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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **25-JAN-2009** TIME: **1125** HOURS

2. OPERATOR: **Apache Corporation**
   REPRESENTATIVE: **Wetzel, Gary**
   TELEPHONE: **(337) 354-8130**
   CONTRACTOR: **ISLAND OPERATORS CO. INC.**
   REPRESENTATIVE: **Eskine, Richey**
   TELEPHONE: **(337) 201-1856**

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

4. LEASE: **00767**
   AREA: **EC** LATITUDE:
   BLOCK: **47** LONGITUDE:

5. PLATFORM: **JP**
   RIG NAME:

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

7. TYPE:
- [ ] HISTORIC INJURY
- [X] REQUIRED EVACUATION **1**
- [ ] 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
- [ ] OTHER

6. OPERATION:
- [X] PRODUCTION
- [ ] 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: **48** FT.

10. DISTANCE FROM SHORE: **20** 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 January 25, 2009, a Field Mechanic (FM) performed a routine quarterly inspection on the platform diesel generator, and then started the unit to check for leaks. Subsequent to the FM's visual inspection of the unit, lube oil was discovered on the radiator shroud. In an effort to clean the oil, the mechanic utilized a rag to wipe the radiator shroud without shutting down the unit. The platform generator is housed inside an enclosure and the radiator shroud is factory designed such that the fan blades are not completely concealed. Due to the amount of air flow created by the fan, the rag came in contact with the fan blades and pulled the FM's hand into the fan blades. The FM was evacuated from the platform and required nine stitches on his left hand. There was no other mechanical damage or pollution resulting from the accident.

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

The combination of the factory designed radiator fan shroud (fan blades not concealed) and the FM not shutting down the unit before attempting to clean the radiator shroud, allowed the rag to come in contact with the fan blades and pull the FM's hand into the fan blades.

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

Human error by the FM as a result of the following:
1. Poor judgment
2. Failure to shutdown the generator
3. Failure to recognize the hazard involved in the task

20. LIST THE ADDITIONAL INFORMATION:

The FM worked three (3) years as a Mechanic's Helper before being promoted to FM approximately three (3) months prior to the accident.

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Since mechanical motion equipment injuries have become a recurrent theme during MMS accident investigations, the MMS Lake Charles District recommends that the MMS Regional Office of Safety Management (OSM) issue a Safety Alert to heighten industry's personnel awareness of the hazards involved with working in close proximity of mechanical motion type equipment. The MMS recommends the Safety Alert address the following concepts and safeguarding techniques:

1. The types of hazardous mechanical motions including rotating, reciprocating, transverse motion, cutting action, punching, shearing, bending and pinch points.
2. Hazards Analysis for evaluating work activities for potential hazards.
3. Safeguarding techniques to include guards, safeguarding devices, awareness devices, administrative controls, Lockout/Tagout (LOTO), and training.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

11-FEB-2009

26. ONSITE TEAM MEMBERS:

Scott Mouton / Bill Olive / Carl Matte /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Williamson

APPROVED

DATE: **09-MAR-2009**

INJURY/FATALITY/WITNESS ATTACHMENT

☐ OPERATOR REPRESENTATIVE	☒ INJURY
☐ CONTRACTOR REPRESENTATIVE	☐ FATALITY
☒ OTHER **Contract Mechanic**	☐ WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE: