



Noble International Ltd.

NOBLE CHARLES COPELAND HIGH POTENTIAL NEAR MISS

**Drilling Operations Incident Review
Committee (DOIRC)**

10-Nov-2008

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What Happened

SUMMARY:

Type of Incident: Near Miss – High Potential

- Date: 06 October 2008
- Rig: Noble Charles Copeland
- Operator: RasGas
- Time: 0405 Hours
- Location of Incident on Rig: Rig Floor

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What Happened Cont



- The drill crew and deck crew were in the process of laying down 3-1/2" tubing. The tubing as prepared and bundled on the catwalk, then the tubing was bundled and placed on the cantilever pipe deck.
- When the catwalk was full of tubing that was being fed from the V-door, the Floormen would tell the Assistant Driller and the process would stop.
- When the bundle of tubing from the catwalk had been placed in the pipe rack and the catwalk was clear, the laying down of tubing from the drill floor would continue.

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What Happened Cont



- Prior to the incident, the catwalk was full of 3-1/2" tubing. No one communicated to the Assistant Driller - who was on the brake at the time - that the catwalk was full and to stop the process.

NOTE: The AD is experienced in his position and the Driller was standing near him observing the job.

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What Happened Cont



- The Floorhands had just picked up a single joint from the mouse-hole and moved the single to the edge of the V-door when they noticed the cat walk was full. The single hanging from the air hoist was then rested on the wood deck in front of the V-door ramp.
- The Assistant Driller had broken out and picked up the next single joint and was lowering it into the mouse hole, when the top drive struck the single joint that was attached to the air hoist line resting near the V-door.
- This resulted in the single joint being bent. There were no injuries.

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Immediate Causes

- The pre-job planning and JSA failed to identify the hazard that could occur with a single joint hanging on the air hoist line and resting on the rig floor and the top drive in motion.
- The Supervisor did not delegate any responsibilities / instructions to the positions (i.e. air hoist operator) about who was to communicate to the person operating the top drive-Asst. Driller.
- Due to the rotation of the workers positions it was not clear to them which one was responsible to carry out the controls. No clear hand-over was conducted when rig floor personnel changed positions.

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Immediate Causes

- Due to the configuration of the derrick, the air hoist line placement allows it to be in line with the side of the top drive. Normal practice for laying down 5" drill pipe would be to install a sheave under the monkey board for the tugger line to deviate it away from the top drive. This was not done for laying down the 3-1/2" tubing.
- The Driller, who just came back from a break was at the Driller's console with the Assistant Driller and both of them were focused on the tubing joint going in the mouse-hole. Neither realized the hazard of the single joint of tubing that was standing near the V-door. They thought the Floorman was pushing it out the V-door.

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Basic Causes

- Inadequate Leadership
 - a) Unclear or conflicting assignment of responsibility.
 - b) Inadequate identification of risk assessment.
 - c) Giving inadequate procedure, practices or guidelines.
- Inadequate Communications: Inadequate communications between peers and work groups.
- Lack of knowledge - Lack of situational awareness

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Lessons Learned

- Ensure that personnel are aware and understand the responsibilities and controls and are obligated to stop a job that deviates from normal procedures.
- Ensure that JSAs are complete with all tasks, hazards and controls specified and responsibilities assigned and communicated.

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Preventive Actions

- Develop a new JSA with all the specific steps and controls required to:
 - a) - lay down DP/ tubing-
 - b) include the hazards involved with tubing /DP hanging on a tugger line
 - c)- TDS coming in contact
 - d) - add tugger line deviation sheave under monkey board as part of the controls.
- Ensure when a JSA is reviewed during the pre-job meeting, the Supervisor delegates responsibilities for the controls indicated on the JSA. The Supervisor shall ensure each member understands his responsibility, and indicate this on the JSA with each person signing their own name.