

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED

DATE: 19-AUG-2012 TIME: 1300 HOURS

2. OPERATOR: ANKOR Energy LLC

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR:

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING DEVICE
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER

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

6. OPERATION:

4. LEASE: 00577

AREA: EI LATITUDE:

BLOCK: 208 LONGITUDE:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

5. PLATFORM: E

RIG NAME:

7. ACTIVITY: EXPLORATION (POE)
 DEVELOPMENT/PRODUCTION
(DOCD/POD)

8. CAUSE:

7. TYPE:

- HISTORIC INJURY
- REQUIRED EVACUATION 1
- LTA (1-3 days)
- LTA (>3 days) 1
- RW/JT (1-3 days)
- RW/JT (>3 days)
- Other Injury

- EQUIPMENT FAILURE
- HUMAN ERROR
- EXTERNAL DAMAGE
- SLIP/TRIP/FALL
- WEATHER RELATED
- LEAK
- UPSET H2O TREATING
- OVERBOARD DRILLING FLUID
- OTHER

- FATALITY
- POLLUTION
- FIRE
- EXPLOSION

- LWC HISTORIC BLOWOUT
- UNDERGROUND
 - SURFACE
 - DEVERTER
 - SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION HISTORIC >\$25K <=\$25K

9. WATER DEPTH: 90 FT.
10. DISTANCE FROM SHORE: 60 MI.
11. WIND DIRECTION: N
SPEED: 25 M.P.H.
12. CURRENT DIRECTION:
SPEED: M.P.H.
13. SEA STATE: FT.

17. INVESTIGATION FINDINGS: -

On 19 August 2012, a Contract Production Operator (CPO) was performing routine operations. A safety meeting and JSA had been performed at 0600 for routine production operations on the facility that day. At approximately 1300 hours, as a squall line was moving through the area, a process alarm sounded. The CPO proceeded from the production office to the production safety system panel on the top deck. There he silenced the horn and saw the air compressor on the second deck had shut in. He was proceeding from the top deck to the stairwell heading to the second deck to check the air compressor, when a second alarm sounded. He turned around and returned to the production safety system panel on the top deck and silenced the alarm due to the #2 Gas Compressor shutting in. He then left the production safety system panel towards the stairwell near the Oil Surge Tank on the top deck with his head looking down towards the deck due to the inclement weather (rain and 20-25MPH winds), at which time he contacted the clean out assembly (nipple and isolation valve) at the bottom of the K-Tec control sight gauge level assembly injuring his left collar bone. The CPO stopped work at this time and proceeded to the Production Office to inform the Person in Charge (PIC) about the incident. At this time the PIC administered first aid. The PIC checked the CPO for swelling and noted that there was no bleeding around that area. The PIC administered an ice pack for swelling and applied a splint to the CPO left arm to provide him with support of his left arm. Due to the inclement weather the remainder of that day transportation was not available to the CPO until the next day. At 1000 A.M. 20 August 2012 he was transported to Ankor's Patterson base by PHI Helicopter. There he was met by an OCS Representative and taken to Morgan City Regional Hospital where he was checked by the attending physician. The CPO was found to have a broken collar bone on his left side.

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

At the time of the incident, the CPO was walking away from the Production Safety System Panel, he moved towards the stairwell going to the second deck. He was leaning forward with his head looking down towards the deck when he impacted the clean out assembly (nipple and isolation valve) at the bottom of the K-Tec control sight gauge level assembly on the Dry Oil Surge Tank.

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

Due to the inclement weather (rain and 20-25MPH winds), these issues had an adverse effect with regards to personnel and personnel response on the Production Platform at the time.

20. LIST THE ADDITIONAL INFORMATION:

*The PIC took a proactive approach and had the production personnel remove the clean out assembly and put a shorter elbow in the opposite direction towards the oil surge tank. This removes about 9.5 inches of piping extension out of the walkway path.

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL): \$

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The BSEE Lafayette District office makes no recommendation to the Regional Office of Safety Management (OSM).

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

23-AUG-2012

26. ONSITE TEAM MEMBERS:

Gerald Gonzales / Raymond Johnson /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED

DATE: 06-SEP-2012

INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

- INJURY

- CONTRACTOR REPRESENTATIVE

FATALITY

OTHER _____

WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

INJURY/FATALITY/WITNESS ATTACHMENT

BUSINESS ADDRESS :

CITY :

STATE :

ZIP CODE :