

DRILLSAFE JUNE 2006

MS Excel Form

Info about your own company
personnel working on site

Submitted monthly
*(first report by end June to include six
separate months Jan-Jun inclusive)*

Each Company to nominate focal point

DRILLSAFE			
Health and Safety Performance Statistics			
ALL RETURNS SHOULD BE SUBMITTED BY 12th of the MONTH to the Drillsafe Administrator. Email: leanne.potter@halliburton.com Returns should relate to the previous Calender Month only			
Company Name:	<input type="text"/>	Month:	<input type="text"/>
Total No Man Hours - Month	<input type="text"/>	YTD Man Hours	<input type="text"/>
Incidents - Injury (total per month):-			
# of Fatalities & Permanent Disabilities	<input type="text"/>		
# of Lost Workday Cases	<input type="text"/>		
# of Restricted Work Cases	<input type="text"/>		
# of Medical Treatment Cases	<input type="text"/>		
Proactive Reports (total per month):-			
# of Near Miss Incidents	<input type="text"/>		
# of STOP (or equivalent) observations	<input type="text"/>		
Frequency Rates (ytd):-			
Lost Time Incident Frequency LTIF (per million man hours)	<input type="text"/>	#DIV/0!	
Total Recordable Case Frequency TRCF (per million man hours)	<input type="text"/>	#DIV/0!	
Incident Location: Total No			
On-Shore	<input type="text"/>		
Off-Shore	<input type="text"/>		
Company Facility / Office / Workshop / Yard	<input type="text"/>		
Vehicle	<input type="text"/>		
Body Part Injured:-			
Head	<input type="text"/>	Groin	<input type="text"/>
Facial	<input type="text"/>	Shoulder	<input type="text"/>
Eyes	<input type="text"/>	Arm	<input type="text"/>
Neck	<input type="text"/>	Elbow	<input type="text"/>
Back	<input type="text"/>	Wrist	<input type="text"/>
Trunk	<input type="text"/>	Hands	<input type="text"/>
Hip	<input type="text"/>	Fingers	<input type="text"/>
		Leg	<input type="text"/>
		Knee	<input type="text"/>
		Ankle	<input type="text"/>
		Foot	<input type="text"/>
		Toes	<input type="text"/>
		Multiple	<input type="text"/>
		Other	<input type="text"/>

CASING STABBING BOARDS

Running 9 5/8 casing :

TDS contacted and damaged stabbing board fold-down flap

Stowing Stabbing Board :

Stabbing board door hinge hung up on guide frame, assembly failed and bolt fell to floor.

Running 9 5/8 casing :

Shoulder popped out when reaching out to stabilise casing joint being made up

September Forum –

Possible preventative and mitigating alternatives.

“EXTERNAL INCIDENT”

REVIEW MEETING – AUGUST 2005



Injured Person:

Assistant Crane Operator

Incident Date

August 25, 2005 @ 05:25 am

Location:

Pipe and Main Deck

Event:

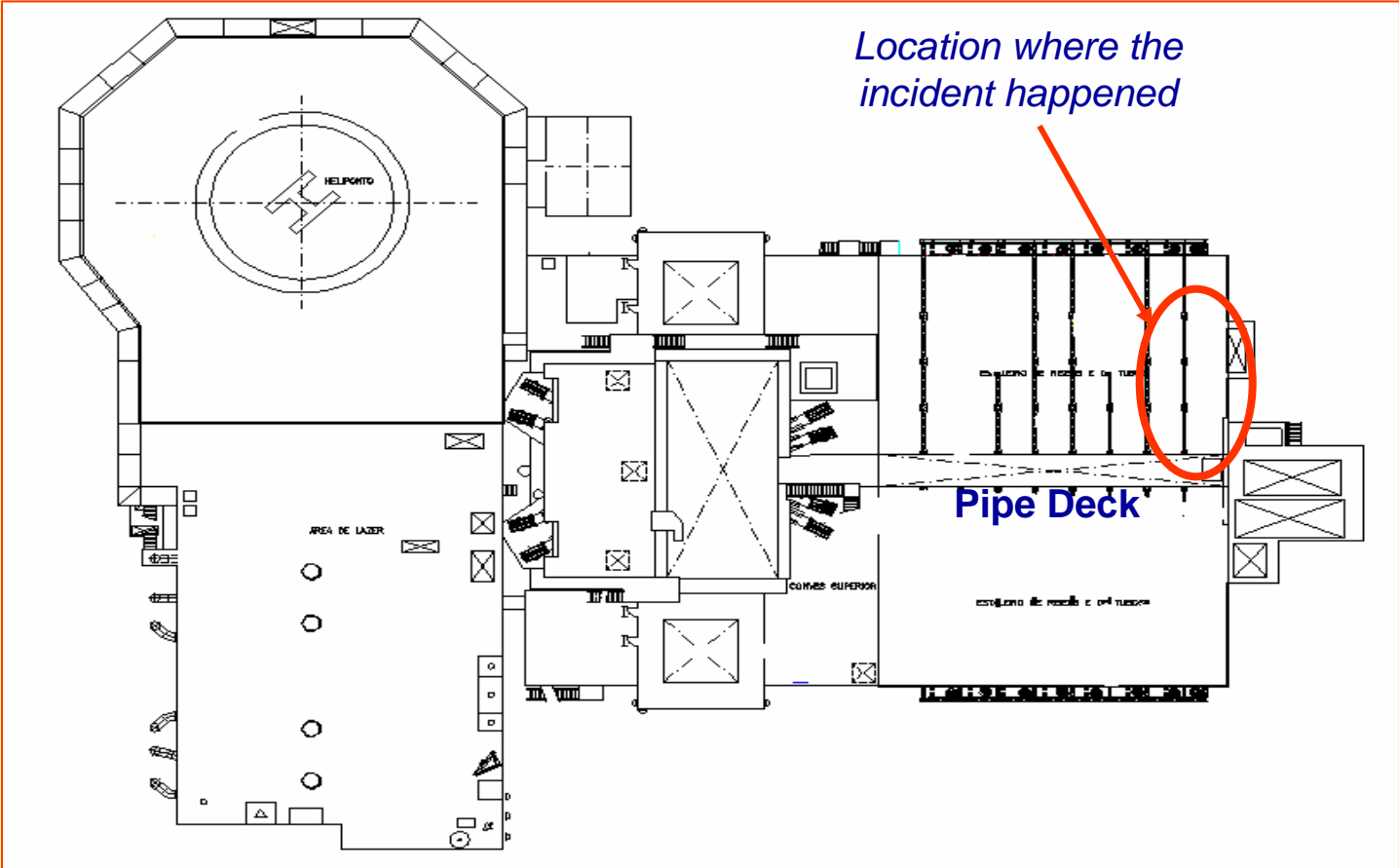
Lifting basket ; IP trapped in tag line

Injury:

Line fissure on the neck of radius arm

INCIDENT REVIEW MEETING – AUGUST 2005

Location



INCIDENT REVIEW MEETING – AUGUST 2005

Incident Description

As IP finished attaching tag line, uncoiling it to straighten it up, suddenly the load was lifted.

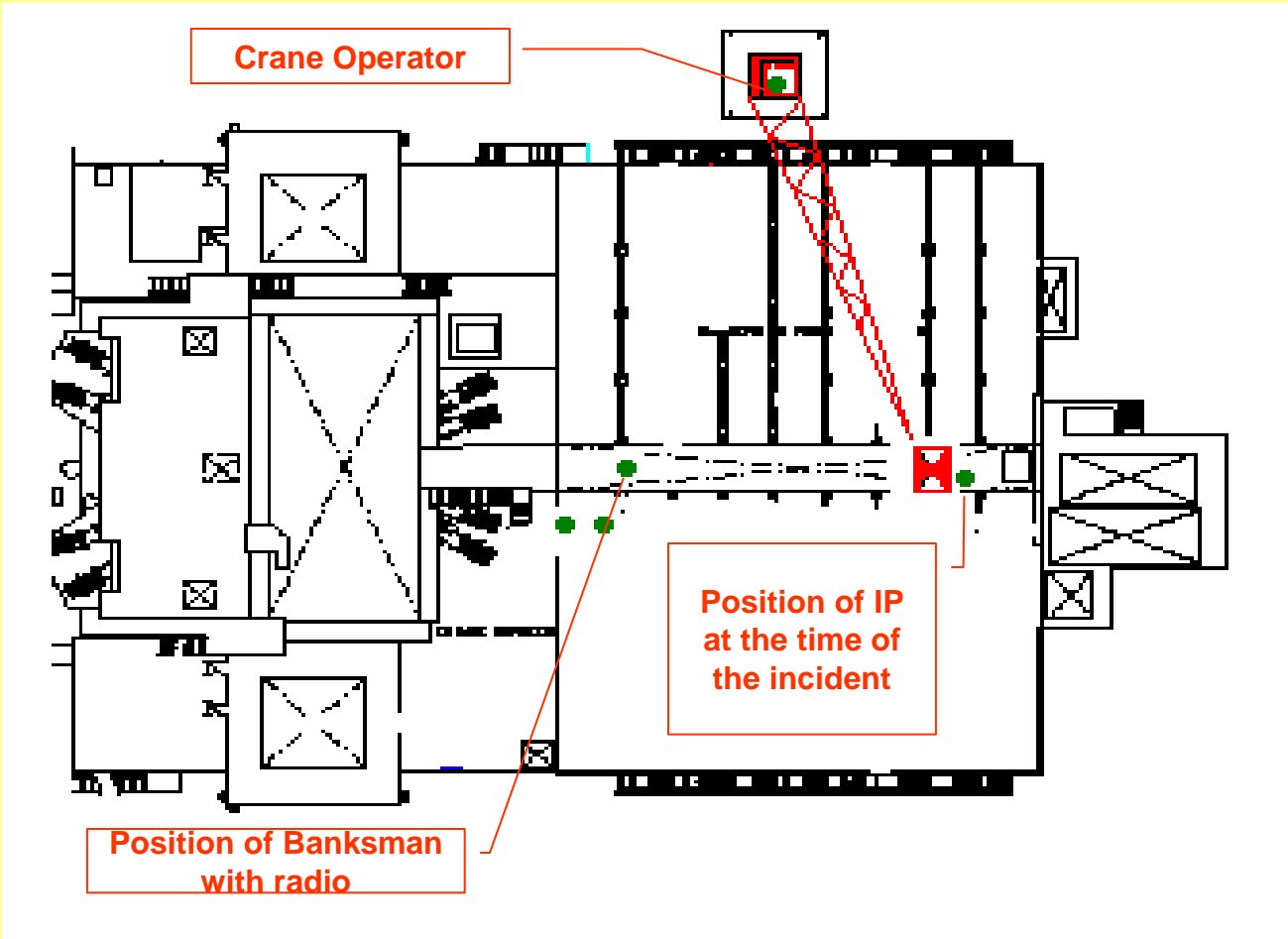
He saw that the tag line was wrapped on his left foot and afraid to be dragged, he jumped on the rope and was lifted with the load that was already swinging to Starboard Aft of pipe deck.

Crane Operator received an order from the Banksman by radio to stop and return with the load.

Crane Operator immediately stopped the crane (load already overboard about 3 meters).

Due to the inertia, the movement of the load hit the rig structure on its way back forcing the IP to release the rope falling onto the escape route from approximately 2 meters.

INCIDENT REVIEW MEETING – AUGUST 2005



INCIDENT REVIEW MEETING – AUGUST 2005

**IP position
before the
lifting operation**

**Tag line
wrapped
on his foot**



INCIDENT REVIEW MEETING – AUGUST 2005

Crane operator's view inside the cabin before the lifting operation



Crane wire



Crane Operator's view at 05:25 am

INCIDENT REVIEW MEETING – AUGUST 2005

Banksman's position with radio



**Load being lifted
with rope wrapped
on IP's foot**

INCIDENT REVIEW MEETING – AUGUST 2005

**IP's position right before
the load hit the structure
on its way back**



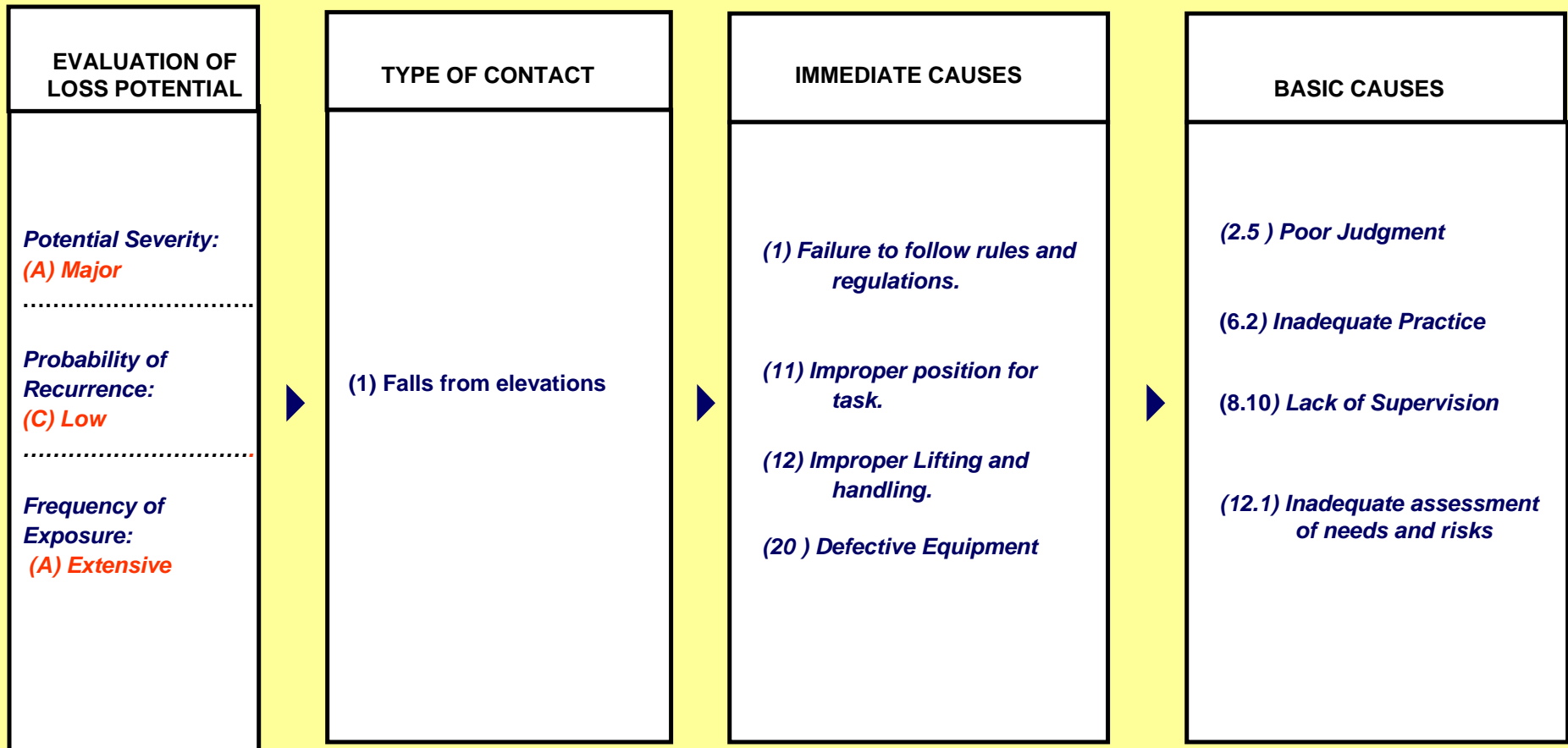
INCIDENT REVIEW MEETING – AUGUST 2005

**IP's position after
falling onto the
main deck**



INCIDENT REVIEW MEETING – AUGUST 2005

Incident Analysis



INCIDENT REVIEW MEETING – AUGUST 2005

IMMEDIATE CAUSES

(1) Failure to follow rules and regulations / (12) Improper Lifting and handling.

The lifting of the load was done without the previous communication between the banksman and roustabout (IP) to certify that the load was safe to be lifted.

(11) Improper position for task

The IP positioned himself near the load having his foot wrapped on the tag line while trying to uncoil the rope on the deck before the lifting.

The banksman was not near the load and could not see neither the IP nor the crane operator as he ordered the lift using the radio.

INCIDENT REVIEW MEETING – AUGUST 2005

IMMEDIATE CAUSES

(12) Improper Lifting and handling.

The IP was alone holding the tag line at the moment of the incident.

20) Defective Equipment

Crane Boom camera was not working during the incident.

(25) Poor Housekeeping

Containers stored on top of risers in the pipe deck obstructing the complete view of the crane operator.

INCIDENT REVIEW MEETING – AUGUST 2005

BASIC CAUSES

(2.5) Poor Judgment

Banksman ordered to lift the load without certifying that the load was prepared to be lifted.

(6.2) Inadequate Practice

The banksman was not well positioned to confirm the load was safe to be lifted.

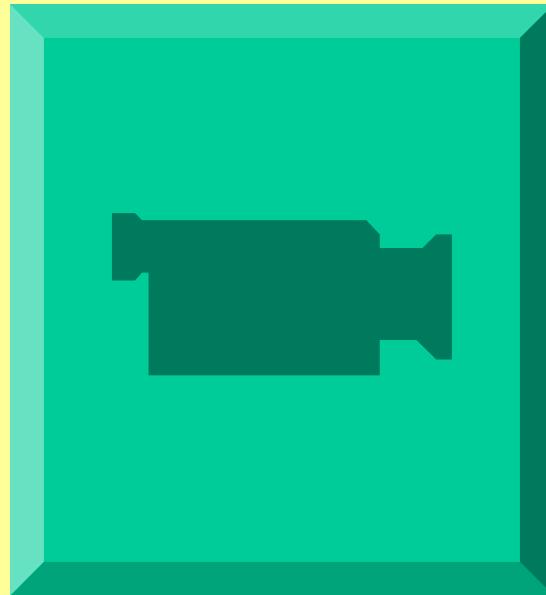
(12.1) Inadequate assessment of needs and risks / 8.6 Inadequate work plan

The Planning Process was not used therefore all potential hazards and associated risks were not identified prior to the operation.

(8.10) Lack of Supervision

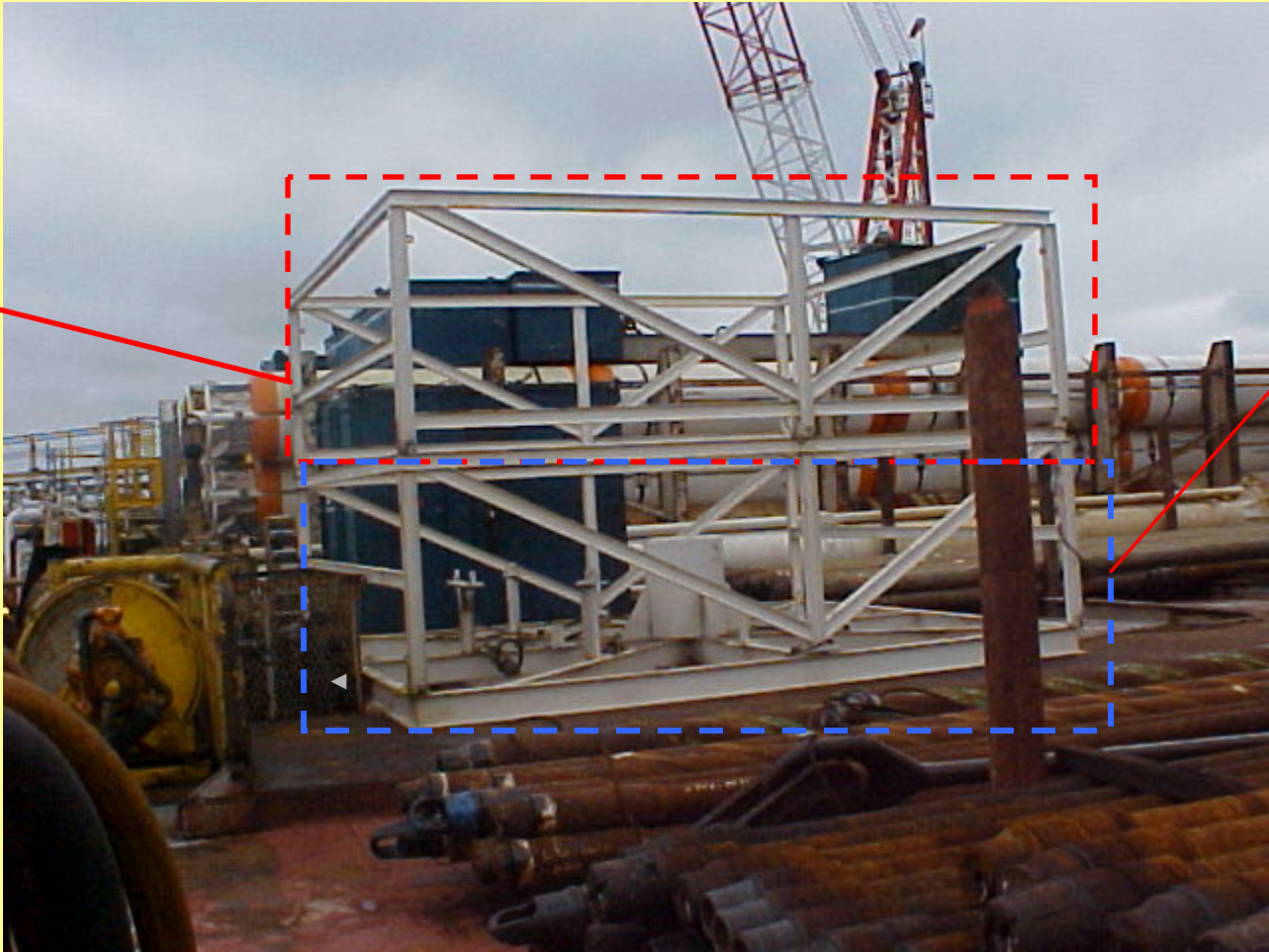
The Planning Process was not used and the supervisor was not involved in the planning stage of the operation with all involved personnel.

INCIDENT REVIEW MEETING – AUGUST 2005



INCIDENT REVIEW MEETING – AUGUST 2005

Upper section
was lifted
before the
accident



This bottom
section was
on the main
deck for lifting

Causes	What will be done	Who	When will it be done	Where	Why will it be done	How will it be done
Improper position for the task. Improper lifting and handling	Redo the Roustabout OJT training / Read and understand the Mechanical Lifting Procedures.	All Marine and Deck Crew	30 th October	On board	Increase awareness of the crew with regards to correct position related to the lifting operations	Redo the OJT for their specific position with 90% score.
Failure to follow rules and regulations <i>Improper Lifting and handling. (Mechanical Lifting Procedures not followed)</i>	Portable radios will not be used as primary means of communication during normal crane operation, only in conjunction with hands signals.	Captain	Immediately	On board	To prevent that banksman use radios as primary communication source	Keep all portable radio under responsibility of marine department in the control room
Failure to follow rules and regulations <i>(Mechanical Lifting Procedures not followed)</i>	Portable radios will be used during crane operation only under WORK PERMIT with Deck Pusher/Chief Mate or Captain's supervision	OIM - Captain - Chief Mate	Immediately	On board	To prevent the use of portable radios as primary communication source	Keeping the inventory of all portable radios in the control room with control of Chief Mate and Captain

Causes	What will be done	Who	When will it be done	Where	Why will it be done	How will it be done
Failure to follow rules and regulations <i>(Mechanical Lifting Procedures not followed)</i>	Operation of only one crane at the time. Two cranes will be used only with Deck Pusher/Chief Mate or Captain supervision under a Work Permit .	Captain & Chief Mate	Immediately	On board	To avoid the use of reduced crew on crane operations	Work Permit will need to be raised to run two cranes.
Defective equipment Boom camera not working .	Consider this safety device as a shut down item keeping a complete spare system onboard	Electrical & Maint. Supv.	Immediately	On board	To prevent use the crane without camera	Insert order point to one in warehouse inventory
Defective equipment Boom camera not working .	Investigate the possibility of identifying and installing a better monitor screen in the Crane's cabin	Electrical & Maint. Supv.	Immediately	On board	Improve Crane Operator's view of load site	Keeping this addition view used to crane operators

Causes	What will be done	Who	When will it be done	Where	Why will it be done	How will it be done
Poor house keeping Excess load on top of Risers	Reinforce with client the necessity to keep top Risers free of loads	Captain/OIM & Rig Manager	During contract duration	On Board	To prevent reduced visibility of crane operators to pipe deck area	Adding note on ADP on a weekly basis expressing the importance to maintain top of Risers without load when the BOP is on the surface
Poor house keeping Excess load on top of Risers	Bring to Asset Team attention to the hazardous condition created when storing loads on top of Risers	OIM & Rig Manager	During contract duration	Rig & Office	To reduce exposure of employees to hazardous operation	Sending Petrobras letters and add this improvement opportunity on monthly and quarterly meetings
Poor Judgment Crew without experience role-playing as Banksman	Roustabouts & Assistant Crane Operators will attend Banksman's training. Green hands will not carry out the role as Banksman	Safety Officers	Sept-30th	Training Room	To be sure the whole crew is fully trained to take the role of Banksman except the green hands	Using a Transocean training CD available

Causes	What will be done	Who	When will it be done	Where	Why will it be done	How will it be done
Poor Judgment Crew without experience role-playing as Banksman	Supervisors to assess their co-workers knowledge and skills	Supervisors	Sept-30th	Training Room	To confirm personnel have work skills required for the position - Know your people	Carry out a quarterly appraisal on Junior staff using Company's appraisal form
Lack of Supervision	Carry out regular audits to verify that written THINK Plans are performed when moving loads over the sea.	Supervisors/OIM	Immediately	On board	To verify if the supervisors are involved on the THINK Planning process	Carry out a documented audit every week and implement corrective actions when deficiencies are found
Lack of Supervision	Be present at work site when Crane Operators are carrying out their handover and participating on THINK Planning exercise.	Deck Pusher/Chief Mate	Immediately	On board	To assure planning will be performed at the start of crew shift	A documentation review will be performed by OIM and logged on focus database on a weekly basis
Inadequate work planning	THINK Planning process must be applied to all tasks.	Supervisors	Immediately	On board	Individual, verbal and written THINK plans will help identify hazards for a specific task.	Supervisors must review SLT Module 6 and present to their department crews

Causes	What will be done	Who	When will it be done	Where	Why will it be done	How will it be done
Inadequate work planning	Hazard ID and "What If" question to be exercised constantly	OIM and RSTC	On going	On board	To change onboard's culture from mitigating to preventive controls.	OIM and RSTC to review supervisor's THINK plans and check for usage of preventive control. Present SLT module 5 - Creating a Safety Culture.
Lower level of Personal Commitment Inadequate orientation	Raise Personal Commitment starting from management and cascading down to department crews.	OIM, RSTC and Perf. Toolpusher	On going	On board	To ensure that supervisors communicate their expectations to their workers.	SLT Module 3 and cascade it down to the crews
Lower level of Personal Commitment Inadequate orientation	Get personal clear agreements	OIM	On going	On board	Crew needs to know what is expected of them, must be Responsible and Accountable	SLT Module 3 and cascade it down to the crews

Causes	What will be done	Who	When will it be done	Where	Why will it be done	How will it be done
Failure on hazard identification	Hazards Identification and "What If" campaign question to be exercised constantly	OIM and RSTC	On going	On board	To change onboard's culture and implement safety culture onboard	OIM and RSTC to review supervisor's THINK plans and check for usage of preventive control more than mitigating.
Failure on hazard identification	Accountability will be followed up after massive investigation of incident	Supervisors	Immediately		Crew needs to know what is expected of them and they must be Responsible and Accountable	Safety Meeting and individual training. SLT Module 3