

Minutes of Meeting

Subject: Drilling Operations Incident Review Committee (DOIRC) Meeting # 22	
Date of Meeting: 19/05/2008	Time: 09:00 hrs
Venue: Al Wajbah Hall, Intercontinental Hotel	
CC: DR and Published in QP Internet website	
Date of Issue: 22/06/2008	
Ref. : DR-E/254/2008	Pages: 4 including this page.

Item	Minutes	Action
1	<p>The meeting kicked off at 9:30hrs with a safety brief and introduction of agenda.</p> <p><u>Welcome address by DR:</u></p> <p>The DOIRC chairman Mr. Talib Al-Murri (QP Drilling Mgr) welcomed all and presented the meeting cardinal objectives – incident review and knowledge sharing on industry best practices. He identified incident reviews as the baseline for better tomorrow in drilling operations. He advised all to ensure due diligence in reporting incidents, information sharing on lessons learned, to imbibe a blame free culture in incident management and most importantly to disseminate learning to the rig floor staff.</p> <p>In addition, he remarked that amid the intense pressure to perform, HSE should always take first priority, bearing in mind that life is irreplaceable and therefore urged all to comply with HSE rules without reservation.</p> <p><i>List of attendees, statistics, presentations and group photo are attached.</i></p>	
2	<p><u>Previous Minutes Acceptance</u></p> <p>Participants accepted the previous minutes of meeting without any changes.</p>	
3	<p><u>DOIRC Members HSE Statistics and Highlights</u></p> <p>Members presented their HSE statistics and highlights achieved in 2007 and Q1 2008.</p>	
4	<p><u>Presentations</u></p> <p>The Highlights are as follow:</p> <p>1- Gulf Drilling International incidents:</p> <p>Incident # 1a (GDI 3, 20th Jan 2008) – FAC (HIPO)</p> <p>While reconnecting the chicsan line to the flare line after flow check, the two floor men cracked open the manual choke valve. Due to the flow of the high pressure gas + water mixture in chicsan line, it wobbled and hit the IPs (A/D & Roustabout) resulting in minor bruises to their legs. No fractures sustained.</p> <p>Lateral learning: Effective communication is key to understanding instructions.</p>	

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	<p>Incident # 1b (GDI 4, 18th Nov 2007) – LTI</p> <p>While trying to free the tong line off the sheave near the crown, the tong counter balance suddenly moved, the IP's hand was trapped between the sheave and the wire. Four fingers were badly injured.</p> <p>Lateral learning: Hand position and effective task time management with respect to weather conditions</p> <p>2- Hercules Incidents</p> <p>Incident # 2a (Hercules, 21st March 2008) – FAC</p> <p>While assisting to guide spool wire being run down hole, the line tangled and shifted the spool which struck the IP's ankle against the kick plate of the handrail and the spool resulting in minor injury.</p> <p>Lateral Learning: Improved hazard identification techniques/JSA.</p> <p>Incident # 2b (Hercules) – HIPO N / M</p> <p>A pin that connects the torque tube to the Derrick "A" Frame fell out and fell approximately 30 feet to the drill floor, not striking any personnel or equipment.</p> <p>Lateral Learning: Secure all pins and adopt DROPS Program approach.</p> <p>3- Ensco Incident</p> <p>Incident # 3 (Ensco 84, 20th March 2008) – FAC</p> <p>AD was making connection with 5" DP with the TP and Driller on the rig floor. As make up torque was reached while making up TDS and verified on the tong line pull gauge, torque was released and the back lash was caught with the rotary brake. After receiving the ok sign from the AD the floor man proceeded to make up the bottom connection to optimum torque (46k ft lbs). The first IP latched the make up tong with the second IP assisting him on the V-door side. The other floor man was at the break out tong. While they were proceeding to get a bite on both the tongs, AD released the rotary brake.</p> <p>The residual trapped backlash from the initial make up caused the string to turn to the left thus resulting in trapping the first IP between the tong arm and the doubled make up line lifting him an inch off the ground.</p> <p>Seeing this, the second IP moved away from the tong movement radius and struck his upper right leg on ST 80 frame.</p> <p>Lateral learning: Use power tongs always.</p> <p>4- Maersk Oil Incidents</p> <p>Incident # 4a (Rowan Gilbert Rowe, 3rd Jan 2008) – LWC</p> <p>While removing protector on stand of 8" Drill Collar with stuck drift, drift released and hit the IP's thumb against the protector hole resulting in fractured thumb.</p> <p>Lateral Learning: Increased awareness on drift management.</p>	

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	<p>Incident # 4b (Rowan Paris, 30TH April 2008) – LWC</p> <p>While repositioning wire, IP slipped and hit tigger control which started rewinding and trapped IP`s finger in snatch block resulting in partly amputated little finger</p> <p>Lateral Learning: Safety guard to remote control handle.</p> <p>Incident # 4c (Rowan Gilbert Rowe, 18th February 2008) – HIPO N/M</p> <p>Load cell system broke causing drop of load and block (about 14 tons) from 18ft height</p> <p>Lateral Learning: Ensure load cell system are covered by rig PPMS.</p> <p>Incident # 4d (Rowan Gilbert Rowe, 15th April 2008) – HIPO N/M</p> <p>A TCP gun dropped when the elevator opened after picking up from mouse hole. Gun fell to rig floor and somersaulted out the V-door onto the cantilever deck.</p> <p>Lateral Learning: Use the right tool (lifting equipment) for every job</p> <p>5- Schlumberger Incident</p> <p>Incident # 5 (Schlumberger Wireline, 21st Feb. 2007) – RWC</p> <p>IP twisted right ankle while walking on the cantilever.</p> <p>Lateral Learning: Always use recommended safety boots at worksite.</p> <p>6- Shell GTL Incident</p> <p>Incident # 6 (Nobel Gene House, 8th Nov. 2007) – HIPO N/M</p> <p>NGH AD fell through the grating. The AD caught himself on a support beam. The grating and hatch cover fell into the sea</p> <p>Lateral Learning: Always secure and constrain gratings.</p>	
6	<p><u>Action Items</u></p> <p>The following were agreed:</p> <ul style="list-style-type: none"> - Prompt submission of presentations for review before the DOIRC meeting. - Statistics shall be of maximum 3 slides (i.e. a slide for HSE statistics using Bird’s triangle and 2 slides for HSE highlights and lowlights). - Timely cascade of safety flashes after incident’s occurrence and not to wait the DORIC meeting as same incidents can be repeated at different locations/companies before the DOIRC meeting. 	All companies

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7	<p><u>Any Other Business (A.O.B)</u></p> <p>1- Unification of lifting colour code system. Unable to arrive at consensus at meeting of the Drilling Managers of all Oil and Gas Operators and companies in Qatar.</p> <p>2- Safety statistics calculations: Reiterated the use of 1,000,000 man hours as factor for safety indices calculation.</p> <p>3- Common Failures in the presentations delivered:</p> <ul style="list-style-type: none"> • Poor supervision • No risk assessment/JSA • Perception /Empowerment of Staff to intervene in unsafe conditions • Position of body and hand – campaign focus • Managing task timing with respect to weather conditions <p>Encouraged members to strategize on improving these common failures in the next 6 months and feedback.</p>	
8	<p><u>Wrap up</u></p> <p>At the end of the deliberations, QP Drilling Manager thanked all participants for the fruitful discussions and AI – Masaoud Oil Supplies for sponsoring the meeting. He reiterated the gains of attending DOIRC meeting and urged all to be accountable for their roles and cascade information gained to their colleagues.</p>	
	<p>Talib Al Murri Manager Drilling</p> <p>Unsigned copy for electronic distribution. Original signed copy is filed with QP.</p> <p><u>Attachments:</u></p> <ol style="list-style-type: none"> I. List of Attendees II. Statistics and Highlights III. Presentations. IV. Photos. 	