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

22. RECOMMENDATIONS TO PREVENT RECURRANCE 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

30. DISTRICT SUPERVISOR:
   Michael J. Saucier

APPROVED
DATE: 12-JAN-2006