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

1. OCCURRED
   DATE: **20-MAR-2008** TIME: **1100** HOURS

2. OPERATOR: **Energy Resource Technology GOM, In**
   REPRESENTATIVE: **Walker, Julie**
   TELEPHONE: **(281) 848-0704**
   CONTRACTOR: **B & S Welding, Inc.**
   REPRESENTATIVE: **Smith, Greg**
   TELEPHONE: **(601) 441-7742**

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

4. LEASE: **G06655**
   AREA: **EC** LATITUDE:
   BLOCK: **346** LONGITUDE:

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

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

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

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

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

9. WATER DEPTH: **313** FT.

10. DISTANCE FROM SHORE: **103** 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:

On the morning of the accident, the crew was attempting to remove a diesel generator from the platform. In order to gain access to the generator, a portion of grating and handrail had to be cut and removed. The B&S welder (injured person) cut out a 3 foot by 3 foot section of the grating to lower the crane rigging through the deck. Personnel utilized ½ inch manila rope with red flagging tape to barricade the open hole.
Before removal operations of the generator were to begin, the decision was made to break for lunch. The welder (injured person), was standing outside the rope barricade. He noticed his jacket lying on top of a toolbox inside the barricade. He then climbed through the barricade to retrieve his jacket to take with him to lunch. At that time he turned around and entered the open hole with his right foot first. He then proceeded to fall 12 foot to the top of the generator enclosure striking the enclosure then falling another 8 foot to the deck.

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

1. Personnel not wearing fall protection while inside of barricade protecting open hole.
2. There was no "hole watch" designated for open hole activities.
3. Operator has no documented policy or procedure for open hole work.

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

1. The safety meeting that was held with regards to the task at hand made no mention of fall protection or hole watch.
2. The JSA that was performed prior to the task at hand made mention of hole watch vaguely and did not cover fall protection. JSA is generic in nature and actually refers back to hot work permit for isolation of open hole for recommended safe job procedure.

20. LIST THE ADDITIONAL INFORMATION:

1. Prime mover for compressor is being changed out.
2. Generator was being removed due to a bad crank shaft.
3. Deck extensions for new equipment are to be installed for two subsea wells.
4. Platform is producing of high pressure gas.
5. Platform is flaring of low pressure gas while compressor is down.

6. Instrumentation personnel on board for hook up of new equipment.

Approximately 30 minutes lapsed from the time the welder removed the grating to the time he entered the open hole. The B&S Supervisor on duty at the time of the incident was at the top of the stairs heading downwards toward the generator with his back turned away from the incident.

First aid was administered until the medivac flight arrived. Acadian ambulance medivac flight arrived at approximately 1:00 pm and flew the injured person to Terrebonne General Hospital where he was treated for fractured wrist (left and right) and right

dislocated fractured elbow.

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

NA

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The lessee shall develop an "open hole" policy or procedure to be used on such activities. Such policies and procedures should be maintained and referenced by platform personnel responsible for open hole work. Safety meetings and JSA's should cover in DETAIL all the hazards, proper PPE, and techniques to be used to prevent open hole injuries.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

Z-106-- Personnel engaged in an activity where there was a hazard of falling 10 or more feet and was not wearing a safety belt or harness secured by a lanyard to a lifeline, dropline, or fixed anchorage.

G-110--Lessee failed to perform operations in a safe and workmanlike manner.
*****Operator has no documented policy or procedure for open hole work. During the investigation, the platform personnel was asked to produce a policy or procedure for open hole activities. Personnel stated that none was available.**
*****The safety meeting that was held with regards to the task at hand made no mention of fall protection or hole watch.**
*****The JSA that was performed prior to the task at hand made mention of hole watch vaguely and did not cover fall protection. JSA is generic in nature and actually refers back to hot work permit for isolation of open hole for recommended safe job procedure.**

G-112--Lessee failed to provide for the safety of all personnel and take all necessary precautions to correct and remove a safety hazard.
*****Barricade material not suitable for protecting open hole.**
*****There was no "hole watch" designated for open hole activities. The "hole watch" prevents personnel from entering a barricaded open hole without proper fall protection.**

25. DATE OF ONSITE INVESTIGATION:

15-APR-2008

26. ONSITE TEAM MEMBERS:

ERIC FONTENOT /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Williamson

APPROVED

INJURY/FATALITY/WITNESS ATTACHMENT

- [ ] OPERATOR REPRESENTATIVE
- [ ] CONTRACTOR REPRESENTATIVE
- [x] OTHER **Welder B&S**

- [x] INJURY
- [ ] FATALITY
- [ ] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: EARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE:

- [ ] OPERATOR REPRESENTATIVE
- [ ] CONTRACTOR REPRESENTATIVE
- [x] OTHER **Crane Operator**

- [ ] INJURY
- [ ] FATALITY
- [x] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE: