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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

   DATE: **10-FEB-2005** TIME: **0430** HOURS

2. OPERATOR: **Apache Corporation**

   REPRESENTATIVE: **Mark Wilson**

   TELEPHONE: **(337) 735-8649**

3. LEASE: **G21685**

   AREA: **ST** LATITUDE:

   BLOCK: **308** LONGITUDE:

4. PLATFORM: **A (Tarantula)**

   RIG NAME **H&P 107**

5. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [X] DEVELOPMENT/PRODUCTION (DOCD/POD)

6. TYPE:
   - [ ] FIRE
   - [ ] EXPLOSION
   - [ ] BLOWOUT
   - [ ] COLLISION
   - [ ] INJURY NO. **0**
   - [ ] FATALITY NO. **0**
   - [ ] POLLUTION
   - [X] OTHER **Crane/Helicopter**

7. OPERATION:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [X] COMPLETION
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO. _____
   - [ ] 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: **484** FT.

10. DISTANCE FROM SHORE: **66** MI.

11. WIND DIRECTION: **N**

    SPEED: **35** M.P.H.

12. CURRENT DIRECTION: **N**

    SPEED: M.P.H.

13. SEA STATE: **10** FT.

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

    Joe Ehnot

    CITY: **Arlington** STATE: **TX**

    TELEPHONE: **(985) 396-4306**

    CONTRACTOR:

    CONTRACTOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:

    H&P IDC

    CITY: **tulsa** STATE: **OK**

    TELEPHONE: **(800) 331-7250**

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

The crane operator had repositioned the tool box to make room for placement of a W/L unit. While attempting to swing the eastside crane around to retrieve the W/L unit, the crane fastline became entangled in the westside (seatrax) cranes' walkway. When the fastline became free, the hook and ball swung in the direction of the helicopter. The crane operator attempted to "pull up" on the fastline but was unable to prevent the hook from colliding with the helicopters' main rotor blade and tail fin.

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

Human error. The signal man should have noticed that the cranes fastline had become entangled and at that time all crane operations should have been stopped immedately and corrective actions taken.

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

Night (early morning hours).

21. PROPERTY DAMAGED:

Air Logistics Helicopters' main rotor blade and tail fin.

NATURE OF DAMAGE:

Dents, scrapes and bulges.

ESTIMATED AMOUNT (TOTAL): **$83,472**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Due to the specific nature of this incident, the Houma district has nc recommendations to the regional office.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

PINC I-101, under the authority of 30 CFR 250.108 as safety dictates in accordance with API RP 2D, paragraph 3.1.5a.

25. DATE OF ONSITE INVESTIGATION:

10-FEB-2005

26. ONSITE TEAM MEMBERS:

Terry Hollier / Freddie Mosely /

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Michael J. Saucier

APPROVED

DATE: **08-APR-2005**