## 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: 07-OCT-2013 TIME: 1030 HOURS	STRUCTURAL DAMAGE CRANE
2.	OPERATOR: Apache Corporation REPRESENTATIVE: TELEPHONE: CONTRACTOR: Blake Drilling and Workover Com- REPRESENTATIVE: TELEPHONE:	OTHER LIFTING DEVICE  DAMAGED/DISABLED SAFETY SYS.  INCIDENT >\$25K  H2S/15MIN./20PPM
3.	OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:	6. OPERATION:
4.	LEASE:  AREA: HI LATITUDE:  BLOCK: A 596 LONGITUDE:-	PRODUCTION  X DRILLING  WORKOVER  COMPLETION  HELICOPTER  MOTOR VESSEL
5.	PLATFORM: - E RIG NAME: BLAKE 1505	PIPELINE SEGMENT NO. OTHER
<b>6</b> .	ACTIVITY:	8. CAUSE:
7.	DEVELOPMENT/PRODUCTION (DOCD/POD)  TYPE:  HISTORIC INJURY-  X REQUIRED EVACUATION 1-  LTA (1-3 days)  LTA (>3 days  RW/JT (1-3 days)	EQUIPMENT FAILURE HUMAN ERROR EXTERNAL DAMAGE - SLIP/TRIP/FALL - WEATHER RELATED LEAK UPSET H20 TREATING OVERBOARD DRILLING FLUID OTHER
	X RW/JT (>3 days) 1- Other Injury-	
	☐ FATALITY	9. WATER DEPTH: 348 FT.
	POLLUTION FIRE EXPLOSION	10. DISTANCE FROM SHORE: 106 MI.
	LWC - HISTORIC BLOWOUT UNDERGROUND	11. WIND DIRECTION: -  SPEED: M.P.H.
	SURFACE DEVERTER SURFACE EQUIPMENT FAILURE OR PROCEDURES	12. CURRENT DIRECTION: SPEED: M.P.H.
	COLLISION THISTORIC T>\$25K T <=\$25K	12 CDA CDADD

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## 17. INVESTIGATION FINDINGS: -

While rigging down casing equipment on rig floor, the elevators were unbolted from the bails. A Frank's Casing Floor Man placed his right hand on the screen carrier that was attached to one of the bails. As the block was being raised, the Frank's Casing Floor Man's right middle finger was caught between the screen carrier and top drive torque tube. Injured Person (IP) was transported to shore for evaluation and treatment.

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- 18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:
  - IP was involved in task and was told by supervisor to only observe. -
  - IP placed his hand on screen carrier. -
  - As block was being raised, IP continued to hold onto screen carrier which struck top drive torque tube.
- 19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

Stop work authority was not utilized by casing crew or rig floor personnel after repeated warnings to the IP for improper hand placement during casing operations. Company representitive and rig crew were unaware that IP was short service employee. Driller was unaware of position of IP.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Jackson District does not any recommendations to the regional office for this event.

- 23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES
- 24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 (S) At the time of the investigation, lessee failed to perform all operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment in the following ways:

Stop Work Authority was not utilized by casing crew or rig floor personnel after repeated warnings to the Injured Person (IP) for improper hand placement during casing operations.

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While casing crew and rig crew were rigging down after running casing, Stop Work Authority was not utilized when all personnel could not be accounted for prior to slacking off on the block and again while coming up with the block. IP was not identified as a Short Service Employee (SSE) as required by the Job Safety Analysis (JSA) during the casing job.

25. DATE OF ONSITE INVESTIGATION:

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08-OCT-2013

26. ONSITE TEAM MEMBERS:

John Orsini / James Holmes /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

John McCarroll

APPROVED

APPROVED DATE: 16-SEP-2014

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