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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.

The testimonials of the hearing are becoming a concern in that the linear approach to evaluating the causes of the uncontrolled flow doesn't give a view of all the complex relationships that have created the situation of the flow itself. There is a likelihood that the actual root cause isn't going to be realised. Please take the following as a suggestion to help align the inquiry so as to achieve the real causes per TOR 1.

I quote the statement

“Notably, however, the blowout the subject of this Commission of Inquiry is the worst of its kind in Australia's offshore petroleum industry history”

In November 1968, the Marlin Development Platform in the Bass Strait of Victoria, had a well where a kick broached the surface casing shoe releasing formation gas into the faults and sediments of the ocean floor adjacent to the platform..

There were no liquid hydrocarbons in the emissions even though the target formations were oil.. The gas did not ignite and the well was killed using Red Adaire and his team.

Is it because there was no liquids being leaked that makes it a lesser blowout than Montara H1? No lessons learned from that event.

It would be such a waste for the global petroleum industry and regulatory agencies for nothing to be learned from the Montara inquiry. Awareness and Transparency of raw data are key to getting a reliable outcome for the inquiry. It is off to a good start in regard to being transparent but it seems to be a bit “managed” with regard to information available.

Discussion for Approach Strategies

By the hearing incorporating un massaged information with time vs activity data for the total period of drilling, running the casing, carrying out the cement job and suspending the well, everyone will get to see how the situation was created for allowing the uncontrolled flow to occur. Confused collaboration as being presented during well construction operations can lead to the same results on the Inquiry.

Data plots vs time and vs depth of loads on the travelling block, any rotation, etc., pump pressures, pump rates, cementing mix rates, density of slurry, displacement rates, times when operations stopped, etc. are required to establish what practices and phases of operation created the final scenario for the uncontrolled flow.

Reports are written and as verified by all participants in the hearing, mistakes can occur.

A news headline says “**Witness denies changing oil spill statement**”

Possibly the Montara Inquiry participants can discuss the experience with persons who carried out the Piper Alpha Royal Commission and the Valdez oil spill inquiries, to gain a full understanding as to how the Montara Inquiry can achieve its goals.

There is a complex matrix of information that is digitally recorded as frequent as every 10 seconds during operations. This is the information that will explain the root cause. The pressures, pump rate and volumes pumped by the cementing unit, the volumes bled back etc, the rate and the time, should all be available in ASCII format.

The total picture of what has happened can be created graphically and spatially to avoid the disjointed discussions that are evolving from the testimonials.

There will be evidence to show that the root cause is more than the cementation process at the casing shoe. If the purpose of the inquiry is to determine the causes so that such an event will not occur again, then it is imperative that the “root cause” be determined, not one of the very superficial ones indicated in the March 15th testimony below.

The press carries statements like “***The inquiry has heard problems emerged during the cementing and while workers thought they fixed it by pumping 16.5 barrels of seawater down the casing and letting the cement set, this action may have weakened the barrier, which has since been identified as a root cause of the 74-day leak.***”

There are a lot of issues as to why gas got inside the casing and slowly migrated up the hole to cause the burp, which in turn underbalanced the formations behind the casing. It can be demonstrated that there are other practices that are the “root cause” of the uncontrolled flow. It is likely that the leaking floats and channeling of different fluids had all ready created a flow channel.

The introduction on first day of hearings state:

This Inquiry, in holding a public hearing, seeks to address the major contested issues relating to the blowout having regard to the material thus far obtained by the Inquiry. These contested issues, in the assessment of counsel assisting, relate in particular to terms of reference 1 to 4, being the cause of the blowout, the adequacy of the regulatory regime and the performance of regulatory obligations by relevant persons and entities connected to the wellhead platform and the West Atlas rig.

As counsel assisting, we note and emphasise that the terms of reference of the Inquiry do not call for the Inquiry to seek to determine the civil liability of any person or entity with respect to the cause of the blowout.

Nor is the Inquiry required to consider any issues of entitlement to compensation as a consequence of the blowout.

The above-stated issues are illustrative only. However, as already noted, the major issues to be addressed in the course of this hearing relate to the causes of and circumstances surrounding the blowout. It is to these issues which I now turn.

They can be broadly divided into four general subject areas, all of which concern, to some extent or other, the question of blowout barriers.

The first general topic is the cementing of the 9 and 5/8 casing shoe and annulus on the H1 well in March 2009.

The second broad topic concerns the installation of a 9 and 5/8 PCC in March 2009 and the non-installation of a 13 and 3/8 PCC in April 2009.

The third broad subject area concerns the suspension of the H1 well in and around March/April 2009.

The final broad subject area concerns the actions taken upon re-entry of the H1 well in August 2009 in the lead-up to the blowout.

I shall now briefly address each of those four broad subject areas in a bit more detail. Firstly, as to the cementing of the 9 and 5/8 casing shoe and annulus on

the H1 well in March 2009 - within that broad subject area, a large number of subtopics arise for consideration. First, it appears that incorrect volumes of cement were used when the casing shoe was cemented in March 2009.

PTT admit, in their submissions to the Inquiry, that 133 barrels of tail cement were used, whereas 199 barrels of tail cement should have been used to achieve what's called top of cement, or TOC, 50 vertical metres in height above the reservoir.

How and why did this occur? Why was the mistake calculation concerning the volume of cement not detected at the time?

What systems were in place to ensure that correct volumes of cement would be used in order to achieve top of cement above reservoir? What was the effect of using the wrong volume of cement in terms of the integrity of the cemented casing shoe as a barrier?

Conclusion

There is a case to be evaluated. Possibly the four subject areas stated on Day one of Testimony are not really linked to the root cause.