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: **25-FEB-2014** TIME: **1500** HOURS

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

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

4. LEASE: **G02587**
   AREA: **SM** LATITUDE:
   BLOCK: **128** LONGITUDE:

5. PLATFORM: **A-PRD**
   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
- [ ] HUMAN ERROR
- [ ] EXTERNAL DAMAGE
- [X] SLIP/TRIP/FALL
- [ ] WEATHER RELATED
- [ ] LEAK
- [ ] UPSET H2O TREATING
- [ ] OVERBOARD DRILLING FLUID
- [ ] OTHER

9. WATER DEPTH: **216** FT.

10. DISTANCE FROM SHORE: **74** MI.

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

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

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS: -

On February 25, 2014 at approximately 1500 hours, a Contract Employee (CE) fell approximately 90 feet into the Gulf of Mexico from the rear of a crane he was previously operating.

The CE had previously repositioned a grocery box to the second deck of the quarters. As he departed from the controls, he walked to the rear deck of the crane to clean a small amount of oil in the skid. The CE utilized absorbent pads to wipe the skid and placed the bag on the grating. The CE stated he stooped down on a beam next to the skid to access the oil in the skid. It was very humid with foggy conditions at the time of the incident. This created slippery surfaces throughout the structure including the beams.

As the CE attempted to stand up, he lost his footing causing him to fall. As he was falling, he stated that his head came in contact with the hand rail next to the skid knocking his hardhat into the Gulf of Mexico. He then came in contact with the safety chain that barricaded the opening to the ladder. As the CE fell, the safety chain struck the CE between his ribs and under his arm on his left side.

The safety chain had a safety latch that connected to a stainless steel u-bolt. As the CE came in contact with the chain, the u-bolt broke causing the CE to fall 90 feet to the Gulf of Mexico. The crane is located on the East side of the platform. Due to the water current, the CE was taken to the North side of the facility. It is unknown if the CE went under the facility or was able to swim around but was able to grab an emergency escape rope located on the North side of the structure.

An employee unloading the grocery box noticed the CE was no longer located on the crane. The employee attempted to page the CE twice before starting to search. As the employee began searching near the crane, he looked over the side of the structure and observed the CE's hardhat floating in the water. The employee activated the man-overboard alarm alerting all employees on the platform to begin to search. A few minutes later, the CE was spotted hanging on to the escape rope located on the north side of the facility. The field boat was contacted immediately to retrieve the CE.

The CE was transported to Lake Charles Memorial Hospital due to his injuries. The CE suffered a severe cut to his forehead, a broken nose and a broken tailbone. He was then transported to St. Patrick's Hospital and placed in ICU.

During the investigation, it was noted that the CE had a large amount of wear on the bottom of his boots. This could have been a factor in the CE losing his footing. The CE was unclear on what caused him to lose his footing.

The BSEE Lafayette District conducted an onsite investigation 2/27/2014.

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

The slippery conditions of the facility due to the weather could have been a factor in the CE losing his footing. Also, the CE placing the absorbent pads in the walkway could have also created a tripping hazard.

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

The CE could have lost his footing due to the amount of wear on the bottom of the CE's boot. The CE should have inspected his boots and requested a new pair through his company prior to the boots becoming a slip hazard.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

None

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

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

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

None

25. DATE OF ONSITE INVESTIGATION:

27-FEB-2014

26. ONSITE TEAM MEMBERS:

Raymond Johnson / Wade Guillotte /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Elliott S. Smith

APPROVED DATE: **23-APR-2014**