PETROLEUM EMPLOYEES UNION

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Since 1954

Date : 09.11.2026

To,
Executive Director - President, Western Offshore,
8th Floor, Vasudhara Bhavan, Mumbai.

Subject: Representation Regarding Severe Crane Safety Violations at NQ Installations, MH Asset, Platform Authority Accountability, and Demand for Immediate Safety Audit and Mandatory Implementation of Preventive Safety Measures.

Respected Sir,

As you are well aware, a fatal crane accident occurred on 13.04.2026 during cargo handling operations at the N-12 unmanned platform under NQ Process Complex. The Oil Industry Safety Directorate (OISD), in its investigation report dated 18.05.2026, identified the failure of the Anti-Two-Blocking (ATB) system and the crane warning alarm as the primary root causes of the accident.

It is pertinent to highlight that the Petroleum Employees Union has been consistently raising concerns regarding crane safety at NQ through various forums, including Safety Committee Meetings and representations to the concerned authorities. These concerns were raised well before the fatal accident. Unfortunately, despite the loss of a precious human life and the subsequent observations of OISD, the required seriousness and urgency in addressing these safety deficiencies are still not evident.

What is even more alarming is that on 27.10.2026, the auxiliary block of the NQG South crane fell during operation. It was only by sheer chance that no one was present beneath the crane at the time, thereby averting another potentially fatal accident. This incident raises serious questions regarding the effectiveness of the corrective and preventive measures undertaken following the fatal accident of 13.04.2026. The occurrence of another crane-related incident after the fatal accident and subsequent OISD observations warrants a critical review of the adequacy and effectiveness of the corrective and preventive actions implemented across NQ installations.

Equally disturbing is the fact that ONGC crane operators have repeatedly brought to the notice of the concerned authorities the non-functioning of the Anti-Two-Blocking system. Instead of being addressed with the seriousness they deserve, these legitimate safety concerns appear to have been overlooked. Despite repeated follow-ups by the Petroleum Employees Union, the Platform Authority continues to disregard essential safety arrangements and is forcibly compelling employees to carry out unsafe work.

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Due to this persistent negligence, another severe accident or loss of human life may occur again. Therefore, appropriate and stringent action should be taken against the Platform Authority.

There are also serious concerns that contractual crane operators are being pressured to undertake crane operations using the auxiliary block despite reported deficiencies in critical safety systems. It is deeply disturbing that even after a fatal accident, the same category of safety deficiencies continues to persist. The loss of one precious life should have been sufficient to trigger a comprehensive review of crane safety across NQ installations. Waiting for another fatality before taking corrective action would be completely unacceptable.

The Petroleum Employees Union strongly objects to this casual approach towards such critical safety issues. No operational requirement, production target, or work pressure can ever justify compromising the safety of personnel. Equally, employees who raise genuine safety concerns must be heard and their observations acted upon rather than being ignored or sidelined.

Given the recurrence of serious crane-related safety incidents after a fatal accident and subsequent regulatory observations, the matter merits immediate intervention at the highest management level.

In view of the above, we call upon the higher management to intervene immediately and ensure implementation of the following measures :

1. **Comprehensive Safety Audit :**

Direct an immediate and comprehensive safety audit of all cranes operating under NQ Process Complex, covering the Anti-Two-Blocking (ATB) system, warning alarms, limit switches, hoisting mechanisms, brakes, wire ropes, hooks, and other critical safety components. The audit shall be conducted by a competent and authorized agency, and its findings shall be properly documented.

2. **Immediate Restriction on Unsafe Operations :**

No crane should be permitted to operate unless all prescribed safety systems are fully functional and its safe operating condition has been duly inspected and certified in writing by the competent authority. Any crane found deficient in safety requirements shall remain out of service until the deficiencies are rectified and its fitness for operation is formally certified. No operational or production requirement shall be allowed to override this restriction.

3. **Investigation, Accountability, and Action Against Authority :**

A time-bound investigation should be ordered into the incident involving the fall of the auxiliary block of the NQG South crane on 27.10.2026. The investigation shall specifically examine the condition of the crane, the status of its safety systems, the circumstances leading to the incident, and the actions or omissions of the officials responsible for ensuring crane safety. Accountability shall be fixed wherever lapses are established, and strict

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administrative action must be initiated against the Platform Authority for disregarding safety protocols and compelling employees to perform unsafe work.

4. **Protection of Employees Raising Safety Concerns :**

Clear instructions should be issued, that no ONGC or Contractual employee shall be pressured, directly or indirectly, to operate a crane having defective or non-functional safety systems. The safety concerns raised by crane operators shall be formally recorded, investigated, and addressed. No employee shall face any adverse action for refusing to undertake an operation on genuine safety grounds.

5. **Time-Bound Compliance and Monitoring :**

Direct the concerned authorities to submit an Action Taken Report on all pending crane safety observations at NQ within 15 days. A consolidated compliance report, including inspection findings, deficiencies identified, rectification undertaken, and certification status of each crane, shall also be shared with the Union. The matter shall thereafter be reviewed periodically at the appropriate Safety Committee forum until all observations are closed.

The Union places on record that these safety concerns have been repeatedly raised through appropriate forums well before and after the fatal accident of 13.04.2026. Accordingly, any future crane-related accident arising from the same unresolved deficiencies cannot be regarded as unforeseen, unavoidable, or beyond the knowledge of the concerned authorities.

We expect the management to treat this matter with the urgency it warrants and ensure that the above measures are implemented within the stipulated timelines. The Union also expects a clear response on the actions initiated and the corrective measures proposed. We trust that the management will take all necessary steps to address these long-pending safety concerns and ensure that crane operations are carried out strictly in accordance with prescribed safety requirements.

Thanking you in anticipation,

Yours faithfully,

09/11/26

(Vaibhav M. Lavekar)
General Secretary

Copy to :

1. GGM - Asset Manager, ONGC MH Asset, 8th Floor, Vasudhara Bhavan, Mumbai.
2. CGM – Surface Manager - MH Asset, Vasudhara Bhavan, Bandra (E), Mumbai.
3. CGM – Head Maintenance - MH Asset, Vasudhara Bhavan, Bandra (E), Mumbai.
4. CGM – Head HSE, MH Asset, Vasudhara Bhavan, Bandra (E), Mumbai.
5. CGM (P) – Area Manager NQO Platform, MH Asset, V. Bhavan, Mumbai.
6. GM (HR) Head FMG – I/C IR, ONGC (W.O.U.), NBP Green Heights, BKC, Mumbai.