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**REFERENCE: COMMISSION OF INQUIRY: MONTARA WELL
HEAD PLATFORM UNCONTROLLED HYDROCARBON RELEASE**

Added Information to **SUBM.1810.0001.0001**

**1. Investigate and identify the circumstances and likely cause(s) of
the Uncontrolled Release.**

Upon reading the PTTEPAA / Atlas Drilling submissions, the opinions of individual engineers, and those concerned with the environment e.g., Rachel Siewert's (listed below as Note 1) there are two issues to be resolved by this commission in TOR 1 for it to achieve total effectiveness.

One: The Root Cause – failure of the cement job –

The failure is due to bad operating practices during the drilling, and during the casing and cementing operations in an area where a large number of kicks (see Note 2, below, Hazard Awareness) have been experienced.

The key point is to recognize that the practices followed on Montara, are in general, the same ones used by all operators, globally, for completions in the circumstances similar to Montara H1. Additionally, all the practices are approved by regulatory agencies, globally.

The commission should demonstrate what this bad practice is, and why it is being followed by the drilling and completion industry. In the process of

revealing this bad practice, it can ensure that issues a) to h) in Rachel Siewerts submission for TOR 1(Note 1) are answered holistically.

Job practices are determined and justified by an operations management team. The first documents to determine how this is done are in the Scope of Work and AFE (Authority for Expenditure) documentation.

Because much of this work will have been done prior to PTTEPAA's acquisition of the project, it should be investigated what data handover occurred to the new operator, and what the well data management and reporting systems were before and after, that ensured the before and after operating teams were fully informed of the expected practices.

Critical information/knowledge regarding the cementing practices will be necessary to see what actions were responsible for the uncontrolled flow.

The way operational procedures are developed and equipment is selected for the job must be clearly understood. Every organization has a work pattern (archetype). Often one of cost cutting prevails and drives decisions that lead organizations (operationally and regulatory) to miss a holistic approach that optimizes organizational learning and ensures reliability.

Exposing this archetype would give confidence to the environmental groups that a reliably centred operational management process can be created in the industry.

Note 1: Submission by Senator Rachel Siewert – TOR 1(Quote)

I believe that key questions that must be addressed within this Term of Reference include:

- a) Was PTTEP Australasia, or any other company, at fault?
- b) Was the well faulty in some way?
- c) Could the uncontrolled release have been prevented?

- d) Was the drilling design and assurance process adequate?
- e) Did the operators do an offset well review to identify known drilling hazards in the area?
- f) To what extent were lessons learned by other companies available to the operator? Apparently other companies have had problems drilling in the Timor Sea area – particularly with horizontal wells. For example,

Laminaria-8 had wellbore stability problems that required several

sidetracks to fix. Problems included drilling through shale at a high

angle. Corallina-3 encountered highly permeable fractures in the

reservoir that could have led to a well control incident if not noticed and rectified. Neither of the above caused an incident due to good contingency planning and good hazard management/control processes. Were these issues built into the design of the well?

- g) Did the activities by the West Atlas rig cause or contribute to the leak?
- h) What caused the fire on the West Atlas rig?
- i) It has been suggested that the Montara field is a marginal development that has changed hands several times. Low cost development may have been required to make this project feasible. Did focus on cost create a loss of focus on safety and on technical integrity?

Note 2: Hazard Awareness

Research by the CSIRO has identified some 50 kicks in and around the Australian continent over the last 20 years, with a majority of them occurring in

NW Australia. Hence, this has ended up being where the bad practice, plus the failure of two non return valves (float shoe / float collar) led to the uncontrolled flow. The planning and procurement process for this project will need to be evaluated in full (eg. Review of emails, programs, tenders and contracts & purchase orders along with the onsite operating and surveillance practices.

2. Review the adequacy and effectiveness of the regulatory regime applicable to operations at or in connection with the Montara oil field, including under the Offshore Petroleum and Greenhouse Gas Storage Act 2006, and including the adequacy and effectiveness of all safety, environment, operations and resource management plans, and other arrangements approved by a regulator and in force at relevant times.

Comments in submission suggest that operator and the regulatory functions were carried out with insufficient staff and experience considering the prolific nature of the reservoirs and the complexities of the well profiles.

This needs evaluation in a systematic way. Recommendations should be taken to ensure the needs of a reliability centred organization have been met. Attached as Note 3,

3. Assess the performance of relevant persons in carrying out their obligations under the regulatory regime.

The opportunity exists for the regulatory authority to create a mentoring/ coaching / just-in time learning reliability oversight group that can collaborate with all parties involved. This would include creating an on-line Induction process and an awareness building program similar to one code named TRUE (training to reduce unscheduled events).

The complexity of operations is well illustrated in a World Oil Online article "Analysis of gas flow yields recommendations for best cementing practices" by Ray T. Oskarsen, John W. Wright and Danny Walzel . Although such an analysis is done by a range of expertise, it is basically approving the practices followed on the Montara drilling and completions operations. This reinforces the requirement of a system that builds the wisdom of an organisation.

The inquiry should consider the role of an oversight group can be like an NGO and operate globally, possibly through the World Banks GDLN (global distance learning initiative). Any party who has a concern as to the reliability of an operation can be given a demonstration of what the hazards are and how the risk is mitigated.

Lastly, consider implementing a systems thinking process developed around the carbon emissions market metrics, where each individual footprint, relevant to the discipline and purpose within an organisation, is intrinsically motivating, and can be used to provide a holistic quality assurance measurement on line using the power of digital multimedia, indexed SQL databases and Internet.