SAFETY FLASH ALERT

Subject : **Collision with Skid Deck Bunding results in Dropped Object (Southern Upper Staircase)**

Platform/ Site : Chirag 1

Number : **Date** : 08/02/2005

What Happened:

On Tuesday 8th February between midnight and 02.30 the rig was engaged in skidding activities from slot 17 to slot 4 this required the rig to skid 16.3-metres from north to south, followed by 3-metres west. Skidding commenced around midnight.

After completing the skid south the rig was skidded to the west. At 02:30, after skidding 1.75-metres to the west, the upper section of the stairway of the SOUTH stairs between the skid deck and the drill floor fell to the skid deck.

The lower section of the stairway had contacted the bund around the well bay hatches (bund height 5.75 inches). As the rig continued to skid the lower staircase remained stationary, this resulted in the top of the lower staircase unhooking itself partially from the intermediate platform until the safety sling prevented further movement. As the rig continued to skid force was applied to the intermediate platform via the safety sling, resulting in the platform being bent.

The foot of the upper staircase which was resting on the intermediate platform was bent away sufficiently from its normal position, to allow the foot of the upper staircase to swing free. During this swinging action it unhooked itself from the landing at the drill floor level and fell to the skid deck. It struck a handrail and made contact with cables and cable tray before coming to rest on the skid deck. By the final position of the staircase it appears the staircase also twisted round laterally by 180-degrees prior to landing.

What Went Wrong:

Critical Factors:

1. Failure to confirm adequate clearance between stair footing and bund during skidding to west.
2. Failure to fit safety slings to upper staircase (drops prevention).
3. Requirement to lift stairs to allow skidding operation

Immediate Causes:

7-8 Mechanical hazard—moving equipment
4-1 Improper decision making or lack of judgement
3-5 Equipment was not secured against movement or falling
8.6 Other (due to design of rig, manual intervention required)

System (Root) Causes:

8-2 Inadequate leadership – the persons assigned (expat. & national) with the responsibility for aspects of safety had not carried out their responsibility to the degree necessary for safe work.
8-4 Inadequate identification of worksite / job hazards
14-4 Inadequate implementation of PSP (DROPS)
10-9 Other- Prior survey recommended engineering modifications to stairways, which were considered but not initiated

Recommendations:

1. Review the adequacy of Work Guideline D.001 and pre skid check sheet
2. Rig Manager to define responsibilities and clarify ownership of tasks as stated in work guideline D.001 of Drillers during one to one discussions
3. Rig Manager to council senior KCAD personnel related to this incident with regards to their supervisory requirements
4. KCAD and BP Safety to visit Chirag on a monthly basis as per annual D&C assurance plan to carry out one of Golden Rule Audits & 5 TKA
5. In view of learning's from this incident it is recommended that a critical review of any "Drops" inspection / survey at present in use is carried out platform wide.

   Consideration should be given to all potential collision areas during general crane and skidding operations or where there is a potential of equipment being dislodged
6. An overall engineering review of the rig's suitability for skidding operations including:
   (1) Manual handing hazards around the handing of hoses cables and general equipment.
   (2) Suitable and certified lifting points. (4) Pinch points
   (3) Collision prevention (5) Slips trips and falls
7. Check the run of the deck in comparison with north / south skid beams.

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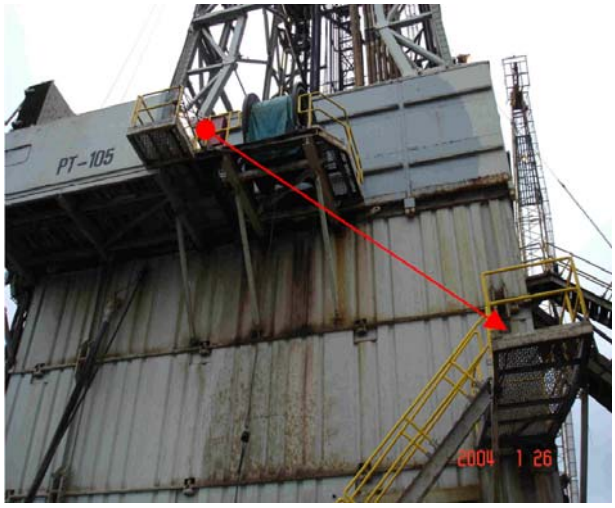
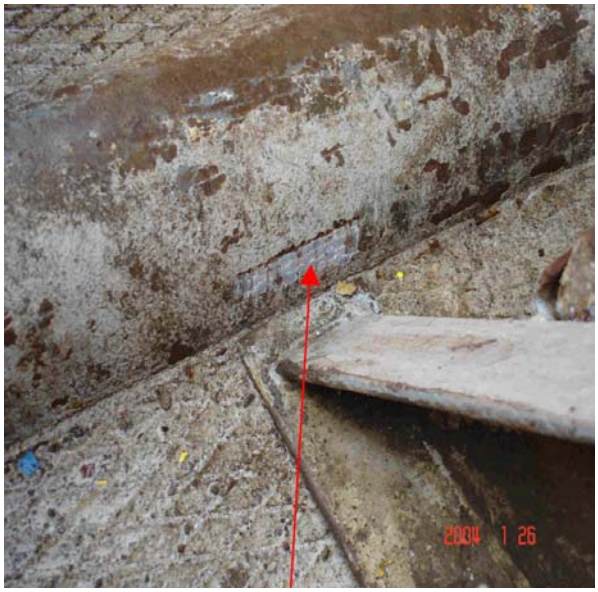
Photographs:



View of missing upper stairway

Position of dropped stairs on south skid deck



Point of contact on bund

Contacts for Further Information:

Originator : Bob Buick …….Senior Safety Adviser D&C AzBu

Technical Authority :