

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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **13-OCT-2012** TIME: **1200** HOURS

2. OPERATOR: **Apache Corporation**

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 **Burn Injury**

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

6. OPERATION:

4. LEASE: **00082**

AREA: **WC** LATITUDE:

BLOCK: **111** LONGITUDE:

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

5. PLATFORM: **F**

RIG NAME:

6. 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

9. WATER DEPTH: **36** FT.
10. DISTANCE FROM SHORE: **18** MI.
11. WIND DIRECTION: **SE**
SPEED: **7** M.P.H.
12. CURRENT DIRECTION:
SPEED: M.P.H.
13. SEA STATE: FT.

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

17. INVESTIGATION FINDINGS:

On October 13, 2012, during normal operations, a flash fire occurred at approximately 1200hrs which resulted in a third party contractor receiving second degree burns on his face, neck, and ears as well as third degree burns on his hands. On the day of the incident, an operator and a third party contractor attended the morning safety meeting at 0600hrs on the main structure. After the meeting they gathered tools and equipment to fly over to an unmanned satellite platform. They were going to perform maintenance on the fog horn which entailed swapping out a set of batteries and troubleshooting the Navigational (NAV) Aids to verify the proper light sequence. Once ready they waited for helicopter transportation which picked them up ~0800hrs. They arrived on location and started swapping out the batteries. At around 1130hrs, they finished their work scope and radioed for helicopter transportation to pick them up. Around 1200hrs, while waiting for the helicopter, the third party contractor opened the master panel door. Upon opening the door a flash fire occurred causing him to receive burns on his face, neck, ears, and hands. At this time, ~1205hrs, the operator called the main structure stating the emergency and requested for the field medic to be dispatched. The helicopter was then routed to pick up the medic and head to the satellite platform. They arrived on location ~1230hrs, picked up the injured party (IP) and flew him straight to the nearest hospital on the beach.

On October 14, 2012, the BSEE Lake Charles District began an accident investigation which included an onsite visitation. Pictures were taken as well as statements gathered from all parties involved. Based on the witness statements it was discovered that ~0930hrs the operator and IP had taken a break. During this break one worker stated he had smoked a cigarette near the crane area on the structure and the other stated he had smoked a cigarette on the heliport. Neither one of these two areas is approved for smoking as per the company's written Smoking Policy. The IP indicated that once the work scope was completed, while waiting on helicopter transportation, he heard a leak inside the master panel. The operator stated this was brought to his attention from a distance as he was in the process of carrying the old batteries up to the heliport to be transported back to the main platform. Neither stop work authority nor a JSA was initiated to evaluate hazards/risks associated with natural gas leaking within the panel. Although the IP was brought out as a third party contractor and his only purpose was to perform maintenance on the fog horn and the NAV Aids, he ignored the fact. The IP stated he went to the panel, opened the door to investigate the leak, upon opening a flash fire immediately transpired, and he then shut the door. This caused him to react by the stop drop and roll method in order to self-extinguish himself. Shortly thereafter he stated he heard and saw the panel doors suck inward. He was then flown in to a medical facility for treatment. The on scene investigation did reveal damage to both the front and rear panel doors which at the time seemed to have imploded. Upon further investigation it was found that on the day of the incident the Field Foreman, Sr. Lead Operator, third party Pneumatic Technician, and the original Operator went to the satellite platform to investigate the accident. At this time, it was noted that a green disposable lighter and a charred cigarette matching the IP's brand were found in the area where he had executed the stop drop and roll. All the evidence was collected and brought back to the main structure which was presented during the BSEE investigation as well as the IP's pack of cigarettes gathered by the on scene medic. On October 16, 2012, the IP's company representative asked whether he had smoked on the platform and reported that the IP responded that he had smoked earlier in the day, and in fact could have been smoking at the time he accessed the panel. It was later discovered that an O-ring on a Haskell pump supply regulator had failed causing a gas leak within the panel enclosure which provided an adequate fuel source and was most likely ignited by a lit cigarette upon opening the panel door.

\$1,920

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

Smoking in a classified area with gas present

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

Human error by all parties involved which included the following:

1. Failure to perform a thorough JSA and identify all the potential hazards associated with a gas leak inside the master panel
2. Failure to stop the job when identifying abnormal platform conditions and mitigate risks involved before continuing to troubleshoot
3. Third party maintenance contractor performing operator duties outside his job scope

20. LIST THE ADDITIONAL INFORMATION:

Apache Gulf of Mexico Shelf Region Safe Work Practices

Smoking Policy

Smoking is only allowed in approved, safe, designated area on platforms or rigs. (Refer to the platform area classification drawing for determining safe smoking area on specific platforms. The Person in Charge (PIC) must approve designated smoking area.)

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21. PROPERTY DAMAGED:

Master Panel Doors
Fisher Regulator

NATURE OF DAMAGE:

Doors imploded
fire melted regulator components

22. ~~RECOMMENDATIONS TO PREVENT RECURRENCE~~ RECCURANCE NARRATIVE:

The Lake Charles District has no recommendations for the Agency.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 Operator failed to perform operations in a safe and workmanlike manner to provide for the safety of personnel.

* Apache's failure to ensure that their policies and safe work practices were followed

25. DATE OF ONSITE INVESTIGATION:

14-OCT-2012

26. ONSITE TEAM MEMBERS:

Rick Smith / Chad Chaffin / Wayne
Webster / Cody Leblanc / Darron
Miller /

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Williamson

APPROVED

DATE: **07-JAN-2013**

FIRE/EXPLOSION ATTACHMENT

1. SOURCE OF IGNITION: **Most likely a lit cigarette**

2. TYPE OF FUEL: GAS
 OIL
 DIESEL
 CONDENSATE
 HYDRAULIC
 OTHER

3. FUEL SOURCE: **Leaking regulator on supply gas to Haskell pump inside master panel**

4. WERE PRECAUTIONS OR ACTIONS TAKEN TO ISOLATE KNOWN SOURCES OF IGNITION PRIOR TO THE ACCIDENT ? **NO**

5. TYPE OF FIREFIGHTING EQUIPMENT UTILIZED: HANDHELD
 WHEELED UNIT
 FIXED CHEMICAL
 FIXED WATER
 NONE
 OTHER

INJURY/FATALITY/WITNESS ATTACHMENT

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER Fire Service Tech

WITNESS

NAME :

HOME ADDRESS :

CITY :

STATE :

WORK PHONE :

TOTAL OFFSHORE EXPERIENCE :

YEARS

EMPLOYED BY :

BUSINESS ADDRESS :

CITY :

STATE :

ZIP CODE :

OPERATOR REPRESENTATIVE

INJURY

CONTRACTOR REPRESENTATIVE

FATALITY

OTHER _____

WITNESS

NAME :

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CITY :

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