause damage to the environment or to property, or endanger life or health.

43 U.S.C. § 1332(6) (2006). It is the lessee's duty to "maintain all operations within such lease area . . . in compliance with regulations intended to protect persons, property, and the environment on the Outer Continental Shelf." 43 U.S.C. § 1348(b)(2) (2006). Implementing regulations are set forth in 30 C.F.R. Part 250.

With respect to ATP's argument regarding factual errors, we begin with ATP's acknowledgment that "three of the landings had been taken out of service by the installation of barriers intended to prevent access from each landing to the rest of the platform," and that only the southwest landing was in full service. SOR at 8, ¶ 17. According to ATP's Root Cause Analysis, Mayon, the boat's captain, reported that they had attempted the transfer at the northeast landing. Also on April 13, 2008, Mayon completed U.S. Coast Guard Form CG-2692, Report of Marine Accident, Injury or Death. It states that the accident occurred on the northeast side of the

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<sup>5</sup> As MMS notes, this Board has no jurisdiction to decide FOIA appeals. 43 C.F.R. § 2.30(a). We consider this argument no further.

platform. AR, Tab 3 (first document).<sup>6</sup> The four Top Coat crewmen (Bailey, Bazaldua, Chris Duran, and Jesse Montemayor) also signed the Coast Guard form.

In his transcribed interview on April 30, 2008, Duran later averred that they had made two attempts to land, first trying “one side and then [they] went around to the other side.” AR, Tab 6 (final document in the Tab). He did not identify the two landings.

As shown by photographs in the record, the helicopter landing pad is on the south half of the platform, and the crane used to lift Saldana is on the west side of the southwest quadrant of the platform. The two plastic water tanks Top Coat was to remove are on the north side of the platform. A one-page set of handwritten notes dated July 29, 2008, was prepared by MMS’ Supervisory Inspector Marcus “Scott” Mouton while Bazaldua was interviewed. Those notes indicate Bazaldua was shown photographs of the Vermillion platform and he identified the southeast landing as the place from which Saldana fell. AR, Tab 19. MMS Inspector Marco DeLeon also took notes of the Bazaldua interview, and those notes likewise state that the witness identified the southeast landing in the photographs. AR, Tab 20. Based on “the operator’s data coupled with the testimony gathered during an interview with one of the crew members,” MMS’ Accident Investigation Report includes a statement that the captain and Saldana had “decided that it would be better to use the boat landing on the Southeast side of the platform due to the Southwest landing being too high.” AR, Tab 5 at 2. The captain “repositioned the vessel and approached the Southeast boat landing stern first.” *Id.* A crewman then unsuccessfully tried to retrieve the swing rope using a hook, followed by Saldana’s failed attempt and fall into the water. The evidence shows that the efforts to save Saldana occurred near that part of the platform where he fell. He was pulled from the water onto the deck of the vessel, from which he was later “lifted by crane onto the helideck of the VR 318A platform.” *Id.* The helideck is more or less located at the southeast landing.

ATP disputes the evidence regarding the height of the waves, contending that there are eight different statements on the subject, though it cites only three documents. *See* SOR at 27 n.2. Item 17 of the MMS Accident/Incident Form states that the decision to use the southeast landing was made by the captain and Saldana “due to the Southwest boat landing being too high.” AR, Tab 6 at 2. Item 20 in the

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<sup>6</sup> The Coast Guard report was submitted by MMS on Jan. 23, 2009. MMS requested that personally identifying and medical information contained in several documents submitted as Tabs 3 and 6 of the AR not be disclosed except to the parties.

same report states that “CCM1” (presumably for construction crew member 1)<sup>7</sup> stated that the crew “made several attempts to board the platform from all corners but were unable [to] due to high seas and the height of the SW boat landing,” and that the seas were at 7 to 10 feet. *Id.* at 3. The April 14, 2008, letter from ATP’s Clay Wilkins to MMS transmitting the U.S. Coast Guard Form CG-2692 completed by Mayon failed to state the wave height in block 22. SOR, Ex. 36. ATP also cites the affidavit of Gregg S. Perkin, a licensed professional engineer. Perkin referred to Cunningham’s statement that the wave height was 7 to 10 feet, but otherwise merely alludes to three other statements that maximum wave height was 3, 5, and 10 feet, without attribution or citation to record evidence, to express his professional opinion about the accessibility of the platform brace Saldana stepped onto, assuming the vessel’s stern was in wave troughs of different depths. SOR, Ex. 29 ¶ 25. Handwritten notes beneath Duran’s and Montemayor’s names indicate waves of 4 to 6 feet in height. SOR, Ex. 6 at 2. According to ATP’s Root Causes Analysis, Mayon stated the waves were 5 to 7 feet high, while Bailey stated they were in 4-foot seas. AR, Tab 5 (second document) at 3, 5. The platform brace Saldana stepped onto is 4½ feet above the water and was wet with wave action, and was 4½ feet below the boat landing deck. *Id.* at 6. Determining the precise height of the waves is not material to the merits of the INC, because whatever the wave height was at any point in the course of events, it was the reason why the crew abandoned the effort to make the transfer at the southwest boat landing and instead renewed their attempts at an out-of-service landing.

[1] ATP contends that the fact of the discrepancy in identifying the landing site *per se* demonstrates the INC is flawed. We cannot agree. Considered as a whole, we find the evidence supports the conclusion that the incident occurred at the southeast landing. However, it ultimately matters little whether it was the northeast landing or the southeast landing, because neither was safe, neither was in service, and so neither should have been used for a personnel transfer. ATP does not refute this critical conclusion. ATP acknowledges that the southeast landing “had suffered extensive damage to its southern portion during Hurricane Rita,” yet also asserts that “there was full grating in place on the portion that remained on the east side of the platform, which was accessible by swing rope,” and “this remaining eastern portion of the Southeast landing is at the same height as the Southwest landing.” SOR at 9, ¶ 20. ATP admits that the remaining southern portion of the landing has no grating, handrails, or stairway, characterizing it as “literally nothing more than an open framework of large-diameter pipes that cannot constitute a place for any manner of safe or useable boarding.” *Id.* ATP further admits that the northeast landing was not in service. What the evidence thus confirms is that the fatal attempt did not occur at the southwest landing, the only in-service landing on the platform, and thus there is

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<sup>7</sup> From the Report’s description of CCM1 as a welder who had worked with Saldana for 7 years and for ATP for 3 years, CCM1 is Bazaldua.

no need to determine which of the two out-of-service landings was used. Accordingly, no hearing is required, and it was not arbitrary or capricious for MMS to deny the request.<sup>8</sup>

ATP also argues that the U.S. Coast Guard and not MMS has jurisdiction over the incident. MMS has provided a copy of the Memorandum Agreement (Agreement) that governs the two agencies' activities and responsibilities with respect to systems and sub-systems on mobile offshore drilling units and fixed and floating offshore facilities. Answer, Attachment B. That Agreement provides that "[f]or those incidents for which both agencies have an investigative interest in the system associated with the incident, one agency will assume lead investigative responsibility with supporting participation by the other party." Agreement at 5. Who is to act as the lead agency is determined by "mutual agreement." *Id.* Because Saldana fell from the platform and not the *Miss Debbie*, MMS and the Coast Guard agreed that MMS should exercise jurisdiction. AR, Tab 18 (e-mail message from the Coast Guard to MMS dated June 4, 2008). ATP's contentions to the contrary are therefore rejected.<sup>9</sup>

ATP's next contention is that MMS improperly relies on documents prepared after the INC was issued. More particularly, ATP argues that MMS "tries to correct the omissions within the four corners of the INC by referring to and incorporating external documents that were issued after the INC, primarily a 'Safety Alert' issued on October 22, 2008." SOR at 29; *see also* AR, Tab 9. ATP charges "that, in truth, the MMS is using it far beyond a mere safety recommendation, but to establish a new regulatory regime outside of proper rulemaking procedures." *Id.* ATP characterizes the Safety Alert as "an enforceable standard, backed by punitive measures" to

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<sup>8</sup> ATP makes a related argument that it was error to deny its request for a panel investigation. SOR at 26-28. As MMS notes, the statute grants the Secretary considerable discretionary authority in determining the kind of investigation to be conducted. *See* 30 U.S.C. § 1348(d)(2) (2006). That discretionary authority is retained in the implementing regulation. *See* 30 C.F.R. § 250.191. ATP lists six points related to the location of the accident, wave height, and Saldana's actions and physical condition that require a hearing before a panel. The list is more accurately viewed as arguments in support of the interpretation of the facts ATP advocates. In the absence of an indication that the investigation overlooked a material fact or aspect of the accident that cannot properly be developed or examined without a panel meeting or panel investigation, we find no reason to disturb MMS' conclusion that neither is required to determine the facts of the accident.

<sup>9</sup> To the extent ATP would challenge the Coast Guard's agreement that MMS had authority over the incident, it must pursue the issue in another forum, as this Board has no jurisdiction to hear appeals involving Coast Guard decisions.

conclude that it has “become a regulation” that must be duly promulgated through formal rulemaking. *Id.* at 30-31. This line of argument is without merit.

The Safety Alert recites the relevant events of the accident and outlines MMS’ findings with respect to safety issues associated with the accident. Seven recommendations follow. For example, one such recommendation states that “Operators should remind all workers of the Operator’s Policy with respect to Stop Work Authority.” Another states that “Operators should consider removing swing ropes from condemned boat landings.” Yet another states, “Operators should perform an assessment of their facilities, for the purpose of identifying hazardous areas and safe means of access and egress, and communicate their policy prior to visitors arriving on location.” AR, Tab 10 at 2. Such recommendations do not in any circumstance purport to be or constitute rulemaking. Nor do we read those recommendations as MMS’ attempt to impose “new regulations for boarding platforms by using swing ropes to access boat landings — whether for platforms in general service or those with minimal landings because they are being dismantled.” SOR at 24-25. The recommendations to improve and enhance safety are exactly that and no more.

[2] ATP argues that MMS has erroneously concluded that ATP is responsible for Saldana’s actions, where those actions violated ATP’s safety rules. ATP further alleges that MMS seeks to impose strict liability. SOR at 32. We think these assertions completely miss the mark. Outer Continental Shelf lessees and operators are responsible for ensuring safe and workmanlike operations and conditions, 30 C.F.R. § 107(a), and that includes contractors acting on their behalf, 30 C.F.R. § 250.146(c) (lessees, operators, and “the person actually performing the activity to which the requirement applies” are jointly and severally responsible for compliance). *See Petro Ventures, Inc.*, 167 IBLA 315, 324 (2005); *BP Exploration & Production, Inc.*, 167 IBLA 315, 377 (2007). Thus, the only question before us is whether ATP is responsible for any unsafe and unworkmanlike operations or conditions involved in the accident. The record answers the question in the affirmative.

No one in the crew exercised or attempted to exercise their individual SWA when it became evident that the only in-service landing could not be reached. No one exercised that authority as the crew proceeded from one out-of-service boat landing to another. No ATP representative was on-site to insist otherwise. The contract supervisor who was to go to the Vermillion platform was sent elsewhere, and ATP’s Foreman remained on the East Cameron Block 299A/B connected platforms. It was ATP’s choice not to send supervisory personnel. Neither Saldana nor anyone else in the Top Coat crew attempted to contact ATP to discuss the situation before determining to try a transfer at the out-of-service landings or between failed attempts. Although one crewman, Bailey, spoke up as Saldana suddenly made his move to mount the platform structure, it was not to exercise his SWA or to request

Saldana to exercise his, but only to dissuade him from attempting the transfer using the maneuver Saldana chose. The swing ropes remained in place, where removing them from the out-of-service landings probably would have immediately and completely quashed any idea of attempting a transfer. Such lapses and circumstances do not serve ATP's obligation to ensure that all operations are performed in a safe and workmanlike manner; to the extent that ATP's safety rules address the issues presented by this incident, no ATP supervisor/person was in charge that day, as ATP's rules require, to ensure they were strictly followed. *See* SOR, Ex. 17, ATP Safety Handbook, at 4-6. MMS properly concluded that ATP failed to comply with 30 C.F.R. § 250.107(a).

[3] What remains is ATP's argument that the INC fails to provide any meaningful specification of the prohibited conduct or proposed corrective action. The one-page INC form advises that the PINC No. is G-110,<sup>10</sup> issued pursuant to 30 C.F.R. § 250.107(a),<sup>11</sup> the enforcement action is code "C" for "component shut-in," and as the basis therefor, states that:

An unsuccessful personnel transfer was attempted from the M/V [motor vessel] Miss Debbie to the "condemned" Southeast 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 construction crew foreman attempted to transfer from the vessel without 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 corner of the platform, but was not utilized because it was determined that the Southwest 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 ATP Foreman at EC [East Cameron] 299A platform.

AR, Tab 6, final page.

Brief though it is, the underlying elements of the INC are readily discernible: (1) attempting a personnel transfer using a boat landing that was not in service;

<sup>10</sup> The PINC No. is the identifier for the specific regulatory requirement violated. *See* Answer, Guideline, Attachment A at iii.

<sup>11</sup> We note that the Guideline identifies 30 C.F.R. § 250.401(e) as additional authority for PINC No. G-110. That regulation is in Subpart D – Oil and Gas Drilling Operations, and states that lessees and operators, and operating rights owners must "[u]se and maintain equipment and materials necessary to ensure the safety and protection of personnel, equipment, natural resources, and the environment."

(2) attempting a personnel transfer without using a swing rope; and (3) ineffective use of ATP's SWA. The MMS letter that transmitted the INC similarly describes the violation as "G-110 In part – An unsafe personnel transfer was attempted from a vessel to a condemned boat landing on the platform. The construction worker attempted the transfer without the assistance of a swing rope and fell into the Gulf of Mexico." *Id.* The letter directed ATP to "implement corrective action to prevent a recurrence of this type of incident." *Id.*

We do not find ATP's argument persuasive in light of the deficiencies recounted above. It is clear that the INC fundamentally rests on failed supervision on ATP's part and the consequent failure to prevent unsafe operations by the contractor. Despite ATP's arguments assailing the decision to issue the INC, it notably does not contest its responsibility for supervising the construction crew's activities.

Given the basic charge of lack of supervision that grounds the INC, we are simply not convinced that ATP cannot understand that the necessary corrective action is to properly supervise its contractors to prevent unsafe operations and incidents such as occurred here. The fact that the platform involved here has been dismantled in the meantime does not relieve ATP of that responsibility going forward.

To the extent ATP nonetheless insists that it has no inkling of what it might do differently to prevent a similar occurrence, that assertion is belied by the fact that MMS has offered a number of recommendations stemming from the incident that could help ATP and other operators on the Outer Continental Shelf reduce or eliminate opportunities for future injuries and fatalities. ATP may adopt any or all of them as it deems necessary or appropriate to fulfill its obligation to perform all operations in a safe and workmanlike manner to protect health, safety, property, and the environment.

Therefore, pursuant to the authority delegated to the Board of Land Appeals by the Secretary of the Interior, 43 C.F.R. § 4.1, the decision appealed from is affirmed.

\_\_\_\_\_/s/\_\_\_\_\_  
T. Britt Price  
Administrative Judge

I concur:

\_\_\_\_\_/s/\_\_\_\_\_  
Christina S. Kalavritinos  
Administrative Judge