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

1. OCCURRED
   DATE: 25-AUG-2006  TIME: 1620 HOURS

2. OPERATOR: Apache Corporation
   REPRESENTATIVE: Renny Shelby
   TELEPHONE: (337) 735-7416
   CONTRACTOR:
   REPRESENTATIVE: Dave Cook
   TELEPHONE:

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

4. LEASE: 00838
   AREA: WD  LATITUDE: 
   BLOCK: 71  LONGITUDE:

5. PLATFORM: E
   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

   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

   PRODUCTION
   DRILLING
   WORKOVER
   COMPLETION
   HELICOPTER
   MOTOR VESSEL
   PIPELINE SEGMENT NO.
   OTHER

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

9. WATER DEPTH: 80 FT.

10. DISTANCE FROM SHORE: 18 MI.

11. WIND DIRECTION: NE
    SPEED: 18 M.P.H.

12. CURRENT DIRECTION:
    SPEED: 2 M.P.H.

13. SEA STATE: 1 FT.
17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On August 25, 2006 at approximately 1620 hours, the crane operator was in the process of lifting a 4' x 8' cargo basket which contained several blind flanges and valves, weighing approximately 9,500 pounds. The crane in question is a Model 500, Mariner, 50 ton Mechanical (Friction) unit. At the time of the incident the operator was utilizing the main load line to perform the lift. During the lift the operator placed the control lever in neutral at which time the boom hoist brake slipped. The ratchet pawl device (Safety device) did not engage causing the boom to free fall to the water. As the boom was falling the operator attempted to boom up but was unsuccessful.

Findings:

Upon investigation it was determined that the cause of the incident was due to several mechanical failures. The boom hoist slipped due to improper band adjustment and an oily residue, which was found on the surface of the brake band. Secondly, the ratchet pawl device was in the open position and exhibited no indication of being engaged. It was determined that the ratchet pawl tension spring was not connected causing the device not to engage. The ratchet pawl mechanism on the boom hoist, on this type of crane, is present to prevent a loss boom control in the event of a brake failure.

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

Upon investigation it was determined that the cause of the incident was due to several mechanical failures. The boom hoist slipped due to improper band adjustment and an oily residue, which was found on the surface of the brake band. Secondly, the ratchet pawl device was in the open position and exhibited no indication of being engaged. It was determined that the ratchet pawl tension spring was not connected causing the device not to engage. The ratchet pawl mechanism on the boom hoist, on this type of crane, is present to prevent a loss boom control in the event of a brake failure.

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

1) Bent 70' Boom 
2) Housing damage to crane. 
3) Boom dog, dog gear and assembly has to be replaced 

ESTIMATED AMOUNT (TOTAL): $250,000 

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE: 

No Recommendations to MMS. 

The New Orleans District concurs with the operator's recommendation to prevent recurrence. 

Corrective Action: Information regarding the findings in the incident were discussed with the Apache Offshore Safety Committee and disseminated throughout the GOM. 

Apache is in the process of changing out mechanical crane to hydraulic type. 

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO 

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE: 

25. DATE OF ONSITE INVESTIGATION: 30-AUG-2006 

26. ONSITE TEAM MEMBERS: Phil McLean / 

29. ACCIDENT INVESTIGATION PANEL FORMED: NO 

OCS REPORT: 

30. DISTRICT SUPERVISOR: Troy Trosclair 

APPROVED 

DATE: 23-OCT-2006