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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **17-FEB-2007** TIME: **1000** HOURS

2. OPERATOR: **Devon Energy Corporation**
   REPRESENTATIVE: **Nick Mallory**
   TELEPHONE: **(337) 269-4218**
   CONTRACTOR: **Nabors Drilling Inc.**
   REPRESENTATIVE: **Larry Holmes**
   TELEPHONE: **(504) 365-3208**

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

4. LEASE: **G03332**
   AREA: **EI** LATITUDE:
   BLOCK: **337** LONGITUDE:

5. PLATFORM: **A**
   RIG NAME: **NABORS S.D. XVI**

6. ACTIVITY:
- [X] EXPLORATION(POE)
- [ ] 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
- [X] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

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

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: **268** FT.

10. DISTANCE FROM SHORE: **96** MI.

11. WIND DIRECTION: **SE**
    SPEED: **15** M.P.H.

12. CURRENT DIRECTION: **SW**
    SPEED: **10** M.P.H.

13. SEA STATE: **5** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

A slight bend in the crane boom heel section occurred on Devon Energy's platform crane (Model No. CH 185 A/36120-01-1) located on Eugene Island (EI) Block 337, A platform on February 17, 2007. At the time of the incident, the crane operator employed by Nabors Sundowner XVI, platform rig, was operating the Devon production platform crane. The Nabors Sundowner XVI crane operator was in the process of repositioning a 6 inch X 30 feet suction hose from the top deck of the platform up to a sidetrack tank on the same deck level. In order to position the suction hose on the sidetrack tank, the crane operator needed to boom up higher than the boom stop would allow. The crane operator activated the boom stop override in order to continue to boom up. As the crane operator continued to boom up, the crane boom heel made sufficient contact with the boom stop to result in a damaging bend to the crane boom heel. There were no injuries or pollution as a result of this incident.

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

The crane boom heel sustained a damaging bend when it made contact with the boom stop.

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

The Nabors Sundowner XVI crane operator placed the crane boom stop in the override position and continued to boom up.
The Nabors Sundowner XVI crane operator had operated the Devon platform crane for only two (2) days prior to the boom contact with the boom stop incident.
It is believed that both the crane operator and the rigger failed to sufficiently monitor the boom to prevent damaging contact with the boom stop subsequent to placing the boom stop in override.

21. PROPERTY DAMAGED:

Crane Boom

NATURE OF DAMAGE:

Slight bend

ESTIMATED AMOUNT (TOTAL): **$15,000**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Devon's recommends the following:
Devon states that approval to override the boom stop by the crane operator was not requested nor would it have been given if it were requested.
The crane operator failed to adhere to Devon's standing policy that the boom stop would not be placed in the override position without approval from the supervisor.
The crane operator and the watchman must have direct communications with each other.
Disconnect the boom stop override.

MMS' recommendations to Devon:
Enforce Devon's standing policy that the boom stop would not be placed in the override position without approval from the supervisor.
Assure that the crane operator is qualified and familiar with this specific crane prior to making a special or unique lift.
Communicate to personnel during safety meetings and JSAs that extra precautions must be employed when operating the crane boom at angles near the boom stop.
Stress the importance of inspecting the boom systems during pre-use inspections.
Provide a crane boom watch person with no other duties than to flag the crane operator when making lifts at angles that place the boom near the crane boom stop.
Adjust and place the lift such that a high boom angle and placing the boom stop in override would not be an option.

MMS makes no recommendations to the Office of Safety Management (OSM).

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

A G-110 Incident of Noncompliance was issued to document that Devon Energy failed to protect health, safety and the environment by not performing operations in a safe and workmanlike manner as follows: Devon Energy failed to properly supervise a crane lift operation to prevent damage to the crane boom heel section. The Nabors XVI crane operator manually activated the boom stop override in order to continue to boom up to make a high boom angle lift. The crane boom heel made sufficient contact with the boom stop to result in a damaging bend to the crane boom heel.

25. DATE OF ONSITE INVESTIGATION:

26-FEB-2007

26. ONSITE TEAM MEMBERS:

Maxie Lambert / Tom Basey / David Suire /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED

DATE: **20-MAR-2007**