UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
DATE: 30-NOV-2012 TIME: 0850 HOURS

2. OPERATOR: ANKOR Energy LLC
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: 00830
   AREA: SS LATITUDE: 
   BLOCK: 229 LONGITUDE:

5. PLATFORM: C
   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
   [ ] HUMAN ERROR
   [ ] EXTERNAL DAMAGE
   [ ] SLIP/TRIP/FALL
   [ ] WEATHER RELATED
   [ ] LEAK
   [ ] OVERBOARD DRILLING FLUID
   [X] SURFACE EQUIPMENT FAILURE OR PROCEDURES
   [ ] COLLISION
   [ ] HISTORIC
   [ ] >$25K
   [ ] <=$25K

8. CAUSE:
   [X] EQUIPMENT FAILURE
   [ ] HUMAN ERROR
   [ ] EXTERNAL DAMAGE
   [ ] SLIP/TRIP/FALL
   [ ] WEATHER RELATED
   [ ] LEAK
   [ ] OVERBOARD DRILLING FLUID
   [ ] OTHER

9. WATER DEPTH: 130 FT.

10. DISTANCE FROM SHORE: 41 MI.

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

12. CURRENT DIRECTION: SE
    SPEED: 8 M.P.H.

13. SEA STATE: 4 FT.
17. INVESTIGATION FINDINGS:

At 0850 hours on 30 November 2012, Ankor Energy LLC (Ankor) had inadvertently dropped the Whitaker 21 Man Survival Capsule into the Gulf of Mexico. Ankor contracted Survival-Craft Offshore Services (SOS) to perform routine and special maintenance on the capsule. SOS was performing a basic winch function test to evaluate launch capability (lower capsule to water and then re-stow). As SOS began lowering the capsule, the bow of the capsule remained stationary in the davit as the stern of the capsule was lowered 64 inches by the winch. The severe angle of the capsule was noticed and the handbrake on the winch was engaged. Once the handbrake was applied, the bow broke free from davit and the capsule began to sway in the hook mechanism. The retainer on the hook mechanism became damaged and the wire rope D-ring slipped out of the hook mechanism. The capsule dropped 45 feet impacting the water bow first. The capsule was retrieved by a field boat with the capsule having severe damage to the bow area. Throughout the incident and the recovery of the damaged capsule, there were no injuries or pollution.

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

The bow of the capsule was stationary as the winch lowered the stern section. When the bow broke free, the capsule was at a severe angle and swung in an attempt to find equilibrium causing damage to the hook mechanism. Had the bow not remained stationary as the stern section of the boat was lowered then the chain of events resulting in the capsule being damaged would not have happened.

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

The evidence following the incident indicated the designed davit skid plate located at the bow end of the capsule exposed an estimated two-inch space between the top side of the skid plate and I-beam attached to the platform. Furthermore, the boarding rope (3/8 poly), which is attached to the exterior hull of the capsule, was broken near the bow end of the capsule. The breakage of the rope indicted the rope was at some point under severe tension. However, it was uncertain to identify when or what time frame the rope actually was under tension to cause the breakage. There were two assumptions concerning the rope breakage as described below:

1. The boarding rope may have been wedged between the davit skid plate and the capsule which could have allowed the bow of the capsule to remain stationary inside the davit as the SOS employee was lowering the capsule.

2. The bow end of the capsule may have wedged between the davit skid plate and the I-beam attached to the platform. When the bow end of the capsule slipped from the davit system it caused the capsule to have a pendulum motion; therefore, the boarding rope may have swung above the capsule and caught the I-beam above the davit skid plate. Due to the capsule moving in a pendulum effect, this could have caused the rope to break.

Additional evidence indicated the capsule's hooking mechanism attached to the winch line was damaged. It was determined during the pendulum motion the hooking mechanism "ring retainer" was bent outward which in turn, caused the capsule to release from the winch line and fall into the water. The severe damage recognized to the bow end of capsule indicated the bow impacted the water first and then the stern.

20. LIST THE ADDITIONAL INFORMATION:
21. PROPERTY DAMAGED: Whitaker 21 Man Survival Capsule

   NATURE OF DAMAGE: The forward part of the capsule was damaged on impact. The front doors were crushed and broken off and many of the internal components were damaged when the capsule impacted the water.

   ESTIMATED AMOUNT (TOTAL): $75,000

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

   The Houma District has no recommendations for the Regional Office.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

   G110: "Does the lessee perform all operations in a safe and workmanlike manner and provide for the preservation and conservation of property and the environment? At time of inspection and upon arrival of the platform, observed platform escape lifeboat afloat. Further information given to inspector was third party inspection was checking unit. Unit became disconnected in an attempt to lower unit from davit. Inspection of D-ring indicated unit was lowered 64 inches from its original davit position. Third party inspector indicated he lowered capsule 1 to 1 1/2 feet, when unit came loose and fell to water approximately 45 feet."

   G111: "Does the lessee maintain all equipment in a safe condition to provide for the protection of the lease and associated facilities? At time of inspection, it was observed that life capsule landing area guide wire not being maintain properly, life capsule seems to have hung-up upon launch."

25. DATE OF ONSITE INVESTIGATION:

   30-NOV-2012

26. ONSITE TEAM MEMBERS:

   Doug Sevin /

29. ACCIDENT INVESTIGATION

   PANEL FORMED: NO

   OCS REPORT:

30. DISTRICT SUPERVISOR:

   Bryan A. Domangue

   APPROVED DATE: 12-JUL-2013