

UNITED STATES DEPARTMENT OF THE INTERIOR
 MINERALS MANAGEMENT SERVICE
 GULF OF MEXICO REGION
ACCIDENT INVESTIGATION REPORT

1. OCCURRED
 DATE: **14-JAN-2009** TIME: **1530** HOURS

2. OPERATOR: **Shell Offshore Inc.**
 REPRESENTATIVE: **DiCarlo, Theresa**
 TELEPHONE: **(504) 728-6237**
 CONTRACTOR:
 REPRESENTATIVE:
 TELEPHONE:

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

4. LEASE: **G05889**
 AREA: **GC** LATITUDE:
 BLOCK: **65** LONGITUDE:

5. PLATFORM: **A-Bullwinkle**
 RIG NAME:

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

FATALITY
 POLLUTION
 FIRE
 EXPLOSION

LWC HISTORIC BLOWOUT
 UNDERGROUND
 SURFACE
 DEVERTER
 SURFACE EQUIPMENT FAILURE OR PROCEDURES

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

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

6. OPERATION:

PRODUCTION
 DRILLING
 WORKOVER
 COMPLETION
 HELICOPTER
 MOTOR VESSEL
 PIPELINE SEGMENT NO.
 OTHER **Crew Change by Boat**

8. CAUSE:

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

9. WATER DEPTH: **1353** FT.

10. DISTANCE FROM SHORE: **90** MI.

11. WIND DIRECTION: **NE**
 SPEED: **12** M.P.H.

12. CURRENT DIRECTION: **SW**
 SPEED: **6** M.P.H.

13. SEA STATE: **2** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On Wednesday, January 14, 2009, at 3:30p.m., Bullwinkle was preparing for a crew change from the M/V Albacore boat. After the Work Control Certificate was reviewed and signed by all involved on the platform and the boat, the Crane Operator lowered the whip line to the boat. The Deck Rigger hooked a 4800-lb. baggage container to the stinger on the lifting device. After it was properly secured, the Deck Rigger called for the Crane Operator to raise the container. As the Crane Operator was lifting the container, the load was swung away from the boat. At this time, half of the anti-two block (6 lbs.) fell to the deck of the M/V Albacore within 12 feet from the Deck Rigger. A second Rigger was located towards the front of the deck. The Crane Operator was raising the load and did not notice the anti-two block falling, but felt the crane shake and jerk. He stopped all operations. Other personnel were observing from the platform when the anti-two block fell. They heard the impact but did not see an object fall. It was observed that there was a {bird nest} of wire around the cable whip line, and the Crane Operator was notified. After a Pause and initial review of incident, the baggage container was safely set back onto the boat, unhooked and the boat pulled away from the platform. The Crane Operator lifted the whip line to ensure it was safely out of the way. The crane was locked down and all operations were stopped. The operation was moved to the North crane where the baggage container and personnel were safely transferred to the platform.

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

The support chain from the anti-two block weight to the anti-two block switch was 3 feet long. This did not leave enough time to stop the winch motion. Also, this crane had the old (crane smart) anti-two configuration which had a design delay of .5 seconds.

While the investigation is ongoing, it is believed that the support chain came into contact with the cable as it is being hoisted, pulling the chain and device into the jib, putting tension back on the switch very quickly. Due to the short chain, the system did not detect a failure. The tacky cable pulled the chain up and separated the A2B weight immediately. This resulted in half of the weight falling onto the back of the boat and the other half falling overboard. The action of pulling the chain/weight into the jib sheave tore the switch apart and broke the strand of cable at the same time and resulted in the 40 foot bird nest.

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

The auxiliary cable was installed on the crane in November. At the time of this incident, the auxiliary cable was still covered with heavy lube as indicated by the amount of lube on the support chain. The weather was cool at the time of the incident, causing the cable lube to have a sticky/ tacky feel.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

**Crane fastline, anti-two block assembly,
and crane jib assembly.**

ESTIMATED AMOUNT (TOTAL):

\$9,700

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

**Due to the specific nature of this incident, the Houma District has no
recommendations to report to the Regional Office.**

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/a

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

MINOR

26. ONSITE TEAM MEMBERS:

29. ACCIDENT INVESTIGATION

Casey Bisso /

PANEL FORMED: **NO**

OCS REPORT:

27. OPERATOR REPORT ON FILE: **NO**

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED

DATE: **26-FEB-2009**