

What went wrong?

While running 30" casing, a worker found a circlip on the rig floor.

The operation was immediately stopped, and a thorough search commenced which identified the 30" elevator hinge pin was missing the circlip.

The elevator was safely lowered to the rig floor and assessed.

The crew identified the elevator was upside down due to the way it was assembled by a third-party supplier.

Visually the elevator gave the appearance it had been correctly assembled (Photo A).

The elevator was reassembled and re-orientated correctly (Photo B).

What was the risk?

The elevator was assembled incorrectly by a third-party supplier.

While the hinge pin was correct the latch pins were installed upside down.

The potential risk of operating the elevator upside down were:

- The hinge pin could have dropped out.
- The elevators could have unlatched allowing the casing to drop.

Photo A – elevator received on site



What were the learnings?

Photo B – elevator reassembled



Learnings:

- Ensure QA documents are supplied with all third-party equipment.
- Having a robust process for receiving equipment on-site and using checklist.
- The importance of continued education and training of all staff.