Wyo

Colton Bryant
Patterson-UTI Drilling Company
307815050/S00706
November 27, 2006

Date and Time of Accident: February 14, 2006 at approximately 9:10 pm.

Notification: Jerry Jacobs, Corporate Safety Director, Patterson-UTI Drilling Co., reported the accident to Wyoming Workers' Safety WWS via a phone voice message on February 15, 2006 at 6:44 am.

The Investigation:

On Wednesday, February 15, 2006 --

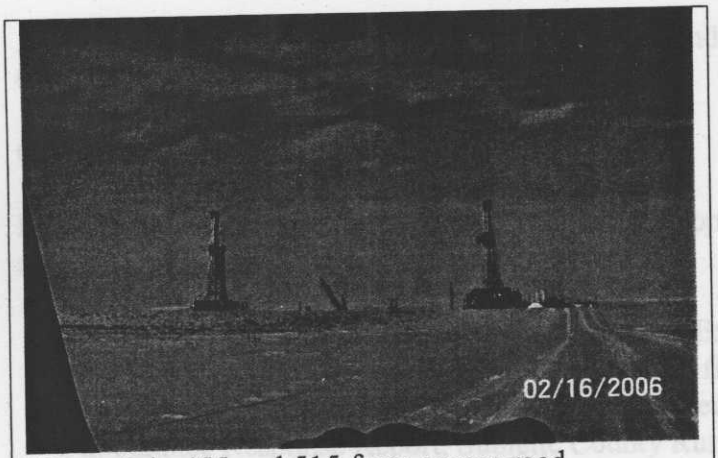
At 8:00 am, following notification of a serious injury with initial prognosis that survival was not likely, Compliance Supervisor Johnnie Hall called Jerry Jacobs to request and receive additional information about the accident. Terry provided point of contact information for Mike VanderLinden, Regional Safety Coordinator, Rocky Mountain Region, for Patterson-UTI Drilling Co.

At about 9:00 am, Lead Investigator Ken Masters from WWS started to gather investigation equipment and materials, and then traveled to Rock Springs, Wyoming to join John Watterson, Assistant Investigator, WWS.

At about 10:00 am, Investigator John Watterson called Mike VanderLinden and coordinated a meeting at the accident site for Thursday, February 16, 2006, at 9:00 am.

On Thursday, February 16, 2006--

At 7:00 am, Investigator John Watterson called Mike VanderLinden to confirm the meeting at the accident site was still taking place. Investigators traveled to the accident site located about 5 miles northwest of Boulder, WY in the Mesa oil field.



View of rig 455 and 515 from access road.

At 9:30 am, Investigators arrived at the accident site and conducted the investigation's opening conference with the following individuals:

Michael VanderLinden, Regional Safety Coordinator, Patterson-UTI Drilling Co.
Bobby Blanchard, Drilling Superintendent, Patterson-UTI Drilling Co.
Cassidy Jace Blanchard, Tool Pusher, Patterson-UTI Drilling Co.
King Brown, Well Site Supervisor, Ultra Resources Inc.
Dave Ault, Drilling Superintendent, Ultra Resources Inc.
Belinda Salinas, Manager, Environmental, Safety, and Regulatory Affairs, Ultra Resources Inc.
Tim Wells, Risk Management, Safety Consultant to Ultra Resources Inc.
Jayme Torgerson, Directional Driller, Baker Hughes INTEQ

At 10:20 am, Investigators conducted a survey of the accident site to include still photos and a video.

At 12:00 pm, Investigators conducted the initial closing conference for the investigation with the following individuals:

Michael VanderLinden, Regional Safety Coordinator, Patterson-UTI Drilling Co.
Bobby Blanchard, Drilling Superintendent, Patterson-UTI Drilling Co.
Cassidy Jace Blanchard, Tool Pusher, Patterson-UTI Drilling Co.
King Brown, Well Site Supervisor, Ultra Resources Inc.
Dave Ault, Drilling Superintendent, Ultra Resources Inc.
Belinda Salinas, Manager, Environmental, Safety, and Regulatory Affairs, Ultra Resources Inc.
Tim Wells, Risk Management, Safety Consultant to Ultra Resources Inc.

At 12:20 pm, Investigators began conducting private interviews with the individuals who were present at the site at the time of the accident. After the interviews, investigators coordinated with Mike VanderLinden to conduct private interviews with the evening drilling crewmembers who were on duty at the time of the accident. The site was also released back to Patterson-UTI Drilling Co. for normal operations.

At 7:15 pm, Investigators started conducting private interviews with the evening shift drilling crewmembers.

At 9:45 pm, Investigators left the accident site and returned to Rock Springs, Wyoming and Cheyenne, Wyoming.

On Tuesday, February 21, 2006 --

Investigator Ken Masters drafted letters requesting copies of the reports generated by the following agencies as result of the accident:

Coroner's Report from Utah University Medical Examiner, Bob Blanchard
Sheriff's Response Report, Sublette County Sheriff's Office, Sheriff Wayne Bardin
Ambulance Response Report, Utah University Medical Records, Chris Auston
Ambulance Response Report, Sublette County Rural Health Care Board, Jerry Jenson

At 11:02 am, Investigator Ken Masters called Shane Doney, Gyrodata Inc. technician who was on site at the time of the accident, and left a message for Shane to call us back so we could interview him.

On Wednesday, February 22, 2006 --

At 8:00 am, Investigator Ken Masters drafted letters requesting copies of the documents relating to Colton Bryant's employment and training to be provided by Patterson-UTI Drilling Co. for our review.

On Friday, February 24, 2006 --

At 11:02 am, Investigator Ken Masters called Shane Doney again, and left a message for him to call back.

On Thursday, March 09, 2006 --

At 3:00 pm, Investigator Ken Masters interviewed Shane Doney. The delay in interviewing Shane was due to not being able to reach him or get him to call back.

During the week of March 24, 2006 and the weeks of April 3 and April 10, 2006 --

Investigator Ken Masters reviewed the materials provided by Patterson-UTI Drilling, the Sheriff's Office, the medical care providers, and the Coroner's Office.

Deceased:

Colton Bryant

Occupation:

Motor Hand

Employer:

Patterson-UTI Drilling Company

Accident Site:

According to signs posted at the accident site, the drilling location was identified as NWSE Section 35, Township 32N, Range 109W. The site is about 5 miles northwest of Boulder, Wyoming as the crow flies, and about 20 miles by road, to Pinedale, Wyoming. It takes about one hour to travel to the site by vehicle from Pinedale. This area is also known as the Mesa Oil Field.

Employees Present at the Time of the Accident

Name	Firm	Job Title
Cassidy Jace Blanchard	Patterson-UTI Drilling Co.	Tool Pusher, rig 455

Wayne Kring	Patterson-UTI Drilling Co.	Floor Hand, rig 455
James Cook	Patterson-UTI Drilling Co.	Floor Hand, rig 455
Carson Shifflet	Patterson-UTI Drilling Co.	Derrick Hand, rig 455
Stan Cook	Patterson-UTI Drilling Co.	Driller, rig 455
Richard Leech	Patterson-UTI Drilling Co.	Tool Pusher, rig 515
Jayme Torgerson	Baker Hughes INTEQ	Directional Driller
Jason Corsten	Gyrodata Inc.	Gyro Trainee
Shane Doney	Gyrodata Inc.	Gyro technician
Colton Bryant	Patterson-UTI Drilling Co.	Motor Hand, rig 455 (deceased)

Employees Interviewed during the Investigation

Name	Firm	Job Title
Cassidy Jace Blanchard	Patterson-UTI Drilling Co.	Tool Pusher, rig 455
Wayne Kring	Patterson-UTI Drilling Co.	Floor Hand, rig 455
James Cook	Patterson-UTI Drilling Co.	Floor Hand, rig 455
Carson Shifflet	Patterson-UTI Drilling Co.	Derrick Hand, rig 455
Stan Cook	Patterson-UTI Drilling Co.	Driller, rig 455
Richard Leech	Patterson-UTI Drilling Co.	Tool Pusher, rig 515
Jayme Torgerson	Baker Hughes INTEQ	Directional Driller
Jason Corsten	Gyrodata Inc.	Gyro Trainee
Shane Doney	Gyrodata Inc.	Gyro technician

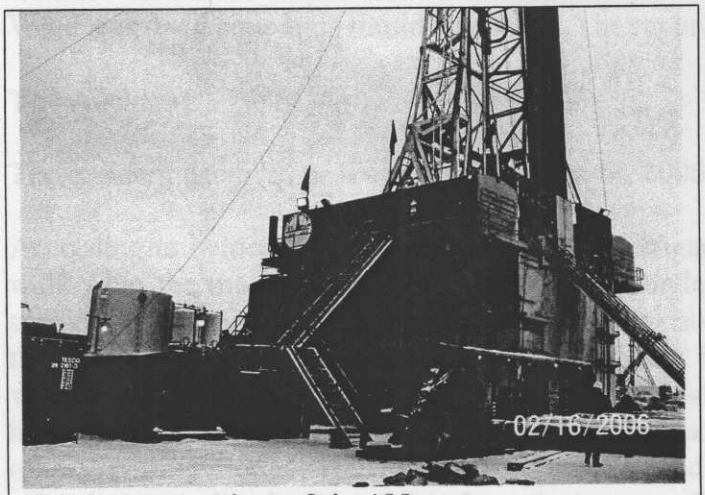
Events leading up to the Accident

After reviewing the documents provided by Patterson-UTI Drilling Co, Investigators were able to determine that Colton Bryant, the deceased, had one year of work experience with Nabors Drilling as a Lead Tong Hand. Colton initially started working for Patterson-UTI Drilling Co. on October 19, 2003 as a Floor Hand. The documents provided showed Colton received the company's New-Short Service Employee Orientation. The documents provided by Patterson-UTI Drilling Co. did not reveal to what level their training programs addressed fall protection issues. There was no indication the fall hazards associated with the floor sub area of the drilling rig were addressed. Colton's initial employment with Patterson-UTI Drilling Co. was terminated on August 18, 2005, because Colton wanted to find a different job.

Colton Bryant re-applied for employment with Patterson-UTI Drilling Co. on November 17, 2005, and was rehired as a Floor Hand to work on rig 455. According to documents provided by Patterson-UTI Drilling, Colton completed the Company's Handbook Orientation, and Rig Pass course, New-Short Service Employee Orientation and tests were administered and certified by Floyd King, Instructor. Colton acknowledged receiving the Patterson-UTI Drilling Company's Employee Handbook by signing a statement to that effect. Colton also acknowledged the Company's fall protection policy by initialing a statement relating to the policy during the New-Short Service Employee orientation process.

Colton changed from being a Floor Hand to a Motor Hand on December 19, 2005. No documents were provided to indicate additional training was provided as part of the position change.

Drilling rig 455 was essentially skidded from another completed well site, located about 25 feet to the north of the accident site, on February 14, 2006 according to the contact sheet filled out by Mike VanderLinden.



This is an overview of rig 455

A review of the JSA/Safety meeting documents provided by Patterson-UTI Drilling Co. revealed that prior to the day of the accident, 32 JSA/Safety meetings were held and documented where fall protection and/or keeping a clean work area were discussed. Based on Colton's signature being found on the documents reviewed, Colton was present for 23 of the meetings during his employment. No JSA/Safety meeting report was provided for the work being accomplished by the crew for the date of the accident. There was no reference to work being accomplished in the substructure area of the rig on any of the documents reviewed.

According to information gathered during the investigation, on Tuesday, February 14, 2006, the evening of the accident, the crew traveled from the man camp in Big Piney, Wyoming to the rig site and went through their normal processes to start working on the rig. Just prior to the accident, the drilling crew had been involved in completing some directional drilling survey measurements. During the survey measurement's equipment set up process, Colton was tasked to provide a power source for the measurement equipment. This task required Colton to enter the floor sub area under the drilling floor. No one witnessed Colton entering the area to accomplish the task. Colton had been observed in the area without fall protection in the past. After completing the task, Colton returned to the drilling floor to observe the survey measurement equipment. During the equipment set up process, the crew had some problems locating a 24-inch wrench needed to attach the survey equipment. The survey measurements were completed, and the crew made a new drill pipe connection and began drilling again. The well depth at this time was about 324 feet.

Crewmembers interviewed indicated Colton appeared to be in good spirits. They remember talking with Colton prior to the accident and all seemed normal relating to his behavior. Once the drilling started again, the crew dispersed to accomplish tasks associated with maintaining and operating the rig. Colton was doing his normal tasks associated with his position as Motor Hand as far as everyone knew. There was no communication between Colton and the other

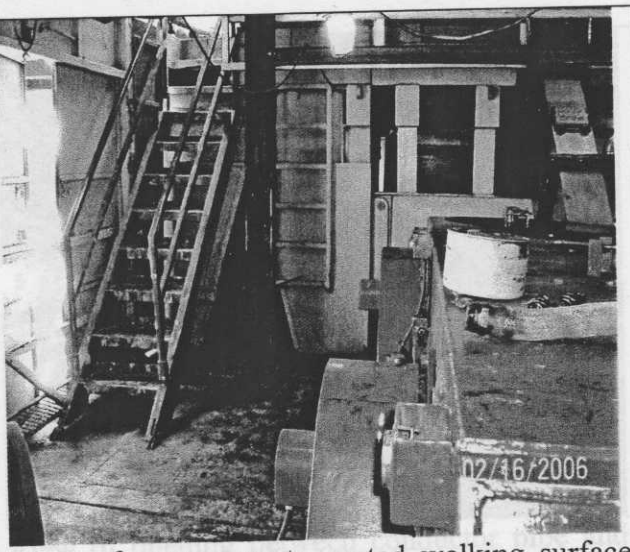
crewmembers as to what his intensions were once drilling began at about 9:00 pm on Tuesday, February 14, 2006.

According to the National Weather Service Forecast Office, on Tuesday, February 14, 2006, the weather conditions in the area at the time of the accident were: Temperature – +10 degrees F, Wind speed – Calm, and Humidity – 79%. The report is included in the case file.

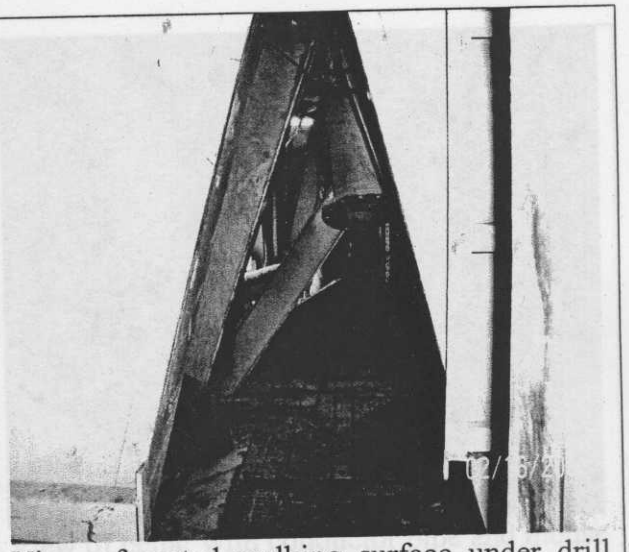
The Accident

The accident occurred on Tuesday, February 14, 2006 at approximately 9:00 pm.

According to evidence collected during the investigation, Colton apparently decided he needed to walk from the motor room to the area directly under the drilling floor using the grated walking surface located on either side of the well and the catwalk installed around the conductor pipe and the mouse hole pipe. Co-workers stated they found Colton's hardhat near the junction associated with the grated walking surface and the catwalk leading to the well's conductor pipe and mouse hole. The conductor pipe essentially ran from the bottom of the cellar all the way to the underside of the drilling floor. The mouse hole pipe extends from the drilling floor down through the substructure and ends about 6 feet from the bottom of the well's cellar.

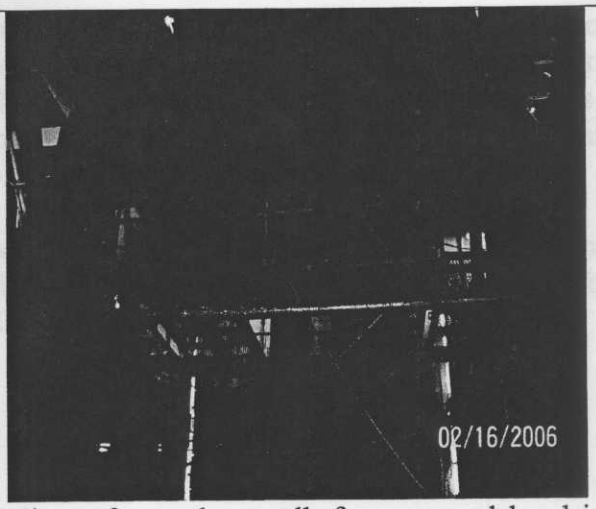


View of entry way to grated walking surface under drill floor of rig 455 while facing south from motor room



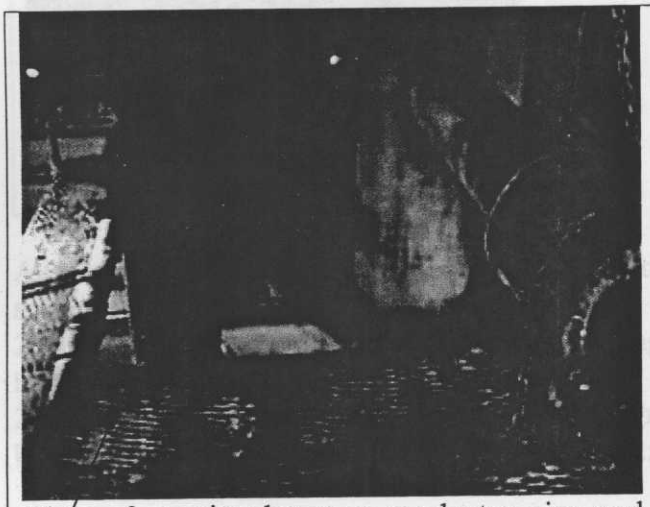
View of grated walking surface under drill floor of rig 455 while facing south from motor room.

View of grated walking surface from ground level in the substructure of rig 455 while facing east.

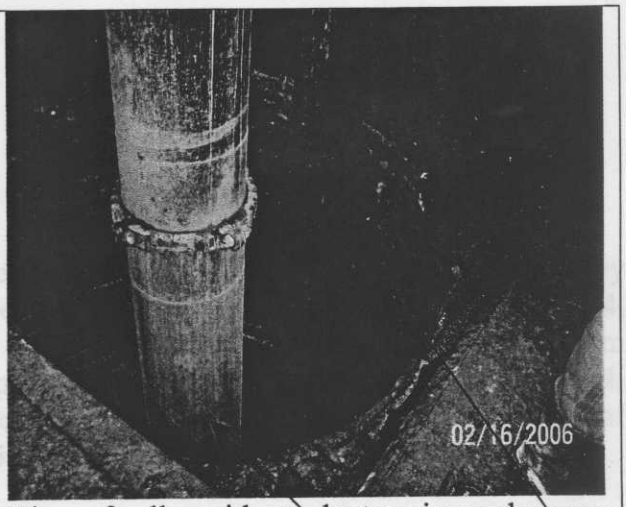


View of grated catwalk from ground level in the substructure of rig 455 while facing south.

Evidence suggests Colton fell through the opening between the catwalk and conductor pipe/mouse hole, falling a distance of about 26 feet into the cellar area. He suffered fatal head injuries.



View of opening between conductor pipe and mouse hole pipe while standing on grated walkway and facing west on rig 455.



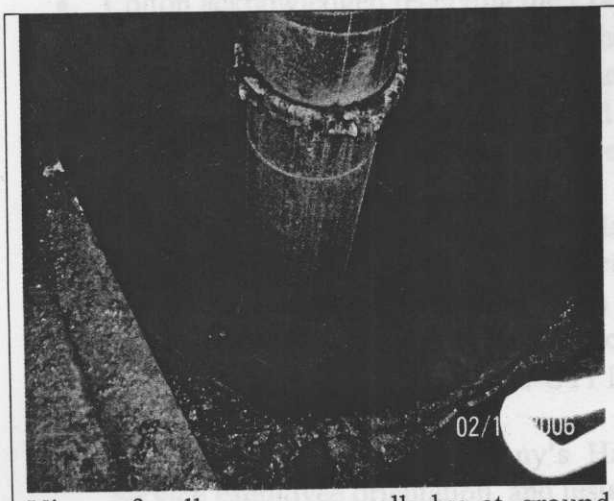
View of cellar with conductor pipe and mouse hole pipe while facing southeast at ground level in the substructure rig 455

Co-workers stated Colton might have been in the area directly under the drilling floor picking up tools or looking for leaks in the substructure area and would have responsibility for this work. There were no witnesses to the actual accident itself.

A pipe wrench was found in the cellar and co-workers indicated they were not sure why it would be there. Colton may have been carrying the wrench when he fell. The wrench and hardhat had been removed from the accident area prior to our investigation. There was no evidence Colton was using any form of fall protection at the time of the accident.

The first hint that something might be wrong came just before 9:00 pm while James Cook, Floor Hand for rig 455, was looking around the substructure for the winter V-doors he had been tasked to install on the drilling floor. James saw Colton lying in the cellar, called to him several times to see what he was doing in the cellar, but got no response. James realized something was wrong and went to the drilling floor to notify the crew that Colton may have injured himself.

Stan Cook, Driller for rig 455, and Jason Carsten, Gyrodata trainee, and a former emergency medical technician, were the first to enter the cellar and provide initial first aid to Colton. King Brown called 911 as soon as the crew determined Colton was in need of medical attention.



View of cellar as you walk by at ground level in the substructure of rig 455 while facing southeast.

According to the report provided by the Sublette County Rural Health Care Board, emergency services received notification of the accident and request for assistance at 9:28 pm on February 14, 2006. They arrived on scene and started attending to Colton by 10:03 pm, and had transported him to the initial treatment facility, Pinedale Clinic in Pinedale, WY, by 11:14 pm on February 14, 2006. Colton was then taken to the Pinedale airport for transport by life flight to the University of Utah Hospital. Colton was pronounced dead at 2:50 pm on February 15, 2006.

Investigators found first aid materials and emergency response actions taken by Patterson-UTI Drilling Co. to be appropriate.

According to the Sublette County Sheriff's Deputy Report, Sgt Koessel and Deputy Sparks were dispatched to the accident site a 9:28 pm, February 14, 2006. The Ambulance crew was on site when they arrived. After Colton was removed from the cellar and en route to Pinedale, WY, Deputy Sparks and Sgt Koessel interviewed the rig crew and took photos of the accident site. The information gathered and documented in their report is consistent with the information WWS Investigators gathered during their investigation.

Findings

During the investigation, Investigators determined through conversations with co-workers and documents gathered that:

- Colton Bryant, deceased, was twenty-five years old.
- Colton was hired by Patterson-UTI Drilling Co. initially in October 2003, and worked for the company for almost two years as a Floor Hand.
- Colton received the company's New-Short Service Employee Orientation.
- Colton acknowledged receiving the Company's Employee Handbook.
- Colton acknowledged he understood the Company's policy on 100% tie off when working at heights 6 feet above a working surface.
- The safety related documents provided by Patterson-UTI Drilling Co. appear to be general in nature and did not specifically address fall hazards associated with the sub floor area of the rig under the drilling floor.
- There was no indication the fall hazards associated with the floor sub area of the drilling rig were addressed in the JSA/Safety meeting held while Colton was present and only briefly mentioned the requirement to be 100% tied off when working at heights above 6 feet.
- Colton quit working for the company to look for a different job in August 2005.
- Colton was rehired by Patterson-UTI Drilling Co. in November 2005, as a Floor Hand to work on rig 455.
- Colton completed the Company's Handbook Orientation, Rig Pass course, and Short Service Employee orientation, and tests were administered and certified by Floyd King.
- Colton acknowledged receiving the Company's Employee Handbook once more.
- Colton was reassigned to work as a Motor Hand for rig #455 in December 2005.
- Colton's source of training to be a Motor Hand is unknown.
- Colton signed JSA/Safety meeting records indicating he was present for 23 of the meetings where fall protection and/or rig safety issues were addressed.
- No JSA/Safety meeting records were provided for the day of the accident.
- The safety railing available in the area associated with the grated walking surface/catwalk directly under the drilling floor is not adequate. The grated walking surface leading up to the catwalk has no railing.
- Safety railings do not completely enclose the catwalk around the conductor pipe/mouse hole pipe.
- The Company demonstrated fall protection methods expected to be used under the drilling floor were seen as not practical methods of fall protection for an individual who was just going to walk through the area, looking for tools or leaks.
- Full body harnesses and double lanyards were readily available for use on the drilling floor, but were not being used at the time of the accident.
- Co-workers stated fall protection requirements in the area under the drilling floor were considered a grey area and were not very clear on what the requirements were for the area.
- Co-workers admitted to not always wearing fall protection while working in the floor sub area and had observed Colton not wearing fall protection while in the area in the past.
- Colton was considered by his coworkers to a very good worker but clumsy.
- Weather reports indicated cold conditions with mild winds.

- Colton appeared to be acting as he normally did and had conversed with co-workers as usual.
- Colton had entered the grated sub floor area prior to the accident to run a power source for the directional measurement equipment. No one witnessed Colton accomplish the task.
- The crew had some difficulty finding some tools during the directional drilling measurement setup process.
- The drilling crew made a new connection after the directional survey measurements were completed and starting drilling again.
- The depth of the well at the time of the accident was 324 feet.
- The drilling crew dispersed to accomplish various tasks while waiting to make the next connection.
- It appears Colton was walking on the unguarded area associated with the catwalk next to the conductor pipe and fell through the opening between the conductor pipe and the mouse hole pipe, and ended up at the bottom of the well's cellar.
- A crewmember was in the process of looking for winter v-doors he intended to install on the drilling floor when he noticed Colton lying in the well's cellar unresponsive.
- The well owner's representative, King Brown, called 911 for help.
- A subcontractor with previous EMT experience assisted with primary first aid care while waiting for EMS to arrive.
- EMS arrived within 35 minutes of being notified.
- EMS transported Colton to the Pinedale Clinic and then to the Pinedale airport for transport by life flight to the University of Utah Hospital for further treatment.
- Colton Bryant was pronounced dead at 2:50 pm on February 15, 2006.
- Information gathered by the Sheriff's Department is consistent with the information gathered by WWS Investigators.
- First aid materials and emergency actions taken were appropriately taken by Patterson-UTI personnel on site at the time of the accident.

Analysis & Conclusions

Several factors led up to this fatal accident:

First, Colton was not wearing any form of fall protection at the time of the accident. The prescribed method of fall protection demonstrated by the Tool Pusher was not all that practical in terms of time spent making sure you were tied off 100% of the time. This would be especially true for a person who's only objective was to pass through the area looking for tools or leaks. The major problem was that you could not actually move any great distance before you would have to reposition the tie off point. Employees interviewed indicated they had been in the accident area without using fall protection and had seen Colton in the area not using fall protection in the past.

Second, the substructure grated walkway/catwalk surfaces located under the drilling floor have inadequate to no safety railing system in some areas. The railing system did not completely enclose the walking surfaces associated with the catwalk constructed around the conductor pipe and mouse hole which creates a fall hazard for anyone not using a tie off method while in the area. There was also no safety railing on the inside of the grated walkway leading to the catwalk.

Third, the combination of safety railing and the use of personal fall arrest systems made workers confused about what method of fall protection was needed while they working in the accident area. With the exception of the Tool Pusher, employees interviewed felt there were grey areas when it came to fall protection requirements in the area associated with the grated walkway/catwalk area under the drilling floor. There was no specific training documentation provided relating to fall protection issues for the substructure area.

Colton did not communicate his intentions to any co-workers. It is likely that Colton was aware of the problem the crew had with not being able to find a tool needed during the directional drilling survey measurements and decided he would go around and pick up tools he knew needed to be picked up. For whatever reason, Colton decided not to wear fall protection. Perhaps he felt it was impractical when he was just making a quick trip into the area and did not intend to stay in the area. The lack of proper safety railings and the lack of personal fall protection resulted in Colton falling some 26 feet into the well's cellar. The fall inflicted fatal head injuries. Based on the Coroner's information, Colton had fatal injuries to the front left side of his head. These injuries are consistent with objects he most likely would have the chance to come in contact with as he was falling into the well's cellar.

Colton was considered a qualified person to be in the area but would not have been expected to be in the area directly under the drilling floor while drilling was taking place. The area could be checked for leaks from the motor room or the substructure's ground level. So it is possible Colton knew of the wrench lying on the grated walkway and went to retrieve it on his own.

Evidence suggests Patterson-UTI Drilling Co. was aware of and understood the proper methods to be used to protect employees from fall hazards but was not enforcing the Wyoming OSHA rules or ensuring proper safety railings were installed in the substructure areas as well as other areas of drilling rig 455.

In summary, the investigation revealed that this accident was the result of several conditions. The deceased apparently had insufficient understanding of the danger associated with what he was doing and misjudged his ability to remain safe. The employer was not enforcing fall protection requirements and had not ensured the rig was properly fitted with safety railing systems that would keep a person safe from falls while walking on and working in the rig's substructure area. The level of training provided by the employer relating specifically to the substructure fall hazards is lacking. The fall protection method that the employer said was to be used when working in the substructure area of the rig was not very practical. Together, these conditions culminated in a fatal accident.

Recommendations

- Brief all employees on the facts and circumstances of this fatal mishap.
- Ensure all employees understand the Wyoming OSHA Oil and Gas fall protection rules.
- Enforce the Wyoming OSHA Oil and Gas fall protection rules and document all non-compliance.
- Document all training accomplished relating to fall protection.
- Re-evaluate the fall hazards under the rig's drilling floor and substructure area.

- Provide specific training on each fall hazard area of the rig rather than generalizing the requirement for fall protection.
- Post signs to identify areas where body harnesses and lanyards are required to be used.
- Implement a more practical method of fall protection for the substructure area.
- Some employees suggested a net system might be installed in the substructure area of the drilling rig.

This report, together with its incorporated findings and resultant items for correction, relate specifically to this particular incident. It is noted that "Recommendations" may not include all existing hazards. The employer and employees continue to have the responsibility for inspection and investigation to assure compliance with safe operating practices as outlined in the applicable rules and regulations.

Kenneth H. Masters

Kenneth H. Masters, Investigator

8-7-2006

Date

THE STATE OF WYOMING

DAVE FREUDENTHAL
GOVERNOR

DEPARTMENT OF EMPLOYMENT
WORKERS' SAFETY - OSHA
Cheyenne Business Center,1510 East Pershing Blvd., Cheyenne WY 82002
(307) 777-7786 Fax: (307) 777-3646

Date: October 27, 2006

Subject: Fatality Report
Colton Bryant
Patterson - UTI Drilling Company

We have recently discovered a typographical error on page # 8 of our report. The time in the first sentence on page # 8 should be 9:28 pm instead of 9:00 pm. The first sentence should read "The first hint that something might be wrong came just before 9:28 pm while James Cook, Floor Hand for Rig 455, was looking around the substructure for the winter V-doors he had been asked to install on the drilling floor".

In order to correct this error, change the time in the first sentence on page # 8 of the report we sent you from 9:00 pm to 9:28 pm.

In addition, we want to clarify our findings on the time the accident occurred. We were not able to determine exactly when Mr. Bryant fell into the cellar of the drilling rig. We know that the last time he was seen before the accident was approximately 9:00 pm on February 14, 2006. We also know that the call to emergency services was received at 9:28 pm on February 14, 2006. Furthermore, we know that the call to emergency services was made in a timely manner after Mr. Bryant was discovered to be in the cellar. Therefore, the accident must have occurred after approximately 9:00 pm and shortly before 9:28 pm on February 14, 2006. Based on employee interviews and other evidence, this was the closest time frame we could determine.

Please attach this sheet to the report we sent you. If you made any copies, please ensure that each copy has this sheet attached as well.

Johnnie Hall

Johnnie A. Hall Jr.
Compliance Supervisor
Workers' Safety