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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **22-MAY-2007** TIME: **0930** HOURS

2. OPERATOR: **Flextrend Development Company, L.**
   REPRESENTATIVE: **Steve Hilestad**
   TELEPHONE: **(210) 528-3005**
   CONTRACTOR:
   REPRESENTATIVE: **Lowell Trahan**
   TELEPHONE: **(985) 516-1197**

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

4. LEASE: **G09743**
   AREA: **VK** LATITUDE:
   BLOCK: **817** LONGITUDE:

5. PLATFORM: **A**
   RIG NAME:

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

7. TYPE:
- [ ] HISTORIC INJURY
  - [X] REQUIRED EVACUATION **1**
  - [ ] LTA (1-3 days)
  - [ ] LTA (>3 days
  - [ ] RW/JT (1-3 days)
  - [X] RW/JT (>3 days) **1**
  - [ ] 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:
- [ ] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [X] OTHER **Crane Inspection**

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

9. WATER DEPTH: **671** FT.

10. DISTANCE FROM SHORE: **34** MI.

11. WIND DIRECTION: **ESE**
    SPEED: **17** M.P.H.

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

13. SEA STATE: FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On May 22, 2007, on Flextrend Development Company, L.L.C's, Lease OCS-G 9743, Visoca Knoll (VK) 817 A Platform, a contract employee conducting an annual crane inspection was injured when he fell 12 feet through an access hatch that he was attempting to close. Injured Person (IP) was not wearing the proper Personal Protective Equipment (PPE) or Fall Protection Equipment as listed in the Safety Pre-Job Meeting Checklist. IP was evacuated to a medical facility and was treated for bruising and superficial scratches to his lower left side of back and hip area. Three days after the incident, the IP was subsequently treated with medication for urinary complications and was placed on restricted duty for 3 days.

Sequence of events:

While conducting the annual crane inspection (Energy Cranes) on VK 817 the contract employee fell through the access hatch. He climbed through the access hatch and stepped on the deck; when he went to turn around to close it, he stepped through the hole. The contracted employee was transported to a medical facility and treated for bruising and superficial scratches. The employee had negative x-rays. The employee started to urinate blood three days later and was returned back to a medical facility where he was treated with medication. The employee is back at work on restricted duty for 3 days. A safety alert was sent out to all facilities to hold a safety meeting and to include the dangers of working at heights and to use all guards and PPE to prevent falls.

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

Human Error:
Employee did not follow the safety procedures of the Safety Pre-Job Meeting.
Employee was working around a hole that was unprotected without fall protection.

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

Not properly supervised.
Not staying focused while working in heights greater than 6 feet.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

None

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The New Orleans District makes no recommendation to MMS.

The New Orleans District concurs with the Operator's recommendations to prevent recurrence.

1) When employees access the hatch they will wear a retractable lanyard with fall protection.

2) Employees that enter through the hatch must ensure that the hatch is closed immediately after entering the inspection area.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-112 Incident of Noncompliance (INC) - Operator failed to follow his safety plan (JSA) when a contract mechanic did not use a required PPE and was injured in the performance of his job assignment on 5-22-2007.

25. DATE OF ONSITE INVESTIGATION:

26-OCT-2007

26. ONSITE TEAM MEMBERS:

Perry Jennings /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Troy Trosclair

APPROVED

DATE: **11-DEC-2007**