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: **11-APR-2013** TIME: **1930** HOURS

2. OPERATOR: **Apache Corporation**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G03733**
   AREA: **MI** LATITUDE:
   BLOCK: **703** LONGITUDE:

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

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

7. TYPE:
   - [ ] HISTORIC INJURY
     - [x] REQUIRED EVACUATION 1
     - [ ] LTA (1-3 days)
     - [ ] LTA (>3 days
     - [ ] RW/JT (1-3 days)
     - [x] RW/JT (>3 days) 1
     - [ ] Other Injury
   - [ ] FATALITY
   - [ ] POLLUTION
   - [ ] FIRE
   - [ ] EXPLOSION
   - LWC
     - [ ] HISTORIC BLOWOUT
     - [ ] UNDERGROUND
     - [ ] SURFACE
     - [ ] DEVERTER
     - [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES
   - COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K
   - [ ] STRUCTURAL DAMAGE
   - [x] CRANE
   - [ ] OTHER LIFTING DEVICE
   - [ ] DAMAGED/DISABLED SAFETY SYS.
   - [ ] INCIDENT >$25K
   - [ ] H2S/15MIN./20PPM
   - [ ] REQUIRED MUSTER
   - [ ] SHUTDOWN FROM GAS RELEASE
   - [ ] OTHER

6. OPERATION:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [x] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] OTHER

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

9. WATER DEPTH: **128** FT.

10. DISTANCE FROM SHORE: **25** MI.

11. WIND DIRECTION:
    SPEED: M.P.H.

12. CURRENT DIRECTION:
    SPEED: M.P.H.

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS:

While attempting to remove D-ring on four part sling load from crane hook after load was landed on deck, rigger on top of Marine Portable Transfer (MPT)tank was having trouble getting the D-ring unhooked. Coiled Tubing Unit (CTU) Supervisor was assisting by pushing up on slings. Rigger on top of MPT tank got the D-ring unhooked and dropped the D-ring over the side of tank. The D-ring caught the right index finger of the supervisor on deck between the side of tank and the D-ring. Supervisor initially stated that he was wearing the company required high-visibility impact gloves but later into the investigation changed testimony to say that he was not wearing any gloves at the time of the incident.

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

Crane Operator did not lower the D-ring low enough for the Riggers to unhook from main-deck.-
It was found that Crane Operator had not been involved in the Job Safety Analysis prior to the job.-
No Stop Work Authority was exercised when crew knew Crane Operator had not been involved in the Job Safety Analysis review.-
After the incident Company Representative did not exercise Stop Work Authority.-
No communication between rigging crew.-
CTU supervisor was not wearing the proper Personal Protective Equipment at the time of-incident.-

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

Rigger was not aware that supervisor was below him.-
Poor communication between supervisor and other crew-
Crane Operator not involved in Job Safety Analysis.-
Lack of supervision from Company Representative.-

20. LIST THE ADDITIONAL INFORMATION:

Injured person manufactured gloves to appear that he had been wearing them and then lied to investigators about the facts.-

21. PROPERTY DAMAGED: NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Onsite supervisors should conduct proper Job Safety Analysis prior to any operations.
All personnel on board facilities should feel comfortable enough to use Stop Work

Authority
Better communication between personnel while performing job tasks if any of the personnel involved in a task are unclear about the task, Stop Work Authority should be utilized.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 Onsite supervisors failed to conduct a proper lessee Job Safety Analysis prior to lifting operations at time of injury.
Onsite supervisors failed to conduct a proper third party contractor Job Safety Analysis prior to the lifting operations at time of injury.
All personnel involved with the night operations did not conduct a safety stand down after injury incident occurred.
G-132 Statements and pictures were falsely and inaccurately submitted to BSEE during the start of accident investigation

25. DATE OF ONSITE INVESTIGATION:

22-APR-2013

26. ONSITE TEAM MEMBERS:

Marco Deleon / Phillip Couvillion /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

John McCarroll

APPROVED DATE: **26-NOV-2013**