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:
   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
   PATALITY
   POLLUTION
   FIRE
   EXPLOSION
   LWC
   HISTORIC BLOWOUT
   UNDERGROUND
   SURFACE
   DEVERTER
   SURFACE EQUIPMENT FAILURE OR PROCEDURES
   COLLISION

8. CAUSE:
   EQUIPMENT FAILURE
   HISTORIC
   HISTORIC BLOWOUT
   UNDERGROUND
   SURFACE
   DEVERTER
   SURFACE EQUIPMENT FAILURE OR PROCEDURES
   COLLISION
   HISTORIC
   $25K
   <=$25K
   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:

13. SEA STATE: 7 FT.
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**

22. RECOMMENDATIONS TO PREVENT RECURRANCE 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