

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

1. OCCURRED

DATE: **18-DEC-2008** TIME: **1400** HOURS

2. OPERATOR: **Hall-Houston Exploration II, L.P.**

REPRESENTATIVE: **Camp, Kathy**

TELEPHONE: **(713) 201-9627**

CONTRACTOR:

REPRESENTATIVE:

TELEPHONE:

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

4. LEASE: **G02663**

AREA: **BA** LATITUDE:

BLOCK: **A 70** LONGITUDE:

5. PLATFORM: **A**

RIG NAME:

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

STRUCTURAL DAMAGE

CRANE

OTHER LIFTING DEVICE

DAMAGED/DISABLED SAFETY SYS.

INCIDENT >\$25K

H2S/15MIN./20PPM

REQUIRED MUSTER

SHUTDOWN FROM GAS RELEASE

OTHER **Tree bleeding gas**

6. OPERATION:

PRODUCTION

DRILLING

WORKOVER

COMPLETION

HELICOPTER

MOTOR VESSEL

PIPELINE SEGMENT NO.

OTHER **Construction**

8. CAUSE:

EQUIPMENT FAILURE

HUMAN ERROR

EXTERNAL DAMAGE

SLIP/TRIP/FALL

WEATHER RELATED

LEAK

UPSET H2O TREATING

OVERBOARD DRILLING FLUID

OTHER _____

9. WATER DEPTH: **155** FT.

10. DISTANCE FROM SHORE: **40** MI.

11. WIND DIRECTION: **N**
SPEED: **23** M.P.H.

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

13. SEA STATE: **7** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

A construction crew was working on platform renovation in preparation for producing a newly sidetracked and completed well. At 1400 hours the platform Foreman noticed gas escaping from the well's manual master valve flange located directly above the tubing hanger. The leak lasted approximately one hour due to a finite tubing gas volume, as a result of the well's Surface Controlled Sub-Surface Safety Valve (SCSSV) being closed and holding. At 1600 hours, subsequent to discussion between the Operator's Regulatory representative and the MMS Lake Jackson District, the decision was made to evacuate the platform by boat, then return with an experienced Wellhead Technician to determine the root cause prior to performing the corrective action.

At 0530 hours, the vessel returned with all appropriate personnel, including the Wellhead Technician. The Wellhead Technician installed the wellhead back pressure valve, bled all pressures to zero, replaced two (2) master valve flange bolts that had been sheared, and properly torqued all flange bolts according to the manufacturer specifications. The caisson and wellhead have been secured at the +10 and well bay area by an I-beam and 1" plate to minimize movement due to wave action. There were no reports of uncontrolled flow, pollution, or injuries resulting from the incident.

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

Investigatory findings suggest the two (2) master valve flange bolts were over-torqued when installed, causing the bolts to be stretched and weakened.

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

Excessive motion due to high seas are also believed to be a contributing cause for the over-torqued bolts to fail.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

Master Valve flange bolts on tree

NATURE OF DAMAGE:

Bolts fatigued from over-torque and excessive caisson motion.

ESTIMATED AMOUNT (TOTAL):

\$5,000

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

The MMS Lake Jackson District makes no recommendations to the MMS Regional Office of Safety Management (OSM).

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

19-DEC-2008

26. ONSITE TEAM MEMBERS:

Craig Pohler /

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

John McCarroll

APPROVED

DATE: **13-FEB-2009**