

**From CEO John Clegg**

Our offshore health and safety regime is built on the principle that the primary responsibility for ensuring health and safety lies with those who create risks and those who work with them. It is important then that the workforce understand and have ready access to the safety case. This allows them to understand the risks they face and the safety management processes they should be working with.

During planned inspections, NOPSA inspectors will typically check to see whether the safety case is readily accessible, either through hard copies or electronically. Recent reports from NOPSA inspections indicate that some safety cases are not readily accessible to the workforce.

I would like to share a positive example of safety case use. Recently NOPSA inspectors asked Health and Safety Representatives (HSRs) about the operator's arrangements for fatigue management. The HSRs recognised they should look in the facility safety case. It is refreshing to hear that the safety case is being used in practice offshore to resolve questions about safety arrangements.

Operators should make the safety case readily available to their workforce and explain the arrangements for accessing it.

Industry matters

Pipework at risk from vibration

NOPSA inspectors recently identified poorly configured small bore pipework susceptible to vibration induced fatigue. Failure of the pipework connections could have led to a hydrocarbon release from pipework surrounding reciprocating gas compressors.

Data published by the UK Health and Safety Executive has shown that, for the UK sector, vibration induced fatigue accounted for over 20 per cent of hydrocarbon releases. According to the Marine Technology Directorate Joint Industry Project Database statistics (1994 to 1997) pipework in the vicinity of gas compression modules was at the highest risk of vibration induced fatigue failure.

Operators should be aware of the risks from vibration induced fatigue and implement adequate controls to ensure that all reasonably practicable steps are taken to ensure plant and equipment are safe and without risk to health, clause 9(2)(c), Schedule 3, *Offshore Petroleum and Greenhouse Gas Storage Act 2006*.

A recent publication by the Energy Institute, *Guidelines for the Avoidance of Vibration Induced Fatigue Failures in Process Pipework* (2nd edition), outlines an industry proven methodology in reducing the risk of this type of failure. This publication can be ordered [online](#).¹

Plan for rescue events

In a recent incident a man fell overboard inside the jacket of an offshore platform and could not be easily rescued. This has raised issues that operators of similar facilities should consider when planning rescue operations.

Issues to consider include:

- the means by which the rescue will be done. It is usually not possible to use a helicopter to recover someone from within the jacket structure, and the use of a lifeboat could also put its crew at risk, particularly in adverse sea conditions.
- in choosing the method of rescue it should not be assumed that the person in the water is conscious and uninjured.
- the additional difficulties of getting to people within the jacket structure in a rescue craft – more safeguards may be required to prevent falls into the water than would be required in normal offshore working conditions.

Untested lifting equipment prompts prohibition notice

NOPSA inspectors issued a prohibition notice preventing the use of lifting equipment on a facility which had recently left a shipyard. The notice prohibited the use of all fixed 'pad eyes' and monorail (trolley) beams where load-test or non-destructive-testing had not been undertaken. The inspectors found that all pad eyes and monorail beams rated below 5 tonnes were untested.

The operator's safety management system (SMS), described in the safety case, required all lifting equipment be proof load-tested on initial installation and inspected annually by an independent inspector. The SMS also required a lifting equipment register be kept, however this register was found to be incomplete.

The failure to verify the integrity of the lifting equipment and the incomplete lifting equipment register were known to be outstanding issues on departure from the shipyard.

NOPSA emphasises all lifting equipment on a facility must meet the relevant testing requirements.

Learn from Baker Report – Recommendation 2

The Baker Report, produced after a devastating process accident at the BP Texas City refinery in 2005, looks at safety culture and contains valuable lessons for industry today. The report called on the operator to give process safety the same priority it had historically given personal safety and environmental performance. Ten milestone recommendations were made by the Baker Report. Each recommendation is examined in a separate issue of this newsletter.

Recommendation 2: Process Safety management:

- *Management should establish and implement an integrated and comprehensive management system that systematically and continuously identifies, reduces and manages process safety risks.*

The Baker Report identified the following weaknesses in the operator's approach to process safety which are paraphrased here:

- its corporate safety management system did not ensure timely compliance with internal process safety standards
- it did not ensure timely implementation of external good engineering practices that could improve process safety performance
- it did not effectively define the level of process safety knowledge or competency required of senior management refinery personnel
- its corporate safety management system did not translate corporate expectations into measurable criteria for management of process risk.

Register your interest in the upcoming HSR Forum

This year's Health and Safety Representatives' (HSR) Forum will be held at the Burswood Convention Centre on August 3. It will be followed by the National Oil & Gas Safety Conference on August 4-5.

NOPSA is chairing the HSR Forum Steering Committee and has issued an invitation to individuals or organisations that wish to make a presentation to the forum on one of the following topics:

- avoiding major accident events
- safety culture; safety case
- safety competency training.

The deadline for presentation submissions (250 word abstract) is April 30. Please contact lily.martin@nopsa.gov.au if you are interested in presenting or have any other queries on the forum.

Safety case guidance note project progresses

The first two workshops in a series organised by NOPSA to seek consultation on a new range of guidance notes on the safety case have proved successful. The workshops were attended by a wide range of industry participants who provided constructive input on the draft guidance note material and positive feedback on the consultation process.

Comments are now being sought on Guidance Note, [Safety Management Systems](#)², which is available on the website as a draft discussion document until April 17. Further workshops will be held throughout the year on more guidance note topics including hazard identification, supporting safety studies, risk assessment and ALARP. You are encouraged to check the schedule of workshops planned on our website under the [Projects](#)³ link.

New report highlights high cost of work related injuries

The total cost of work-related injury and disease for Australian employers, workers and the community has been estimated at \$57.5 billion for the 2005-06 financial year.

The estimate is contained in a [report](#)⁴ released by the Office of the Australian Safety and Compensation Council (ASCC)

Stakeholder relations

Safety regime topics discussed

The NOPSA executive team recently conducted a round of meetings with key stakeholders in the offshore occupational health and safety regime. They included representatives from the Commonwealth Government, the Australian Maritime Safety Authority, the Australian Government Solicitor, some offshore operators and the Australian Council of Trade Unions. Matters discussed included the ongoing review of levies, the regulatory inquiry, legislative amendments including the appropriateness of the dis-application of the Navigation Act and the health and safety performance of the offshore petroleum industry. Offshore operators were reminded of the legal requirement to comply with the commitments made in their safety cases and benefits which accrue from workforce involvement.

International

Investigation of fatal helicopter crash off Canada

Investigators from the Transportation Safety Board of Canada are continuing their examination of [an incident](#)⁵ where a Sikorsky S-92 helicopter crashed off the east coast of Newfoundland, killing all but one of the 18 people on board.

Reports were received that two main gearbox filter bowl assembly mounting studs were found broken on the helicopter. The Federal Aviation Authority in the United States has issued an emergency airworthiness [Directive](#)⁶ for the Sikorsky-92 helicopters calling for the immediate replacement of all titanium studs with steel studs on this aircraft before further flight.

Safety alert on broken deck winch footings

A safety [alert](#)⁷ on the Oil and Gas Producers (OGP) website draws readers' attention to an incident in which the footings of a deck winch were found to have cracked through. The alert recommends that the whole bodies of winches including the mounting points need to be carefully checked at regular intervals for cracking.

Website

Leaflet highlights health and safety

The latest edition of NOPSA's [Boot Room News](#)⁸ which highlights health and safety issues for the offshore workforce has been distributed and is available on the website. Hard copies of the leaflet can be ordered from: info@nopsa.gov.au

Regulatory activities

As at 26th March 2009

Disclaimer: Activity and incident quantities identified here may vary as further information becomes available. Statistics are prepared just prior to the last Friday of the month

Assessment

March 2009				
Assessment Type	Submitted	Notified	Rejected	Being Assessed / Negotiated
Safety Case NEW	1	2		7
Safety Case REVISED	8	6		11
Pipeline SMP REVISED	1			1
Diving SMS				1
Scope of Validation	3	5		10
Field Development Plan	1	1		1
TOTALS	14	14		30

Inspections

Nine inspections were conducted in March. Some of the issues included:

- lifesaving equipment removed from MODU for service without replacement
- crane certification and maintenance
- management of in situ asbestos-containing material
- inadequate consultation on OHS matters

Incidents and complaints

There were a total of 29 incidents and three complaints reported in March. Incidents included 26 Dangerous Occurrences and three Lost Time Injuries.

The major incidents included:

- one collision - vessel and MODU
- one electric shock
- one dropped object
- one crane hook caught container – lifting operation

The significant incidents included:

- three LTIs – foot (landing), dropped sling on foot, lacerated leg (trapped)
- one HC gas release between 1 and 300 kg from pilot valve
- one HC leak in small bore line caused by internal erosion
- one dropped object
- one passing contact with pipeline – by vessel
- seven unplanned events requiring implementation of emergency response plan – one gas alarm, five smoke detector alarms, one power failure
- ten damage to safety-critical equipment including:
 - shackle parted on elevator
 - wellhead damaged by dropped subsea intervention device
 - leak in manifold - deluge system
 - power failure - loss of station
 - valve failure to close
 - faulty chain block

The complaint issues included:

- excessive hours being worked – fatigue
- roster changes without workforce consultation
- improper use of equipment (no dry-breakers of bunkering hose)
- poor condition of equipment – cranes
- time extensions given for compliance with Improvement Notices
- uncertainty about safety regulation jurisdictions

Enforcement

The following Enforcement Actions were issued in March:

- One Prohibition Notice to prohibit use of uncertified ‘pad eyes’ and monorail beams
- Four Improvement Notices for:
 - Revising systems for hazard and risk assessment
 - updating communication between shifts
 - updating Permit to Work system
 - providing a barrier for fluids entering moonpool
- Four Written Advice/Warnings for:
 - failure to take all reasonable steps to ensure safety
 - failure to implement and maintain safe work systems
 - interference with a manual call point alarm – rendering it ineffective
 - life rafts removed for servicing

Subscribe

[Past issues of this newsletter](#)⁹ are available from the NOPSA website. Operators and other employers are encouraged to circulate this newsletter to their workforce. Please add your details to our [distribution list](#)¹⁰ to receive future copies of this newsletter.

Find out more

¹ <http://www.energyinstpubs.org.uk/cgi-bin/open.cgi?page=index>

² <http://www.nopsa.gov.au/projects/safetycaseguidance/safetymanagementsystems.asp>

³ <http://www.nopsa.gov.au/projects.asp>

⁴ <http://www.ascc.gov.au/ascc/AboutUs/Publications/StatReports/CostofWork-relatedInjuryandIllness.htm>

⁵ <http://news.aol.ca/article/scotland-oks-coast-guard-helicopters-after-parts-upgrade/574526/>

⁶ [http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgAD.nsf/0/81a534702e44a030862575820077edb8/\\$FILE/2009-07-53_Emergency.pdf](http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgAD.nsf/0/81a534702e44a030862575820077edb8/$FILE/2009-07-53_Emergency.pdf)

⁷ <http://info.ogp.org.uk/safety/>

⁸ http://www.nopsa.gov.au/CEO_Emails/Boot%20Room%20Gossip%20-%20March%202009.pdf

⁹ http://www.nopsa.gov.au/CEO_emails/index.asp

¹⁰ info@nopsa.gov.au