

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

1. OCCURRED

DATE: **08-JAN-2006** TIME: **1030** HOURS

2. OPERATOR: **Forest Oil Corporation**

REPRESENTATIVE: **Greg Stoutes**

TELEPHONE: **(337) 265-2613**

3. LEASE: **G01182**

AREA: **SM** LATITUDE:

BLOCK: **11** LONGITUDE:

4. PLATFORM: **A**

RIG NAME

5. ACTIVITY: EXPLORATION(POE)

DEVELOPMENT/PRODUCTION
(DOCD/POD)

6. TYPE: FIRE

EXPLOSION

BLOWOUT

COLLISION

INJURY NO. 1

FATALITY NO. _____

POLLUTION

OTHER _____

7. OPERATION: PRODUCTION

DRILLING

WORKOVER

COMPLETION

MOTOR VESSEL

PIPELINE SEGMENT NO. _____

OTHER Construction Operations

8. CAUSE: EQUIPMENT FAILURE

HUMAN ERROR

EXTERNAL DAMAGE

SLIP/TRIP/FALL

WEATHER RELATED

LEAK

UPSET H2O TREATING

OVERBOARD DRILLING FLUID

OTHER _____

9. WATER DEPTH: **70** FT.

10. DISTANCE FROM SHORE: **37** MI.

11. WIND DIRECTION: **E**

SPEED: **15** M.P.H.

12. CURRENT DIRECTION:

SPEED: _____ M.P.H.

13. SEA STATE: **4** FT.

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

None

CITY: _____ STATE: _____

TELEPHONE: _____

CONTRACTOR: **Baker Energy, Inc.**

CONTRACTOR REPRESENTATIVE/
SUPERVISOR ON SITE AT TIME OF INCIDENT:

Joshua Roy

CITY: _____ STATE: _____

TELEPHONE: **(337) 329-2436**

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On January 8, 2006 at approximately 10:30 hours a fall resulting in serious injury occurred at Forest Oil Corporation's South Marsh Island Block 11 A/D platforms. In an attempt to silence a platform ESD alarm, Baker Energy Inc. contract operator fell approximately sixteen feet through an open hatchway located next to the platform master panel. The contract operator attended and signed a Job Safety Analysis (JSA) moments prior to the incident. During the JSA, the contract operator was made aware of all activities that were scheduled to be conducted through the open hatchway. Operations planned at the time of the incident involved the lowering of a twenty foot section of angle iron through an open hatchway to a lower deck. The load was positioned in a way that contract construction riggers could open the hatch covers and maneuver the angle iron down to the next deck while guarding the opening. When the hatch covers were lifted open, one corner of the hatch cover hit the master panel setting off an ESD alarm.

The contract operator was inside the living quarters when the ESD alarm sounded. In his original verbal statement of events given to Forest Oil Corporation HS&E, the contract operator stated that he made a mistake, in that, upon hearing the ESD alarm, he ran out the quarters building door adjacent to the platform master panel, disregarded the open hatchway and warning from the person attending the open hatchway, pushed past the person guarding the open hatchway and fell through the open hatchway as he continued in the direction of the master panel to silence the ESD alarm.

In a later written statement submitted to the MMS on February 13, 2006 the contract operator stated that upon hearing the alarm, he proceeded from the control room through the galley door leading outside to the top deck. As he turned to the right and walked towards the master panel, his attention was focused on the panel in an attempt to trouble shoot the problem and prevent the platform from shutting in. He saw the contract rigger on the opposite side of the panel, however, there were no physical barricades or verbal warnings communicated to him that the hatchway was open. As he approached the master panel, he had no knowledge that the hatchway had been lifted into the upright position. As a result of the open hatchway, he fell approximately seventeen feet to the production deck below.

The contract rigger stated that he was located next to the opening and raised his arm to prevent the contract operator from going to the panel. The contract operator was able to push him out of the way and continued toward the panel. The contractor operator lost his balance while attempting to straddle a narrow section of walkway located along side a welding machine and the opening through the deck. The contract operator fell approximately 16 feet to the lower production deck.

The lower deck area where the contract operator landed was clear of any obstructions. Platform personnel aided the injured contractor operator for approximately one hour before a medi-vac helicopter from Houma arrived. He was transported to Lafayette General where he underwent emergency surgery to his left arm that was broken in two places. Other injuries incurred from the fall were a cut to his lower left hand and an ankle sprain to his left ankle. He has since been moved to Houston for continued health care.

It is significant to point out that the injured has given two versions of events that led to his fall.

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

failed to adhere to the instructions given during the JSA meeting conducted prior to the proposed opening of the hatches. Not only did attend the JSA but also ignored the actions taken by personnel guarding the open hatch covers.

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

When the hatch covers were opened, caution was not used to avoid hitting the master panel which immediately sounded the ESD alarm.

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

None

None

ESTIMATED AMOUNT (TOTAL):

\$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

MMS recommends that Forest Oil Corporation assure that the following are implemented and adhered to in all open hole operations:

- Forest Oil Corporation employees and all contract personnel hired to conduct offshore operations must adhere to all instructional guidelines given when JSAs are conducted.
- Forest Oil Corporation employees and all contract personnel must perform operations in accordance with company safe work practice procedures as they pertain to guarding and barricading open holes.
- Forest Oil Corporation employees and all contract personnel must follow company policies and procedures for use of fall protection devices in and around open holes.

Based on MMS' investigation of this incident, the results of initial and subsequent interviews with witnesses and a review of all documents and written statements acquired during the investigation, a determination is made that this incident could have been avoided if would have followed the cautions addressed in the JSA and Forest Oil Corporation's open hole safe operation plan. Also a determination is made that decision to respond to the ESD alarm located adjacent to the open hatch covers was an unsafe act.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

As a result of this incident, an Incident of Noncompliance (G-110) was issued to Forest Oil Corporation during an operation review meeting held in the Lafayette District on January 11, 2006. The Incident of Noncompliance was issued to document that a production contractor operator employed by Baker Energy Inc, sustained serious injury when conducting operations in an unsafe manner.

25. DATE OF ONSITE INVESTIGATION:

09-JAN-2006

26. ONSITE TEAM MEMBERS:

Tom Basey /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED

DATE: 08-MAR-2006

INJURY/FATALITY/WITNESS ATTACHMENT

<input type="checkbox"/>	OPERATOR REPRESENTATIVE	<input checked="" type="checkbox"/>	INJURY
<input checked="" type="checkbox"/>	CONTRACTOR REPRESENTATIVE	<input type="checkbox"/>	FATALITY
<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>	WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE: (337) 329-2436 TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY: Baker Energy, Inc. / 20290

BUSINESS ADDRESS: 163 Park Ten Place

Suite 320

CITY: Houston

STATE: TX

ZIP CODE: 77084