

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

1. OCCURRED

DATE: **08-NOV-2005** TIME: **1600** HOURS

2. OPERATOR: **Shell Offshore Inc.**

REPRESENTATIVE: **Jose Mota**

TELEPHONE: **(281) 544-5372**

3. LEASE: **G07995**

AREA: **GC** LATITUDE: **27.7909917**

BLOCK: **158** LONGITUDE: **-90.6574452**

4. PLATFORM: **A-Brutus TLP**

RIG NAME **H&P 202**

5. ACTIVITY:  EXPLORATION(POE)

DEVELOPMENT/PRODUCTION  
(DOCD/POD)

6. TYPE:  FIRE

EXPLOSION

BLOWOUT

COLLISION

INJURY NO. \_\_\_\_\_

FATALITY NO. \_\_\_\_\_

POLLUTION

OTHER \_\_\_\_\_

7. OPERATION:  PRODUCTION

DRILLING

WORKOVER

COMPLETION

MOTOR VESSEL

PIPELINE SEGMENT NO. \_\_\_\_\_

OTHER \_\_\_\_\_

8. CAUSE:  EQUIPMENT FAILURE

HUMAN ERROR

EXTERNAL DAMAGE

SLIP/TRIP/FALL

WEATHER RELATED

LEAK

UPSET H2O TREATING

OVERBOARD DRILLING FLUID

OTHER \_\_\_\_\_

9. WATER DEPTH: **2950** FT.

10. DISTANCE FROM SHORE: **93** MI.

11. WIND DIRECTION: **SE**

SPEED: **5** M.P.H.

12. CURRENT DIRECTION: **ESE**

SPEED: **1** M.P.H.

13. SEA STATE: **4** FT.

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

**Clyde Adcock**

CITY: **Morgan City** STATE: **LA**

TELEPHONE: **(504) 728-5996**

CONTRACTOR: **Helmerich & Payne**

CONTRACTOR REPRESENTATIVE/  
SUPERVISOR ON SITE AT TIME OF INCIDENT:

**Tony Miller**

CITY: **Morgan City** STATE: **LA**

TELEPHONE: **(504) 728-5932**

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

A BOP test had been completed on the Green Canyon 158 A-7 well. The fresh water that was used for the test had been pumped out of the stack thru the overboard discharge line. The shaker hand was told by the driller to close the overboard discharge line valve and prepare to fill the BOP stack with mud. The shaker hand moved the valve handle to what he thought was the closed position. In reality, he had only partially closed the butterfly valve to a "hard" spot. The driller then turned the pump on to fill the hole from the trip tank thinking everything was lined up. When the stack filled up, the excess mud went down the discharge line, instead of going back in the active system. This allowed 15 barrels of synthetic base mud (50% oil and 50% water) to go into the water.

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

The shaker hand did not realize that the valve was not fully closed.

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

The shaker hand was new to the position and the driller was new to the rig. There was lack of communication between the driller and the shaker hand.

20. LIST THE ADDITIONAL INFORMATION:

none

21. PROPERTY DAMAGED:

**none**

NATURE OF DAMAGE:

**n/a**

ESTIMATED AMOUNT (TOTAL):

**\$**

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

**Due to the specific nature of this incident, the Houma District has no recommendations to report to the Regional Office.**

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

**none**

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:

**Amy Gresham /**

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

**Michael J. Saucier**

APPROVED

DATE: **12-JAN-2006**