

# Fra hendelse til læring

Sikkerhetsforums årskonferanse 8 juni. 2022

Sondre Svenningsen

Principal Engineer Drilling Technology Well Control, Equinor og medlem i Well Incident Task Force

# Innhold

“Fra hendelse til læring”


- 1- Introduksjon
- 2 - Brønnkontroll hendelser
- 3 - “Sharing to be better”
- 4 - Veien videre

# 1- Introduksjon

- Reduksjon av brønnkontroll hendelser og fokus på brønn integritet er svært viktig for å kunne redusere risiko for storulykker på Norsk sokkel.
- Systematisk kunnskapsdeling av brønnehendelser i følgende Norsk olje og gass nettverk:
  - Drilling Managers Forum (DMF)
  - Well Integrity Forum (WIF)
  - P&A forum (PAF)
  - Well Incident Taks Force (WITF)
- Well Incident Task Force ble opprettet i 2010 da DMF og Norges rederiforbund etablerte en arbeidsgruppe med fokus på økt læring fra hendelser og med mål om at sannsynlighet og konsekvens av brønnkontroll hendelser blir redusert.
- Kunnskapsdeling også mot internasjonale interesseorganisasjoner som UK OG og IOGP.


## 2 - Brønnkontroll hendelser

- Alle hendelser blir klassifisert iht NOROG guideline 135 og presentert iht felles mal.
- Fokus også på “non classified”
- Presenteres fortløpende i Drilling Managers Forum og Well Incident Task Force.
- Direkte og underliggende årsak



### Well control incident

<b>Location:</b> <Location> <b>Rig type:</b> <Rig type> <b>Well type:</b> <Well type> <b>Date:</b> <Date>	<b>Well control incident category:</b> ..... <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="background-color: red; color: white; padding: 2px 5px;">Level 1</div> <div style="background-color: yellow; padding: 2px 5px;">Level 2</div> <div style="background-color: green; color: white; padding: 2px 5px;">Level 3</div> <div style="border: 1px solid black; padding: 2px 5px;">None class.</div> </div>																								
<b>Plan:</b> <ul style="list-style-type: none"> <li>• Description of plan.....</li> </ul>	<b>Impact:</b> Lost time, HC release, etc...:																								
<b>Operation with course of events:</b> <ul style="list-style-type: none"> <li>• Event description.....</li> </ul>	<b>Illustration / Well bore schematic</b>																								
<b>Reason for events:</b> <ul style="list-style-type: none"> <li>• Free text evaluation</li> </ul>	<b>Critical Issues:</b> <ul style="list-style-type: none"> <li>• Free text evaluation</li> </ul>																								
<b>Lessons Learned:</b> <ul style="list-style-type: none"> <li>• Free text evaluation</li> </ul>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Direct Cause:</th> <th style="width: 50%;">Underlying Cause:</th> </tr> </thead> <tbody> <tr><td>Prognosis incorrect</td><td>Risk accepted</td></tr> <tr><td>Shallow gas</td><td>Error in program / procedure</td></tr> <tr><td>Shallow water flow</td><td>Procedure not followed</td></tr> <tr><td>Incorrect mud weight</td><td>Lack of competence</td></tr> <tr><td>Swabbing</td><td>Communication error (missing, wrong, incomplete, etc.)</td></tr> <tr><td>Ballooning</td><td>Incorrect use of equipment</td></tr> <tr><td>HC accumulation below barrier element</td><td>Equipment failure</td></tr> <tr><td>Surface pressure control system failure</td><td>BOP failure</td></tr> <tr><td>Downhole mechanical barrier failure</td><td>Other: .....</td></tr> <tr><td>Downhole cement / casing barrier failure</td><td></td></tr> <tr><td>Other: .....</td><td></td></tr> </tbody> </table>	Direct Cause:	Underlying Cause:	Prognosis incorrect	Risk accepted	Shallow gas	Error in program / procedure	Shallow water flow	Procedure not followed	Incorrect mud weight	Lack of competence	Swabbing	Communication error (missing, wrong, incomplete, etc.)	Ballooning	Incorrect use of equipment	HC accumulation below barrier element	Equipment failure	Surface pressure control system failure	BOP failure	Downhole mechanical barrier failure	Other: .....	Downhole cement / casing barrier failure		Other: .....	
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## 2 - Brønnkontroll hendelser

- Årlig oppsummering av egen arbeidsgruppe utnevnt av DMF.

- Utvalgte hendelser blir en læringspakke -> «Sharing to be better».



Incident Causes			
Direct Cause		Indirect Cause	
7	Prognosis incorrect	13	Risk accepted
3	Shallow gas	3	Error in program/procedure
	Shallow water flow	1	Procedure not followed
3	Incorrect mud weight		Lack of competence
2	Swabbing		Communication error
	Ballooning	2	Incorrect use of equipment

### Conclusion

- The total risk related to well control incidents in 2021 has increased in 2021 compared to 2020
- In a longer perspective the total risk related to well control incidents remains flat.
- PPP continues to be a common root cause
- The serious (yellow) incident was caused by shortcomings in operational plans and lack of precision during execution
- Continued shallow hazard incidents with low potential
- Learning from non-classified incidents indicate some weaknesses with barrier awareness and competence

### 3 - “Sharing to be better”

- Tilgjengelig åpent på web-siden til Norsk Olje og Gass.
- Rundt to «læringspakker» utarbeidet årlig fra 2010 til dags dato.
- Operatøren som eier hendelsen utarbeider læringsmaterialet.
- Materialet blir gjennomgått av WITF før publisering.
- Brukes i både on- og offshore i for eksempel «Well control forum»

#### Sharing to be better - Incidents

[Sharing to be better #1, Well control incident in 9,5 inch section](#)

[Sharing to be better #2, Well control incident in 8,5 inch section](#)

[Sharing to be better #3, Shallow gas incident](#)

[Sharing to be better #4, Gas influx from shale](#)

[Sharing to be better #5, Well control incident - Completion](#)

[Sharing to be better #6, Well control incident – pulling tie-back string](#)

[Sharing to be better #7, Drilling 8,5 inch reservoir section, HPHT](#)

[Sharing to be better #8, Incident – Drilling of reservoir section](#)

[Sharing to be better #13, Total mud loss followed by kick from a semisubmersible drilling unit in "karstified carbonates"](#)

[Sharing to be better #14, Well control incident during plugging](#)

[Sharing to be better #15, Well control incident during completion](#)

[operations](#)

[Sharing to be better #16, well control incident during preparation of side-track after plugging](#)

[Sharing to be better #17, well control incident during perforation](#)

[Sharing to be better #18, Influx while drilling with a Managed Pressure Drilling Unit in use](#)

[Sharing to be better #19, Influx in overburden section of \(HPHT\) exploration well - MAASP at shoe significantly exceeded](#)

[Sharing to be better #20, Well control incident - Drilling 8-1/2" hole section](#)

[Sharing to be better #21, Well Control Incident - Failed downhole mechanical isolation barrier](#)

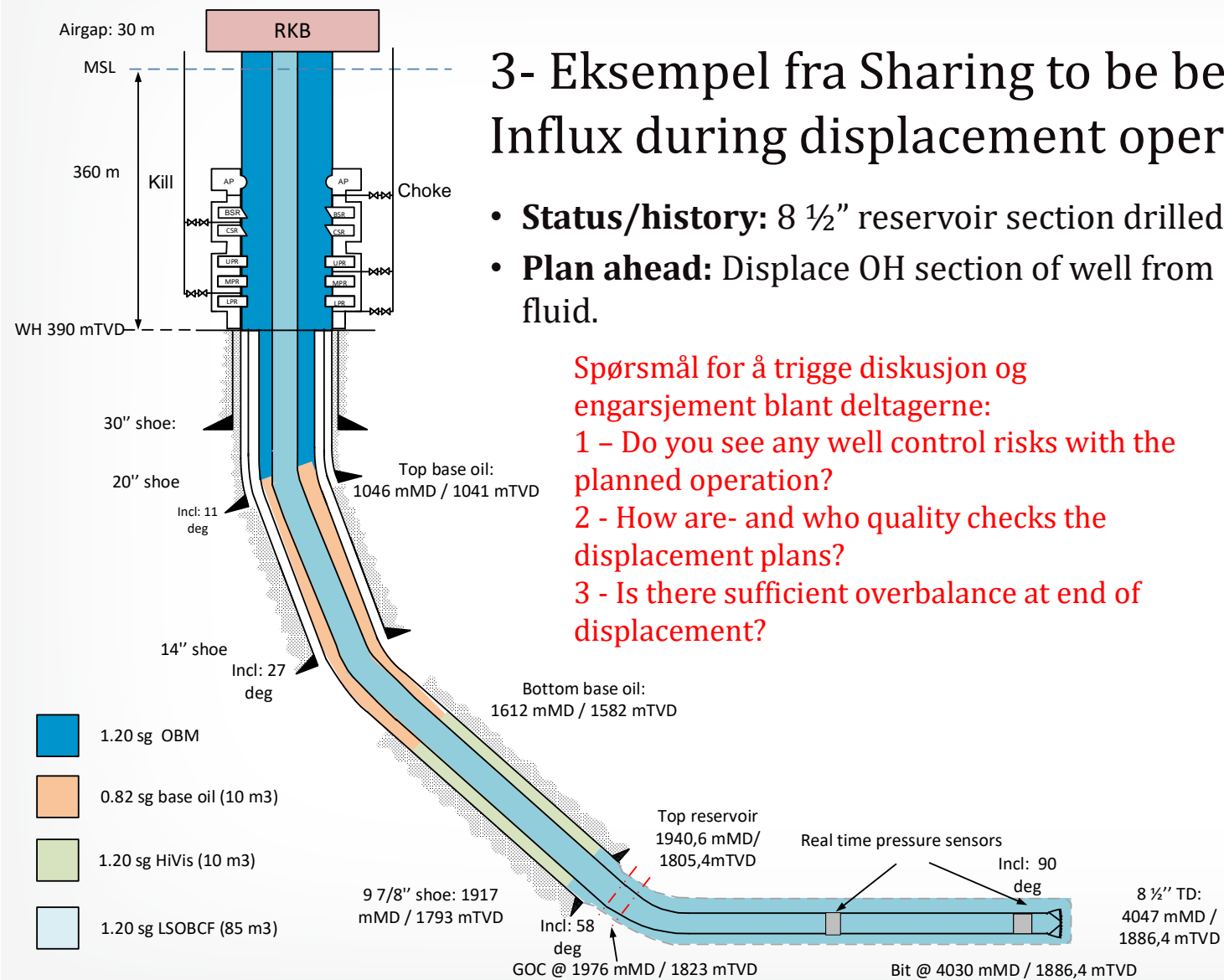
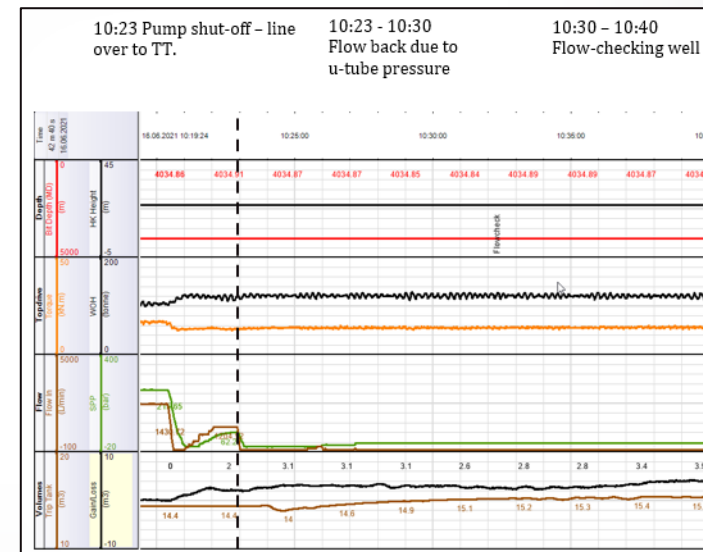
### 3- Eksempel fra Sharing to be better #22 – Influx during displacement operation

- **Status/history:** 8 ½” reservoir section drilled to well TD at 4047 mMD
- **Plan ahead:** Displace OH section of well from OBM to low solids completion fluid.

Spørsmål for å trigge diskusjon og engasjement blant deltagerne:

- 1 – Do you see any well control risks with the planned operation?
- 2 - How are- and who quality checks the displacement plans?
- 3 - Is there sufficient overbalance at end of displacement?

### Faktisk data fra hendelsen



## 4 - Veien videre

- WITF og Norsk olje og gass vil fortsette arbeidet med læring og erfaringsoverføring fra brønnehendelser.
- Viktig med åpenhet og deling av informasjon blant alle involverte.
- Det er i alles interesse at alle lærer mest mulig for å unngå brønnehendelser og at vi bidrar til kontinuerlig forbedring og reduksjon av risikonivået på norsk sokkel.