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)
- [X] 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
- [X] CRANE
- [ ] OTHER LIFTING DEVICE
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [X] INCIDENT >$25K **Crane damaged**
- [X] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [X] OTHER **crane**

6. OPERATION:
- [X] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER

8. CAUSE:
- [X] EQUIPMENT FAILURE
- [X] 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 racket 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 racket 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: NATURE OF DAMAGE:

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**