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Sent: Sat Feb 02 00:42:38 2008

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Subject: GOM Safety performance

Importance: Normal

Attachments: 2007 Performance v8 (3).ZIP

Colleagues,

Attached find a brief summarizing the status of our safety performance, which has been deteriorating over the past two years and the actions we decided to take in 2008 to get our safety performance back on track. Please use this context to engage your teams. Each and every one needs to make safety their number 1 priority. We want to create an incident and injury free workplace where everyone takes personal responsibility for their own safety and that of their co-workers. It is imperative that we turn our safety performance around if we want to become #1 in the GoM.

Thank you,

Neil

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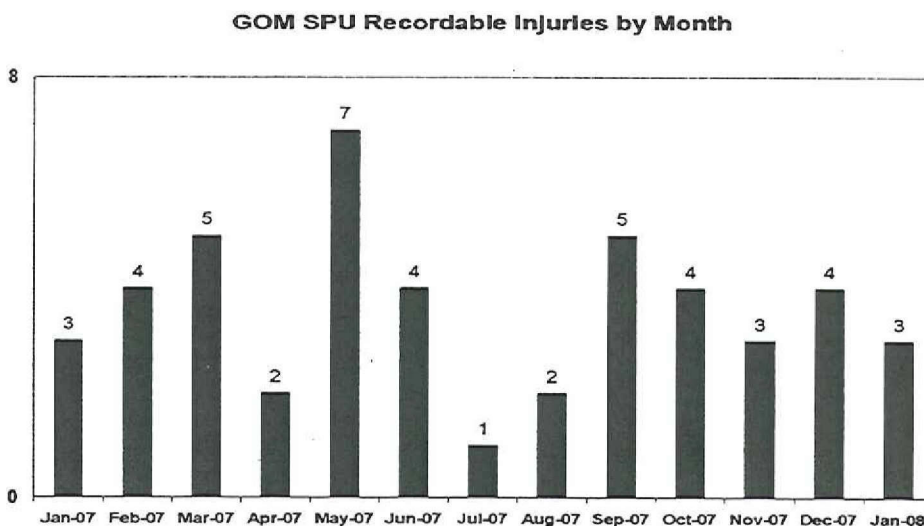
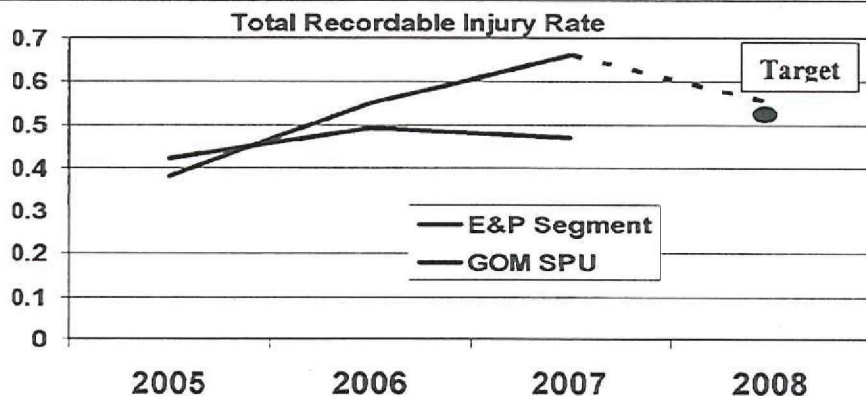
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GOM Safety Performance

As we begin 2008, I want to emphasize to everyone in the SPU that each of us plays a key role in delivering an incident and injury free workplace –be it offshore or in the office - where everyone returns home safely at the end of every working day.

Context

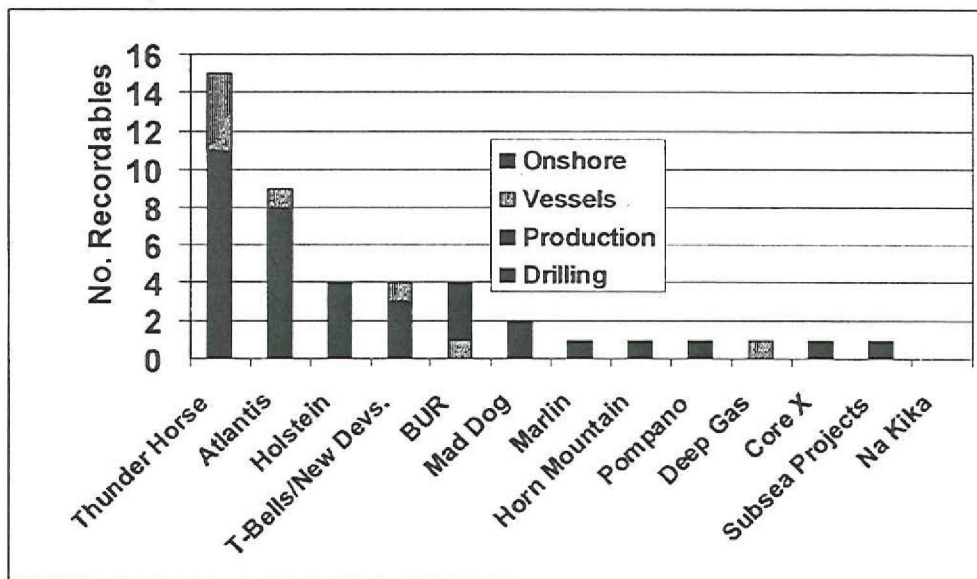
In 2007, we failed to achieve this and we had 44 recordable injuries – almost 4 per month, all of which were preventable. Our recordable injury frequency rate in 2007 was 0.66, which continued the deteriorating trend we have seen in the SPU since 2005 which is in sharp contrast to the improving trend experienced at the E&P segment. In addition, we ended the year with a rising trend of injuries and High Potential incidents, with 4 HIPOs in the last two months of 2007. This performance is clearly unacceptable.



In 2008, I want everyone to make your personal safety and the safety of your colleagues your #1 priority. Working injury-free is possible. Na Kika has not experienced a recordable injury since June 2004 and has worked over 1 million hours during this time. Unfortunately we had two DAFWCs and one recordable since the beginning of the year, all of which were entirely preventable. One of the events will be live changing for the injured party. This is a very disconcerting trend and it is imperative that we change course.

Where and how injuries have occurred

Our injuries are occurring in all aspects of our business - wells, operations, construction, and the Houston office.



53% of these injuries were to the hands and arms. 59% were the result of inattention while performing normal, routine tasks and 73% were due to performing non-permitted tasks. Another large category of injuries fell under the Control of Work (CoW) Standard. We need to remember the four key components of the CoW Standard.

- Plan the Job
- Identify and Mitigate the Risk
- Safely Execute the Job
- STOP the job if the job scope or conditions change, or if the job appears to be unsafe

This is in line with the comments from Jeff Childs and Jeff Hohle on findings from recent high potential (HIPO) incident investigations:

- "the team did not take the time to truly think through and understand the risk, we need to ensure the JSEA is more than a paper exercise"

- “our focus was on the other major non-routine risks and we were blind to the risks associated with the routine tasks”.

Actions for 2008

To help us get back on track and turn around our safety performance, I want to reinvigorate our focus on safety within the SPU. Today the SPU HSSE Management Committee endorsed a safety improvement plan which will focus on the following actions:

- **Safety pulse checks** – Complete engagement sessions with all operational teams and rigs to listen to ideas and concerns by end of March. Conduct jointly with contract management where appropriate and develop asset and rig based safety improvement plans by end of March.
- **Focus interventions on several high risk areas** including;
 - D&C – Transocean to develop and implement a safety improvement plan (building on the success of the Pride intervention in 2007) by the end of March
 - Actively plan for and manage new contractors, rigs, vessels coming into the GOM SPU.
 - Implement hand safety and dropped objects improvements programs consistently across the GOM.
- **Learning from Recordable injuries**; If we are to achieve our goal of an incident and injury free workplace, we need to learn from all recordable injuries and systematically implement these learnings. We will now elevate the investigation and communication of all recordable injuries so that they follow the same process that we have previously just used for DAWFC's and HiPO's. Each recordable will be investigated by one of the SPU ELT and a one-pager created to share learnings
- **Workplace oversight** – Reprioritize front line supervision to take a more active role 'on the deck', understand what gets in the way through the pulse check

I would like to thank you for your active participation and engagement during the GOM wide safety standdown that we held over the Holiday period. The following key themes emerged from the Stand down which are all good points to take back to your work:

- Loss of Focus / Distraction / Complacency
- Inspect third party / rental equipment to ensure it is functioning properly
- Following Procedures as shortcuts can lead to incidents and injuries
- Focus on 'when to stop the job' and 'willingness to stop the job'
- Recognize importance of pre-job planning and that routine tasks have risks
- Be proactive in recognizing hazards throughout the work and permit process, strive to eliminate hazards
- Ensure new employees and contractors understand and comply with BP's policies and procedures through active verification

Our goal is simply to create an incident and injury free workplace. I need everyone's commitment and focus to get our safety performance back on track.

Neil Shaw
SPUL Gulf of Mexico
29th January 2008

Attachments: Summary and Lessons Learned from HIPOs and DAFWCs of the last 3 months



Summary of
Incidents and Lesson.

Summary of Incidents and Lessons Learned

Since November of 2007 we experienced 4 HIPOs and 2 DAFWCs. Summaries of the incidents and lessons learned below.

Pompano Gas Release HIPO

On 2 November, a gas release was experienced in the Pompano field while flowing back a subsea well. The leak occurred in a flanged connection on the first valve above the riser. ESD of the facility commenced immediately, and there were no injuries or spills. However, the gas volume in the 9-mile flowline resulted in the leak persisting for several hours before the system could be blown down. The investigation showed that the leak occurred after the riser moved downward relative to its clamp by 1" and it was also discovered that the riser had slipped previously 12" while it was being hydrotested. Lessons learned are as follows:

- The criticality of riser clamp installations must be recognized during the Harzard identification process.
- Verification of appropriate clamp installation must be completed by competent BP personnel.
- The proper torqueing of the bolts must be documented following commissioning of equipment and the work should have been stopped and a MOC review completed once it was determined that the riser slipped ~12" following the hydrotest.

Nakika Dropped Scaffolding HIPO

On 9 December, a high potential incident occurred on Nakika when a contract scaffolding crew dismantled the scaffolding erected for crane maintenance activity. While lowering two 20 lb boards simultaneously from the crane deck, the two pieces slid from the rope and fell, landing on the intermediate deck below. No injuries occurred. The area where the boards fell was partially marked with yellow "Caution tape" which was inappropriate for the dismantling activity and required the red "Danger tape. The lessons learned are:

- Changed execution method with no MOC and no risk assessment
- During job interfaces, need to assign a single point of accountability for overall scope of work to manage the transition.
- Increase focus on permit spot audits by leadership is required.
- Permit issuing authority must ensure that sites are properly prepared before, during and after work

Thialf Electrical Shock HIPO

On 16 December, a high potential incident occurred on the Heerema Thialf vessel working on Thunder Horse when a Heerema employee received an electrical shock while disconnecting the 2nd of two HPU hoses, which were connected to a 440 V wall unit, from a hydraulic cylinder of a suction pile

lifting frame. The shock occurred when the employee made contact with a steel member of the lifting frame. The employee sustained a minor injury and returned to work. The investigation showed that 4 factors that happened simultaneously contributed to the incident: (1) The electrical extension cord had a defective ground, (2) the HPU was on rubber tires and not bonded to the vessel's steel deck, (3) the HPU had a defective control switch that faulted allowing electrical current to flow to the HPU case, (4) the individuals involved did not recognize the significance of the minor tingling sensation in their hands when the first hydraulic hose was disconnected. Lesson learned are as follows:

- Developing and implementing a more robust assured grounding program including an inspection and documentation process for all electrical equipment is critical. All portable equipment needs to be grounded locally or bonded to the ship's steel.
- All non-floating portable equipment needs to be included in the vessel maintenance program.
- Focus on training on electrical hazards is required.

Marianas Dropped Object HIPO

On 19 December while running riser on the Marianas, an insert in the riser joint (25 lbs) came free and fell approximately 80 feet to the rig floor. There were no injuries. Inspection of remaining riser inserts revealed 25 additional inserts were improperly installed or missing snap rings. Key lessons learned are:

- Learnings from previous incidents must be rigorously and systematically applied across all rig operations.
- Risk assessment tools and procedures must incorporate previous incidents and safety alerts and need to specifically identify dropped object hazards.
- Leadership must specifically act on identified risks and establish clear accountability for implementation of mitigation plans.
- A rig based quality assurance and inspection process needs to be applied for all equipment brought on board the rig.

Marianas Backstrain DAFWC

On 11 January, a contractor on the Marianas currently on Nakika experienced a backstrain when manually moving an annular preventer element into a container. This resulted in a DAFWC. Key findings and lessons learned are as follows:

- Alternative methods for moving the element were not considered and there was a lack of supervision during the task.
- There was no JSEA prepared for moving the annular elements
- Everyone is accountable for remaining vigilant in exposure and hazard recognition, and for stopping the job until proper controls can be established.

Marianas Lost Toes DAFWC

On 13 January, a contractor on the Marianas sustained a serious foot injury loosing four of his toes while resting his foot on the A-frame of a winch drum. His foot was pinched between the A-frame and the bracing gussets of the winch drum. This resulted in a DAFWC. Key findings and lessons learned are:

- No guarding was in place over the pinch point between the gusset and the A-frame and failure to recognize the pinch point; the manual cable spooling required a lot of manpower resources and attention.
- Everyone is accountable for hazard recognition and exposure and for stopping the job until proper controls can be established.