

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: **24-MAR-2014** TIME: **1630** HOURS

2. OPERATOR: **Apache Corporation**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **Blake Drilling and Workover Com**

REPRESENTATIVE:

TELEPHONE:

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

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

6. OPERATION:

4. LEASE: **G02721**

AREA: **HI** LATITUDE:

BLOCK: **A 595** LONGITUDE:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER **Platform Rig demobing**

5. PLATFORM: **D**

RIG NAME: **BLAKE 1505**

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

8. CAUSE:

7. TYPE:

- HISTORIC INJURY
- REQUIRED EVACUATION **1**
- LTA (1-3 days)
- LTA (>3 days)
- RW/JT (1-3 days)
- RW/JT (>3 days) **4**
- 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

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

9. WATER DEPTH: **395** FT.
10. DISTANCE FROM SHORE: **107** MI.
11. WIND DIRECTION: **NE**
SPEED: **25** M.P.H.
12. CURRENT DIRECTION:
SPEED: M.P.H.
13. SEA STATE: **4** FT.

17. INVESTIGATION FINDINGS: -

On March 24, 2014, at approximately 16:30, while conducting stringing down block operations, a member of a four man work crew was struck with the 1 3/8 inch drill line when it failed to remain in the snake grip. The Injured Person (I.P.) was manning the hydraulic drill line spool winch control at the time of the incident. As the drill line cable attached to the snake grip was going through the last deadman sheave in the crown block an "all stop" was given by another member of the work crew when he noticed the drill line cable coming out of the snake grip. Approximately ten to thirty seconds after the "all stop" was given, the drill line cable came free from the snake grip and fell toward the hydraulic drill line spool winch control striking the I.P. on the left shoulder and right hip. The I.P. was put on to a litter and lowered to the main deck, where he was treated by the Rig Medic. At 18:20, the I.P. was transported to Lake Charles, LA.

It was determined that the drill line cable was not properly degreased before being inserted into the snake grip.

The proper clamping recommended by the manufacturer's specifications was not utilized for the snake grip. Instead, manila rope and duct tape were used to secure the snake grip which may have affected the drill line cable and prevented the snake grip from going through the block smoothly, also contributing to the injury incident.

An investigation by BSEE concluded the following factors contributed to the incident: The work crew was limited to a small deck space.

Although communications for stop work were given, the speed of the operation did not allow enough time to prevent the incident from occurring

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

It was determined that the drill line cable was not properly degreased before being inserted into the snake grip.

The proper clamping recommended by the manufacturer's specifications was not utilized for the snake grip. Instead, manila rope and duct tape were used to secure the snake grip which may have affected the drill line cable and prevented the snake grip from going through the block smoothly, also contributing to the injury incident.

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

An investigation by BSEE concluded the following factors contributed to the incident: - The work crew was limited to a small deck space.

Although communications for stop work were given, the speed of the operation did not allow enough time to prevent the incident from occurring. -

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The Lake Jackson District forwarded a safety alert to OSM for consideration but has no other recommendation to the Regional OSM office related to this incident. Also see additional information section 20.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

At the time of the investigation, March 25, 2014, the lessee failed to comply with 30 CFR 250. 107(a) which states that the lessee will perform all operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment.

On March 24, 2014 at approximately 16:30, while conducting stringing down block operations, a member of a four man work crew was struck with the 1 3/8 inch drill line when it failed to remain in the snake grip. The Injured Person (I.P.) was manning the hydraulic drill line spool winch control at the time of the incident. As the drill line cable attached to the snake grip was going through the last deadman sheave in the crown block an "all stop" was given by another member of the work crew when he noticed the drill line cable coming out of the snake grip. Approximately ten to thirty seconds after the "all stop" was given, the drill line cable came free from the snake grip and fell toward the hydraulic drill line spool winch striking the I.P. on the left shoulder and right hip. The I.P. was put into a litter and lowered to the main deck, where he was treated by the rig medic. At 18:20, the I.P. was transported to Lake Charles, LA.

It was determined that the drill line cable was not properly degreased before being inserted into the snake grip, and the proper clamping for the snake grip was not utilized according to the manufacturer's specifications. Manila rope and duct tape were used to secure the snake grip which may have prevented the drill line cable and snake grip from going through the block smoothly contributing to the injury incident.

In the future, lessee will assure that the manufacturer's specifications and instructions for use of a snake grip are followed completely during stringing down block operations.

25. DATE OF ONSITE INVESTIGATION:

25-MAR-2014

26. ONSITE TEAM MEMBERS:

Ed Keown /

29. ACCIDENT INVESTIGATION

PANEL FORMED: NO

OCS REPORT:

30. DISTRICT SUPERVISOR:

John McCarroll

APPROVED
DATE:

20-AUG-2014