





Prevention or Mitigation



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Major Accidents Vapour Cloud Explosions

Flixborough (1974)



Mexico (1984)



Piper Alpha 1988



Pasadena 1989



Few Major Accidents

Esso Longford (1998)



Tolouse (2001)



BP Texas (2005)

Feysin

1966





Buncefield (2005)



Vapour Cloud Explosions



1966 (4th January) - Feyzin, France



1974 (1st June) - Flixborough



1984 (19th Nov)) – Mexico (Pemex LPG Terminal)

500 fatalities, Terminal destroyed





167 fatalities, Platform destroyed





1998 (25th Sept) – Esso Longford



Abnormal operating condition

Toulouse 21st September 2001



2005 (23rd March) BP Texas Refinery

15 fatalities, Over 170 injured

1999 Thai refinery

7 fatalities











2005 (11th Dec) – Buncefield



Major Accidents - Fall outs

Major Accidents - Fall out Low freq / High consequences events

Remember !!!

All efforts are of questionable value if ultimate objectives are not achieved

Options – Prevent OR Mitigate

Will mitigation approach help?

No easy answers. You are judged on the basis of what you did, and not what you said.

VCE Incidents – Typical aspects



- Anger in the local community,
- Intense regulatory scrutiny,
- Litigation,

- Massive media coverage, and
- Attacks on motives, competence and commitment to safe operation



Mitigation

What did we do so far?

More on mitigation !!! (Fire Fighting Measures, Detectors, CCTV)

Full Drive / Attention

at all levels

Will mitigation take care of media attention, community anger & litigations.

Mitigation Measures- Issues

Fire Fighting Efforts Big Dimensions !!!

Will detection help? Smoke! Fire! Gas/HC





(4) Large-volume monitors and large-diameter hose are required to battle a large tank fire.





Prevention What to do?

Prevention - What to do?

Buncefield 2005 – Tank overflow



2005 (11th Dec) – Buncefied



Buncefield after the incident – Close up



Figure 6 Buncefield after the incident: Tank 912 is in the centre foreground and Tank 12 is in the top left of the picture © Chiltern Air Support

Buncefield 2005



Buncefield Oil Depot What happened

300 tons gasoline overflow in 30 minutes



- Incident involved overfilling of a large storage tank with petrol supplied through a pipeline.
- As the petrol flowed over the topside of the tank, it formed a large vapour cloud that subsequently ignited.

2005 (11th Dec) – Buncefield

Matters that matter

Basis : HSE Report Why did Buncefield happen?

Buncefield – Matters that matter



2005 (11th Dec) – Buncefield

Matters that matter Prevention of primary release Attention not as warranted



Buncefield 2005

What happened?

- No means to alert control room operators.
- Supervisors relied on alarms to control filling process.
- Tank overfilled. Vapour cloud formed . Massive explosion





Floating Lid

2005 (11th Dec) – Buncefield

Matters that matter

No MOC (Management of change) – Why! Why!! Why!!!



2005 (11th Dec) – Buncefield



Understand Design Intent Protect Design Intent

Take care of MOC

Not only interlock & protection bypass

2005 (11th Dec) – Buncefied

Focus not only on personal safety

Focus on Primary containment

2005 (11th Dec) – Buncefied

Matters that matter PSM Principles / Tenets

PSM – Principle / Tenets

- There should be a clear understanding of major accident risks and the safety critical equipment and systems designed to control them.
- There should be systems and a culture in place to detect signals of failure in safety critical equipment and to respond to them quickly and effectively.
- If understanding & culture then no problems
- Why did Buncefield happen? Absence of clear understanding and Culture
- Ensure clear understanding & Culture
 Senior management down to shop floor

Points to ponder

- Is there a clear understanding? (SCEs for major hazard risks & their design)
- IHLS not operative : Design not understood
- Is there a culture/ system to manage SCEs? (Detection of SCEs failure & quick response)
- Gauge stuck up problem 14 times in 4 months (No attempt to identify definitive cause)

Points to ponder

 Understanding & culture exists for PSV (SCE) Attention / Drive at all levels Reason : Perception (fear) of hazard / risk Does it commensurate with hazard / risk

Less Attention / Drive at all levels for other SCEs (Level alarms, ROVs, Remote Switch-off, Dykes) Reason : Poor understanding of hazard / risks Shift in understanding and culture for other SCEs

Story same in oil industries worldwide

Safety Critical Equipment

Do they get attention as warranted Understand SCEs

Matters that matter – Attention / Drive

Focus not on primary containment

Vapour Cloud Explosions Tank / Column overflow

2005 BP Texas Refinery

> 1999 Thai Refinery

2005 Buncefield

2009 Puerto Rico

Management of Major Hazard Risks Core Issues

Management of Major Hazard Risks Core Issues

- Focus not only on personal safety
- Focus on Major Hazard Risks
 - Particularly primary containment
- Pay extra attention to SCEs as warranted
- Take care of MOCs (Management of change)
- Know safety critical actions & their consequences

Raise awareness of hazards and risks

Understand design intent

Protect the design intent

Thank you