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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **06-NOV-2004** TIME: **0800** HOURS

2. OPERATOR: **ATP Oil & Gas Corporation**
   REPRESENTATIVE: **Greg Roland**
   TELEPHONE: **(713) 403-7007**
   CONTRACTOR: **Wood Group Production Services**
   REPRESENTATIVE: **Troy Gaspard**
   TELEPHONE: **(337) 370-9675**

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

4. LEASE: **G02833**
   AREA: **WC** LATITUDE:
   BLOCK: **237** LONGITUDE:

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

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

7. TYPE:
- [X] 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
- [ ] 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.
- [ ] OTHER

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

9. WATER DEPTH: **70** FT.

10. DISTANCE FROM SHORE: **43** MI.

11. WIND DIRECTION: **SE**
    SPEED: **10** M.P.H.

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

13. SEA STATE: **3** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

The lead operator was instructed by the production foreman to proceed to WC-237-A and offload wireline equipment. The lead operator stated that when stepped on well A-6 hatch cover it gave way and Mr. Nichols and the hatch cover fell to the deck below. The lead operator also stated that it was the first time they had ever been on the platform. Although there was no JSA filled out, the lead operator mentioned that safety issues related to the scope of the job were discussed.

The TODCO-152 departed the platform in August 2004 after working on three different wells. While the rig was on location it conducted a sidetrack operation on well A-6. Our investigation of the A-6 well access opening revealed that the structural beams which support the access hatch cover were cut. Other large openings in the deck were discovered while conducting our inspection of the facility. Our investigation also revealed that A construction crew was on location approximately 10 days prior to the date of the incident, running a new pipeline riser and flowline for a new incoming well (WC-237#5).

The hatch cover was picked up from the deck below in order to find out the possible position the hatch cover may have been in prior to the accident. The first way we tried it, the opening was to large allowing the cover to fall straight through the opening and when the hatch cover was turned it allowed approximately 1/4" to 1/2" of the angle iron frame to set on the edge of the opening. With the beams being cut it allowed the hatch cover to move freely inside the opening.

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

1. The structural beams being cut and not returned to their original design.
2. The hatch cover not being secured in place.
3. Lack of on site supervision.
4. Lack of hazard recognition training.
4. Lack of structural hazard analysis upon completion of the well work.

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

The lack of communication between the rig personnel and ATP with regards to cutting the beams as well as the absence of an on site ATP supervisor possibly contributed to the accident. The contract operators not being familiar with the sequence of events which have taken place on this platform and the personnel not recognizing the hazard of placing the unsecured hatch cover back in place contributed to the accident.

21. PROPERTY DAMAGED:

none

NATURE OF DAMAGE:

none

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The District recommends a safety alert be issued to include rig personnel communicating clearly with the operator when structural modifications have been done to the production facility. The lessee should review their companies safe practices and procedures for documenting and proper notification process when structural modifications are done and remind all parties of the importance of the Management of Change process. Upon completion of all construction activities the lessee should conduct an evaluation of the site in order to identify any hazards.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

The structural beams which support the well A-6 access hatch cover were cut and not returned to their original design causing injury to personnel.

25. DATE OF ONSITE INVESTIGATION:

08-NOV-2004

26. ONSITE TEAM MEMBERS:

Scott Mouton / Ricky Deville /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Pausina

APPROVED

DATE: **03-DEC-2004**