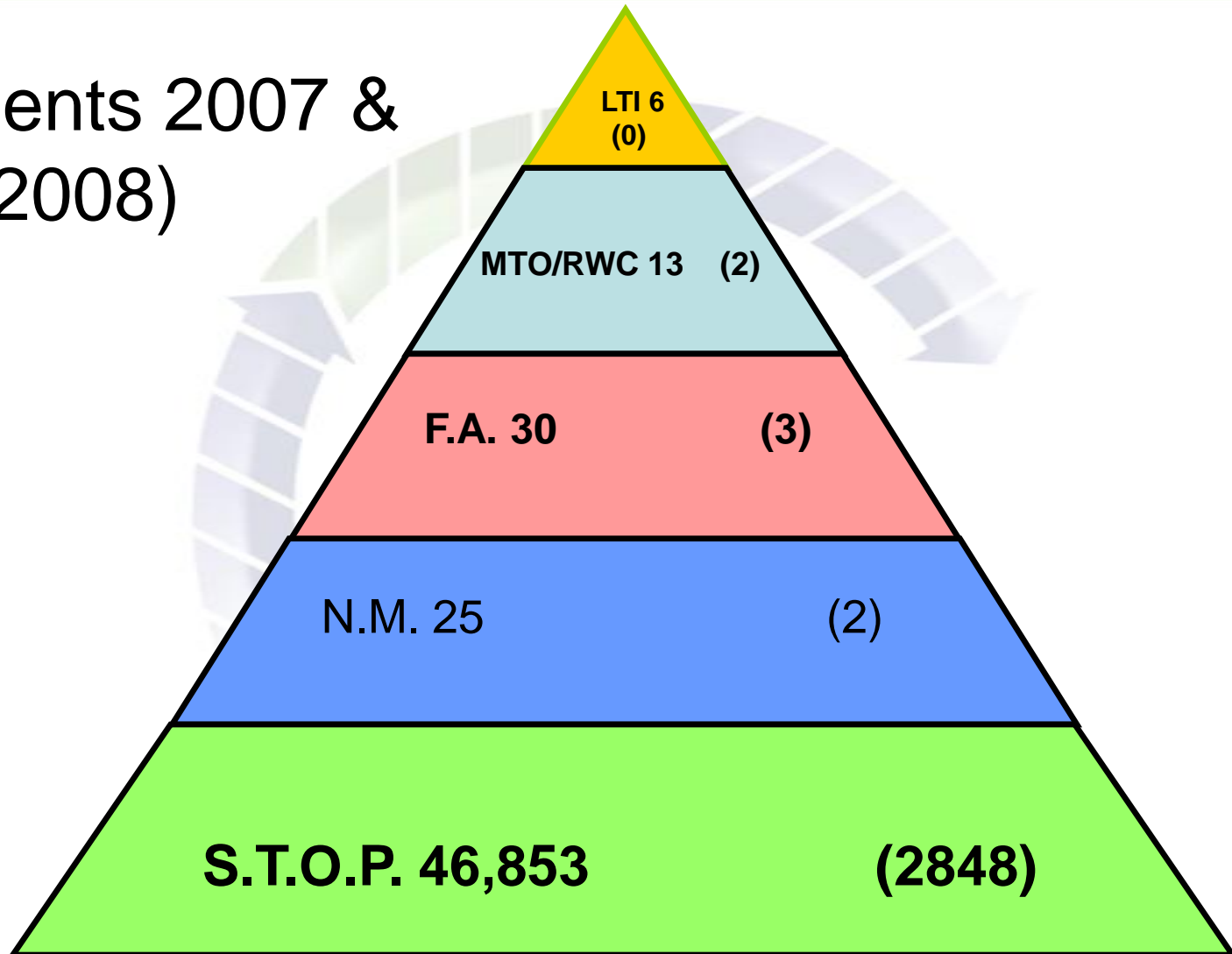


DOIRC#22, May 19th 2008



S.T.O.P. Card & Incident Statistics

Incidents 2007 &
(Q1 2008)



Near Miss (choke manifold)

GDI 3 on 20-Jan-08

- **During killing operations on DK-40, Assistant Driller and Roustabout were trying to connect the chicksan line to the flare line that was previously disconnected to check blockage, when two floor men cracked open the manual choke valve. Due to the flow of the high pressure gas + water mixture in chicksan line, it started webbing and hit the IPS (A/D & Roustabout). Causing minor bruises to their legs. No fractures. IPS resumed duty next shift.**

Choke manifold



IPS connecting flare line

LOCATION OF
PEOPLE
AT TIME OF
INCIDENT

Choke manifold

Incident

Immediate Causes

Underlying Causes

Opened Choke manifold valve, high pressure contents came out and hit flare line Chicksan on leg...

1
Poor job plan

4
Inadequate pretask checking

6
Inadequate matching of individual qualifications to job / task requirements

3, 8
Inadequate leadership knowledge, ability / supervision

7
Misunderstanding of instructions

Why?

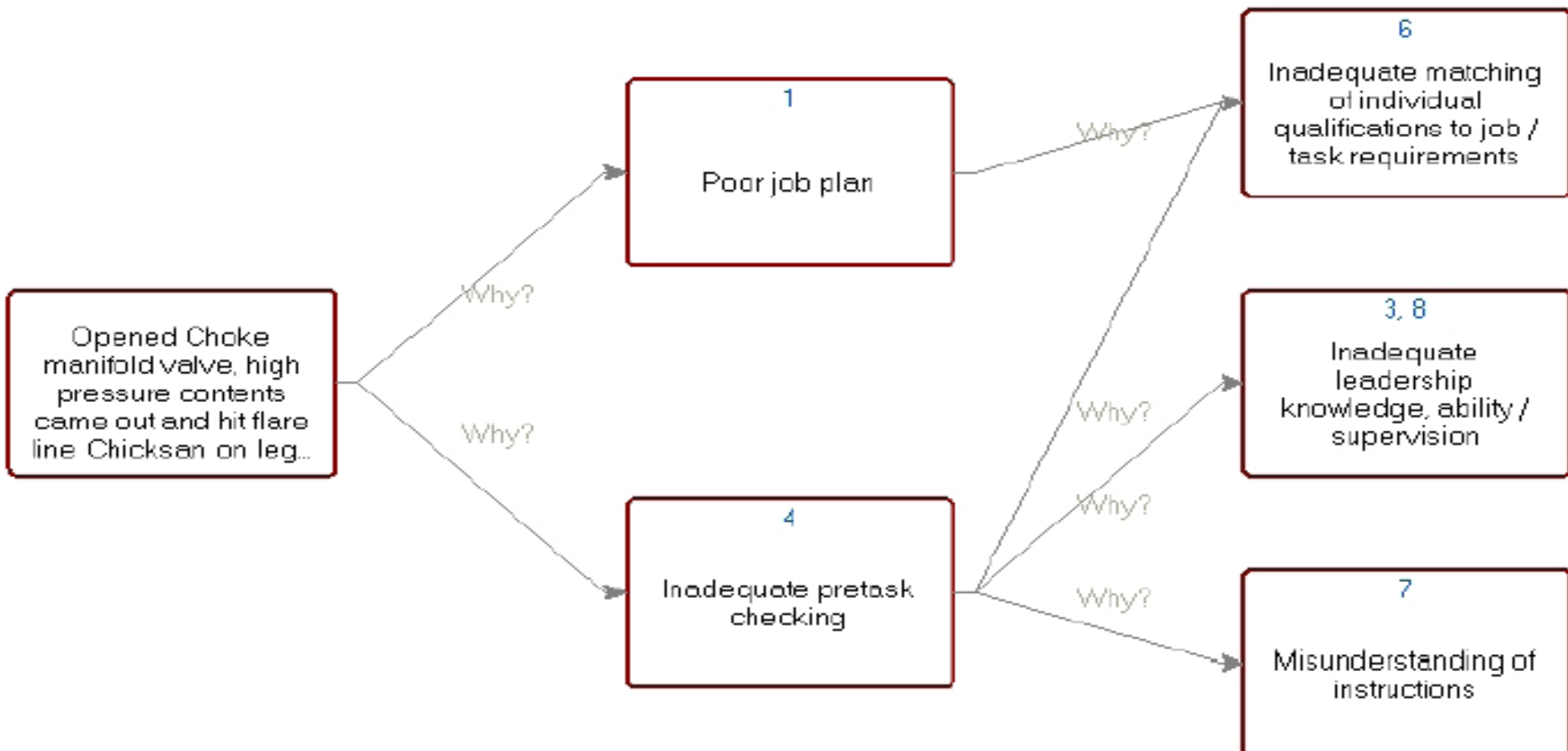
Why?

Why?

Why?

Why?

Why?



Immediate Cause:

- **No Positive Isolation**
- **No testing of flare line**
- **Mud pump not used for potential blockage**
Depending on Well pressure & fluid??
- **Improper Communication**
- **No Pretour safety meeting, toolbox talks and JSA**
- **Operators of choke not IWCF certified.**

Underlying Cause:

- **Supervision and commitment to safety**
 - **Job Planning,**
 - **Risk perception**
 - **Safe work procedures**
 - **Time Out for Safety**
- 

Corrective Actions Taken

- **Only positive isolation, test flare line**
- **Develop safe work procedure**
- **Pretour, Tool box talks, JSA are mandatory**
- **Instructions to go through company man to toolpusher then to crew**
- **Time out for Safety**

Lessons learned

- **Communication and commitment to safety is the KEY**
- **If unsure STOP and ask**
- **If the job changes at all. . . STOP and discuss before continuing with job**

Old school pre job meeting

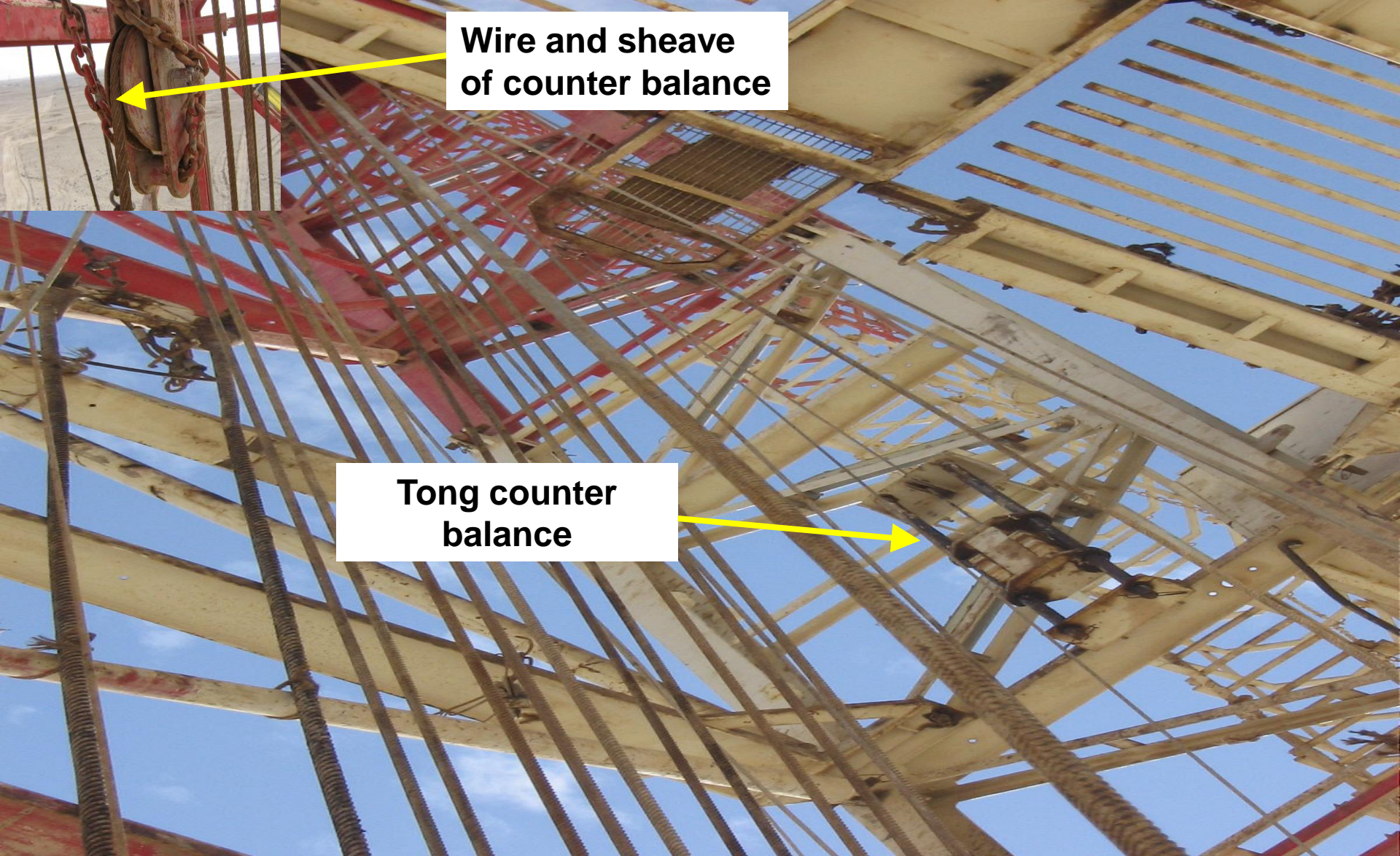


LTI (finger injury)

GDI 4 on 18-Nov-07

- **The tong line was off the sheave near the crown. IP/ floorman was lifted by man riding and tried to free the wire with his hand, the Tong counter balance suddenly moved and his hand trapped between the sheave and the wire. Four fingers were badly injured.**

Hand Incident



Wire and sheave
of counter balance

Tong counter
balance

Immediate Cause:

- **Poor supervision**
- **Supervisor commitment to safety?.**
- **Not following policy and procedure**
- **No PTW, toolbox talks and JSA**
- **Night (Foggy) was an assistant factor.**

Underlying Cause:

- **Supervisor role and responsibility?**
- **Risk perception**
- **Man-riding procedure not followed**
- **Night time operations.**

Corrective Actions Taken

- **Safety leadership to be introduced for all supervisors (June 08).**
- **Non urgent work shall not be at night or during adverse weather conditions**
- **Job by A/D or driller**
- **PTW, Tool box talks & JSA**
- **Risk Assessment Awareness**

Lessons learned

- **Company Policies and Procedures MUST be followed at all times**
- **If it is NOT 100% safe to do the job, STOP and reassess the job**



**Shukran / Thank you
for your time and patience**

QUESTIONS?