

UNITED STATES DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: 16-MAR-2007 TIME: 1345 HOURS

2. OPERATOR: Devon Energy Production Company, I
REPRESENTATIVE: Nick Mallory
TELEPHONE: (337) 269-4218
CONTRACTOR:
REPRESENTATIVE: M Brown/ OOS
TELEPHONE:

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR
ON SITE AT TIME OF INCIDENT:

4. LEASE: G02115
AREA: EI LATITUDE:
BLOCK: 330 LONGITUDE:

5. PLATFORM: C/TOPPLED
RIG NAME:

6. ACTIVITY: EXPLORATION (POE)
 DEVELOPMENT/PRODUCTION
(DOCD/POD)

7. TYPE:

HISTORIC INJURY
 REQUIRED EVACUATION 1
 LTA (1-3 days)
 LTA (>3 days) 1
 RW/JT (1-3 days)
 RW/JT (>3 days)
 Other Injury

FATALITY
 POLLUTION
 FIRE
 EXPLOSION

LWC HISTORIC BLOWOUT
 UNDERGROUND
 SURFACE
 DEVERTER
 SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION HISTORIC >\$25K <=\$25K

STRUCTURAL DAMAGE
 CRANE
 OTHER LIFTING DEVICE
 DAMAGED/DISABLED SAFETY SYS.
 INCIDENT >\$25K
 H2S/15MIN./20PPM
 REQUIRED MUSTER
 SHUTDOWN FROM GAS RELEASE
 OTHER Fall through open deck
grating

6. OPERATION:

PRODUCTION
 DRILLING
 WORKOVER
 COMPLETION
 HELICOPTER
 MOTOR VESSEL
 PIPELINE SEGMENT NO.
 OTHER

8. CAUSE:

EQUIPMENT FAILURE
 HUMAN ERROR
 EXTERNAL DAMAGE
 SLIP/TRIP/FALL
 WEATHER RELATED
 LEAK
 UPSET H2O TREATING
 OVERBOARD DRILLING FLUID
 OTHER _____

9. WATER DEPTH: 254 FT.

10. DISTANCE FROM SHORE: 82 MI.

11. WIND DIRECTION: N
SPEED: 20 M.P.H.

12. CURRENT DIRECTION: E
SPEED: 2 M.P.H.

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS:

On 16 March 2007 at approximately 1345 hours, an Offshore Oilfield Services contract construction worker (Injured Person - IP) fell through an open hole on an elevated (15') walk around main deck of a production platform. The IP sustained minor injuries as a result of the fall. Just prior to the fall a four (4) man construction crew, including the IP, had removed a four (4) feet wide by forty (40) feet long sheet of grating from the elevated walk around deck located adjacent to the living quarters. The sheet of grating was being removed in order to install a same size (4' X 40') containment drip pan. Prior to initiating the grating removal operations, the two entrance/access points leading up to the elevated walk around deck area had been sufficiently barricaded to prevent inadvertent access by other personnel. Once the grating had been lifted from its initial installed position, an unprotected, unguarded four (4) feet wide by forty (40) feet long open hole existed in the elevated walk around area. The IP was positioned next to the open hole as the grating was being lifted, was wearing a full body fall arrest harness, but had not attached his full body arrest harness to the inplace retractable life line. Subsequent to lifting the sheet of grating and stabilizing it above the opening, the IP made a grab for the tag line that was attached to the suspended sheet of grating. As the IP grabbed for the tag line, his foot slipped off the edge of the grating opening and he fell through the opening to the next deck level fifteen (15) feet below. The IP attempted unsuccessfully to save himself from falling through the hole by trying to grab onto a crossing beam. The IP's co-workers immediately responded and administered first aid onsite.

18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:

The IP failed to connect his full body fall arrest harness to the inplace retractable life line as he worked in the immediate vicinity of an open hole in the deck grating.

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

Devon failed to ensure that all personnel in the immediate vicinity of the four (4) feet by forty (40) feet opening were following the fall protection procedures outlined in Devon's Environmental, Health and Safety Handbook and Behavioral Job Safety Analysis (JSA) Worksheet. Devon's JSA documents state that fall protection equipment must be worn with a 100% tie off.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

None

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The Lafayette District makes no recommendations to the Regional Office of Safety Management.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

An "After the fact" G-112 Incident of Noncompliance was issued on April 26, 2007 to document Devon's failure to properly supervise and enforce the use of fall protection equipment to provide for the protection of personnel as they perform job duties around an unguarded open hole on March 16, 2007.

25. DATE OF ONSITE INVESTIGATION:

20-MAR-2007

26. ONSITE TEAM MEMBERS:

Maxie Lambert / Tom Basey / Leo Dartez / Jason Abshire /

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED

DATE:

10-MAY-2007

INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

CONTRACTOR REPRESENTATIVE

OTHER _____

INJURY

FATALITY

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE:

OPERATOR REPRESENTATIVE

CONTRACTOR REPRESENTATIVE

OTHER _____

INJURY

FATALITY

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE:

INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER _____

WITNESS

NAME:

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STATE:

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TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

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CITY:

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