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Ocean Bounty Dropped Riser Stand Incident

Incident Number OB 144-03-07

Result - LTA

Well Location: AP-4

16th January 2007 @ 02:40



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Incident Details

- Completion Phase on 1st Angel well – Completion run, Tree was down and tested.
- Rigging up and running 9-5/8 Production Riser ready for well clean-up.
- Completion Riser had previously been run to land the tree.
- Change of plan – Riser was racked back rather than laid out in singles, and run through the V-door.
- Forward plan was to run LRP + EDP on Riser, then make up the surface flow tree.
- Immediately Prior to the Incident, 1 Stand of Riser had been run by the day shift crew utilizing the Racking Arm.
- Shift change, Night Supervisors absent from the pre-tour meeting –running the Production Riser was not mentioned .
- New crew started work in moon pool – on LRP + EDP.
- Then went to drill floor to run 2nd stand of riser.



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Operations leading up to the Incident

- A toolbox meeting & generic JSA (for tubulars) was held before the job commenced, but the associated Risks were not recognised or discussed. The Asst Derrickman (new to the rig) was in the derrick and did not attend the toolbox meeting.
- The Driller instructed the crew to tail in the Riser with rope.
- The Driller contacted the Asst Derrickman & informed him to get ready, he removed the stand from the fingers and positioned it in front of the monkey board.
- The Driller proceeded to bring the blocks up in low gear and at a slow pace.
- Whilst this was happening the IP was on the floor wrapping rope around the stand to tail it in.



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Incident

- The TDS service guard momentarily contacted the Riser's lifting collar, which caused the Riser to lift up approx 4-6 Inches, & simultaneously it moved towards the RT.
- The Asst Derrickman noticed the above and pulled back on the tugger line, this caused the Riser stand to come off the contact point on the TDS, allowing the stand to drop to the Rig Floor.
- The dropped stand (approx 2.5T) landed on the IP's right foot & bounced before coming to rest on the deck, giving the IP the opportunity to pull his foot away.
- The job was stopped immediately and the IP was carried down to the Rig Hospital, where the medic administered trauma care and prepared him for a medivac to Karratha.



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Post Incident

- Once the IP had been examined in Karratha Hospital, he was airlifted via the RFDS to Jandakot airport and then transferred to St. John of God Hospital in Murdoch where surgery was carried out that night to his foot.
- The Surgery resulted in the amputation of his three middle toes, partial amputation of his little toe and tip amputation of his big toe.
- The IP is currently undergoing rehabilitation and he is expected to lead a normal life and should be able to return to his previous job with no restrictions to what his duties entail.



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This is the lifting collar on the stand of production riser. Note the 2" lip above where the elevators would have latched.

Below, you can see where the joint's lifting collar caught on the VARCO front guard which caused the joint to lift up and land on IP's foot. Remember, by habit of running drill pipe/collars, the Derrickhand took the stand out of the rack/finger and the stand leaned into the upcoming top drive because there is not a lot of space between the top drive and stabbing area.



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This is the best approximation of where his foot would have been from the perspective of the other hands on the rig floor at the time. His position is between the stand and the stump in the rotary.

Note: the joint was not in this exact position when the actual event occurred, but where the joint finally stopped after the incident.







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Root Causes

Communications

- Risk not formally assessed by Rig Leadership. A RA was asked for but not carried out.

Competency / Compliance

- JSA Process not followed. A new JSA was not created to address the change in the program.
- Poor Leadership attendance at Safety Meetings – senior leadership was not present at the 23:30 pre-tour meeting.
- Basic hazard awareness (operation seen as routine)

Supervision

- Inadequate supervision / support for new / green hands (derrick man + driller)



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Corrective Actions

- Hazard awareness training for crews (Diamond + Woodside)
- Changes to the drilling procedures to be approved by the WEL Superintendent.
- Procedures for pre-tour meetings to be tightened and audited by Rig Management, WEL Supervisors & Ops Manager. Attendance at meetings mandatory.
- Greater clarity / rules around change control requirements / compliance (Woodside)
- Induction process for new derrickmen (even if experienced in industry) to highlight O. Bounty systems.
- JSA training for all crews (with updated material) – (Diamond)



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Corrective Actions - Contd

- Tool Box meetings to be attended by all that will be involved in the job.
- Flash Alert sent to the Diamond Offshore Fleet to highlight Incident and learning's from the Incident.



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Questions to ask your team

- If you ask for a risk assessment to be done, how do you know it has been?
- When there's a change to the plan, how do you assure it's managed safely?
- Does your well site leadership team drive safety performance at key pre-tour and TBT meetings?
- Is preplanning for managing hazards understood and complied with?
- How does someone new to your rig come up to speed?