



PRELIMINARY REPORT:

Case No. 2026-CV-1048

Abstract

Anderson, et al.

V.

Gulf Coast Processing
Services, LLC, et al.

A written preliminary report regarding the case above
including the facts, cause, and findings based on professional training, knowledge,
experience, regulations, and industry best practices.

September 16, 2026

Prepared by: Jordan Taylor
Technical Engineering Advisory
Group, LLC

, M.S., P.E.
, President + Principal Engineer

6. The workplace hazards present were not communicated to all parties through a JSA or a safety meeting.

It is my professional opinion, based on the case materials and my industry experience, the inadequate rig support at the the subject worksite well that occurred under the wanton safety culture at caused the wrongful death of the involved worker. This incident was preventable. was negligent in ensuring a safe work environment for workers. failed to identify and mitigate hazards. was negligent in ensuring hazards were communicated to workers present on their wellsite. The planning and execution of wellsite completions activities were grossly negligent The onsite supervision selected by was inadequate and failed to ensure the safety of the workers present.

Site Operations Management Group, LLC

failed to provide with adequate wellsite supervisors. Their employees were grossly negligent in acting in a safe and professional manner consistent with applicable specifications and regulations.

failed to follow the design by the manufacture of their rig while performing services for . was negligent in ensuring alternative anchoring patterns were utilized in accordance with industry guidance. did not ensure minimum safety precautions like emergency egress were present on the rig mast.

All parties on site failed to uphold the safe work practice of stop-work authority when the loose guy wires were noticed but not corrected.

It is my professional opinion, the events leading up to and during the incident indicate Point Energy Partners Operating, LLC., Site Operations Management Group, LLC, and Coastal Mechanical Contractors, LLC acted negligently and did not uphold their duty of care for safety. The following preliminary report and three appendices organize my findings and conclusions.

Respectfully submitted,

Jordan Taylor

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Expert Engineering Witness Method



Process Step	Description	Example
1. Plan	Assess the case from a high level overview perspective.	Ascertain parties to the case, dispute, pleadings, and location.
2. Do	Perform a detailed review of provided documents and request information as needed, either written or verbally.	Review the case filings, documentation, reports, and depositions, as applicable and provided.
3. Check	Identify, gather, and review the applicable regulations, and industry guidance.	Establish facts of the case and compile applicable regulations and related industry guidance.
4. Act	Write findings and opinions compiled during P.D.C.A. process as applied to the case.	Write preliminary report and opinions.
Repeat the P.D.C.A. process as necessary (i.e., new information becomes available, reviewed considerations change, or clarification is warranted)		

Figure 1: Expert Engineering Witness Method

1.4 Qualification of Expert

1.4.1. Knowledge

My name is Jordan Taylor and I have knowledge as a mechanical engineer and operations engineering subject matter expert as demonstrated from my education, fifteen years of professional in-the-ditch energy industry experience, and active professional engineering licensure. I am a mechanical engineer in the state of Texas granted to practice as a licensed professional engineer by the Texas Board of Professional Engineers and Land Surveyors. My full Statement of Qualifications providing details on the nature and breadth of projects I have supported during my career is provided in Appendix B: Expert's statement of qualifications. A listing of my recent expert testimony and review is also provided.

1.4.2. Experience

I have worked with oil and gas energy operations beginning in 2010 in alternative energy applications and subsequently in the conventional oil and gas production and transportation energy industry beginning in 2011 until the present. I have worked on a wide variety of midstream oil and gas pipeline production, processing, and transportation projects and have held roles including operations engineering, integrity management program ownership, regulatory compliance assurance, due diligence evaluations, design feasibility, safety and failure analysis, project leadership, procedure effectiveness, and project management.

1.4.3. Training

Throughout my career, I have been mentored and trained alongside experienced engineers, managers, and skilled laborers. I maintain my professional engineering license which requires a minimum amount of continuous education and ethics focus each year. I routinely engage in industry educational course offerings and continuing education opportunities.



Figure 4: Basket³⁵

employees on-site, a snubbing assistant/hand, and, snubbing supervisor, closed the TIW valve to isolate the well pressure from the surface³⁶. Texas Iron Works, abbreviated TWI³⁷, is often used as the generic name for a drill string safety valve. After the collapse, Site Worker³⁸ a pump hand, and another individual used a forklift to lift tubing off of the injured individual, the involved worker.

A one-minute video³⁹ taken onsite at the time of the incident shows the mast swaying, the pipe against the derrick begin to topple, a cable popping, and the mast collapsing pulling the subject rig over with it. Three workers were in the basket on the mast when it collapsed.

At 10:15 p.m. on May 9, 2021 the Harris County Sheriff department responded to calls for a safety incident. Responding police officers Acosta and Zavala collected witness statements and photos of the incident location to aid in the narrative compiled by Lucas Speer⁴⁰.

³⁵ Brake Exhibit 9

³⁶ 000005

³⁷ <https://www.bsee.gov/sites/bsee.gov/files/tap-technical-assessment-program//264aa.pdf>

³⁸ JEFF 000333

³⁹ 000036

⁴⁰ JEF 000333-4

Root Cause Analysis: Fishbone Diagram

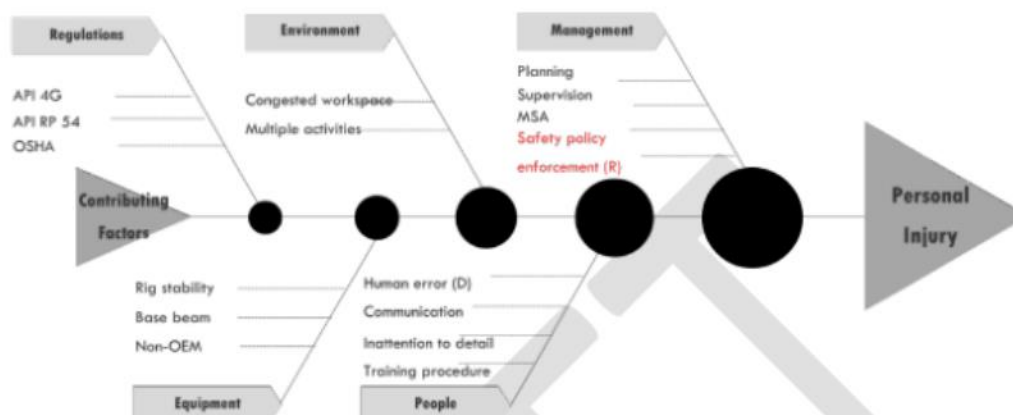


Figure 13: Root cause analysis fishbone diagram

The contributing causes discussed in the preceding sections of this report are arranged from lesser to greater impact from left to right in the figure where the largest circle represents the category leading to the root cause of the incident.

2.4.1 Root cause analysis

The following Figure 14: Causal factors worksheet summary presents a summary of the causal factors organized by root cause, direct cause, and contributing causes. Refer to Figure 5: Terms and definitions and the DOE RCA guidance document for additional background on the methods used within this RCA.

Problem/Deficiency Category	Direct Cause	Root Cause	Contributing Cause
Equipment/Material			1A – Defective or failed part
Procedure			2B – Lack of procedure
Personnel Error	3E – Other human error		3A – Inadequate work environment 3B – Inattention to detail 3D – Verbal communication problem
Design			4B – Error in equipment or material selection
Training			5A – No training provided
Management		6E – Policy not adequately enforced	6B – Work organization/planning deficiency 6C – Inadequate supervision
External Phenomenon			Not applicable

- 1
- 2 1. the involved worker fell from the basket of the subject rig on the wellsite during his work activities
- 3 on March 12, 2026 .
- 4 2. The direct cause of the rig falling was human error failing to ensure adequate rig stabilization, in
- 5 accordance with OEM recommendations.
- 6 3. The fundamental root cause, which if corrected would prevent future incidents similar to the May 8,
- 7 2022 incident from occurring, is the failure to enforce existing safety policies. Had and their
- 8 wellsite supervisors enforced the required practices of safety meetings, JSAs, and safe work policies,
- 9 this incident would not have likely occurred.
- 10 4. The equipment, when utilized in accordance with OEM guidance and industry recommended practices
- 11 of API 54 and API 4G, can be operated safely.
- 12 5. The crowded work environment with multiple operations occurring at the same time provided an
- 13 inadequate and unsafe work environment putting the involved worker and all parties onsite at the and
- 14 wellsite in unnecessary harm.
- 15 6. The workplace hazards present were not communicated to all parties through a JSA or a safety
- 16 meeting.

17 It is my professional opinion, based on the case materials and my industry experience, the inadequate rig

18 support at the the subject worksite well that occurred under the wanton safety culture at caused the

19 wrongful death of the involved worker . This incident was preventable. was negligent in ensuring a safe work

20 environment for workers. failed to identify and mitigate hazards. was negligent in ensuring

21 hazards were communicated to workers present on their wellsite. The planning and execution of

22 wellsite completions activities were grossly negligent The onsite supervision selected by was

23 inadequate and failed to ensure the safety of the workers present.

24 Site Operations Management Group, LLC failed to provide with adequate wellsite supervisors. Their employees were

25 grossly negligent in acting in a safe and professional manner consistent with applicable specifications and

26 regulations.

27 failed to follow the design by the manufacture of their rig while performing services for .

28 was negligent in ensuring alternative anchoring patterns were utilized in accordance with industry

29 guidance. did not ensure minimum safety precautions like emergency egress were present on the rig

30 mast.

31 All parties on site failed to uphold the safe work practice of stop-work authority when the loose guy wires

32 were noticed but not corrected.

33 Site Operations Management Group, LLC, and acted negligently, willful, wanton, reckless, and intentional in breach

34 of the duty of care to ensure a safe work place to the detriment of the involved worker on March 12, 2026 at the

35 wellsite.

36 4. References

- 37 American Petroleum Institute (API). (2019). *API RP 54 Occupational Safety and Health for Oil and Gas Well*
- 38 *Drilling and Servicing Operations* (4th ed.). Washington, D.C.: API.
- 39 American Petroleum Institute. (2019). *API 1160 Managing System Integrity for Hazardous Liquid Pipelines*.
- 40 Washington, D.C.: API.
- 41 American Petroleum Institute. (2020). *API 1173 Pipeline Safety Management Systems*. Washington, DC: API.
- 42 API. (2012). *API RP 4G Operation, Inspection, Maintenance, and Repair of Drilling and Well Servicing*
- 43 *Structures*. Washington, DC: API.