



# High Potential Near Miss with - Lessons Learned

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Schlumberger Wireline

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# Agenda

- Incident and root cause
- Actions and Lessons Learned
- Managing Alertness
- Addressing Behavior factors
  - Empowerment and Accountability
- Progressive Accountability Guidelines

# Cable Near-miss

## Immediate Causes:

### 1. Contact / Exposure:

- Fell to Lower Level

### 2. Substandard Practices

- Failure to secure
- Improper Placement

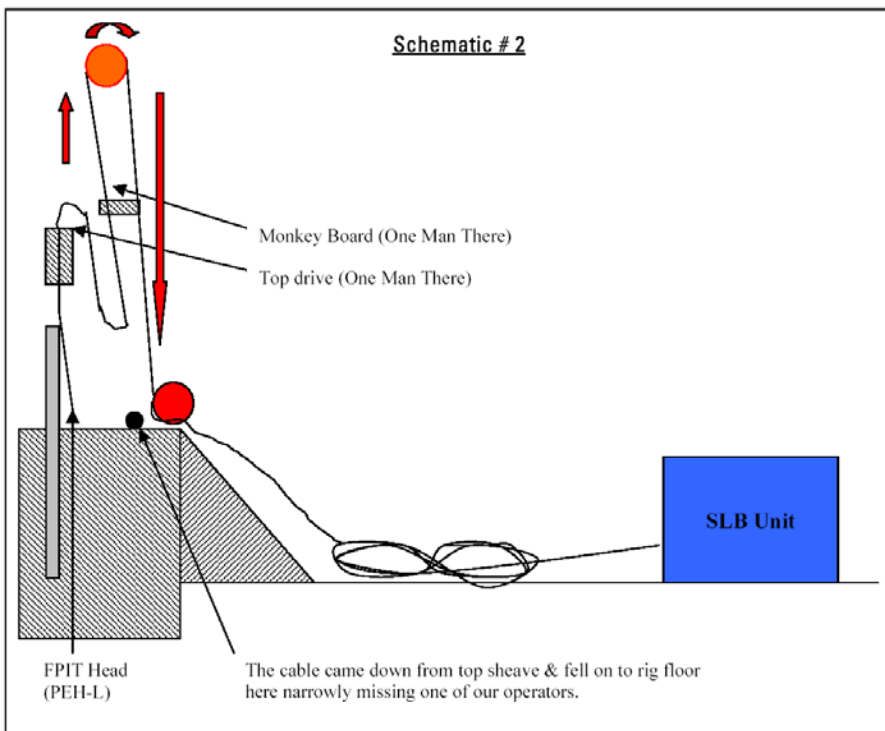
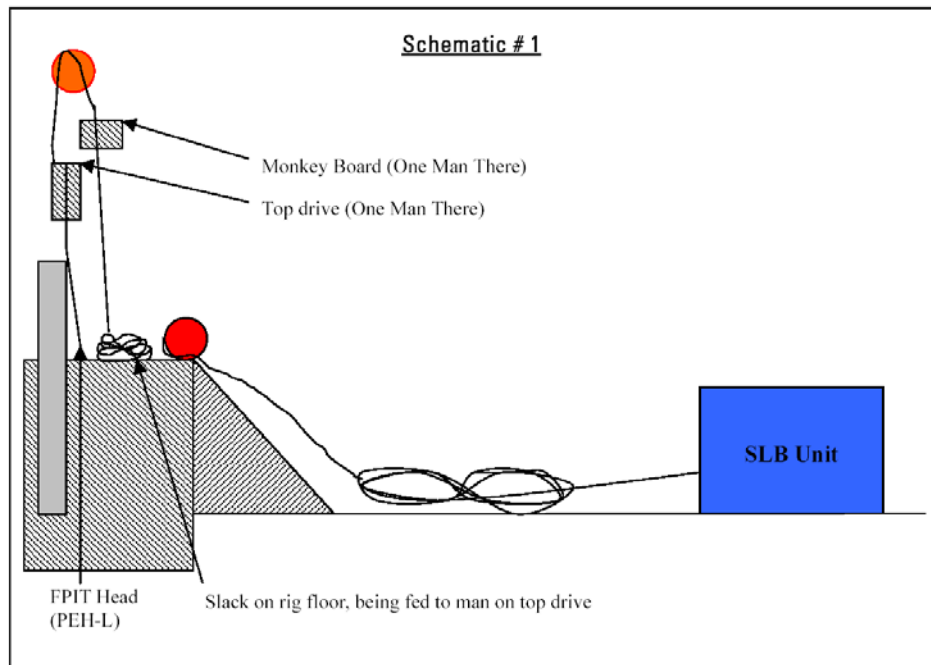
## Root Causes:

### 1. Personal Factors

- Lack of Knowledge
- Stress - Awareness

### 2. Job Factors

- Inadequate Leadership / supervision
- Inadequate work standards



# Remedial Actions



- Addressing Awareness
  - Develop Lesson Learnt and distribute to all operating crews
  - Share Lesson Learnt with Drilling Community via SLB Drill Safe Committee Member
- Review JSAs for "Standard" and "Non-Standard" Operations
- Share Investigation results, Incident Analysis with Rig OIM
- Present Circadian Rhythm to OMV, Rig OIM, Rig personnel & refresher to SLB employees
- Rollout of “We are Each Accountable” initiative across region

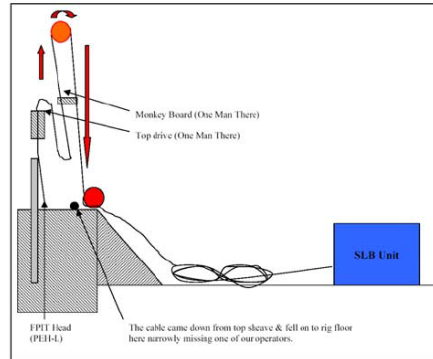


## “High Potential Risk” from a cable free-falling to rig floor

### Incident Summary:

On Dec 18, 2004 at 4:45, and when passing FPIT head through the Top Drive, there was excessive slack on rig floor that was not spooled back to the unit. As the head was having a controlled descent to the rig floor, all of the cable slack was picked up from the rig floor, but some slack existed between the top drive and the upper sheave wheel as per schematic below. This caused imbalance of cable weight at both sides of the upper sheave, that resulted in the cable moving backwards towards the unit (as per arrows). The rig-crew member, who was stationed on the monkey board, could not prevent the cable from moving and was lightly struck by the cable as it made an uncontrolled descent, free-falling, to the rig floor. The cable missed a SLB operator, who was standing on the rig floor.

No one was injured but incident had **Major** potential.



### Immediate Causes:

#### Substandard Conditions

1. Exposure:
  - Fell to Lower Level
2. Substandard Practices
  - Failure to secure
  - Improper Placement

### Basic Causes:

#### Substandard Job/Personal factors

1. Personal Factors
  - Lack o Knowledge
  - Stress
2. Job Factors
  - Inadequate leadership/supervision
  - Inadequate work standards



Are The **KEY** to Prevention

### Lack of Control

- Design and Planning
- Risk Management

### Suggestions for Improvement

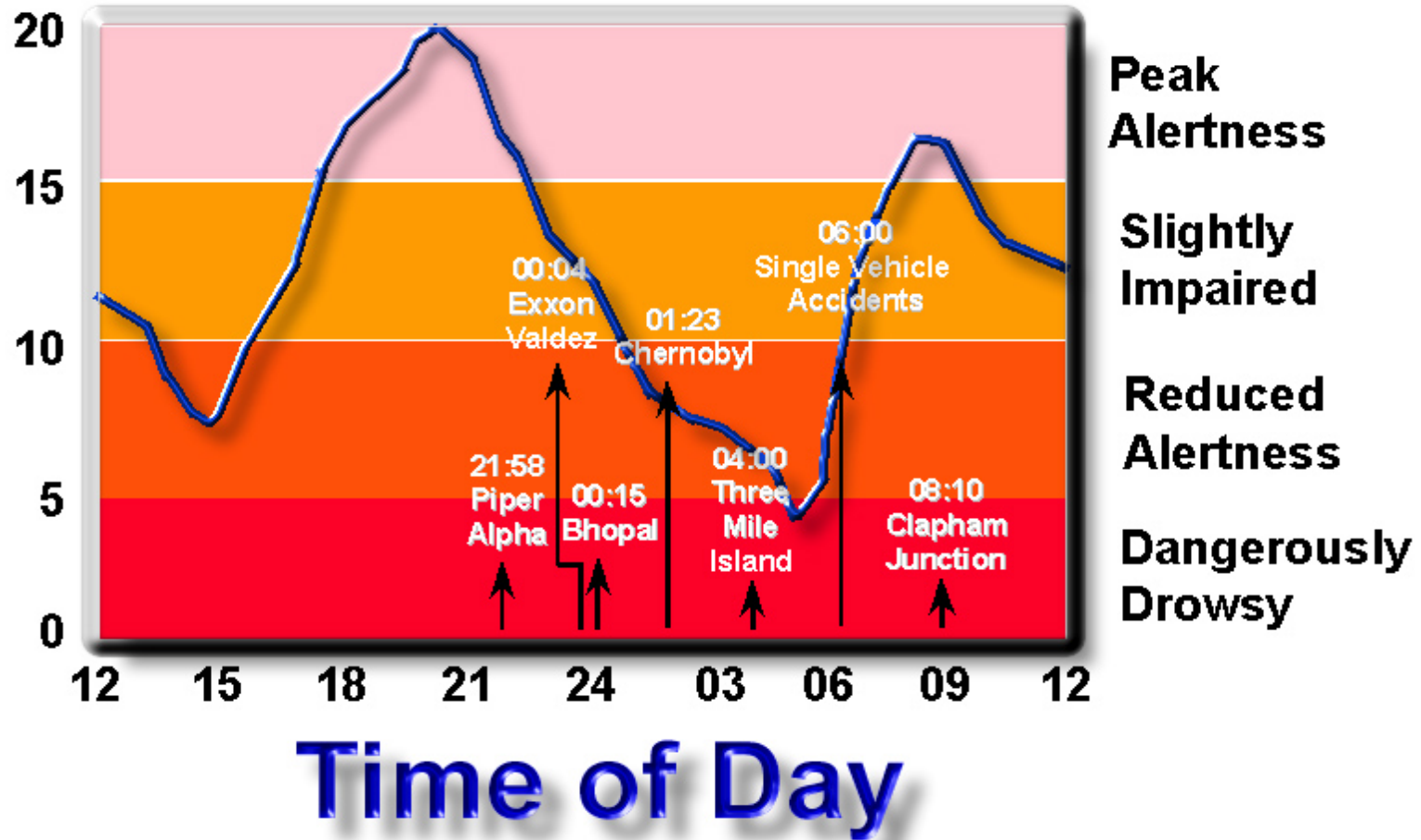
Lack of risk identification and lack of judgment of cable weight imbalance at the two sides of the sheave could have led to a **major** accident.

JSA review by SLB Field Engineer and the crew is critical to the safety of the operation, where operational activities are discussed, potential associated risks are explored and mitigation measures shared.

For more details, please find in QUEST Report No. 20041222124215

Alert No.	Applicability	Issued by	Approved by	Date
	All	Adam Mooney	Odd Oeen	1-Jan-2005

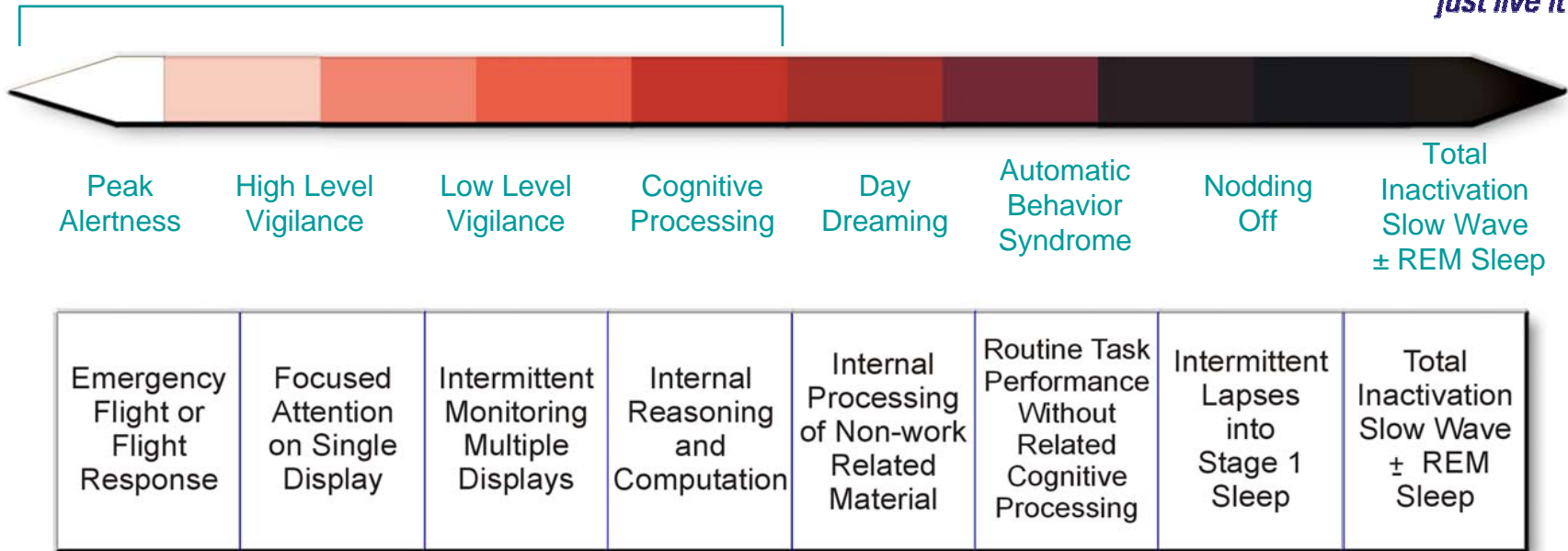
# Fatigue Related Human Error and Circadian Rhythm



# Human Alertness



## Desired On-Duty Operating Range



## Actual On-Duty Operating Range in Continuous Round-the-Clock Operations

- Take a prework nap
- Manage points of low alertness
- Vary routine of the job
- Manage breaks
- Manage environment
- Manage nutritional intake

# Behavior, Accountability, Empowerment

