

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT  
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED

DATE: 16-MAR-2018 TIME: 1630 HOURS

2. OPERATOR: Shell Offshore Inc.

REPRESENTATIVE:  
TELEPHONE:

CONTRACTOR:  
REPRESENTATIVE:  
TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING Chain Hoist Trolley
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT: 8. OPERATION:

4. LEASE: G31195

AREA: AC LATITUDE:  
BLOCK: 728 LONGITUDE:

5. PLATFORM:

RIG NAME: T.O. DEEPWATER PONTUS

6. ACTIVITY:

- EXPLORATION(POE)
- 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

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

9. CAUSE:

- EQUIPMENT FAILURE
- HUMAN ERROR
- EXTERNAL DAMAGE
- SLIP/TRIP/FALL
- WEATHER RELATED
- LEAK
- UPSET H2O TREATING
- OVERBOARD DRILLING FLUID
- OTHER \_\_\_\_\_

- 10. WATER DEPTH: 8596 FT.
- 11. DISTANCE FROM SHORE: 182 MI.
- 12. WIND DIRECTION: SE  
SPEED: 15 M.P.H.
- 13. CURRENT DIRECTION:  
SPEED: M.P.H.
- 14. SEA STATE: 3 FT.
- 15. PICTURES TAKEN:
- 16. STATEMENT TAKEN:

17. INVESTIGATION FINDINGS:

**For Public Release**

While lifting a 2.69 Ton Mission L (Premium) discharge module from a 14-P-220 Mud Pump, a 3 Ton chain hoist trolley failed causing the discharge module to fall approximately 3 inches onto metal grating. The grating received minor damage, but it was still in usable condition. Third party testing was utilized to determine which part(s) of the chain hoist failed. The internal chain guides of the chain hoist were damaged and in a bent condition. Third party testing concluded the failure of the lifting device was the result of an overload incident. The reported load, 2.69 Tons, at the time of failure should not have caused the hoist failure. The load (discharge module) was 89.7% of the working load limit (WLL) of the chain hoist trolley. The angle of the lift from vertical was approximately 16.43 degrees. The JSA did not identify any additional forces working against the lift besides the weight of the discharge module itself. Witnesses stated they were having difficulty lifting the discharge module over a lip edge and being caught on some bolts.

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

Potential unforeseen forces and stresses working against the lifting gear may have occurred just prior to the chain hoist failure. These contributing factors may include: Friction (the load being caught up on a bolt or lip edge, sliding across a surface, etc.), shock loading, and the backup equipment (come along) pulling against the load. These contributing factors may have caused the chain hoist to be overloaded beyond its WLL, resulting in the chain hoist's mechanical failure.

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

The lift plan did not identify the accurate weight of the load to be lifted. The lift plan did not identify all of the lifting gear which was to be used during the lift. The lift plan was not updated or changed when personnel decided to deviate from the original lift plan. The safety measures in place failed to ensure the lift plan was accurate, thorough, and completely understood by all personnel prior to conducting the work.

20. LIST THE ADDITIONAL INFORMATION:

The crew member operating the chain fall was rigger certified and trained to operate the equipment in use. His qualifications are on record and have been provided to BSEE. This particular piece of lifting equipment is commonly used during operations.

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

A 3 Ton chain hoist trolley and metal grating.

The chain hoist is a complete loss. The metal grating is currently in-use

ESTIMATED AMOUNT (TOTAL): \$600

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lake Jackson District has no recommendations for the Office of Incident Investigations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

**21-MAR-2018**

28. ACCIDENT CLASSIFICATION:

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

26. INVESTIGATION TEAM MEMBERS:

**Danny Gonzalez / Casey Conklin / James  
Holmes- office /**

30. DISTRICT SUPERVISOR:  
OCS REPORT:  
**Stephen P. Martinez**

27. OPERATOR REPORT ON FILE:

APPROVED

DATE: **20-JUN-2018**