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

1. OCCURRED

   DATE: 13-FEB-2009  TIME: 1012  HOURS

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

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

4. LEASE:  G04240
   AREA:  ST    LATITUDE:  
   BLOCK:  300  LONGITUDE:  

5. PLATFORM:  A
   RIG NAME:  

6. ACTIVITY:  X  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
   ■ PATALITY
   ■ 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
     X REQUIRED MUSTER
     X SHUTDOWN FROM GAS RELEASE
     □ OTHER

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

9. WATER DEPTH:  337  FT.

10. DISTANCE FROM SHORE:  60  MI.

11. WIND DIRECTION:  ESE
    SPEED:  13  M.P.H.

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

13. SEA STATE:  FT.

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EV2010R  29-JUN-2009
17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

Shell initially reported that, while lowering a capsule winch (further referenced as load), the load appeared to have struck an external level control column on the Popeye subsea separator. When the load struck the level column, a bull plug was dislodged from the top of the level control column resulting in gas venting from the top of the column (approximately 1.532 SCF). While the gas was venting, the internal level control float appears to have risen and stopped the gas venting from the top of the level control column by plugging off the hole at the top of the control column. Upon hearing the escaping gas, the operations team activated the ESD and mustered. No actual witnesses saw the load strike and there were no injuries. After further investigation, Shell believes that the tagline wrapped around the bull plug assembly rather than the load striking the bull plug, as was initially reported. The investigation has revealed that the crane and the load were idle at the time of the incident. There was tension on Tagline #1 while Tagline #2 potentially wrapped around the bull plug assembly.

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

At this time, Shell feels like a tagline wrapped around the bull plug assembly; the bull plug was tightened to 2 threads. Shell thinks that the load was being repositioned using the second tagline, the other tagline unknowingly became entangled with the bull plug.

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

(1) The bull plug was tightened to 2 threads. (2) A change to the lifting plan was not properly communicated to all that were involved.

20. LIST THE ADDITIONAL INFORMATION:

N/A
21. PROPERTY DAMAGED: Equipment damage was torque tubes, linkage, bolts, and gaskets.

22. RECOMMENDATIONS TO PREVENT RECURRANCE 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:

26. ONSITE TEAM MEMBERS:

Casey Bisso /

27. OPERATOR REPORT ON FILE: NO

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

AMENDED

APPROVED

DATE: 11-MAY-2009