

## A regulators' perspective on improving safety

*Presentation delivered by Jane Cutler, NOPSEMA CEO*

### Slide 1 - Introduction

Thank you Ernie.

I would like to reflect for a moment on the events of 27 August 2012. Nearly one year on, as friends and loved ones of two workers killed on the Stena Clyde bear the burden of loss, NOPSEMA's investigation team is working hard to determine what went wrong.

Timely then to review preliminary considerations of NOPSEMA's independent investigation that, incidentally, relate closely to conference theme, "Protecting your team".

Preliminary considerations published on Home page of NOPSEMA website.

### Slide 2 - Preliminary considerations – Stena Clyde investigation

1. An appropriate risk assessment system should be implemented for all stages of work. Workers involved should have an opportunity to contribute to this assessment, including consideration of factors such as:

stored energy; equipment design limits; and, impact of external conditions.

2. Communication is a key part of any work offshore. Supervisors should verify that all workers involved in any task understand their role and any associated risks.

3. All equipment utilised in planned work should be fit for purpose and in good working order. If the equipment is not working correctly, a reassessment of the risks associated with the work or task should be conducted.

What appears to be common sense for the many health and safety professionals here today does not necessarily translate to good practice, every hour, every day offshore.

I also ask you to reflect on the recent death on drill rig, onshore, here in Australia and in June the two lives lost and one worker seriously injured in the Dutch Sector of the North Sea. I understand that the workers were involved in testing a heat

exchanger at the time. While the exact circumstances may be a little different, testing of equipment also caused a fire on West Kingfish on 6 November 1986. One engineer died and another was seriously burned.

Brings me to what ideally should be the outcome from my presentation today – and that is:

I would like you to think about:

- High consequence, low frequency events happen ..... eventually
- Manage the risk not the regulator .... Consider your conversations do you ask “have you got a handle on the risks ?” or “did you get that approval from the regulator?”

What interests me – the regulator – should fascinate you – the offshore industry.

What interests me – the regulator – is whether the risks to people and the environment are clearly understood and what those who generate the risks are actually doing to reduce those risk to as low as reasonable practical and acceptable levels.

A key principle by which NOPSEMA regulates – is that the core objective that industry should *and can* use the regulator’s work as a catalyst for continuous improvement.

Before I expand, let me present some of the latest industry-wide safety data. These are published on NOPSEMA’s website every quarter.

### Slide 3 - Injuries

Have said previously that lower injury rates should be commended as they represent actual harm avoided. Indicates efforts made by petroleum organisations to prevent further fatalities and harm to the workforce.

This rate remains on watch as it’s shown a slight increase in 2013 to 7.08 per million hours worked (6.57 in 2012).

### Slide 4 - Accidents

Remaining steady around historically low rate of 1.21 reached in 2012.

Majority accidents recorded in 2013 to date were due to moving objects injuring hands or feet.

Six of the eight occurred on MODUs (Mobile Offshore Drilling Units). MODUs account for 75% of accidents this year but only 39% of hours worked offshore.

### Slide 5 – Dangerous occurrence

The current rate at June 2013 is 24.21 incidents per million hours worked, which is comparable to 2012 levels.

### Slide 6 – Hydrocarbon release

Uncontrolled hydrocarbon releases reported as OHS incidents totalled 17 in 2012 compared to 10 in the first six months of 2013. (All gas released under 300 kg). I am encouraged by David Knox's words about APPEA's goal to reduce hydrocarbon releases by 50% by 2017.

### Slide 7 – Accidents root causes

### Slide 8 – Dangerous occurrences root causes

Of course, I would expect that some causes of accidents and incidents will be more prevalent across industry from time to time – warranting special attention from the industry – and the regulator.

What does *not* make sense is why you report to us the same root causes of accidents and incidents year after year?

Why – when NOPSEMA:

- records indicate the same basic causes in accident and dangerous occurrences offshore
- documents these in inspection and investigation reports
- shares them direct with the operators concerned and more widely across industry...

**are we seeing history repeat itself?**

## Slide 9 – Annual Offshore Performance

Would expect that most here have read NOPSEMA's *Annual Offshore Performance Report*.

Released in May. Offers a valuable perspective and alternative to the reports generated within your organisations.

The chapter on Topic-based inspections (Chapter 8) shares NOPSEMA's observations about areas for improvement covering:

- Ageing facilities
- Contractor management
- Maintenance management
- Operator auditing

For example our **Ageing facilities** inspections identified shortcomings across:

- **Asset Integrity Management** – inadequate organisational roles, responsibilities and processes
- **Fabric maintenance and maintenance inspection scope** - delays and backlogs not risk-assessed, maintenance impacts of new materials not analysed
- **Failure to apply knowledge** – failure to incorporate analysis results into revised work plans, integrity of 'passive fire protection' not reviewed, no 'corrosion under insulation' inspection program.

## NOPSEMA key priorities

We use these findings to help set NOPSEMA's priorities aimed at improved industry safety performance.

And I propose that these can also be used by industry *ahead* of any inspection.

NOPSEMA has already flagged them as areas warranting your special attention – and there certainly appears no point waiting for the regulator to "catch you out".

## Slide 10 – NOPSEMA priorities

### Technical Controls

- Hazardous area equipment
- Application of well barrier policy
- Escalation (response plans)

## Performance standards

- Implementation of controls to specified performance standards
- Lack of developed performance standards and associated integration into testing / inspection / maintenance regimes
- Commissioning and start up

## Process safety

- Maintenance Management
- Asset Integrity
- Management of Change
- Internal auditing (do not rely on NOPSEMA to identify problems – your own management systems and audits should be highlighting weaknesses before NOPSEMA inspections.)

## Slide 11 – Involve to engage

“workforce involvement” – is a valuable legacy of the lessons from Piper Alpha 25 years ago – must be part of the equation?

Is industry putting enough focus on the goal of “workforce **engagement**”?

Continuous improvement depends on the genuine “**engagement**” in all aspects of safety by those making decisions, those designing the equipment and systems and those who supervise and carry out the work offshore.

### Workforce involvement

- Opportunity to identify risks and impacts
- Role in defining systems and procedures

### Workforce understanding

- Opportunity to ask questions
- Role in applying knowledge

### Workforce engagement

- Opportunity to protect self and team
- Role in continuous improvement

I would encourage all of us to move towards a more collaborative way of driving the work of industry to improve safety outcomes.

Thank you.