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PDI Rig 724 Near Hit & Equipment Damage 30th May 2006

HIGH POTENTIAL

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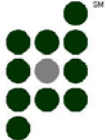


Incident Details

Rig Name/No. : PDI Rig 724
Location : Mimosa # 1
Incident Date : 30 May 2006
Incident Time : 20:00 Hours
Equipment : 8-5/8" Casing - Elevator
Operation : Running 8-5/8" Casing
Incident Type : Dropped Object
Type of Injury : No Injuries
Incident Class : Near Hit & Equipment Damage

Actual Matrix : A1
Potential : B4 (High)

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Incident Description



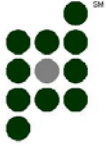
On 30th May 2006 at approximately 20:00 hours, the rig picked up a joint of 8-5/8" Casing from the V-Door and stabbed. The rig floor tugger was being used to align the joint for makeup.

Whilst doing so, the tugger line came in contact with the Elevator latch and unlatched the Elevator. The casing at first remained stationary.

The rig crew was instructed to clear the area. The Derrickman was instructed to climb the derrick and attempt to re-latch elevators from the derrick ladder.

Before derrickman got into position, the casing fell over, across the doghouse roof. The joint came to rest with the box end on the ground and the pin end jammed between the handrails on the doghouse roof.

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Incident Photo#1



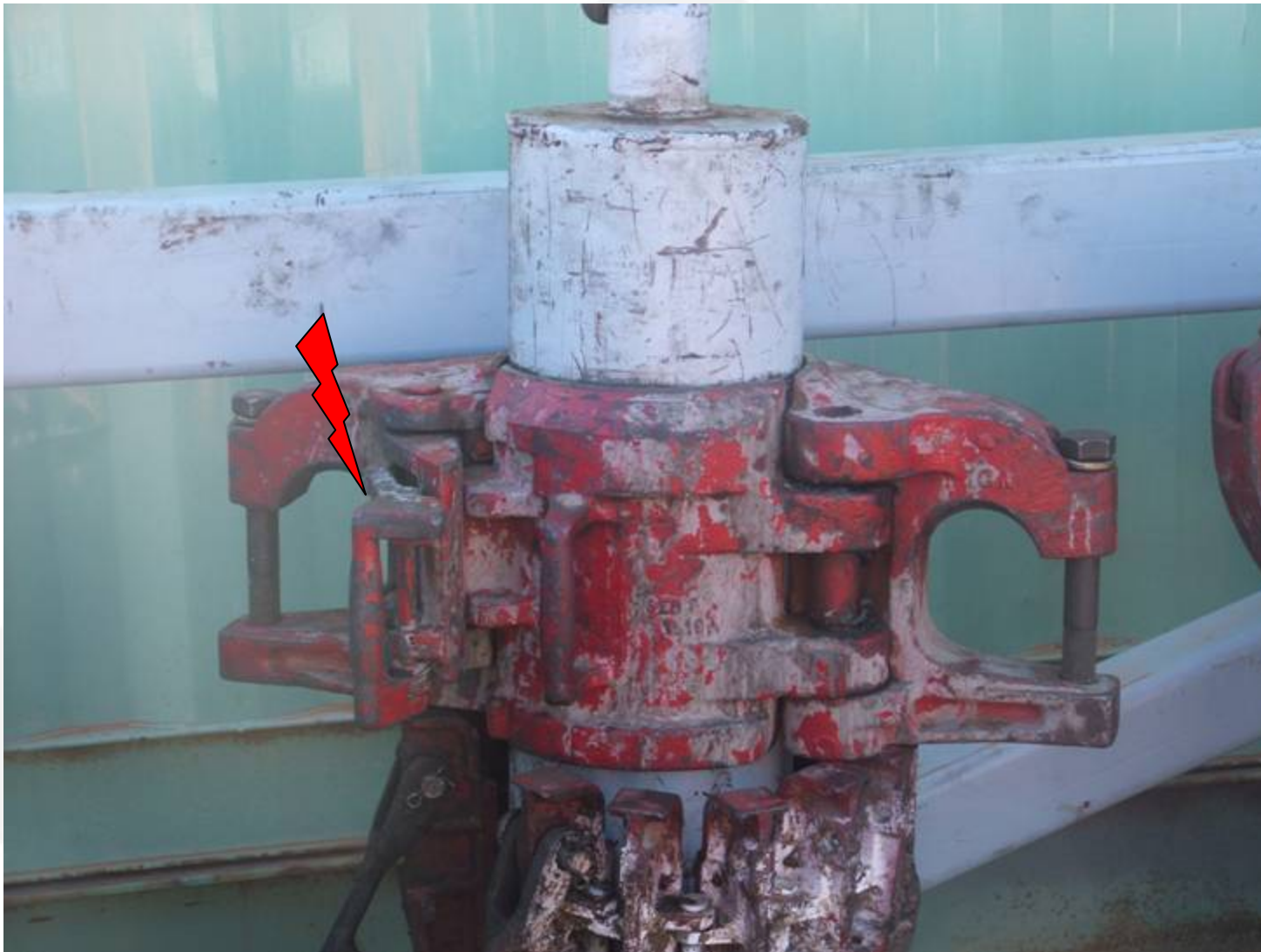
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Incident Photo#2



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Elevator Used



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Damages

Doghouse Roof Glass



Handrails



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Investigation Findings

POSITIVE

- ✓ Training Conducted on “Equipment Familiarization”
- ✓ Running Casing operation was discussed in the pre-tour meeting.
- ✓ Written TRA was in place that was originally issued on 6th May 06.
- ✓ Crew members are actively involved in reporting Haz-ID's
- ✓ Crew members are actively involved in reporting TRA Prompt Cards.
- ✓ As the elevator unlatched all crew were evacuated to safe point.

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Contributing Factors



1. THE TUGGER LINE UNLATCHED THE ELEVATOR :

- 1.1 Failure to follow the procedure (TRA). TRA issued does not include use of tugger for running casing.
- 1.2 Elevator design with protruding latch highly susceptible to accidental snagging and unlatch.

2. FAILURE TO RECOGNIZE THE HAZARD'S:

- 2.1 Whilst performing the task, no one recognized the hazard of possibly unlatching the elevator.
- 2.2 Prior to the task, no one recognized possible hazard of elevator latch design.

3. NO SOP's EXISTED FOR THIS TYPE OF OPERATION:

- 3.1 At the time of the incident, no S.O.P. had been developed on this rig for running casing.

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Root Cause



1. DIFFERENT TYPE OF ELEVATOR USED:

1.1 The elevator type used has a protruding latch handle.

1.2 No HAZ ID or Safety Observations provided by the rig personnel.

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Corrective Actions



1. Provided another type of elevator with a recessed latch handle and safety pin secondary latch.

✓ Status: Complete



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2. Created Standard Operating Practices (SOP) For Running Casing specific to Rig 724.

✓ Status: Complete



Microsoft Word
Document

3. Issued and distributed of HSE Warning Bulletin to PDI worldwide.

✓ Status: Complete



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Recommendations



Item	Description	Action	Completed By	Responsibility	Status
1	Policy/Procedure Rig 724 - A	Issuance of Standard Operating Practices (SOP) For Running Casing specific to Rig 724	01 st June 06	Senior Toolpusher Rig Superintendent	Complete
2	Policy/Procedure Rig 724 - B	Full Investigation	01 st June 06	HSE Manager/Rig Superintendent/Senior Toolpusher & Santos	Complete
3	Policy/Procedure Rig 724 - C	Add into SOP; Stab Casing into Stump lightly, maintain weight on elevators until rotation is started to assist in starting threads correctly	01 st June 06	Senior Toolpusher/Rig Superintendent	Complete
4	Information Rig 724 - A	Issuance and distribution of HSE Warning Bulletin to PDI worldwide	01 st June 06	HSE Manager	Complete
5	Information Rig 724 - B	Safety Meeting with all Crew	01 st June 06	Senior Toolpusher/Santos DRR	Complete
6	Engineering Rig 724 - A	Investigate further alternative elevator for future prevention of similar incidents	10 th June 06	Rig Superintendent	Complete

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Used elevators taken out of service



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