



Operating in the Post Piper Alpha environment - An Operator's Perspective

Ian Grant, Chief Operating Officer, Quadrant Energy Australia Limited Presentation to the Society for Underwater Technology 13th June 2018



Agenda





- Post Piper Alpha, Summary of Findings
- The Safety Case
- Inherent Safety through Design and Case Study
- Process Safety
- Human Factors and HSE Culture
- The Case for Change, Safety Collaboration in Australia

Post Piper Alpha

The Findings





The Main Cullen findings [1]:

- New legislation requiring safety cases;
- Goal-setting legislation;
- A single regulator;
- Offshore safety reps and safety committees;
- Revision of permits to work;
- Process control;
- Mandatory incident reporting;
- Hydrocarbon inventory;
- Fire and gas detection and emergency shutdown;
- Fire and explosion protection;
- Emergency centres and system;
- Pipeline emergency procedures;
- Evacuation, escape and rescue plans and equipment;
- Standby vessels;
- Command in emergencies;
- Regular drills and Emergency training

106 recommendations:

- 57 overseen by Health and Safety Executive
- 40 executed by Operators
- 8 for the entire industry to progress
- 1 for Standby Ship Owner's Association

All accepted in the UK

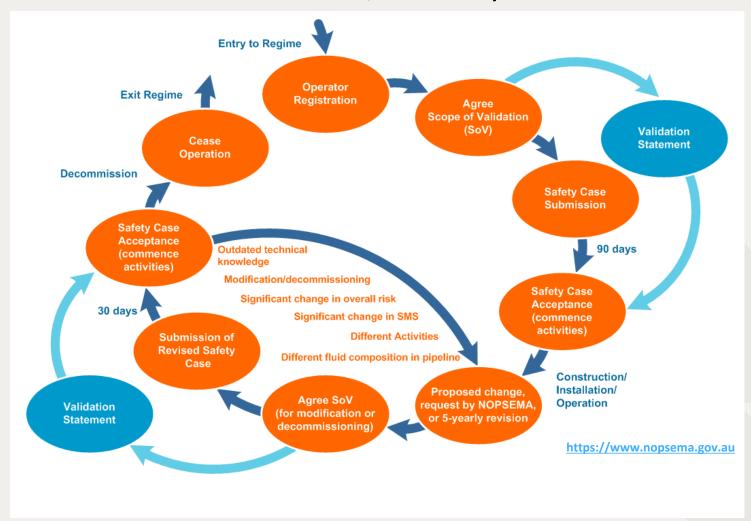
The Safety Case

- A Key Finding from Lord Cullen





Identifies the hazards and risks, how they are controlled and SMS



The Safety Case



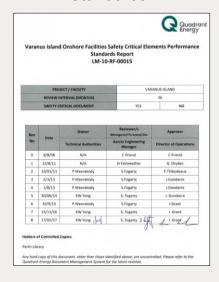


- Asset Integrity Management in a Safety Case Regime
- Safety Case is accepted (or not) & compliance routinely audited by regulator
- Identification of Major Accident Events* (MAE)
- Identification of Safety Critical Elements (SCE i.e. barriers)
- Setting of associated SCE Performance Standards (PS i.e. testing & inspection requirements)

Safety Case



SCE Performance Standards



Assurance Plans



Maintenance Management System



Feedback loop to Assurance Plans to ensure actual performance is utilised



STRICTLY CONFIDENTIAL

Inherent Safety through Design





- Why is Inherent Safety design so important?

Because we're human.....

"human factors either caused the incident or made it worse. These human factors included.... confusing procedures,.... insufficient training, ineffective coordination and communication, lack of a reporting and learning culture, confusing low personal injury rates as indicators of process safety performance,.... lack of awareness of risk factors and normalizing signs of danger"

Lord Cullen at IOGP in 2017

Inherent Safety through Design





- Building to avoid risks

"An inherently safer design is one that <u>avoids</u> <u>hazards instead of controlling them</u>, particularly by reducing the amount of hazardous material and the number of hazardous operations in the plant." [2]

Inherent Safety through Design

- Devil Creek Gas Plant, A Case Study







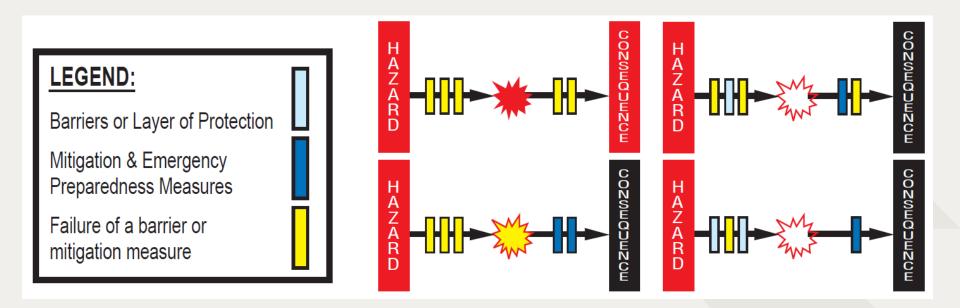
Process Safety

- Containing the Danger





"Process safety is a disciplined framework for <u>managing the integrity of operating systems and processes</u> that handle hazardous substances. It relies on good design principles, engineering and operating and maintenance practices. It deals with the prevention and control of events that have the potential to release hazardous materials and energy." [4]



Example barriers vs human

Process Safety

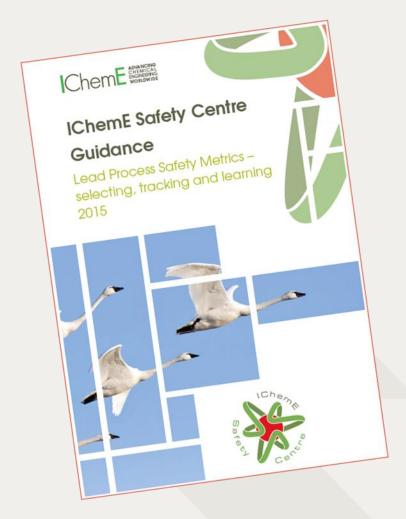






Leading Metrics

- Requires identification and understanding of all barriers
 - Understand demand on the system
 - Understand level of barrier performance
- Inspection / testing of barriers
- Monitoring / Auditing to ensure barriers are providing required protection
- Probing / investigating to ensure barriers aren't being compromised
- Leading Metrics require deep understanding of barriers before an incident and review post incidents
 - Review of barrier requirements so correctly specified / identified
 - Monitored / reviewed barriers have a high likelihood of being effective when called upon



Process Safety

Insights





- "You don't improve what you don't measure".
- "A key to prevention is effective Process Safety Management"

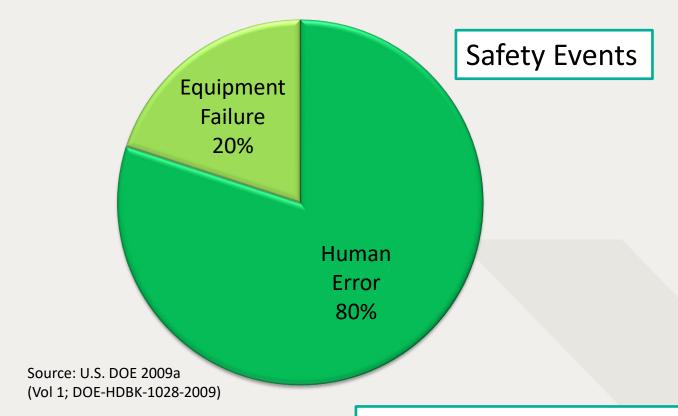
My View:

- Industry needs a common language to improve process safety understanding
- Process Safety methodology has yet to fully penetrate the workforce
- We need to stay current with the way we communicate and educate

Safety Literature Tells Us...







"We all make errors irrespective of how much training and experience we possess or how motivated we are to do it right."

(Source: HSE HSG48 pg10)

Human Factors





- The Workforce Equation

"Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety." [7]

Five (Golden Principles of Human Performance: [8]
1	People are fallible, and even the best people make mistakes
2	Error-likely situations are predictable, manageable and preventable
3	Individual behaviour is influenced by organisational processes and values
4	People achieve high level of performance because of the <u>encouragement</u> and <u>reinforcement</u> received from leaders, peers and subordinates
5	Events can be avoided through an understanding of the reasons mistakes occur, and the application of the <u>lessons learned</u> from past events

Human factors API RP75 designed to remove the need for human intervention (simplification message) both during operations and when things go wrong.

Embedding the Culture





Our HSE Culture

it's what we do that matters

	STANDARDS	COMMUNICATION	RISK MANAGEMENT	INVOLVEMENT
Managers, Directors & Executive Officers	Set high standards	Communicate openly	Confront risk	Involve the workforce
Supervisors	Ensure compliance	Encourage the team	Promote risk awareness	Involve the team
Everyone	Follow rules	Speak up	Be mindful	Get involved

What is Quadrant's HSE culture?

Quadrant's HSE culture framework describes positive behaviours that support a strong HSE culture. We should all model ourselves against the **Everyone** set of behaviours. People in supervision and management should also model themselves against the **Supervisors** or **Managers**, **Directors and Executive Officers** behaviours.



Safety30

- Securing a Safer Future





 Conference held in Aberdeen 6th to 8th June 2018, organised by OGUK in association with International Regulators Forum

Learn from the Past

Consider the Present

Commit to the Future

The Case for Change









https://vimeo.com/259587886

Closing Points

- Securing a Safer Future





Please,

- Keep things simple! (procedures, systems etc.)
- Promote Effective Process Safety Management
- Increase mitigation of Human Factors by:
 - Inherent Safety in design
 - Transfer lessons learned and educate the workforce (linking events to current procedures and systems)
 - Consider the audience and how they learn
- Sharing Best Practice (overseas, other industries, Safer Together etc.)





".... individuals will only learn the lessons of previous incidents if the organisations that they belong to understand the need for such individual learning and create the conditions under which the learning can occur. It is organisations that need to foster the kinds of storytelling from which everyone can learn."

Andrew Hopkins, Disastrous Decisions Book 2012, pp. 121

Last Slide

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