

**From acting CEO Simon Schubach**

There is a simple, vital safety message contained in the extensive data that NOPSA collects from the Australian offshore industry.

Amongst the detailed graphs and tables which track industry progress against key performance indicators this one “takeout” message emerges - *prevent accidents by addressing their root causes*.

The three most common root causes of incidents are: preventive maintenance requiring improvement; procedures not used or followed; and design specifications needing improvement.

These three factors were behind the majority of incidents that NOPSA has examined over the last 12 months of collecting data. CEOs and senior management are encouraged to take leadership by addressing these root causes to prevent accidents. When you are planning your operations these three factors should take prominence.

Accordingly, NOPSA plans to conduct at least ten safety leadership and asset integrity ‘themed’ audits in 2009-10. We will seek demonstrations that industry is acting on these main findings on root causes of incidents.

## Industry matters

**Leadership is one of four key focus areas for NOPSA**

The annual [operating plan](#)<sup>1</sup> for NOPSA for 2009-10 has now been released showing four main areas of focus for the agency in this period. These are:

- **industry leadership in major accident prevention** - commitment and leadership drive strong safety cultures which are vital to prevent major accidents. NOPSA will be examining ‘process safety culture’ within organisations.
- **asset integrity** – NOPSA will conclude its National Programme on Facility Integrity which looked at loss of containment of petroleum fluids and seek to expand this focus area to all types of facilities, instead of only production facilities
- **contractor management** – NOPSA is concerned that the health, safety and welfare of contractors’ employees is protected as effectively as non-contractor members of the offshore workforce
- **emergency response** – NOPSA will look at emergency response key actions. Planning, preparation and resources are crucial in an operator’s ability to respond appropriately to an emergency such as a cyclone.

The focus areas have been chosen after reviews of data from the previous year and will ensure NOPSA's resources are channelled most effectively towards those areas identified as requiring regulatory oversight.

### **HSR forum and national oil and gas safety conference approaches**

NOPSA, in conjunction with the Australian Petroleum Production and Exploration Association (APPEA), has organised a challenging and stimulating agenda, with plenty of opportunities for sharing safety experiences, for the Health and Safety Representatives Forum 2009 to be held on 3 August. The [forum](#) precedes APPEA's [National Oil and Gas Safety Conference](#) to be held on 4-5 August at the Burswood Convention Centre, Perth. The safety conference offers a wide range of topics for anyone associated with offshore health and safety. A key theme is: *By Working Together Nobody Gets Harmed*. Topics include:

- Industry performance and initiatives
- Contractor and workforce engagement
- Leadership and culture
- Process safety and risk management
- Health and hygiene

### **NOPSA releases guidance note on criteria for operator registration**

The operator of an offshore facility has the principal responsibility for safety at a facility and must be registered by NOPSA. The laws governing offshore safety require that a registered operator be a person ("person" is defined as an individual or a corporate entity) who has day-to-day management and control of an actual or proposed offshore facility.

A new [guidance note](#)<sup>2</sup> is now available which provides information on the criteria used by NOPSA to determine if a nominated organisation should be registered as the operator of a facility. The preparation of the guidance note follows consultation with industry last year.

Key features of the guidance note are that in order for an operator to meet the 'day-to-day management and control' criterion, an operator would ordinarily need to have:

- An individual physically present at the facility who is considered by the facility's workforce to be at the top of the 'chain of command' in relation to all activities and the physical environment at the facility. This person would normally be the offshore installation manager/person-in-charge or master and would also be the 'operator's representative' at the facility.

- The ability for the operator's onshore managers to make significant decisions in relation to the facility in terms of the workforce, the safety management system, and the physical environment at the facility.

This guidance note may have implications for organisational and commercial arrangements being contemplated by companies for both proposed and existing facilities.

### **Trial of leading safety indicators underway**

Industry participants have demonstrated their willingness to examine ways of improving safety culture by taking part in the APPEA health, safety and operations (HSO) committee trial of new leading indicators for health and safety. Leading indicators are important because they can give early warning of possible weaknesses in safety systems. Details of the three indicators currently being trialled include:

- *numbers of safety tours conducted by senior management per 100,000 hours worked*  
Safety tours should be a formal programme that could include audits and work site inspections, attendance at a toolbox or other safety and health meeting, participation in a job-specific analysis or delivery of a safety presentation.
- *numbers of high potential incidents reported per million hours worked*  
A high potential incident is an incident where there is the potential for fatality or multiple fatalities.
- *percentage of identified improvement/corrective actions arising out of planned audits closed off within specified timeframes*  
The intent is to focus on the safety management systems (SMS). There is a need to measure the effectiveness of the SMS and continuously improve it. The SMS must include audit, monitoring, measuring and review elements and the essential feedback loop to correct and improve inadequacies.

### **Promoting process safety**

The importance of process safety is highlighted in a range of health and safety initiatives. Recent examples include the APPEA series of ten leaflets sharing information on safety activities. The latest [leaflet](#)<sup>3</sup> "Promoting Process Safety" highlights initiatives undertaken by industry to improve health and safety in the Australian oil and gas industry.

### **Lessons from Baker Report – Recommendation 6**

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 6: **Support for line management:** *More effective and better coordinated process safety support for refinery line management*

- The Baker Panel recommended that a full time process safety leader be appointed at each refinery and that whilst line management would be to the refinery manager, who would retain responsibility for process safety, a functional reporting role to what is in effect a chief process engineer should be established reporting to the head of safety and operations.

### **HSR handbook reminder**

The [handbook](#)<sup>4</sup> for Health and Safety Representatives (HSRs) produced by NOPSA is available electronically or in hard copy. The handbook has proved popular as a concise explanation of the laws that govern occupational health and safety on offshore facilities and the role that HSRs play in this. You can request copies of the handbook by contacting [publications@nopsa.gov.au](mailto:publications@nopsa.gov.au)

### **New NOPSA leaflet addresses facility definition**

A new leaflet in NOPSA's general information series in question and answer format discusses the topic of facility definition. [What is a facility?](#)<sup>5</sup> gives broad information on determining whether a vessel or structure falls within the scope of the offshore health and safety laws. The leaflet is on the NOPSA website or copies can be ordered from [publications@nopsa.gov.au](mailto:publications@nopsa.gov.au). There are ten leaflets in NOPSA's information series. Other leaflets include: *Understanding the role of HSRs; Issue of Provisional Improvement Notices; Prescription and Standards; What is a planned inspection?*

## **Stakeholder relations**

### **Cyclone preparedness focus of joint agency workshop**

NOPSA is committed to close cooperation with relevant safety authorities and recently combined with the Australian Maritime Safety Authority to hold a cyclone preparedness workshop jointly with industry. Industry participants shared their experiences and systems in order to create opportunities to improve health and safety performance.

### **Facility integrity forum**

Awareness and recognition of risks was amongst topics highlighted at a recent forum that focused on facility integrity organised by NOPSA in conjunction with APPEA. Representatives from industry and NOPSA delivered presentations and participated in forum discussions. Presentations also addressed the top three root causes of accidents and dangerous occurrences – preventative maintenance, procedures followed adequately and design specification problems.

## **International**

### **UK report sees improvements in asset management – cautions against complacency**

A [report reviewing progress](#)<sup>6</sup> against 2007 findings by the UK Health and Safety Executive (HSE) into asset integrity management of offshore facilities is now available on the HSE website. The original findings based on three years of inspection data highlighted significant problems with the maintenance of safety-critical systems.

The report shows that industry has allocated considerable resources to improving offshore assets and compliance with relevant standards with good cooperation from industry leadership. The report however, found that work on the identified issues is not complete and further effort is required to avoid facilities degrading to the extent found in 2007. The report also warned against allowing fluctuating economic environments to slow progress on achieving asset improvements.

The findings of this report reinforce the results of NOPSA's National Programme on [Facility Integrity](#)<sup>7</sup> which are available on NOPSA's web site.

### **Report on US offshore lifting fatality released**

The report of an investigation into a [lifting incident](#)<sup>8</sup> on an offshore facility in the Gulf of Mexico which killed one worker and injured another has been released by the US Department of the Interior, Minerals Management Service. A floor hand was fatally injured when he was struck by a hose assembly which de-coupled while being lifted back into the derrick. Another worker received abrasions in the incident. The Minerals Management Service investigation concluded that the accident was preventable. The possible contributing causes were identified as improper monitoring of the equipment inspection programme, the location of the lift crew during the bulk hose lifting operation, the lack of a formal written job safety analysis (JSA) to accompany the pre-job safety meeting and inadequate JSA policy oversight by rig management.

A [safety alert](#)<sup>9</sup> has also been issued by the Minerals Management Service on this incident which explains that the direct cause of the incident was the use of non-certified lifting equipment. A modified hammer union with welded bale had been used as the lifting connection despite a policy stating that homemade or modified lifting equipment should never be used.

### **More findings from investigation of fatal UK Super Puma helicopter crash**

A [safety bulletin](#)<sup>10</sup> from the UK Air Accidents Investigation Branch of the Department for Transport has been produced with two new safety recommendations following an earlier report and safety recommendations after the crash of a Super Puma helicopter off the coast of Scotland on 1 April with the loss of 14 passengers and two crew members. The new safety recommendations concern the need to review the design, operational life and inspection of the planet gears used in the main rotor gearbox as well as the need to correctly identify magnetic particles in the oil system of the power transmission systems.

### **Report on potential adverse effect of personal locator beacons**

The Air Accidents Investigation Branch of the UK Department for Transport has released a [bulletin](#)<sup>11</sup> looking at the impact on emergency signals of personal locator beacons. Safety recommendations in the bulletin highlight precautions on use of personal locator beacons in aircraft.

### **Diving incident - near miss**

A [safety alert](#)<sup>12</sup> now available on the International Association of Oil and Gas Producers (OGP) website details a surface air dive which could have caused a serious accident. The diver did not have the right gas mix in the bail-out cylinder for the depth of the dive which caused the dive to be aborted after he bumped a control valve. Recommendations included in the safety alert included the need for all bottles to be colour coded and labelled with the percentage of the gas mix.

### **Young worker dies after pressure testing oil field piping**

The death of a young worker while undoing the connection between piping being pressure-tested and the testing device, has prompted [a safety alert](#)<sup>13</sup> from WorkSafe British Columbia, Canada. The alert contained recommendations to ensure a pressurised system is completely depressurised before carrying out work on the system. The importance of detailed, step-by-step, written safe-work procedures and training and supervision for new and young workers were some of the issues highlighted by this incident.

## Website

### New on NOPSA website

New items on the NOPSA website include:

- New [Guidance note](#) on operator nomination
- A new leaflet in NOPSA's information series, [What is a Facility?](#)
- [NOPSA Annual Operating Plan](#) 2009-10

## Regulatory activities

### As at 29<sup>th</sup> July 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

The following assessment activity was undertaken in July.

<b>July 2009 Assessment Type</b>	<b>Submitted</b>	<b>Accepted / Agreed</b>	<b>Recalled by Operator/ Returned by NOPSA</b>	<b>Rejected</b>	<b>In Progress</b>
Safety Case NEW	2	1			8
Safety Case REVISED	5	5		1	15
Pipeline SMP REVISED					2
Diving SMS NEW	1				1
Diving Project Plan					2
Scope of Validation	2	1			7
Field Development Plan	1	1			1
	<b>11</b>	<b>8</b>		<b>1</b>	<b>36</b>

## Inspections

Twelve inspections were conducted in July. Some of the scope items included were:

- helicopter operations
- ballast system
- lifting operations
- hazardous substances
- dropped objects
- cyclone response
- separator vessels integrity
- medical /pharmaceutical supplies management

## Incidents and complaints

There were a total of 17 incidents and no complaints reported in July. The incidents included:

### Accidents

- three lost time injuries (LTIs) - one back strain, two crush injuries

### Dangerous occurrences

- one dropped single drill pipe
- one electrical fire
- one gas leak from subsea manifold
- one gas release
- three could have caused LTIs (one electric shock, one slip/fall, one, one dropped object)
- one damage to crane
- one compressor oil leak
- one valve failure

## Enforcement

Two enforcement actions were taken in July as follows:

- one Improvement Notice for a split in a firewall
- one written warning regarding failure to close out an inspection recommendation for a facility-specific corrosion management plan.

## Subscribe

[Past issues of this newsletter](#)<sup>14</sup> 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](#)<sup>15</sup> to receive future copies of this newsletter.

## Find out more

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<sup>1</sup> <http://www.nopsa.gov.au/Corporate/Plan%20-%20NOPSA%20Annual%20Operating%20Plan%202009-2010.pdf>

<sup>2</sup> <http://www.nopsa.gov.au/document/N-01000-GN0007%20-%20Criteria%20for%20Registration%20and%20Deregistration.pdf>

<sup>3</sup> [http://www.appea.com.au/content/pdfs\\_docs\\_xls/Publications/Flowline/sss\\_10\\_esso\\_web\\_2.pdf](http://www.appea.com.au/content/pdfs_docs_xls/Publications/Flowline/sss_10_esso_web_2.pdf)

<sup>4</sup> [http://www.nopsa.gov.au/document/HSR\\_Handbook.pdf](http://www.nopsa.gov.au/document/HSR_Handbook.pdf)

<sup>5</sup> <http://www.nopsa.gov.au/media/>

<sup>6</sup> <http://www.hse.gov.uk/offshore/kp3review.pdf>

<sup>7</sup> <http://www.nopsa.gov.au/programmes/>

<sup>8</sup> <http://www.gomr.mms.gov/PDFs/2009/2009-042.pdf>

<sup>9</sup> [http://www.gomr.mms.gov/homepg/offshore/safety/safealt/SA\\_281.pdf](http://www.gomr.mms.gov/homepg/offshore/safety/safealt/SA_281.pdf)

<sup>10</sup> [http://www.aaib.gov.uk/publications/special\\_bulletins/s5\\_2009\\_\\_\\_eurocopter\\_as332l2\\_super\\_puma\\_\\_g\\_redl.cfm](http://www.aaib.gov.uk/publications/special_bulletins/s5_2009___eurocopter_as332l2_super_puma__g_redl.cfm)

<sup>11</sup> [http://www.aaib.gov.uk/publications/special\\_bulletins/s4\\_2009\\_\\_\\_eurocopter\\_ec225\\_lp\\_super\\_puma\\_\\_g\\_redu.cfm](http://www.aaib.gov.uk/publications/special_bulletins/s4_2009___eurocopter_ec225_lp_super_puma__g_redu.cfm)

<sup>12</sup> <http://info.ogp.org.uk/safety/>

<sup>13</sup> <http://info.ogp.org.uk/safety/>

<sup>14</sup> [http://www.nopsa.gov.au/CEO\\_emails/index.asp](http://www.nopsa.gov.au/CEO_emails/index.asp)

<sup>15</sup> [info@nopsa.gov.au](mailto:info@nopsa.gov.au)