
Atwood Eagle

Dropped Stand of 2-3/8" Drill Pipe

Outline

- Description of the Incident
 - The Investigation
 - Corrective Actions as a result of the investigation
 - Atwood Actions
 - Woodside Actions
 - Summary
-

Description of the Incident

- Derrickman moved the stand of 2-3/8" DP from the racking board finger to latch it in the elevators
 - Floormen below saw it hang up on the CSB, giving it a tug the DP bowed
 - Derrickman could not hold onto the pipe as the top of it fell below the racking board
 - The stand of DP continued to bow and fall out the aft v-door
-

Description of the Incident

- The lower end of the stand remained on the drill floor



Description of the Incident

- The top end of the stand fell across the aft pipe deck onto the well testing equipment below



Description of the Incident –

Stand of DP mid section final resting place – Looking up towards Drill Floor



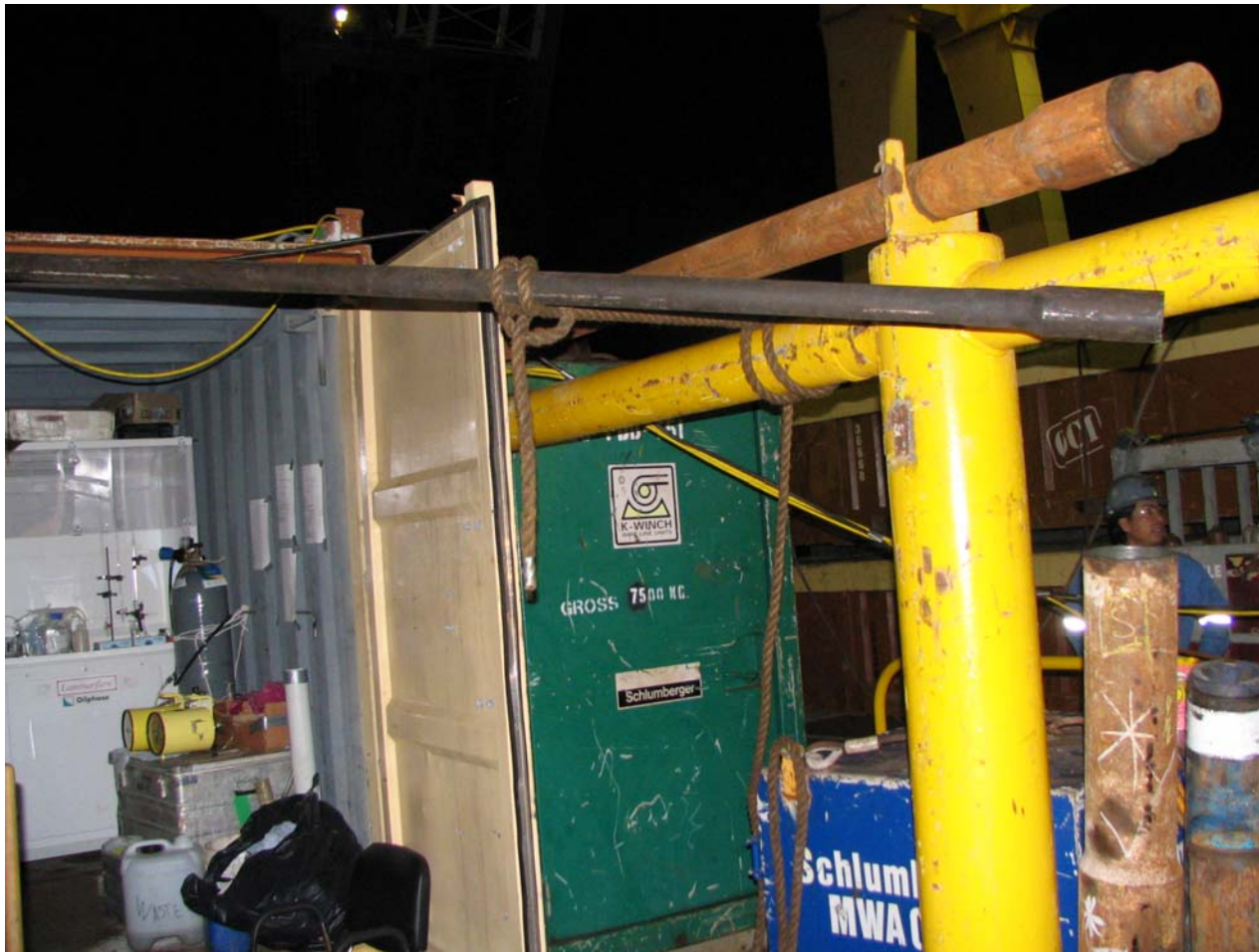
Description of the Incident –

Stand of DP final resting place – looking down towards pipe rack



Description of the Incident –

Stand of DP final resting place – top end on well test container



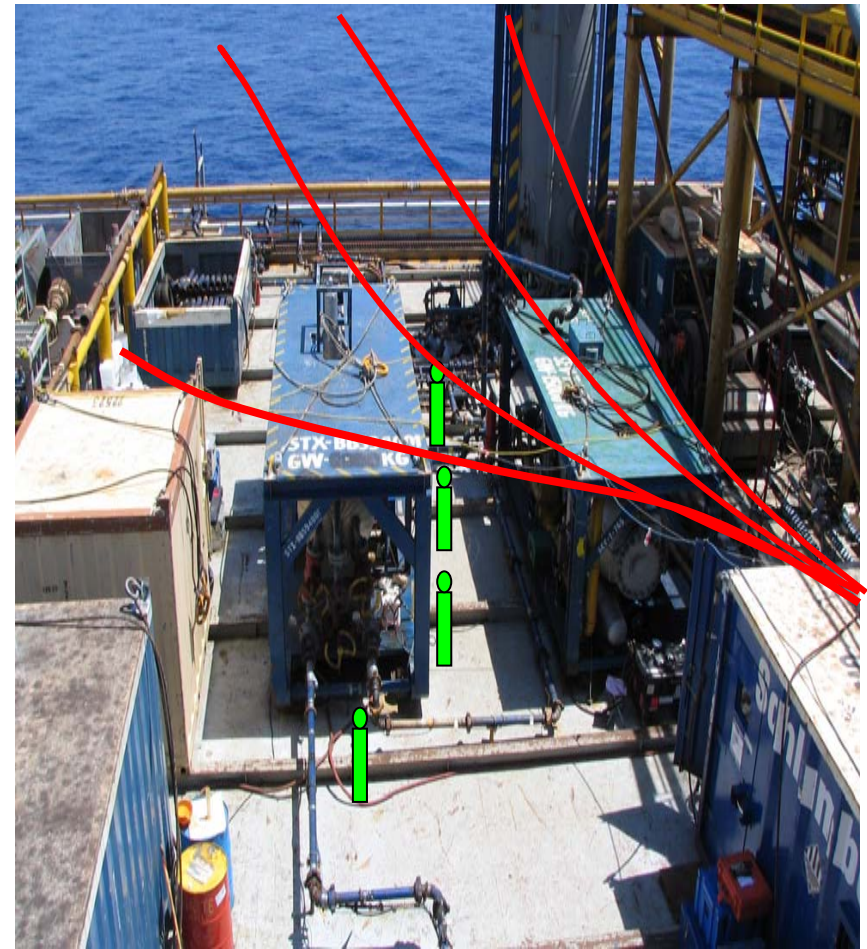
Description of the Incident – Drill Floor

- When the stand fell, the lower end of the stand struck a floorman on the shin lacerating it



Description of the Incident – Pipe Deck

- Location of several Well Testing personnel when the stand fell out of the derrick
- High potential for the DP stand to have hit one of them



The Investigation

- Team approach - joint investigation Operator, Contractor and Government
 - Investigation team consisted of 3 Woodside reps, 3 Atwood reps, and 2 NOPSA reps
 - The sight of incident was surveyed, personnel were interviewed
-

The Investigation - Findings

- *Due to hole problems, a contingency 6" Hole with 4-1/2" liner was implemented, using 2-3/8" DP to clean the liner*
- *Prior to the incident, the crew had much difficulty racking back a stand of 2-3/8" DP*
- *Perceived time saved by racking the DP*
 - *Lack of risk vs. reward assessment for this non-routine task*
- *Lack of experience with 2 3/8" DP*
 - *Failed to understand hazard*
 - *No recognition of the lack of experience*

The Investigation - Findings

- *No formal risk assessment before attempting to pick up the stand*
 - *after a number of warning signs*
 - *liner clean out program formal risk assessment did not identify hazards associated with handling 2-3/8" DP*
- *Communication & handover*
 - *verbal instructions to layout 2-3/8" DP not passed on via handover*
 - *handover while relieving not thorough*
 - *drillers log book didn't capture difficulty racking back 2-3/8" DP*
- *Rig was not equipped to rack 2 3/8" DP*

The Investigation

Root Cause

Inadequate risk assessment

Corrective Actions - Atwood and Woodside

- Issue directive:
 - Do not rack 2-3/8" DP on any rig that is not set up to handle small tubulars
 - Woodside and Atwood to notify all sites – fleet wide safety alert
 - Non-routine activities must always have appropriate level of risk assessment – onshore & offshore
 - Safety critical items given verbally, must be followed up in writing
-

Corrective Actions - Atwood and Woodside

- Add to campaign/well Hazard Register
 - Reinforce use of Driller's Handover Book
 - Supervisors to establish routine checks on Drillers Handover book to ensure the appropriate data is being recorded
 - Define standard ranges of tubulars that can be racked in derrick
-

Summary / Key Points

- Investigation report was presented to each crew – share the findings/involve the crews
 - Non-routine activities need to have the appropriate risk assessment performed (both onshore and offshore)
 - Take the time necessary to communicate important information during handovers
-

Any Questions?
