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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **09-DEC-2006** TIME: **1015** HOURS

2. OPERATOR: **Devon Energy Corporation**
   REPRESENTATIVE: **Ronald Trahan**
   TELEPHONE: **(337) 258-5090**
   CONTRACTOR:
   REPRESENTATIVE: **Mike Brown**
   TELEPHONE: **(337) 896-1900**

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

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

5. PLATFORM: **C**
   RIG NAME:

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

7. TYPE:
- [ ] HISTORIC INJURY
  - [ ] REQUIRED EVACUATION
  - [ ] LTA (1-3 days)
  - [ ] LTA (>3 days
  - [ ] 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
- [X] CRANE
- [ ] OTHER LIFTING DEVICE
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

6. OPERATION:
- [X] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [X] OTHER **Construction**

8. CAUSE:
- [X] EQUIPMENT FAILURE
- [X] 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: **SE**
    SPEED: **15** M.P.H.

12. CURRENT DIRECTION: **SE**
    SPEED: **2** M.P.H.

13. SEA STATE: **6** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

Fifteen (15) pieces of 1 / 4 " X 12 " X 20 ' flat iron was lost overboard adjacent to the EI 330, C platform on December 9, 2006. The flat iron lift was being made from the M/V Ms. Jessica to the platform with nylon slings. As the lift approached the platform top deck level, the center of gravity of the load shifted causing the load to be un-level and off balance. Once the load became un-level and off balance, the inner plates of flat iron began sliding through the nylon slings. The sliding inner plates of the flat iron acted as a knife that sliced through the nylon slings.

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

Improper slings (nylon) were used for a flat iron load lift.

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

The rigger, deckhand on the M/V Ms. Jessica, was apparently not sufficiently trained or experienced in the proper techniques to attach the slings to a flat iron load. The rigger failed to double wrap the nylon slings around the load and align the center of gravity on the center top of the flat iron rather than the edge prior to the lift being initiated. The single wrap around the load resulted in the slings adjusting unevenly and out of balance with the weight of the load subsequent to initiating the lift.

The crane operator was apparently not communicating with the rigger and not providing instructions to the rigger on how to double wrap the nylon slings around the flat iron load. The improper rigging of the nylon slings around the load was not observable by the crane operator from the + 70 feet level of the platform. The crane operator was not aware of the inadequate rigging of the flat iron load until the load began shifting and sliding through the single wrapped nylon sling.

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

Nylon slings Fifteen (15) pieces of
1 / 4 " X 12 " X 20 ' flat iron Lost overboard

ESTIMATED AMOUNT (TOTAL): **$3,720**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

MMS' recommendations to Devon:
1. Only qualified riggers and crane operators are to be used for any lift.
2. Verify training and experience of M/V riggers prior to initiating lift.
3. Establish communications between crane operator and rigger prior to initiating lift.
4. Discuss and pre-plan unique loads and lifts with crane operators and riggers.

Lafayette District's recommendation to the Office of Safety Management:
Discuss the potential value of generating an MMS Safety Alert that would address the limited safe use of nylon slings.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

Incident of Noncompliance (INC-G-112) was issued as an "After the Fact INC" to document that Devon Energy Corporation failed to conduct onsite operations in a safe and workmanlike manner to provide for the safety of personnel, preservation and conservation of property and the environment.During onsite crane operations conducted on December 9, 2006, Devon failed to provide proper supervision to the crane operator and rigger to prevent the discharge of 15 pieces of 1/4"x 12"x 20'of flat iron into the OCS waters. Operator will clear the lease of all debris when the platform is removed.

25. DATE OF ONSITE INVESTIGATION:

27-DEC-2006

26. ONSITE TEAM MEMBERS:

Wade Guillotte /

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED

DATE: **08-DEC-2007**