



ऑयल एण्ड नेचुरल गैस कॉरपोरेशन लिमिटेड
Oil and Natural Gas Corporation Limited

निगमित स्वास्थ्य, संरक्षा एवं पर्यावरण
तीसरी मंजिल, टॉवर- ए, दीनदयाल ऊर्जा भवन
5- नेल्सन मंडेला मार्ग, वसंत कुंज, नई दिल्ली –
110070
Corporate Health, Safety and Environment
03rd Floor, Tower- A, Deendayal Urja Bhawan
5- Nelson Mandela Marg, Vasant Kunj, New
Delhi-110070
+91-11-26753148 | chse@ongc.co.in

Ref No. CHSE/Near Miss Analysis- June/2025

Date: 29th July 2025

From: Head Safety, Corporate HSE

Sub: Near Miss Analysis for June 2025

Major highlights for this month are as follows:

- **Drilling Services Mumbai** has retained its **first position** in the reporting of *unsafe acts* and *unsafe conditions* in the **offshore category** comprising assets with 5 or more installations.
- **Mehsana Asset** has emerged as the best performer in the **onshore category** having 5 or more installations.
- In the third category having less than 5 installations, **Uran Plant** is the best performer.

Low-lights:

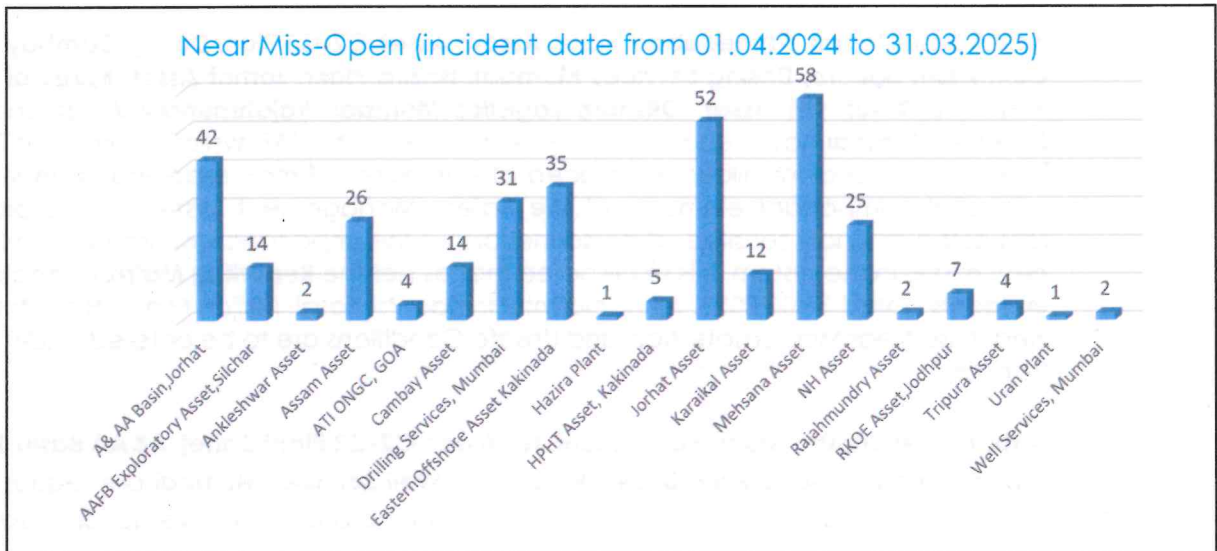
- **A&AA Basin Jorhat, Ahmedabad Asset, Assam Asset, C2-C3 Plant Dahej, Cambay Asset, CBM Asset Bokaro, Drilling Services Mumbai, Hazira Plant, Jorhat Asset, Karaikal Asset, Mehsana Asset, NH Asset, Offshore Logistics Mumbai, Rajahmundry Asset and Well Services Mumbai** have reported some near misses in the SAP system more than 7 days late and the list of installations is placed at *Annexure-1*. Timely reporting of near miss is one of the important elements of the Safety Management System. Therefore, it is requested to kindly sensitize all personnel about the importance of timely reporting of near misses in the system. It is to be noted that as per the **Reporting Matrix of Accidents/ Incidents** dated 31.03.2023, All Accidents/ Incidents- Fatal, Major, Minor, High Potential Near Miss, Near Miss, Unsafe Acts and Unsafe Conditions are to be entered in SAP within 24 hours.
- **Jorhat Asset, Tripura Asset, Hazira Plant, NH Asset, C2-C3 Plant Dahej, A&AA Basin Jorhat, EOA Kakinada, AA Forward Base Silchar, and Well Services Mumbai** are requested to expedite the closure of near misses as both reporting and corrective actions taken are part of the process safety management.

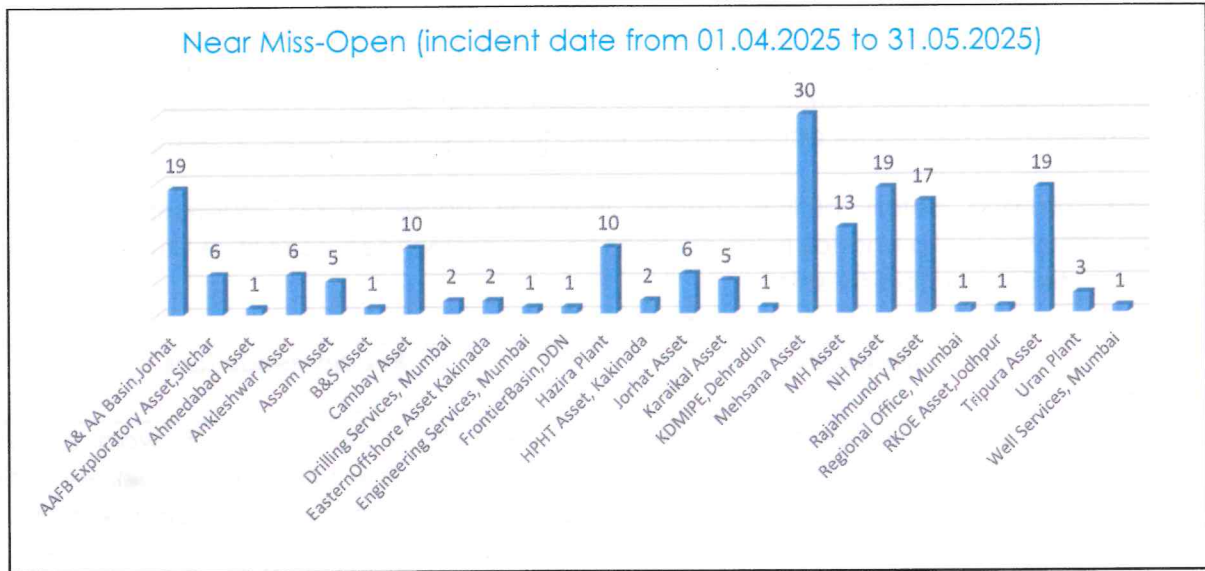
Performance of assets/services is depicted graphically in subsequent pages on various dimensions of near miss reporting.

Important findings and suggestion:

1. Total **1093** near miss were reported across all work centres (*status as on 8th July 2025*) in the month of June 2025 with **164** still open. Immediate action is required for closure of all open Near Miss.

2. The following three graphs represent the work centre-wise status of near miss incidents that remain open as of 08th July 2025, for three incident reporting periods: 01.04.2023 to 31.03.2024, 01.04.2024 to 31.03.2025, and 01.04.2025 to 31.05.2025. Each graph illustrates the number of incidents still open within each period, detailing the distribution of these incidents by work center and their respective status (open or unresolved).

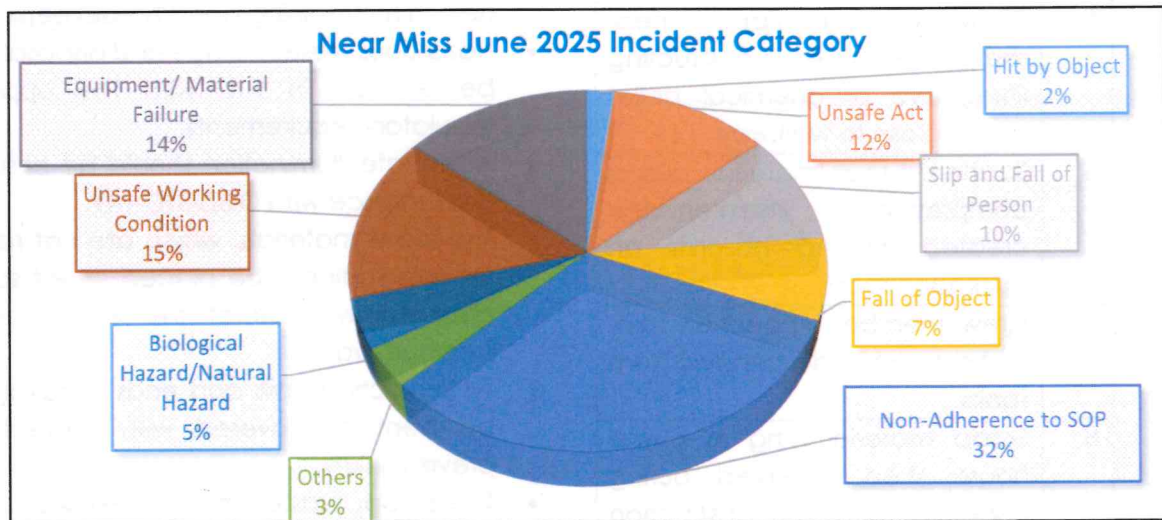




It is with deep concern CHSE notes that there are several near misses "open" in SAP since long time. Despite consistent reminders, and ongoing communication efforts, these incidents are not closed because remedial action is remaining incomplete either at field or in the system.

It is reiterated that these incidents are given the immediate attention they warrant and that corrective measures are swiftly implemented to prevent any potential harm or invite adverse observations from internal/external auditors.

3. The category wise details of reported near misses is as follows:



Instances of slip and fall incidents have been reported with increasing frequency, primarily attributable to deficiencies in housekeeping protocols, not clearing the unwanted/rejected material after jobs are finished, not keeping preparatory material/structures intact when task is completed, etc. Such conditions present considerable occupational hazards, necessitating immediate and comprehensive remediation. Failure to address these issues promptly could

result in severe personal injury and significant operational disruptions. Therefore, strict adherence to housekeeping standards is not merely advisable but imperative for cultivating a secure and efficient work environment. Proactive intervention in these areas will substantially diminish the potential for accidents and enhance the overall welfare of all personnel.

The following details outline specific improper housekeeping practices identified as contributing to slip and fall hazards, alongside recommended corrective actions in order to mitigate risks and bolster safety.

S. No.	Incidents	Recommendations
1	Oil spillage made the muster station slippery; one person nearly slipped but avoided injury by holding the door handle.	To prevent these incidents and avoid any injury cases, it is crucial to follow the guidelines outlined below, as per Clause no. 7.6.9 of OISD-GDN-206 and regulation no. 116 of OMR 2017.
2	Water hose lying across walkway in shaker area created a trip hazard; a crew member nearly slipped but regained balance.	<ul style="list-style-type: none"> • Working areas should be kept clean and organized, trash should be removed, damaged equipment should be repaired, paint and surface finishes should be maintained, and abandoned equipment should be demolished.
3	Slippery floor observed near welding shop, posing a potential slip hazard.	<ul style="list-style-type: none"> • Emergency escape routes should be free of any obstructions.
4	Unstable stacking of chemical jumbo bags on main deck and protruding bag created fall and trip hazards.	<ul style="list-style-type: none"> • 5S (sort out, set in order, standardize, shine and sustain) are some of the practices which help in maintaining good housekeeping.
5	Crew member tripped near shaker area due to obstructing lifting eye of chemical pallet stored close to walkway.	<ul style="list-style-type: none"> • Hazardous waste storage and disposal should be ensured in line with the applicable regulatory requirements.
6	Scattered tools/materials during compressor maintenance created tripping hazards on approach road.	<ul style="list-style-type: none"> • Adequate illumination should be ensured in accordance with OISD-STD-149.
7	Crew member slipped on rain-wet stairs while descending from tanks.	<ul style="list-style-type: none"> • The loose materials, which are not required for use, shall not be placed or left so as to dangerously obstruct the workplace and passage-way.
8	Scrap material lying in pump house shed observed during inspection, causing obstruction risk.	<ul style="list-style-type: none"> • All projecting nails and ends of railings shall be bent or covered with protection to prevent injury.
9	Poor housekeeping in chemical storage area with empty bags scattered near pathway created trip hazard.	<ul style="list-style-type: none"> • The scrap, waste and rubbish shall not be allowed to accumulate in work places, access or egress. • Workplace and passage-way that are slippery owing to oil, mud or other causes shall be cleaned up and made safe.

10	Mechanical crew slipped on stairs near mud pump but regained balance, avoiding injury.	<ul style="list-style-type: none"> • The portable equipment shall be returned after use to its designated storage place. • The equipment, tools and small objects shall not be left lying about where they could cause an accident either by falling or causing person to trip. <p>Additional Precautionary Measures:</p> <p>To further enhance safety and reduce the likelihood of injuries, the following points must also be adhered to:</p> <ul style="list-style-type: none"> • Stairways and ladders should remain clear, unobstructed, and well-lit at all times, in line with the provisions of <i>Appendix 16-B: PGI – HSE & PS Inspection Checklist</i> of the HSE Management System Manual. • While ascending or descending stairs, maintaining three-point contact (i.e., two hands and one foot, or two feet and one hand) is essential for stability, particularly on slippery surfaces. • The use of appropriate Personal Protective Equipment (PPE) including safety shoes, helmets, and gloves is mandatory to minimize injury risk in the event of a slip or fall. • Supervision should be tightened. • CCTV surveillance can be made wherever jobs are carried out to check whether site has been restored to its original condition or not, once job is finished. <p>By incorporating these measures, we can reduce the occurrence of slip and fall incidents, thereby safeguarding personnel and ensuring seamless operational performance.</p>
11	Crew member nearly slipped due to waterlogging near washroom but managed to stabilize.	
12	Poor housekeeping near catwalk and cellar pit posed high risk of slip and fall hazards.	
13	Scattered used barite and chemical bags around hopper motor area created tripping hazard.	
14	Scattered hand tools near shaker area access caused a roustabout to nearly fall; avoided injury by holding the guard rail.	

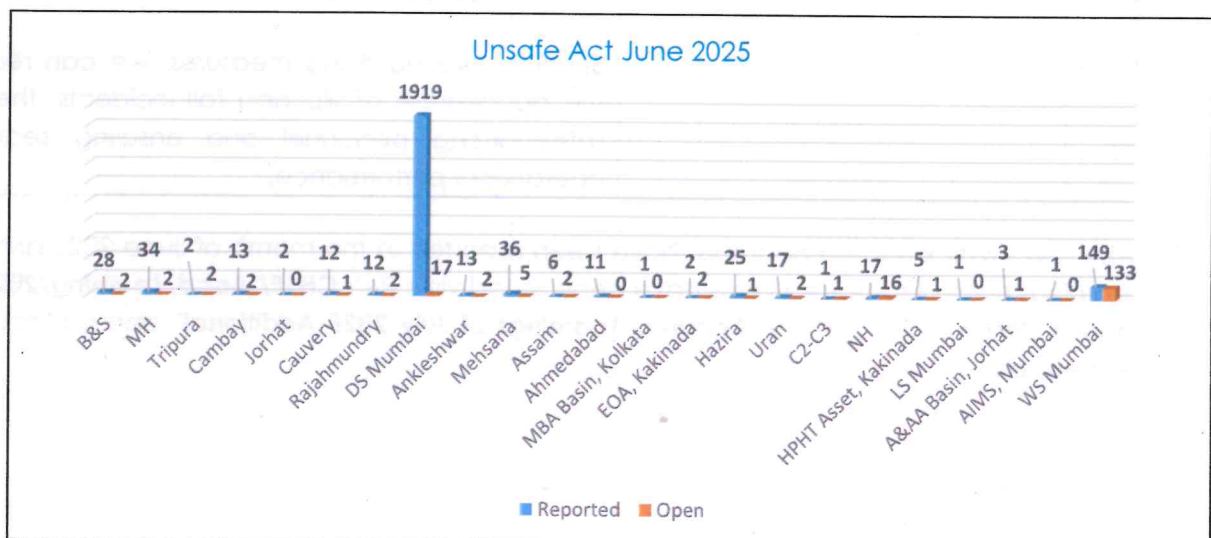
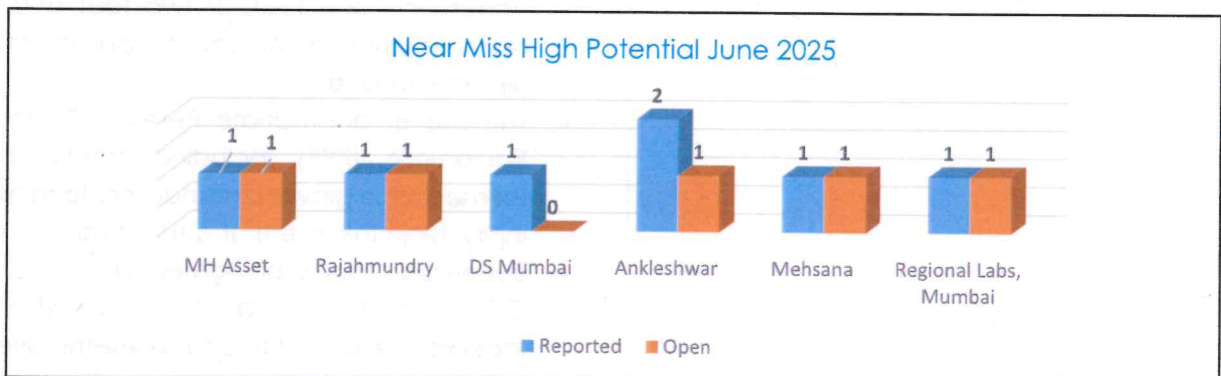
Also few joystick related near miss have been reported in the month of June 2025 and the learnings related to these events have been issued vide Ref: **CHSE/ Accd. Learning/2025-26** dated 23rd July 2025, titled "**Accident Learnings of July 2025-Additional**" and is placed at Annexure-2.

4. The work centre wise detailed status of the near miss reported and open during June 2025 is as follows:




Concerned Head HSE's are requested to close these near misses as early as possible.

5. Work centre wise detailed status of the reported and open Near Miss High Potential, Unsafe Act and Unsafe Condition for the month of June 2025 is as given:





6. Timely remedial action on near miss, near miss high potential, unsafe act, and unsafe condition is critical to preventing injuries, property loss, and future accidents. It is imperative that such cases are addressed, with appropriate corrective measures implemented and all relevant personnel informed of the key learnings. Head HSE's are requested to advise the concerned officials to ensure prompt action on all pending events. Proactive closure and communication of these issues are essential for strengthening our safety culture and maintaining a secure work environment.
7. As per Annexure C – *Accident/Incident Investigation, Monitoring and Acceptance Matrix* of the Reporting Matrix of Accidents/Incidents (placed at Annexure-3), the role of initiating and ensuring remedial actions is clearly outlined. In case of a near miss high potential, **Head HSE** is responsible for initiating and ensuring appropriate remedial action. For near miss, unsafe act, and unsafe condition, the responsibility of taking remedial action lies with the **respective Installation/Unit Manager**.
8. All Head HSE's are requested that respective work force is sensitised on above findings and recommendations and action may be taken on gaps, on priority.


Uday Deole
CGM(P)
Head Safety CHSE
 29/7/2025

To:

All Head HSE

Copy for kind information to:

1. EO to Chairman & CEO
2. CEA to Dir(Production)/Dir (HR)/ Dir (Expl)/ Dir(Finance) / Dir (S&CA)/ Dir (T&FS)
3. ED Chief HSE
4. Key executives

Annexure-1

List of work centres along with their installation/functional locations that reported near miss in the SAP system more than 7 days late during the month of June 2025.

Work Centre	Functional Location
A&AA Basin, Jorhat	DRILLING RIG NG-1500-5
	DRILLING RIG-E760-X
Ahmedabad Asset	DRILLING RIG SS-1500#01
	WELL STIMULATION SERVICES - AHMEDABAD
Assam Asset	DRILLING RIG- EV-2000-V
	DRILLING RIG NG-1500-6
	DRILLING RIG NG-2000-4
	DRILLING RIG-E1400-VI
	DRILLING RIG-F6100-I
	LAKWA-ETP-2
C2-C3 Plant, Dahej	DAHEJ GAS PROCESSING PLANT
Cambay Asset	DRILLING RIG CW IPS-K 700 -IX
	DRILLING RIG NG-1500-1
	RIG DRIP-I
	RIG JOHN-18 (LCI-1000)
	Well Completion & Testing Cambay
CBM Asset, Bokaro	Drilling Rig DR-27
Drilling Services, Mumbai	COMPACT DRILLER
	DRILLING RIG GD CHITRA
	RIG SAGAR GAURAV, JACK-UP RIG
	RIG VIVEKANAND 1 JACKUP
	SEA CHALLENGER-CHARTED HIRED
Hazira Plant	HAZIRA GAS PROCESSING PLANT
Jorhat Asset	SHER-1, J30/1700CZ
Karaikal Asset	CEMENTING SECTION KARAİKAL
	EPS KAMALAPURAM
	ROM-50-IX .WORKOVER RIG
Mehsana Asset	AHWR-100-02 (100 MT)
	BALOL GGS-I
	DRILLING RIG CW IPS700-V
	NANDASAN GGS-I
	RIG DR-06
	VISHAL -100-II WOR
	WOR REPL-24 (50 Ton)-Chartered Hired
	Work Over Rig WO-01
NH Asset	Ratna-R-12B Platform
Offshore Logistics, Mumbai	AIR LOGISTICS-JUHU
Rajahmundry Asset	RIG JOHN 31
Well Services, Mumbai	SAMUDRA NIDHI
	WSV AM Passion-Well Stm Vessel-Contract



निगमित स्वास्थ्य, संरक्षा एवं पर्यावरण
तीसरी मंजिल, टॉवर- ए, दीनदयाल ऊर्जा भवन
5- नेल्सन मंडेला मार्ग, वसंत कुंज, नई दिल्ली – 110070
Corporate Health, Safety and Environment
03rd Floor, Tower- A, Deendayal Urja Bhawan
5- Nelson Mandela Marg, Vasant Kunj, New Delhi-110070
+91-11-26753148 | chse@ongc.co.in

Ref: CHSE/ Accd. Learning/2025-26

Date: 23rd July 2025


Sub: Accident Learnings of July 2025-Additional

1. Minor Accidents/ Incidents

SN	Location	Date	Incident	
			Type	Brief
1.	Rig NG-1500-4, Ankleshwar Asset	01.07.2025	Equipment Failure	<p>During a drill pipe (DP) breaking operation, the driller picked up a drill pipe stand using the elevator while the link tilt was still engaged. When attempting to activate the link float function via joystick, the command failed, the link did not respond.</p> <p>As the DP stand was being slowly lowered into the mouse hole, the elevator collided with the stabbing board railing, resulting in shearing of the stabbing board eye pads. Consequently, the stabbing board detached from the diving board and fell onto the drill floor.</p> <p>Two top men immediately raised an alert, enabling all rig floor crew members to evacuate to safe zones.</p> <p>The joystick float command malfunctioned, causing the float command to fail and preventing the proper positioning of the elevator, which led to the structural impact. This is suspected as the root cause, pending further investigation.</p>
<p>Learnings: The incident highlights critical lessons for improving safety, equipment reliability, and crew response during drilling operations:</p> <ol style="list-style-type: none"> 1. It is advised to devise safe system of work in case of joystick failure and display it at the strategic locations at all new generation rigs. Joystick failure may be included as a hazard during Tool box talks, whenever joystick operations are involved. 2. The failure of the joystick's float command resulted in improper elevator positioning, causing a collision with the stabbing board railing. This highlights the importance of ensuring that all control systems especially joystick functions, are fully operational before initiating any operations. As per <i>Clause 7.2(a) of OISD-STD-190</i>, the shift-in-charge must inspect all instruments and controls at the driller's console, draw works, mud pump, casing line, cat line, 				

BOP assembly, etc., at the beginning of every shift. Any identified faults must be recorded and addressed immediately. Additionally, as per DGMS (Tech.) Circular No.5 of 2020 dated 24.02.2020, all machinery used in oil mines must be inspected weekly by competent personnel, ensuring compliance with OEM guidelines and Oil Mines Regulations, 2017. All inspection records must be properly maintained at the site.

3. In line with Drillmec's troubleshooting procedure, failure of the joystick's float command should be addressed by systematically checking the solenoids, electrical connectors, and verifying the integrity and pressure levels of the hydraulic system. These steps are essential to isolate the root cause whether electrical or hydraulic and ensure safe restoration of link tilt operation and elevator control before resuming operations.
4. The joystick float command malfunction must be subjected to a Root Cause Analysis (RCA) to ensure that the underlying failure mechanism is accurately identified. Findings from the RCA should be used to revise and strengthen the relevant Standard Operating Procedures (SOPs), maintenance checklists, and operator training protocols to prevent similar incidents in the future.
5. As per OISD-GDN-202, the link tilt assembly should be periodically inspected to ensure functional integrity.
6. The incident underscores the essential role of well-trained operators in preventing and mitigating equipment-related hazards. Operator training programs must be strengthened to include hands-on troubleshooting of control system malfunctions, accurate identification of malfunction indicators such as float command failures. Therefore, continuous skill development, refresher courses, and real-time simulations should be an integral part of rig training schedules to maintain a high level of preparedness and competence.
7. This incident, involving a joystick malfunction, elevator collision, and stabbing board detachment, must be documented as a hazard in the risk register to ensure proactive management and prevent recurrence.


Uday Deole
 Head Safety CHSE
 23/7/2025

To:

- Key Executives
- All ONGCians through ONGC Reports

Copy for Kind Information to:

1. Chairman & CEO
2. Director (Production) / / Director (HR) / Director (Finance) / Director (S&CA) / Director (T&FS) & Director (Exploration)

Accident/Incident Investigation, Monitoring and Acceptance Matrix

Accident /incident	Committee Constitution Within 24 hours of the Accident/ Incident	Timeline for Report Submission	Authority for Acceptance of Recommendations	Issue of Safety Alerts	Remarks
Fatal	Chief HSE	Fortnight	Concerned Director and Chairman & CEO	Corporate HSE	Head of the Enquiry Committee shall be from different work centre.
Major	Chief HSE	Fortnight	Concerned Director	Corporate HSE	Head of the Enquiry Committee shall be from different work centre.
Minor	Concerned Key Executive	Fortnight	Concerned Key Executive	Respective Head HSE	Report and Action Taken to filled in SAP.
Hi-Po Near miss	Head HSE/ In charge HSE	Action to be entered in SAP	Head HSE/ In charge HSE	Respective Head HSE	Report and Action Taken to filled in SAP.
Near Miss	To be enquired by concerned Installation/ Unit Manager	Action to be entered in SAP	Concerned Installation/ Unit Manager	Concerned Installation/ Unit Manager to ensure awareness	Report and Action Taken to filled in SAP.
Unsafe Act and Unsafe Condition	To be enquired by concerned Installation/ Unit Manager	Action to be entered in SAP	Concerned Installation/ Unit Manager	Concerned Installation/ Unit Manager to ensure awareness	Report and Action Taken to filled in SAP.