

# Sedco 703 Riser Spider

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# OMV “Maier-1”

Re-manned following  
Cyclone evacuation

BOP run & tested

Lay down handling gear

Install rotary bushings

P/U BHA & RIH

Metocean :

Pitch	0.1 - 0.4	deg
Roll	0.1 – 0.3	deg
Heave	0.4 – 1.1	ft
Wind	10 – 12	kt
Sea	2 – 4	ft

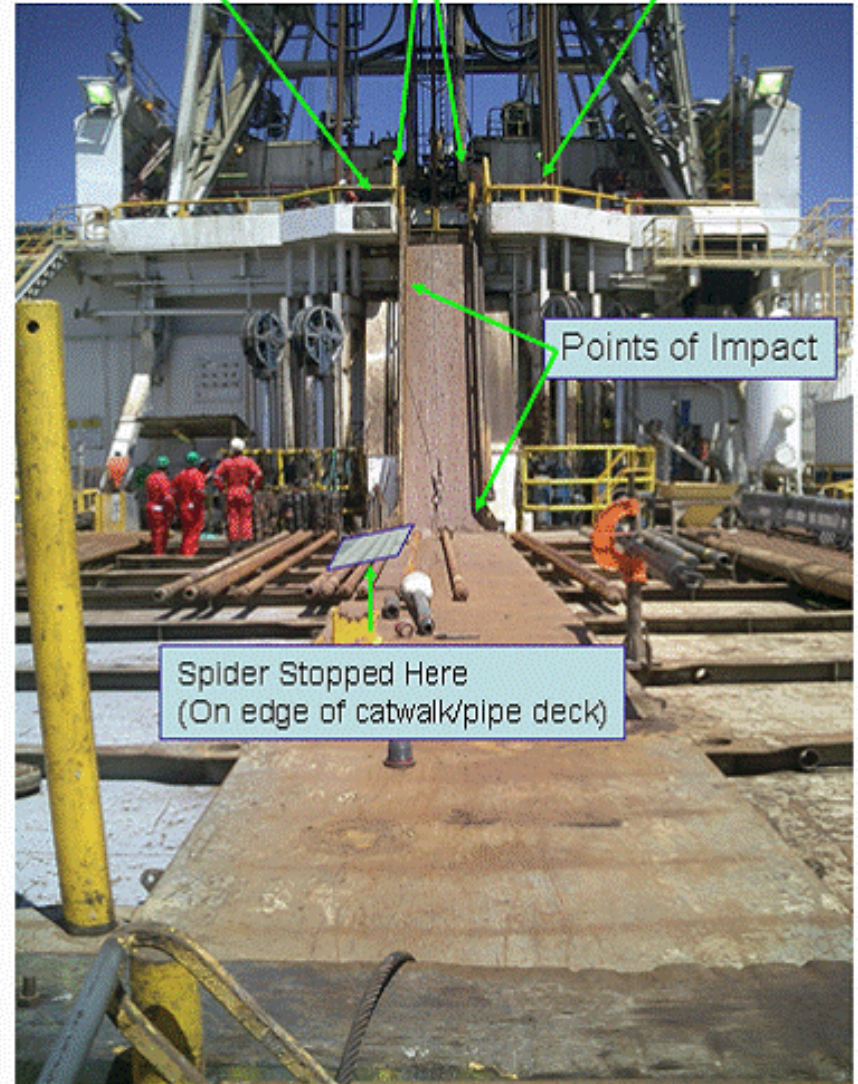




**While laying down the Riser Spider, the tugger line parted, resulting in the Spider descending unrestrained down the V-Door.**

**No injuries.**

Blue Tugger      Vee-Door Posts      Grey Tugger



View from Catwalk Tugger  
(Picture taken on 16-March)  
Spider resting position superimposed on this picture

# Investigation Results (Plans)

## Driller (SN)

Written THINK Plan for running the T/J

Verbal THINK Plan for L/D spider (incl. 3 floormen)

Used Riser-Running TSTP as basis

Planned to use tugger to lift spider

Planned activity sequence :

1. Release Diverter R/T
2. Remove Riser Spider
3. Install Master Bushing Ring
4. Install Master Bushing

# Investigation Results (Plans)

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Floorman (CP) Confirmed participation in Verbal THINK Plan for l/d down spider  
Described discussions and actions during THINK Plan

Floorman (HJ) Absent from Verbal THINK Plan (meal break)  
Received personal instruction from Driller upon return

Roustabout (GP) Received personal instruction from Driller when needed

Dogman (RM) Received personal instruction from Driller when needed

# Investigation Results (Plans)

Details of the incident using the THINK Process	
Was there a plan? What was the Plan?	There was a Verbal THINK Plan to Release Diverter Running Tool, Remove Spider, Install Master Bushing (M/B)Ring, Remove Diverter Running Tool (R/T) Install Master Bushing
Who Developed the plan?	Driller
Who was Informed about the Plan?	were involved directly. was advised upon returning to the rig floor from a meal break.
What equipment/ Material/Tool were inspected?	Blue tugger, Spider, Vee-Door, Catwalk tugger
Who Conducted the Inspections?	
What were the findings of the Inspections?	Tuggers working order, Spider lifting points identified, Vee-Door , Catwalk and Drill floor was free from debris and clear of personnel, .
What Potential Hazards were identified before, during and after the incident occurred?	Movement of the Riser Spider causing striking and crushing. Items falling down hole through Rotary Table opening. Spider falling down Vee-Door.
Who Identified these potential hazards?	
Who was informed of the Potential Hazards?	service hands, WIRELINE service hands (requested to leave the area – and complied)
What Control Measures were used to ensure the job was conducted safely (PPE, Guards, Barriers, warning, PTW, Isolation, supervision...)	Diverter Running Tool deliberately left in place as hole protection until Riser Spider removed. Supervision of Pipe Deck by Driller and Dogman to keep area clear of personnel.
Does the individual(s) involved consistently use the THINK Planning Process?	Very clearly it is commonly used.
Does supervisor(s) involved consistently promote and use the THINK Planning Process?	Strong support during all interviews for Driller's ( ) active promotion of the process

# Investigation Results (Actions)

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- Rigged up blue tugger to Diverter R/T (per plan), through elevators
- Released R/T, but left it in place – to serve as hole cover
- Transferred tugger to spider, attached catwalk tugger
- Picked up spider, pulled out V-Door
- Tugger line failed as Spider was crossing Vee-Door posts
- Spider fell down Vee-Door, striking rails twice, then settling on catwalk edge

(video playback)

# Investigation Results (Findings)

## Results of the Investigation

### Positive Findings

Training Systems used and highly regarded by crew members  
THINK system is actively used and working effectively  
Work area had been cleared of personnel (Drill Floor and Pipe Deck)  
Proactive safety attitude noted of all interviewees

### Immediate Causes:

Overloading tugger line.  
Inadequate knowledge of weight of load (investigation revealed that this extends to other similar-sized items which may be delivered to the rig floor).  
Supervisor getting too close to the job (driving tugger and giving signals).  
No independent observer providing co-ordination & oversight.  
Running tugger line through elevators resulted in increased tugger line load (to point of failure).  
Gap in Task-Specific-THINK-Procedure for running riser (no riser-spider handling details).

# Learning Points - Closing Considerations

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- Benefit gained from “No-injury investigation”
- Importance of “Good Oilfield Practice” - here, Keep Clear !  
At each stage, potential for spider to fall was emphasised  
(Verbal THINK Plan, Instructions to Deck crews, Instructions to service hands)
- Function of THINK plans