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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **08-JAN-2007** TIME: **1200** HOURS

2. OPERATOR: **Northstar Gulfsands, LLC**
   REPRESENTATIVE: **Keith Krenek**
   TELEPHONE: **(361) 727-3337**
   CONTRACTOR: **Wood Group Production Services**
   REPRESENTATIVE: **Pat Johnson**
   TELEPHONE:

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

4. LEASE: **G07199**
   AREA: **MI** LATITUDE:
   BLOCK: **605** 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)
  - [X] LTA (>3 days **1**
  - [ ] 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

6. OPERATION:
- [X] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] 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: **89** FT.

10. DISTANCE FROM SHORE: **20** 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:

DUE TO WEATHER CONDITIONS, MMS INPECTORS WERE UNABLE TO INVESTIGATE ON SITE. JIM HAIL, SUPERVISORY INSPECTOR, CONDUCTED THIS INVESTIGATION BY PHONE.

Lead-Operator, , and A-Operator, , arrived on location to open and flow the MI-605 A-1 well. The objective was to pressure-up the 12-inch actuator and open the master SSV. An alternate source (nitrogen) of sufficient pressure was not available on this platform. Also, a mechanical device which could be used to manually open the actuator was not available. A vessel was on location with an alternate fuel source that the operators identified, but did not use. Operators were jumping pressure from the FTP (flow tubing pressure) gauge manifold located on the production deck with poly-flow, which was connected to a street tee holding a PSV and into the inlet of the Baker 12 inch actuator located on the well deck. (Lead Operator) was positioned on the production deck at the FTP gauge manifold and ("A" Operator) was standing next to the Actuator on the lower deck. ("A" Operator) was prepared to install (screw-on) the lock-out cap over the actuator stem once valve opened. The FTP gauge and flowline segment indicated 50 PSI. (lead operator) opened the needle valve and looked down at the Actuator and noticed that the Actuator stem started to move inward on the SSV. He started closing the needle valve once he saw the stem move. He noted that the FTP gauge jumped up to 900 PSI. He shouted down to to let him know they had 900 PSI. At approximately the same time the Actuator front section blew off hitting lower right arm and hand causing the injury.

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

Excess pressure applied to the component (Actuator) causing the component to rupture.

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

Failure of PSV on Actuator. Lab test on component confirmed failure.

Due to weather and transportation constraints over a three day period, operators felt/perceived and urgency to bring on the well.

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Lake Jackson District recommends that a Safety Alert informing industry of the dangers releaded to using flow line pressure to open SSV's.

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:

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Stephen P. Martinez

APPROVED

DATE: **26-MAR-2007**