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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **27-JAN-2009** TIME: **2135** HOURS

2. OPERATOR: **Linder Oil Company, A Partnership**
   REPRESENTATIVE: **Mike Luke**
   TELEPHONE: **(985) 395-8393**
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G05283**
   AREA: **WC** LATITUDE:
   BLOCK: **168** LONGITUDE:

5. PLATFORM: **A**
   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.
   - [ ] INCIDENT >$25K
   - [ ] H2S/15MIN./20PPM
   - [ ] REQUIRED MUSTER
   - [ ] SHUTDOWN FROM GAS RELEASE
   - [ ] OTHER

6. OPERATION:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [X] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [X] OTHER **Zone Change well-A-2 with e-line**

8. CAUSE:
   - [ ] EQUIPMENT FAILURE
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [X] OTHER **2 inch Nylon sling parted**

9. WATER DEPTH: **43** FT.

10. DISTANCE FROM SHORE: **25** MI.

11. WIND DIRECTION: **SE**
    SPEED: **20** M.P.H.

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

13. SEA STATE: **5** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On the evening of January 27, 2009 the e-line crew and production personnel were engaged in an approved zone change operation on well A-2. The e-line crew was at a point in the approved procedure which required running in the hole with a perforating gun. In order to accommodate the overall length of the entire tool string, another section of lubricator had to be installed. As the e-line crew prepared for installation of the lubricator and while the crane was static, the nylon sling parted. The e-line lubricator was equipped with a lifting bracket designed for suspending the lubricator in position over the well with a two part sling. The e-line crew elected to use a 2 inch nylon sling cinched in a choker type manner just below the lifting bracket as this is their common practice. The sling was cinched in a manner which allowed the sharp edge of the lifting bracket to chafe the nylon material at a point that was not visible to personnel involved with this task. The lubricator and tool string were several feet above the well deck when the nylon sling broke causing the lubricator and tool string to hit the grating deck and fall into the Gulf of Mexico.

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

The movement of the lubricator while in use caused the sharp edge of the lifting bracket to rub against the nylon sling and chafe to the point that it parted. Although the lubricator was equipped with a lifting bracket designed for use with a two part sling, the e-line operator elected to utilize a nylon sling.

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

Improper rigging practice when the decision was made to utilize a nylon sling cinched in a choker type manner just below the lifting bracket in lieu of using a two part sling on the lubricator's lifting bracket.

20. LIST THE ADDITIONAL INFORMATION:

The lubricator was able to be recovered without the use of divers since the hoses remained attached. The tool string consisted of one 1-7/6 inch rope socket, one 1-11/16 inch weight bar and one 1-11/16 inch shooting gamma ray which was fully recovered on January 30, 2009 by divers. Although this incident did not involve any injuries or pollution, the potential for serious injury and loss of was well control was present.

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Charles District recommends that the MMS Regional Office of Safety Management (OSM) issue a Safety Alert to heighten industry's personnel awareness of the hazards involved with improper use of nylon slings.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

1. I-102 (C) 30 CFR 250.108 - API RP 2D C.3.2.2c and C.5.2.1
*** Personnel utilized improper rigging practice for lifting the lubricator. (The lubricator was equipped with a lifting bracket for use with a two part sling, but the decision was made to utilize a nylon sling cinched in a choker type manner just below the lifting bracket)**
*** Personnel failed to provide suitable protection between the (nylon) sling and the lifting bracket on the lubricator.**

25. DATE OF ONSITE INVESTIGATION:

30-JAN-2009

26. ONSITE TEAM MEMBERS:

Scott Mouton /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Larry Williamson

APPROVED

DATE: **01-APR-2009**