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, L
   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
   BLOCK: 330
   LATITUDE:
   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)
   ■ REQUIRED EVACUATION 1
     LTA (>3 days)
   ■ RW/JT (1-3 days)
   ■ RW/JT (>3 days)
   □ Other Injury
   ■ FATALITY
   □ POLLUTION
   □ FIRE
   □ EXPLOSION
   □ HISTORIC BLOWOUT
   □ UNDERGROUND
   □ SURFACE
   □ DEVERTER
   □ SURFACE EQUIPMENT FAILURE OR PROCEDURES
   □ COLLISION
   □ HISTORIC
   □ $25K
   □ <=$25K

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.

MMS - FORM 2010
EV2010R
PAGE: 1 OF 7
20-SEP-2010
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

22. RECOMMENDATIONS TO PREVENT RECURRANCE 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

30. DISTRICT SUPERVISOR:

Elliott S. Smith
INJURY/FATALITY/WITNESS ATTACHMENT

☐ OPERATOR REPRESENTATIVE  ☐ INJURY
☒ CONTRACTOR REPRESENTATIVE  ☐ FATALITY
☐ OTHER ______________________  ☒ WITNESS

NAME:
HOME ADDRESS:
CITY: STATE:
WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS
EMPLOYED BY:
BUSINESS ADDRESS:
CITY: STATE:
ZIP CODE: