**ACCIDENT INVESTIGATION REPORT**

1. OCCURRED
   DATE: 31-JUL-2014  TIME: 1830  HOURS

2. OPERATOR: *Apache Corporation*
   REPRESENTATIVE: -
   TELEPHONE: -
   CONTRACTOR: *Tetra Technologies, Inc.*
   REPRESENTATIVE: -
   TELEPHONE: -

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

4. LEASE: G03068
   AREA: MU  LATITUDE: -
   BLOCK: A 111  LONGITUDE: -

5. PLATFORM: - A
   RIG NAME: -

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

7. TYPE:
   [X] HISTORIC INJURY -
   [X] REQUIRED EVACUATION 1 -
   [X] LTA (1-3 days)
   [X] LTA (>3 days)
   [X] RW/JT (1-3 days)
   [X] RW/JT (>3 days)
   [X] Other Injury 1 med. eval -

8. CAUSE:
   [X] EQUIPMENT FAILURE
   [X] HUMAN ERROR
   [X] EXTERNAL DAMAGE -
   [X] SLIP/TRIP/FALL -
   [X] WEATHER RELATED
   [X] LEAK
   [X] UPSET H2O TREATING
   [X] OVERBOARD DRILLING FLUID
   [X] OTHER Decommissioning (P&A)

9. WATER DEPTH: 304 FT.

10. DISTANCE FROM SHORE: 46 MI.

11. WIND DIRECTION: SE -
    SPEED: 5 M.P.H.

12. CURRENT DIRECTION: SE -
    SPEED: 5 M.P.H.

13. SEA STATE: 3 FT.
During a hazard hunt, Injured Person (IP) was pulling a welding lead from the middle deck up to the main deck. While pulling on the welding lead, the IP's hard hat strap, fastened to the side hole of his hard hat, became caught on the lead. When the strap came free, it snapped back toward the IP's face striking the left eye. He was unable to determine whether it struck his safety glasses causing the glasses to hit his eye or if the strap went between the safety glasses and his face striking his eye directly.

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

Personal Protective Equipment (PPE) was improperly utilized / positioned while performing the job task causing the hard hat safety strap to catch on the welding lead.

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

The underlying cause of the incident can be attributed to the IP's placement of the lanyard's lower clip mechanism attached to the side of his neck area on the shirt collar. This placement allowed the possibility of equipment such as the welding lead when manually handled to come in contact with the lanyard.

20. LIST THE ADDITIONAL INFORMATION:

Onsite personnel reviewed the incident and circumstances within their safety meeting recommending to all personnel, whenever possible, to attach the lanyard's lower clip as far to the center back of the collar as possible. This position would minimize the possibility of contact by equipment being manually handled. Additionally, the company offers the use of chin straps for anyone who elects not to utilize the hard hat lanyard.

21. PROPERTY DAMAGED: None

NATURE OF DAMAGE: None

ESTIMATED AMOUNT (TOTAL): $

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

No recommendations.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

MMS - FORM 2010

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28-APR-2015
26. ONSITE TEAM MEMBERS: 
James Holmes /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

30. DISTRICT SUPERVISOR: 
OCS REPORT: 
John McCarroll

APPROVED DATE: 13-APR-2015