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

1. OCCURRED
   DATE: 24-JAN-2007  TIME: 1200  HOURS

2. OPERATOR:  BP Exploration & Production Inc.
   REPRESENTATIVE:  Greg Wiltz
   TELEPHONE:  (281) 366-5647

   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE:  G19925
   AREA:  MC  LATITUDE:  
   BLOCK:  127  LONGITUDE:  

5. PLATFORM:  A-Horn Mountain
   RIG NAME:

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

7. TYPE:
   [ ] HISTORIC INJURY
   X  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

8. CAUSE:
   [ ] EQUIPMENT FAILURE
   [ ] HUMAN ERROR
   [ ] EXTERNAL DAMAGE
   [ ] SLIP/TRIP/FALL
   [ ] WEATHER RELATED
   [ ] LEAK
   [ ] UPSET H2O TREATING
   [ ] OVERBOARD DRILLING FLUID
   [ ] OTHER

9. WATER DEPTH:  5400  FT.

10. DISTANCE FROM SHORE:  60  MI.

11. WIND DIRECTION:
    [ ] SPEED:  M.P.H.

12. CURRENT DIRECTION:
    [ ] SPEED:  M.P.H.

13. SEA STATE:  FT.
17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

While cleaning up after a job around the Methanol tank, Operations personnel started to remove tools from an elevated work platform. The crew was lowering a pry bar down to the work deck, attempting to tie a 1/2 inch rope around the pry bar when the pry bar slipped out of crew member's hand falling at an angle, striking the ladder cage causing the pry bar to deflect and strike the injured person (IP), who was standing approximately 5 feet from the caged ladder. The job was stopped and the IP immediately left the worksite and notified medic. HSSE Advisor and OIM was notified. IP was evacuated. The IP lost three teeth and received a laceration on his mouth/lower lip that required 25-30 stitches.

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

1) Not staying alert of the task at hand.
2) Employee on lower level not paying attention to surrounding and overhead hazards.

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

Poor planning or the lack of planning.

20. LIST THE ADDITIONAL INFORMATION:
21. PROPERTY DAMAGED: None

NATURE OF DAMAGE: None

ESTIMATED AMOUNT (TOTAL): $

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

No Recommendations
No Onsite Investigation

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Troy Trosclair

APPROVED

DATE: 20-APR-2007