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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **23-APR-2006** TIME: **0830** HOURS

2. OPERATOR: **Apache Corporation**

REPRESENTATIVE: **Wilton Andre Pont**

TELEPHONE: **(337) 735-8251**

3. LEASE: **G02193**

AREA: **MP** LATITUDE:

BLOCK: **140** LONGITUDE:

4. PLATFORM: **B**

RIG NAME:

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**

7. OPERATION:
- [X] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] 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: **150** FT.

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

11. WIND DIRECTION: **S**

SPEED: **6** M.P.H.

12. CURRENT DIRECTION: **S**

SPEED: **3** M.P.H.

13. SEA STATE: **0** FT.

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

CONTRACTOR: **Wood Group Production Services**

CONTRACTOR REPRESENTATIVE/ SUPERVISOR ON SITE AT TIME OF INCIDENT:

Kenny Domingo

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On April 23, 2006 a crane boom failure occurred on Apache's Main Pass 140 B platform. The crane boom failure occurred at approximately 0830 hours while the contract operator was in the process of moving an empty tote tank, weighing approximately 300 pounds closer to the pedestal, using the fast line on the platform's permanently mounted, mechanical crane. The crane operator stated during the lift he heard a loud snap and saw the boom fall to the deck. As he exited the crane he looked over his shoulder and saw the end of the boom over the "A" frame.

Investigation Findings:

The Roto 30 Model crane was manufactured in 1975.
The crane was equipped with an 80 foot boom.
An annual crane inspection was preformed on 9-15-200. The crane passed inspection.
All quarterly and pre-use crane inspections from 9-15-2005 passed inspection.

Apache personnel along with a crane inspector conducted a thorough investigation of the boom collapse and reported the following findings. The incident occurred due to the crane boom being raised to a high angle (towards the vertical) which caused the boom to collapse or fold. The boom fell across the "A" frame or gantry of the crane causing considerable damage. Also revealed during the investigation, was that the crane boom contacted the fixed boom stops and that metal scarring and paint removal confirmed that the boom was pulled past the boom stops.

The investigation therefore was focused on determining whether or not the "Boom Stop" safety feature was operating properly or if the safety feature could have been deliberately overridden by the operator to allow for the tote tank to be positioned closer to the crane pedestal.

The boom stop feature was confirmed to have been operational prior to the incident as stated in the pre-use inspection checklist completed by the operator. The crane was damaged to the extent that testing of the boom stop safety feature could not be accomplished after the incident occurred. There were no injuries sustained to any personnel during this incident nor environmental pollution.

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

The crane operator continued to raise the boom pass the "boom stop" which is a safety devise used to limit the angle of the boom at the highest recommended position.

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

21. PROPERTY DAMAGED:

Crane Boom

NATURE OF DAMAGE:

Bent and distorted.

ESTIMATED AMOUNT (TOTAL): **$85,000**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

No Recommendations to MMS

MMS New Orleans District concurs with the Operator's recommendation to prevent recurrence.

Apache has an ongoing awareness/training campaign to remind all crane operators as to the purpose of the boom stop safety feature and out prohibition against operating the crane in an unsafe manner.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 - The Lessee did not perform all operations in a safe and workmanlike manner and provide for the perseveration and conservation of property and the environment.

25. DATE OF ONSITE INVESTIGATION:

25-APR-2006

26. ONSITE TEAM MEMBERS:

Justin Josey / Perry Jennings /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

FPausina for TTrosclair

APPROVED

DATE: **20-JUN-2006**