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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: 03-JUN-2012 TIME: 1045 HOURS

2. OPERATOR: Apache Corporation
   REPRESENTATIVE: 
   TELEPHONE: 
   CONTRACTOR: ISLAND OPERATORS CO. INC.
   REPRESENTATIVE: 
   TELEPHONE: 

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

4. LEASE: 00071
   AREA: PL LATITUDE: 
   BLOCK: 11 LONGITUDE: 

5. PLATFORM: F
   RIG NAME: 

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

7. TYPE:
   HISTORIC INJURY
   REQUIRED EVACUATION 2
   LTA (1-3 days)
   LTA (>3 days)
   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

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

9. WATER DEPTH: 37 FT.

10. DISTANCE FROM SHORE: 7 MI.

11. WIND DIRECTION: N
    SPEED: 1 M.P.H.

12. CURRENT DIRECTION: N
    SPEED: 1 M.P.H.

13. SEA STATE: 1 FT.

For Public Release

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

MMS - FORM 2010
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EV2010R
12-OCT-2012
Two Island Operating employees were filling a chemical tank (Coastal Chemical 6763 Paraffin Solvent - Flash Point 75 degrees) at PL 11-F (an unmanned platform). They lifted a chemical tote tank by crane from the boat and boomed up to get the tote near the chemical day tank on the platform. They had a hose extended from the tote tank that was suspended in the air by the crane to the tank on the deck. They were gravity feeding the chemical. The shut off valve was on the tote tank that was suspended. As they were filling the tank with one man in the crane and one man on the tote, they received a call from a different boat, saying that their lunches were there. The crane operator, thinking he had more time than he did, shut the crane down and left to go drop a basket down by rope to retrieve the lunches. Once he retrieved the lunches, he got a call, by radio, from the man on the tote saying that he needed him back in the crane because the chemical level was near the top of the tote being filled. Before the crane operator could get back, the chemical began overfilling.

The shut off valve for the manual transfer of the chemical tank was placed out of reach of the operator monitoring the fill operation. Crane operator was not at the crane controls and was unable to lower tank to shut off the valve. The wind direction was blowing into the platform toward the pipeline pumps. The exhaust stack of one of the pipeline pumps was approximately 8 feet away. Once the chemical struck the exhaust, it ignited and the fire spread back to the totes. The man on top of the tote stated that he was knocked off the tote. Once he was on the deck, he said fire was all around him so he ran and jumped off of the platform (approximately 40'). The crane operator who was heading back in the direction of the crane, saw the fire and went down to the boat landing, grabbing a PFD on the way down. He also entered the water but from the boat landing. Both personnel were retrieved within a few minutes. One of the boats pulled the ESD on the boat landing. There were several boats in the area and 3 of them began spraying water onto the fire with their fire monitors and were able to extinguish it. It is believed that the duration of the fire was from 10:30 a.m. to 11:02 a.m.

Both Island employees were flown in and evaluated at Terrebonne General Medical Center in Houma. Both were given a full release.

Inspection of the platform by the engineering department determined that there was no structural damage to the platform. There was heavy damage to some tote tanks (chemical tanks) and surrounding equipment: contact tower, oil transfer pump & engine, with associated piping and insulation and wiring.

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

The shut off valve for the manual transfer of the chemical tank was placed out of reach of the operator monitoring the fill operation. Crane operator was not at the crane controls and was unable to lower tank to shut off the valve.

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

Storage capacity of tote tank #2 being filled could not hold all the liquid that the tote #1 had.

20. LIST THE ADDITIONAL INFORMATION:

n/a
21. PROPERTY DAMAGED: Unknown at this time.

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Operations that are designed to be manual operations should always be manual operations. Equipment should be placed in reach of the person or persons present during the task at hand.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

A Incident of Noncompliance, G-111, was issued as a result of this incident.

25. DATE OF ONSITE INVESTIGATION:

05-JUN-2012

26. ONSITE TEAM MEMBERS:

Douglas Sevin BSEE /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED DATE: 04-OCT-2012
1. SOURCE OF IGNITION: **Pipeline Pump Exhaust**

2. TYPE OF FUEL:  
   - [ ] GAS
   - [ ] OIL
   - [ ] DIESEL
   - [ ] CONDENSATE
   - [ ] HYDRAULIC
   - [x] OTHER **Paraffin Solvent**

3. FUEL SOURCE: **Tote Tank being filled**

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

   - [ ] HANDHELD
   - [ ] WHEELED UNIT
   - [ ] FIXED CHEMICAL
   - [ ] FIXED WATER
   - [ ] NONE
   - [x] OTHER **Firewater monitors on nearby boats**