CONSIDER THE GRAPH. It displays total reports on minor incidents for 22 rigs over 18 months during 2000-2001. Rigs on the left share a high number of reported minor incidents—either near misses or first-aid cases; those on the right, fewer reports of minor incidents. Given this data, where would you rather work?

At first glance, the right-hand rigs loom large as clearly less dangerous—so few reports! What a safe workplace!

But nothing is simple. Actually, the right-hand rigs suffered a far worse record of serious injuries and even fatalities. These units show fewer minor cases only because they reported fewer cases. The 11 right-most rigs accounted for a whopping 90% of serious injuries. Those on the left, in contrast, reported more minor cuts and scrapes, and of dodging the proverbial bullet, the workers enjoyed a far safer overall environment—10% of serious incidents.

Why the counter-intuitive result? This data was developed by Kevin Rollins, HSE Manager for Kuwait Drilling Co. Mr Rollins, speaking at the IADC Drilling HSE Europe 2006 conference in Amsterdam during October, noted that this analysis covered the same types of rigs and equipment doing the same type of work with the same type of people in the same environment under similar safety management systems.

Mr Rollins joined KDC in 2004, and the company suffered a rig fatality late that year. It was a tragic wake-up call. “When we looked at the rig’s incident statistical performance, the alarm bells should have been ringing, but they weren’t,” he said. “These sort of figures support the safety pyramid in the sense that there must have been incidents ignored and not reported. But—a big but—the rig’s performance was good, so they could not have a problem.” (The safety pyramid, familiar to accident-prevention professionals, postulates that each serious accident is underpinned by a large number of minor incidents or injuries.)

• Report that! You must be joking;
• It won’t happen again;
• He knows what he did wrong. Only an idiot would do that twice;
• We could lose the contract;
• If I report this, I won’t get a safety bonus;
• We look better with fewer incidents, and reporting could trash our good record;
• Why report? Nothing changes!
• Too many forms! What report do I use for what incident?

Perversely, a “no blame” culture encouraged to improve safety actually can discourage reporting. “There has to be accountability,” says Mr Rollins. “Someone must have done something wrong. 90% of all incidents are caused by human error.”

KDC worked to build a report-focused culture—standardizing incident forms, developing guidelines for reporting and investigation, measuring reporting, and providing feedback.

By 2005, incident reporting had increased 50% over 2004. Better yet, lost-time incident frequency plummeted 80%—to 0.47 from 3.43. KDC slashed total recordable frequency in half—to 7.88 in 2005 from 15.85 in 2004, a 55% decrease.

Results tell. Where would you rather work?

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