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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
DATE: **13-NOV-2007** TIME: **1000** HOURS

2. OPERATOR: **Shell Offshore Inc.**
REPRESENTATIVE: **DiCarlo, Theresa**
TELEPHONE: **(504) 728-6237**
CONTRACTOR:
REPRESENTATIVE: **Speers, Kevin**
TELEPHONE: **(713) 232-8455**

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

4. LEASE: **G19967**
AREA: **MC** LATITUDE:
BLOCK: **568** LONGITUDE:

5. PLATFORM:
RIG NAME: **T.O. DEEPWATER NAUTILUS**

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
- [X] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER

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

9. WATER DEPTH: FT.

10. DISTANCE FROM SHORE: MI.

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

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

13. SEA STATE: FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On November 13, 2007, at Shell Offshore Inc.'s, Lease OCS-G 19967, Mississippi Canyon (MC) Block 586, while offloading a cargo basket of drilling tools weighing approximately 16,500 lbs. from the OSV Mr. Henry into Transocean's Deepwater Nautilus's riser bay, the crane hoist control received an electronic overload fault signal and the load dropped 4 feet to deck. Employees were using tag lines and were clear of the dropped basket. No injuries. No damage to deck or crane, and minor damage to drilling tools. The crane has been taken out of service and investigation is underway to determine why overload fault activated prematurely (the weight of the load did not approach operating limit of crane).

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

Investigation Results:
Due to a previous electronic malfunction of the starboard crane's main block weight indicator, a temporary repair had been instituted prior to this incident whereby the main block's weight indicator signal was simulated using a spare output from the fast line weight indicator. This repair allowed continued operation of the fast line while the main block was out of service and awaiting permanent repairs. During a subsequent fast line lift, which resulted in the incident, the crane's computer factored both the actual fast line load and the simulated load of the out-of-service main line. This resulted in the computer perceiving the crane as being overloaded and the activation of the Gross Overload Protection (GOP) system. Once the GOP system activated, the crane automatically lowered the load back onto the deck. Operations and Maintenance personnel were not aware of the potential to activate the GOP system as a result of the temporary repairs.

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

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: **Drilling Tools**

NATURE OF DAMAGE: **Dropped**

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The New Orleans District makes no recommendations to MMS.

The New Orleans District concurs with the operator's recommendations to prevent recurrance.

Training was conducted with all operators and maintenance personnel.
Rig operating and maintenance procedures were revised.
An information sharing/lessons learned document was drafted and disseminated throughout the organization.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:

No onsite investigation /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Troy Trosclair

APPROVED

DATE: **19-JAN-2008**