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
2. OPERATOR: Apache Corporation  
   REPRESENTATIVE:  
   TELEPHONE:  
   CONTRACTOR: Blake Drilling and Workover Com.  
   REPRESENTATIVE:  
   TELEPHONE:  
3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:  
4. LEASE:  
   AREA:  HI  LATITUDE:  
   BLOCK: A 596  LONGITUDE: -  
5. PLATFORM:  E  
   RIG NAME: BLAKE 1505  
6. ACTIVITY:  
   EXPLORATION(POE)
   DEVELOPMENT/PRODUCTION (DOCD/POD)
7. TYPE:  
   HISTORIC INJURY  
   REQUIRED EVACUATION  
   LTA (1-3 days)
   LTA (>3 days)
   RW/JT (1-3 days)
   RW/JT (>3 days)
   Other Injury  
   PATLTLITY
   POLLUTION
   FIRE
   EXPLOSION
8. CAUSE:  
   EQUIPMENT FAILURE
   HUMAN ERROR
   EXTERNAL DAMAGE
   SLIP/TRIP/FALL
   WEATHER RELATED
   LEAK
   UPSET H2O TREATING
   OVERBOARD DRILLING FLUID
   OTHER
9. WATER DEPTH: 348 FT.
10. DISTANCE FROM SHORE: 106 MI.
11. WIND DIRECTION:  
   SPEED: M.P.H.
12. CURRENT DIRECTION:  
   SPEED: M.P.H.
13. SEA STATE: FT.

MMS - FORM 2010  
EV2010R-  
15-MAY-2015-
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.

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 representative 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.
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:
08-OCT-2013

26. ONSITE TEAM MEMBERS:
John Orsini / James Holmes /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

30. DISTRICT SUPERVISOR:
John McCarroll

APPROVED DATE: 16-SEP-2014