From: Sims, David C

Sent: Mon Apr 19 23:10:47 2010

To: O'Bryan, Patrick L

Subject: Rig Visit Talking Points 4-15-10.ppt

Importance: Normal

Attachments: Rig Visit Talking Points 4-15-10.ppt

Pat,

Here are some talking points for the rig visit. Horizon, Macondo, and Safety Leadership related stuff.

I'll have a hard copy for you tomorrow.

See you in Houma,

David

<<...>>

# Leadership Focus Areas for Upcoming Rig Visits



# Focus areas are based on recent incidents and 2010 HSSE Agenda items

- Difficulty performing jobs may lead to workers taking shortcuts
  - Basis Marianas Fall Inciden
  - Potential Question(s): Are there any jobs you do that are extremely difficult to perform using existing procedures? What is needed to make it easier?
- \* Ongoing risk and hazard recognition



- Ungoing risk and hazard recognition

  Basis Enterprise Casing Protector Incident

  → Basis Enterprise Casing Protector Incident
- $\triangleright$  Potential Question(s): Tell me how you risk assess the work you are doing? How do you re-assess hazards when conditions change?
- Dropped Object and Hands Injury Devention
  - ➤ <u>Basis</u> D&C HSSE Agenda
  - > Potential Question(s): What is your rig doing for hand injury prevention this year? Do you know what is being done to prevent dropped objects on this rig?

# Leadership Focus Areas for Upcoming Rig Visits Updated 4/15/10



# Focus areas are based on recent incidents and 2010 HSSE Agenda items

- \* Control of Work
- <u>Basis</u> Recent recordable where lifting job being conducted should have had permit to work.
  - Potential Question(s): How do you know what jobs need to have a permit to work?
  - > For Supervisors: How do you make sure that all the jobs under your supervision have the proper permits and control of work?
- \* Slips, Trips, Falls
- \* <u>Basis</u> Recent recordable incident on DD3 where IP slipped after stepping down 27" onto a slick surface.
  - <u>Potential Question(s)</u>: How do you assess the slip potential when stepping up or down in irregular situations?
  - What areas on this rig have irregular ingress/egress that poses potential for injury from slip/trip/fall or that require abnormal/irregular body position?

# Talking Points for Horizon Rig Visit Updated 4/15/10



- ★ 6+ years since last DAFWC
- ★ 1+ year since last Recordable
- ★ Sustained top quartile drilling performance

# Hallmarks of Horizon team

- Genuine concern for health, safety and environment not just ticking the box
- Tremendous rigor put into risk awareness, mitigation, reporting, investigations, lessons learned
- Absolute focus on same goal no conflict between Operator and Contractor
- \* Fast recovery from problems, setbacks
- $^{\circ}$  No blame, 'can do' culture fix the problem, learn, move on
- \* No Egos, no divisions, no agendas on the rig all share equally
- \* Prudent risk-taking freedom to fail, no fear of second-guessing.
- \* Utilizes all available resources to get back on track
- \* Excellent communication on rig and between office and rigsite

# Talking Points for Horizon Rig Visit Updated 4/15/10



Key Factors to Excellent, Sustained Performance

- Trust within the well team and of management, management trust in well team
- Out of the Box thinking
- Follow rig contractor policies, management systems, etc. as much as possible.
- \* Incentivize crews and encourage ownership of the well
- Rigorous communication and preparation for upcoming tasks
- \* Constant appreciation of good work
- Horizon ahead of benchmarks in most categories of Transocean KSMs
   (Key Step Measures)

# Talking Points for Horizon Rig Visit



# <u>Macondo</u>

Moved on well Jan. 31 following Kodiak 2. Well originally spud and drilled through 22" with Marianas.

Days/10K

70.3 - total well w/o hurricane

Days/10K

61.3 - since Horizon

Days/Cost

3 days/\$9MM under AFE

NPT

48%

\* DAFWC/HIPO/Recordables

0/1/0

Dropped Objects

2

\* First Aids

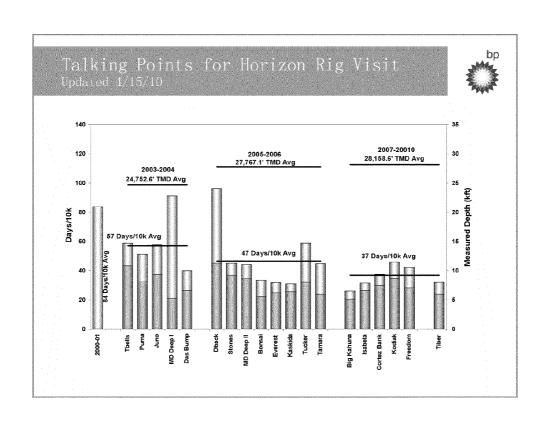
4

Incidents

9

\* Spills

0



# safety

# Marianas Fall from Top of Riser HiPo/DAFW

sharing the experience

**INCIDENT:** Fall from Top of Riser

TYPE OF INCIDENT: Days Away from Work /

HiPo

**BUSINESS UNIT:** GoM Drilling & Completions

LOCATION OF INCIDENT: Transocean

Marianas

**COUNTRY:** United States

Traction No: 2009-IR-3304711

DATE OF INCIDENT: November 15, 2009

## **BRIEF ACCOUNT OF INCIDENT:**

While moving three joints of riser from the port riser bay to the starboard riser bay with the gantry crane, a Roustabout (IP) fell 27 feet from top of riser to the deck.

The IP had just attached the web slings from the gantry crane to the 2<sup>nd</sup> joint of riser. After securing the slings, he was seen falling between the stacked riser joints and the shaker house bulkhead. He was attended by the rig medic and medivaced to a hospital onshore. IP suffered chest and shoulder injuries. He was released from the hospital on November 20, 2009.

# **ROOT CAUSES:**

- The information gathered during the investigation indicates that the IP was not tied off when he fell. There was no damage to harness or lanyards and shock absorber was not extended.
- The investigation results also indicate that the IP did not use ladder on stanchion to exit riser as noted in job plan. IP was positioned on opposite side of riser joint than would have been expected and may have been attempting to leave riser bay by climbing over the handrail to the shaker house deck. Footprints on port and starboard vents outside of handrail indicate others had moved between deck and riser bay in the past.
- Work area was difficult to access. The height
  of riser stacked in the bay prevented easy
  access to the top of the riser from the
  stanchion ladders. Normal procedure for
  handling riser is to access it with a scissor lift
  and tying off to a self retracting lifeline. Due
  to riser being stacked too high, scissor lift
  could not be used to install rigging on riser.
- Supervisors did not fully identify the inherent risks in the procedures being used (location

of anchor points for fall protection and difficulty in accessing the work site) when riser was stacked to the top of the stanchions.

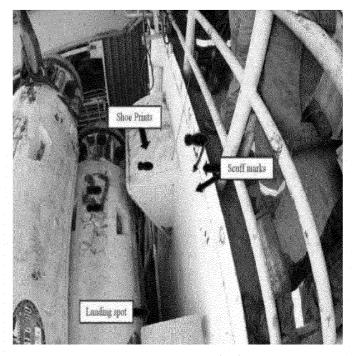
# **SUMMARY LOCAL ACTIONS:**

- Revise procedures for working with riser to ensure that a suitable fall arrest system is in place or other mechanism to reduce fall risks.
- Define maximum height of riser joints which can be stacked in the riser bay to provide safe access and mark stanchions accordingly. Ensure this height is referenced in procedures.
- Reinforce the role of supervisors to identify hazards associated with Management of Change and ensure that appropriate controls are put in place
- Re-emphasize to all crews the necessity of remaining 100% tied off when outside of handrails and when working at height. Revisit training on tie off procedures, suitable anchor points, and other fall protection procedures.

### **LESSONS LEARNED:**

- Constantly review jobs to identify safer ways to perform them.
- Significant difficulty in performing jobs may lead people to take shortcuts.
- Proactively address where controls are difficult to achieve through reengineering or supervisory reinforcement of controls.

### PHOTOGRAPHS:



CONTACT: George Gray, Marianas Wells Team Leader

# safety

sharingtheexperience

# D&C Casing Protector Incident Discoverer Enterprise



INCIDENT: Caught Between Finger Injury
TYPE OF INCIDENT: Medical Treatment
BUSINESS UNIT: GoM Drilling & Completions

LOCATION OF INCIDENT: Discoverer Enterprise

**COUNTRY:** United States

Tr@ction No: 2010-IR-3364864

DATE OF INCIDENT: January 7, 2010

# **BRIEF ACCOUNT OF INCIDENT:**

The incident occurred while a Contractor Injured Person (IP) was removing protector caps off of 16" casing. IP used a 24" pipe wrench for the work and held the wrench on a protector cap in the 10 o'clock position. The IP ensured that his hand/fingers were placed lower on the wrench handle, away from a pinch point. The IP could not get the protector cap to break loose and repositioned the wrench to a 12 o'clock position for additional leverage. The IP pulled on the wrench from this position and the protector cap broke free quickly, while the IP's left hand was at the top of the wrench handle. The IP's finger was pinched between the wrench handle and another joint of casing

# **ROOT CAUSES**

- Although used frequently, the tool used for the job (pipe wrench) created a pinch point potential
- After planning how to safely accomplish a task by measuring where to place hands, a change in job scope occurred that was not managed correctly. The Injured Person disregarded hand placement when he changed the tool position, placing his hands where they could be injured

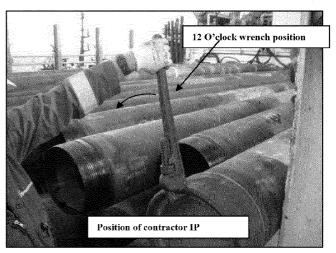
# SUMMARY OF LOCAL ACTIONS:

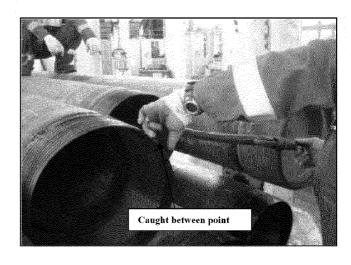
- Revise contractor Task Specific Think Plan (TSTP) to include detailed steps for removing thread protectors
- Explore an alternative method / tool to remove casing thread protectors.

## **KEY REMINDERS / LESSONS LEARNED:**

- Even a minor change in a job plan requires re-evaluation and risk assessment. When a job scope changes, take a time out to review the new plan and associated risks, focusing on identifying and mitigating the risk
- Don't assume that just because a job was done this way before, that it must be safe. Evaluate the tools and set up options every task for risk elimination

# PHOTOGRAPHS:





CONTACT: Andy Frazelle, D&C Operations Manager– Thunder Horse



Area	Milestone	Drlg SPA	HSSE Support	Drlg Cont SPA	Target Date	Status YTD	Comments
	Continue HSSE Performance Management System	Rich	Tink		Ongoing	0	Steering Committee, Performance Review and WSL Teleconference Meetings on calendar
	Move D&C ELT to Houma for a week to engage rig level leaders in safety conversations	Holf	Davis		Plan by 10	0	Meetings on calendar
Contractor	Conduct monthly dedicated leadership flights offshore	Frazelle	Neumeyer		Plan by 1Q	0	Flights on calendar
Engagement	Develop LT HSSE talking points for rig visits	TIPK	Honeycutt		Bi-monthly		Output from D&C HSSE Steering Committee
	Safe Start-up Plans for Ascension & Clarion	Nohavitza	Honeycutt		2Q & 4Q	0	
	HSSE meeting with contractors and service providers	Daigle	Davis	Andread active control of the contro	3Q	0	Meeting on calendar
	Dropped object prevention - CIP Plan & audit follow-up	Little	Neumeyer		Feb / 3Q	0	Elements of CIP plan complete
Continuous Improvement Areas	Hand injury prevention - CIP Plan & video program	Frazelle	Galtier		Feb/2Q	0	Elements of CIP plan complete
	Continue SMS Self Assessment - focus on execution	Tink	Thibodeaux		Ongoing	0	Monthly
Now Forite Areas	Participate in Segment CoW Improvement Plan	Rich	Tink		40	0	
CONTRACTOR OF THE CONTRACTOR O	Regulatory Compliance Plan Rollout	Tink	Honeycutt		Δt	0	

D&C 5Q Plan (2010 HSSE D&C HSSE Agenda) - Draft

Updated:2/15/10

# Dropped Object CIP

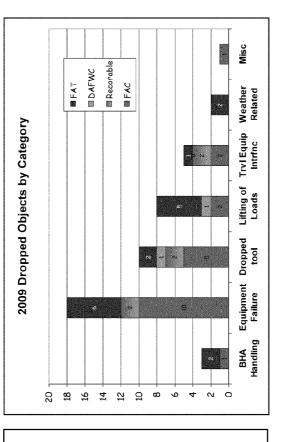


# The Problem

Dropped objects have increased in GoM operations.

# Background:

- 22 total dropped objects 08', 46 total dropped objects 09'
- Application of DROPS protocol not consistent
- Equipment failure and dropped tools major areas



Root Cause	Actions	SPA	Due Date
Application of DROPS protocol not consistent	All rigs conduct annual 3rd party drops audits and drops steering committees	ПЩе	Ongoing
Use of non-approved drops tool kits on rigs	All rigs to have approved drops tools and crews trained in their use	Little	1Q Tools 2Q Training
Equipment Failures	Form work team through the D&C HSSE Steering Committee to evaluate equipment failure causes	ГЩ	20

# Hand Injury CIP



# The Problem

Increased number and severity of D&C related hand injuries from 2008 – 2009

# **Background:**

 2008 – 23 total hand injuries (1st Aid & Recordable), hand injures were 59% of the total recordables 2009 – 32 total hand Injuries (1st Aid & Recordable), hand injuries were 62% of the total recordables

yory		Material Handeling
Dropped Objects by Category		Hand Placement
ed Object	■ First Aid ■ Medical Treatment ■ Restricted Work	Equipment Op Hand Placement
Dropp	0 8 7 9 5 4 8 7 7 6	Hand Tools

Root Cause	Actions	SPA	Due Date
Hands Free Operations not consistently implemented and enforced on all rigs	Standardize a GoM Hands Free operations requirement and training to be utilized by both Pride and Transocean	Frazelle	Q
No personal risk assessment tool in place	Form work team through the D&C HSSE Steering Committee to evaluate personal task specific risk assessment tool	Frazelle	20

### **DWX Drilling Performance Slide**

Prospect	PI Submitted Days/10k	Total Depth (ft)	Drilled Interval (ft)	NPT Days	NPT Days/10k	Productive Days/10k	Dryhole Drilling Days	Avg TD ft MD 98-99	Avg TD 1 MD 00-01
Holstein	65.2	12200			0	65.2		20719.11	
East Dominica	71	19808			0	71		20719.11	
Atlantis	85	20097			0	85		20719.11	
Dominica	36.9	20500			0	36.9		20719.11	
Mad Dog	147.8	22410			0	147.8		20719.11	
Big Horn	42	17649			0	42		20719.11	
Metallica	82	22969			0	82		20719.11	
Timon	54	25057			0	54		20719.11	
Thunder Horse	85.5	25782			0	85.5		20719.11	
West Bison #1	129	7527			0	129			22241.14
Thunder Horse North	47.2	26060			0	47.2			22241.1
Timon ST	100	26442			0	100			22241.1
Thunder Horse II	93	29100			0	93			22241.1
West Bison #2	80	27356			0	80			22241.1
Blind Faith West	71	25135			0	71			22241.1
Blues Image	113.2	14068			0	113.2			22241.1
2000-01						84			
Tbells	58.8	31131	26722	41	15.3	43.5	157.1		<del> </del>
Puma	51.4	19034	14817	28	18.9	32.5	76.2		
Juno	57.8	26569	23569	48	20.4	37.4	136.2		<del>                                     </del>
MD Deep I	91.4	17181	12028	85	70.7	20.7	109.9		
Das Bump	39.9	29848	22215	30	13.5	26.4	88.6		
Dback	96.1	23847	16898	86	50.9	45.2	162.4		<b> </b>
Stones	45.2	28639	18985	16	8.4	36.8	85.8		
MD Deep II	44.1	25085	18256	17.7	9.7	34.5	80.6		<u> </u>
Bonsai	33.6	30125	26431	29.7	11.2	22.4	88.8		
Everest	31.8	22530	18139	12.9	7.1	24.7	57.7		
Kaskida	31.0	30450	24516	13.0	5.3	25.7	75.9		
Tucker	59.0	29630	22698	61.1	26.9	32.1	142.0		1
Tamara	44.8	31831	27052	56.8	21.0	23.8	122.8		
Big Kahuna	26.0	26061	20753	11.3	5.4	20.7	54.2	T	т
Isabela	31.5	19350	12842	6.2	4.9	26.6	40.4		-
	37.5		25,956	27.0	7.5	30.0	97.4	<b></b>	<del> </del>
Cortez Bank Kodiak	46.0	31,462 31,146	29,697	34.2	11.3	30.0 34.7	139.1		-
Freedom	42.2	29,533	23,363	32.8	14.1	28.2	98.6		
riccuoiii	1 42.2	29,333		=includes Tiber		20.2	517.1	=includes Tiber	<del> </del>
Tiber	32.1	31400	27193	21.54	7.9	24.1	87.4	-moludes riper	
	J JZ. I	1 31400	1 41100 1	Z 1.J4	1.0	L 24.1	1 01.4	1	1

NOTE: Tiber data represents dryhole metrics through Paleogene only (31,400').

1998-1999

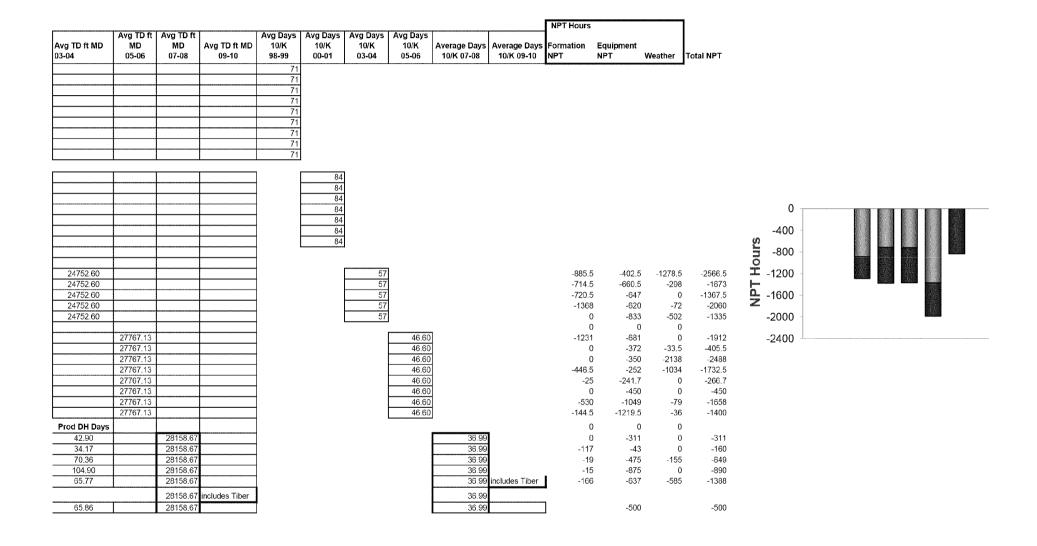
2000-2001

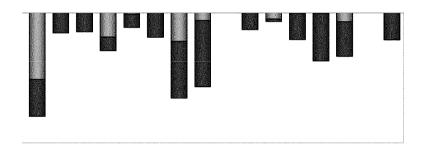
2003-2004

2005-2006

2007-2008

2009-2010



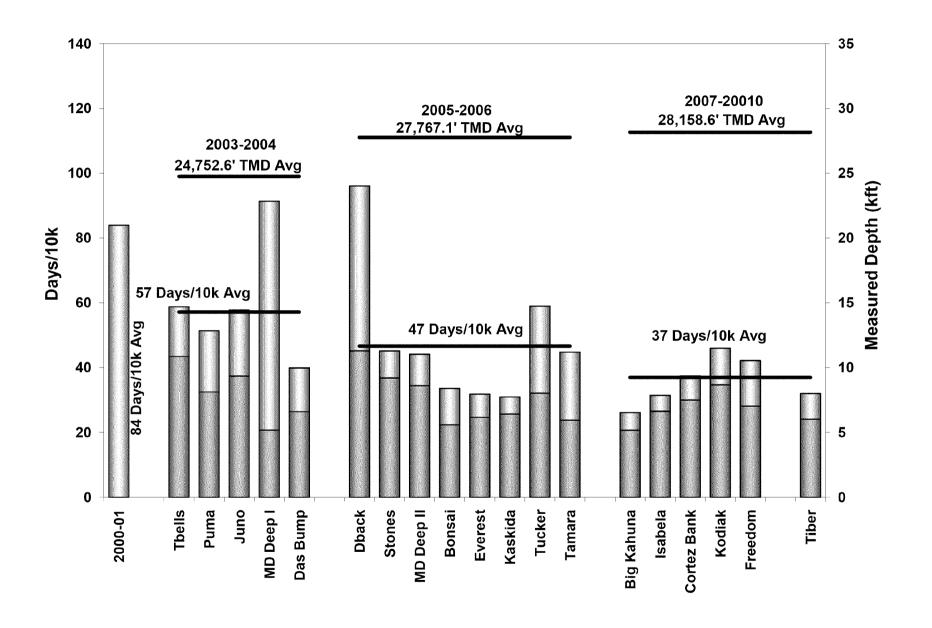


NOTE: Kodiak & Freedom data does not include success logging time

Prospect	PI Submitted Days/10k	Total Depth (ft)	Drilled Interval (ft)	NPT Days	NPT Days/10k	Productive Days/10k	Dryhole Drilling Days	Avg TD ft MD 98-99	Avg TD ft MD 00-01
	,	•	, ,		•		31.2		•
2003 - Present	54,8	26569			19.3		31.2		
2003 - 2004	57.2	24753	59.86						
2005	51.8	26924					36.79		
2006	42.1	28610							
2007 - 2008	36.6	27510							
2008	46.0	31146							
	D/10k								
Approximations	Salt Exit	Tar	Other	Total NPT	Footage				
off chart for 03-04	9	3	14	26	99351				
2005	0	0	18.5	18.5	80570				
	5.0	17	16.0	22.7	-				

	Avg TD ft	Avg TD ft		Avg Days	Avg Days	Avg Days	Avg Days						1
Avg TD ft MD	MD	MD	Avg TD ft MD	10/K	10/K	10/K	10/K	Average Days	Average Days	Formation	Equipment		1
03-04	05-06	07-08	09-10	98-99	00-01	03-04	05-06	10/K 07-08	10/K 09-10	NPT	NPT	Weather	Total NPT

-1



	Tubular Bells	Puma	Juno	Maddog Deep	Das Bump	Diamondback	Stones	Maddog Deep	Bonsai	Everest	Kaskida	Tucker	Tamara	Big Kahuna	Isabella	Cortez Bank
Formation	885.5	714.5	720.5	1,368	0	1,231	0	0	446.5	25	0	530	144.5	0	117	19
Equipment	402.5	660.5	647	620	833	681	372	350	252	241.7	450	1049	1219.5	311	43	475
Weather	1278.5	298	0	72	502	0	33.5	2138	1034	0	0	79	36	0	0	155
Total	2566.5	1673	1367.5	2 060	1335	1 912	405.5	2488	1733	266.7	450	1658.5	1400	311	160	649

lodiak	Freedom	Tiber
15	166	0
875	637	500
0	585	0
900	1388	1388

