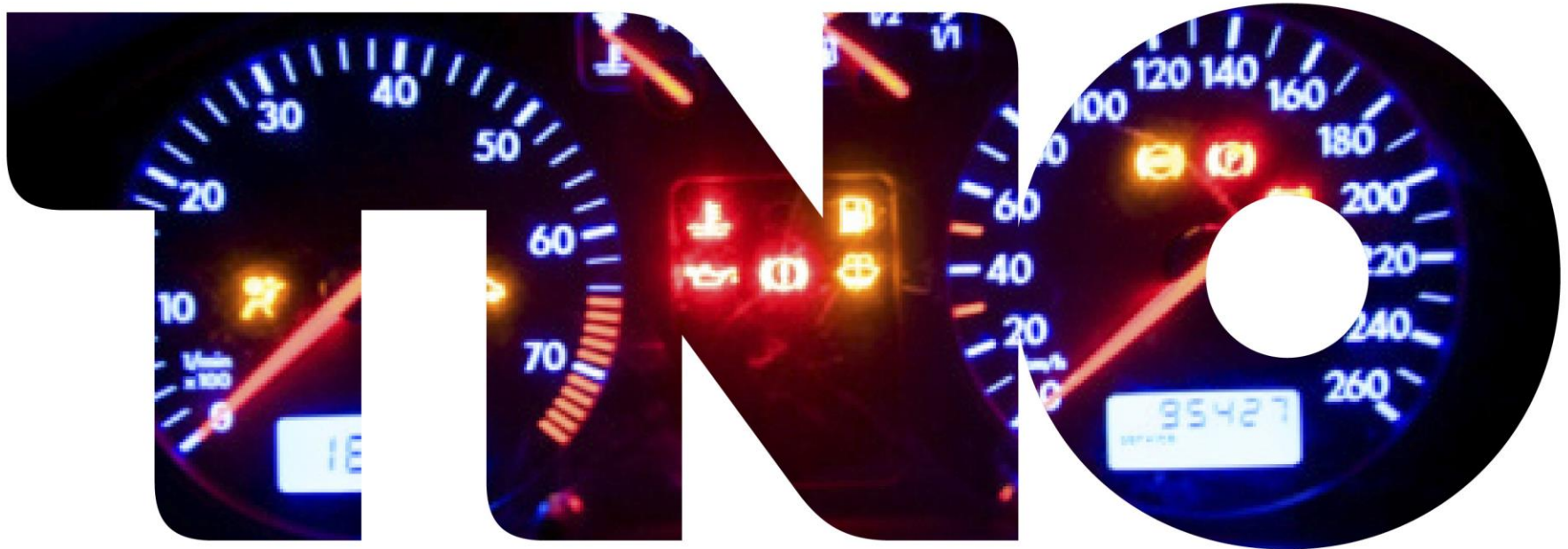




Different perspective?

A view from the safety II domain

Raphaël Gallis





Aim

Still confused but on a higher level

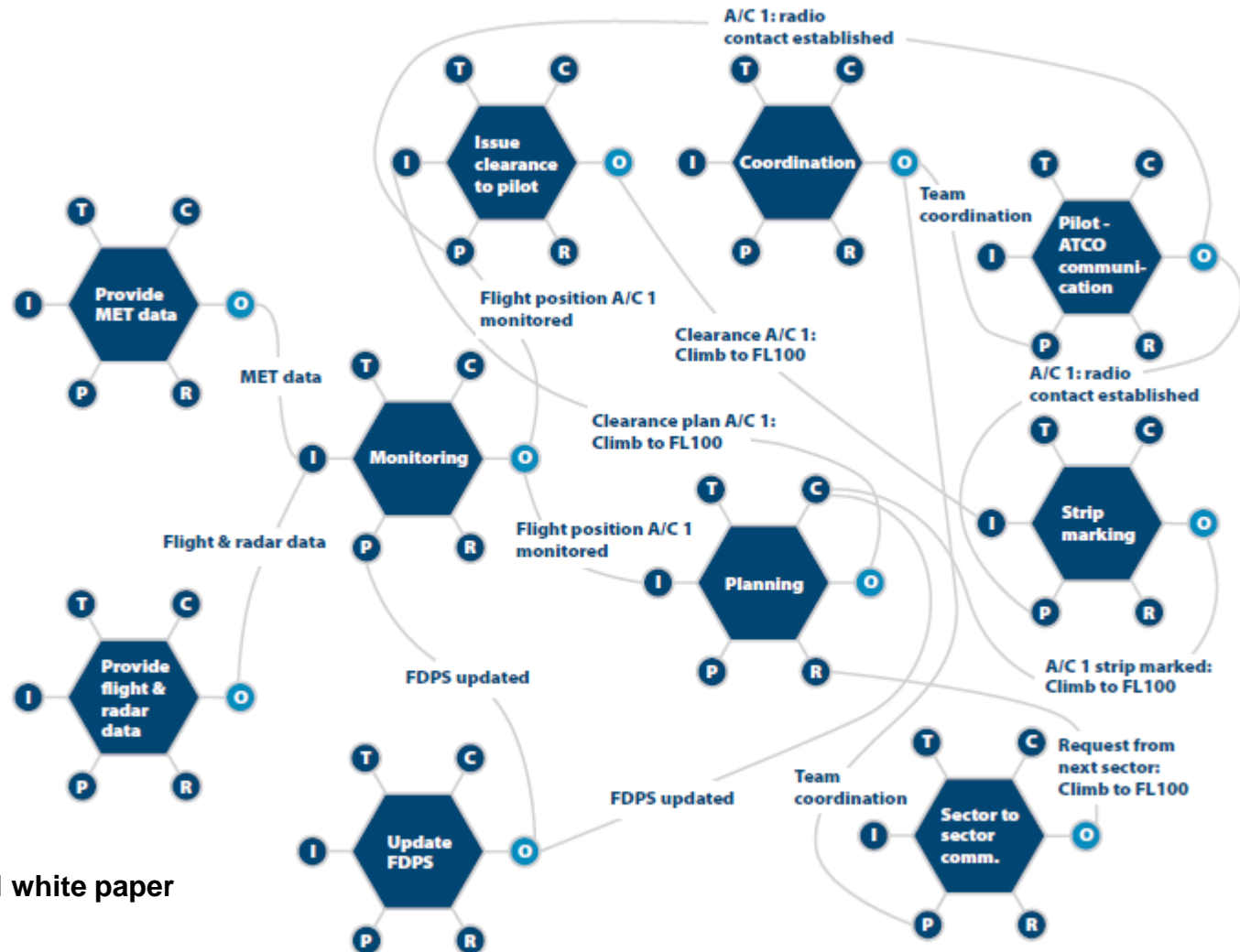
(Enrico Fermi)

[illegible]

Alas...



Now



Source: Eurocontrol white paper

Figure 8: Instantiation of the FRAM model for the overflight scenario



What is the difference between safety I and II?

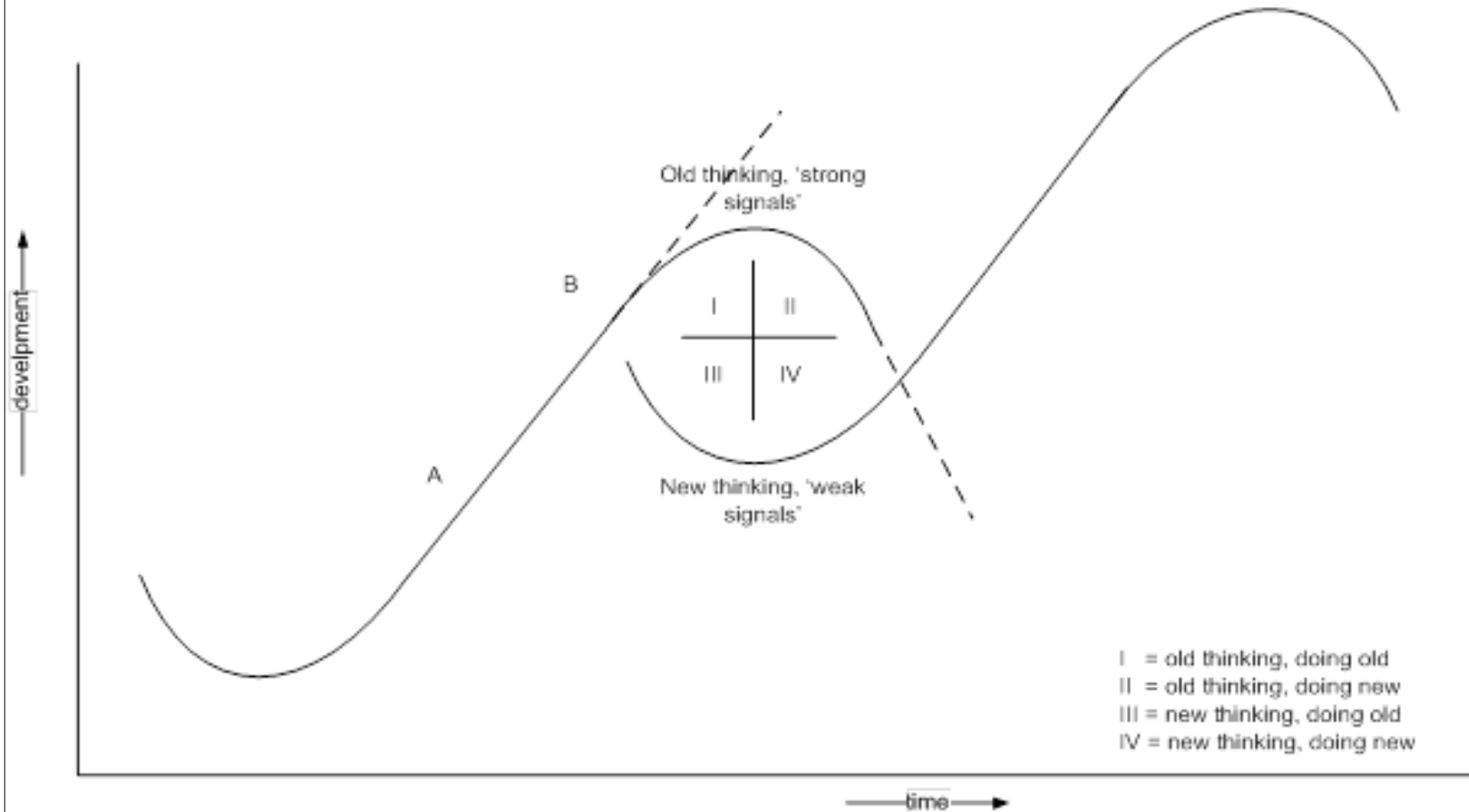
In order to answer that question we need to answer to following:

- › What is a paradigm shift
- › What is complexity
- › What are Complex Adaptive Systems (CAS)
- › Link to Deepwater Horizon

- › Why is this important
- › Safety II in a nutshell
- › Take home message



Paradigm shifts

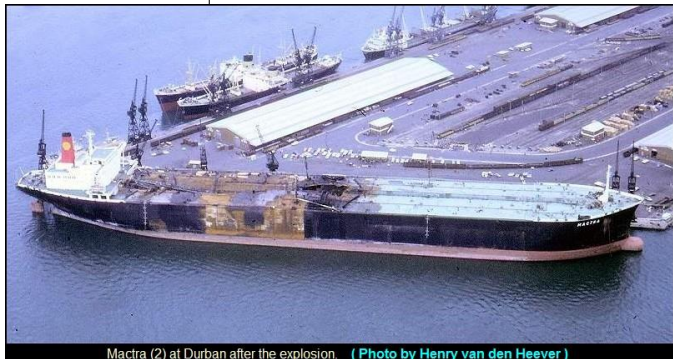


Model by Frans van Eijnatten / TUE



Examples

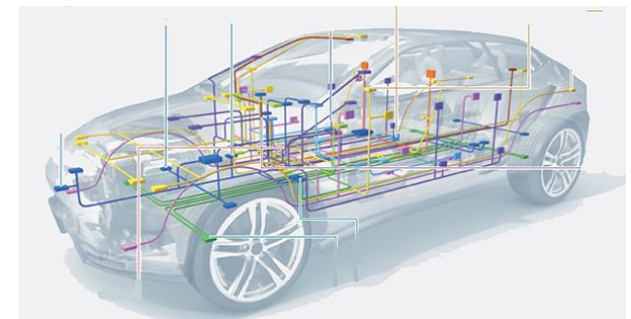
- › Jet airliners (De Havilland Comet)
- › VLCC's (Mactra, King Haakon VII, Marpessa)



Mactra (2) at Durban after the explosion. (Photo by Henry van den Heever)



- › PLC assisted automobiles
- › Electric cars, king size structures, etc





Complexity

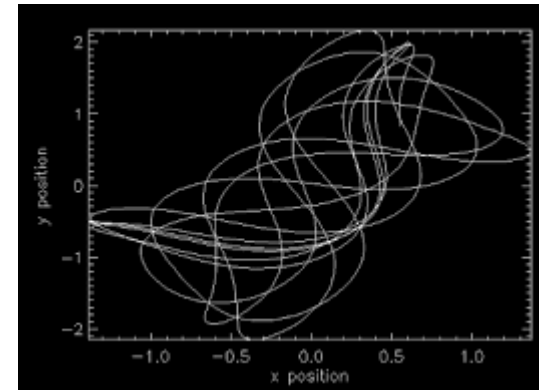
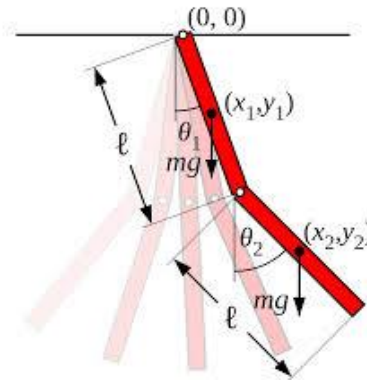


Cynefin model by Dave Snowden



Examples of complexity

› Double Pendulum



› The butterfly effect





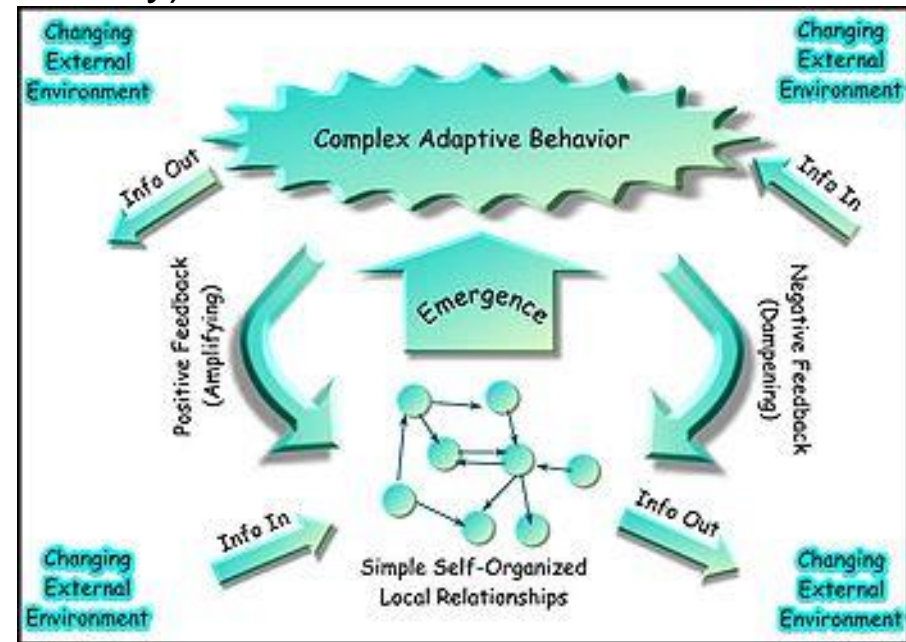
Complex Adaptive Systems (CAS)

- › From small to large (OR team – society)
- › Human body

The end of Newtonian Models

Characteristics:

- › Emergent properties
- › Agents
- › Self organisation
- › Adaptive
- › There is NO helicopter
- › Local control
- › not 'bi-model'
- › Non linear cause – effect relation ships





Over to the Deepwater Horizon





SIX STEPS THAT DOOMED THE RIG

The diagram illustrates a wellbore with a central 'Well' and an outer 'Metal casing'. The space between them is filled with 'Cement'. A 'Liner hanger' is shown at the top of the casing. A red arrow points upwards from the 'OIL LAYER' at the bottom into the well. Another red arrow points upwards from the bottom of the casing into the annulus. A third red arrow points upwards from the annulus towards the surface. Text boxes provide context: 'A liner hanger was not placed between the two lowest casings', 'Bottom cement failed, possibly because it was contaminated or poured incorrectly', and 'May have given gas a clear path to the rig'.

A liner hanger was not placed between the two lowest casings

Bottom cement failed, possibly because it was contaminated or poured incorrectly

May have given gas a clear path to the rig

OIL LAYER

Labels: Metal casing, Well, Cement

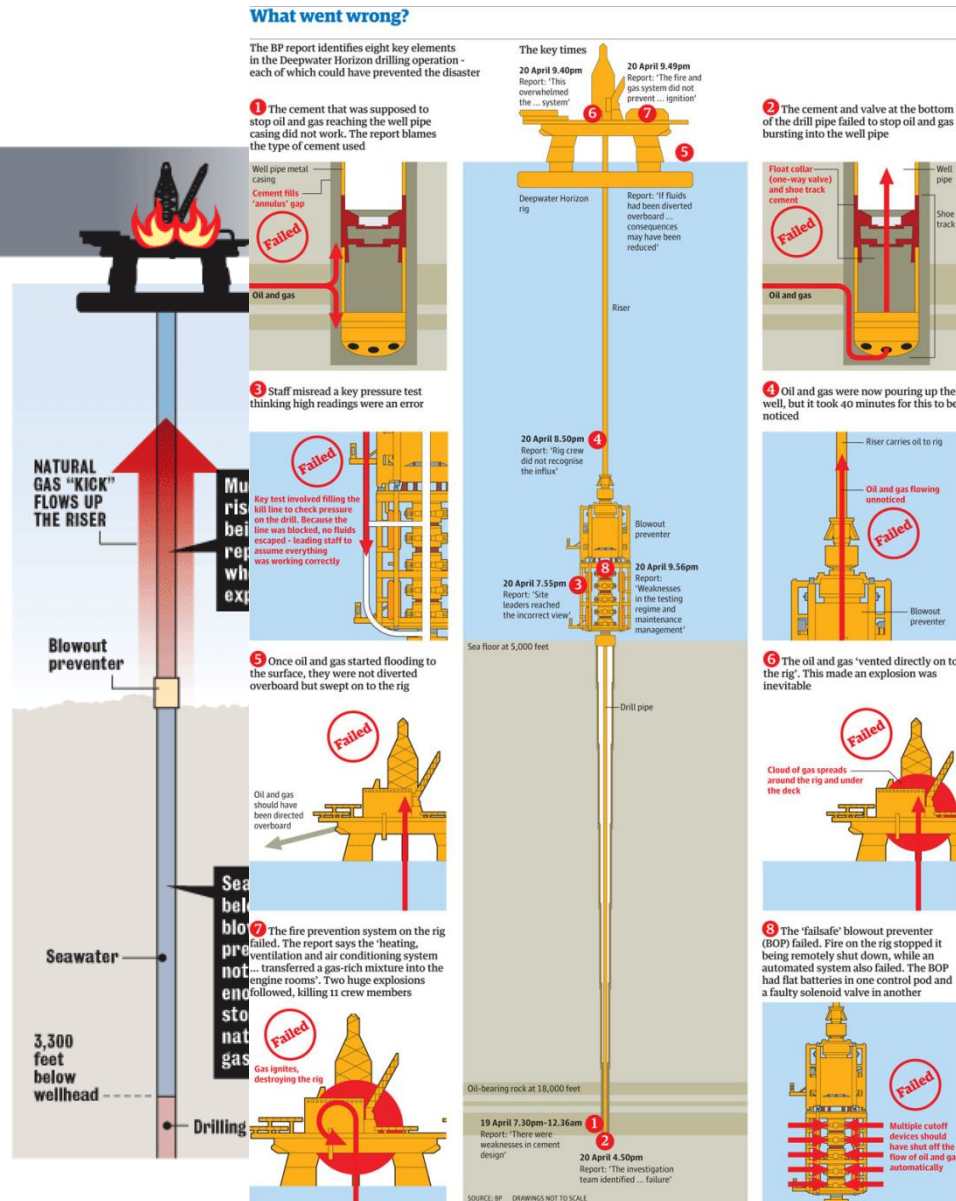
TOP VIEW

Casing shifted to the side

Poorly cemented area where gas can leak through

This diagram shows a top-down view of a wellbore. The central part is a dark grey circle representing the wellbore. Surrounding it is a white ring representing the casing. The casing is not perfectly centered; it is shifted to the right side of the wellbore. The area between the casing and the wellbore wall is shaded light blue, representing the cement. A red, irregular shape is shown on the right side of the casing, indicating a poorly cemented area where gas can leak through. Two callout boxes with black backgrounds and white text point to these features: 'Casing shifted to the side' points to the white casing ring, and 'Poorly cemented area where gas can leak through' points to the red area.

BP decided to take heavy drilling mud out of the system, to 3,000 feet below the normal point, and earlier than usual. The barrier wasn't there to stem the gas kick that destroyed the rig. The mud is used to keep any upward pressure under control.

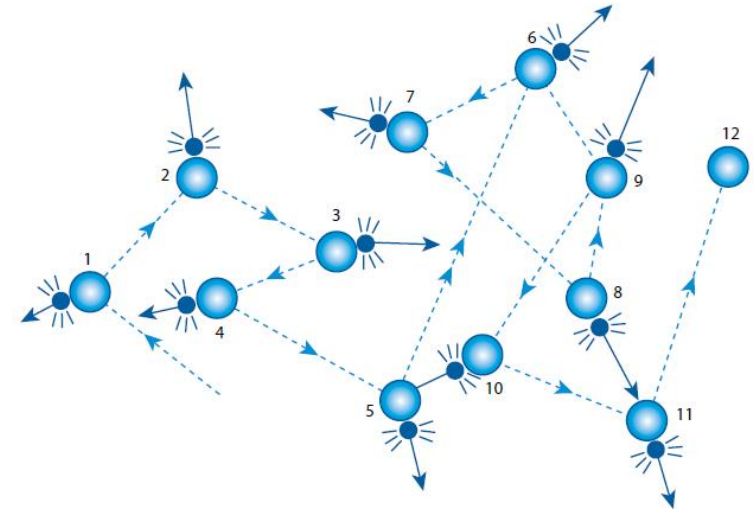




Apply our new insights to the Deepwater Horizon incident:

- › Paradigm shift not recognized:
 - › from 250 to 1500/6000m
 - › Old technologies
 - › Old frame, new environment

- › Complex adaptive system (not recognized)
 - › Hyundai, Transocean (Triton asset leasing), BP, Halliburton, Anadarko, MOEX offshore, Minerals Management Service,





Why is this important?

- › We love simple, tend to rationalize (after the fact)
- › We are notoriously bad in recognizing paradigm shifts
- › We attempt to linearize
- › We attempt to determine simple cause – effect relationships
- › We suffer from hind sight bias
 - › If only.....
 - › Golden rivets
- › We do not recognize nor acknowledge complexity

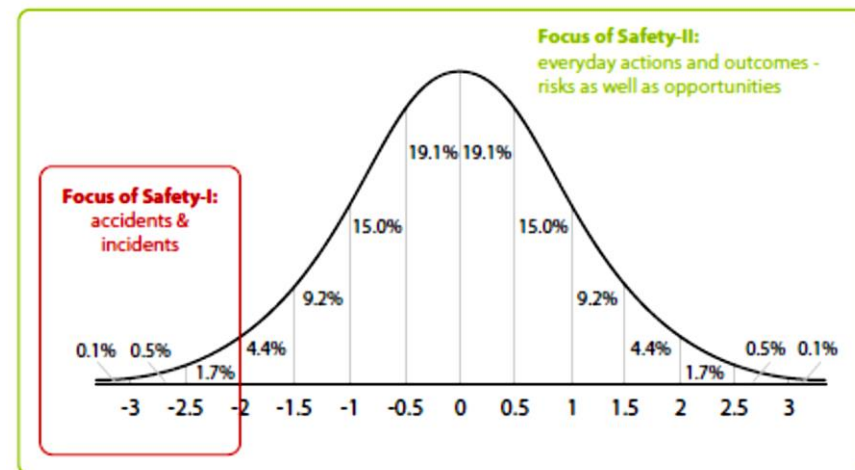
We try to apply tools from one system for another: → does not work

Thus: we need something else



Safety II (in a nutshell)

- › Things basically happen in the same way, regardless the outcome
- › Zero risk is not possible (ETTO principle)
- › Variation is inevitable and needed
- › Humans are seen as resource necessary for system flexibility and resilience
- › Risk assesment: to understand the conditions when performance variability can become difficult or impossible to monitor and control
- › Safety management: proactive, continiously trying to anticipate developments and events
- › Definition of safety:
- › As much as possible goes right



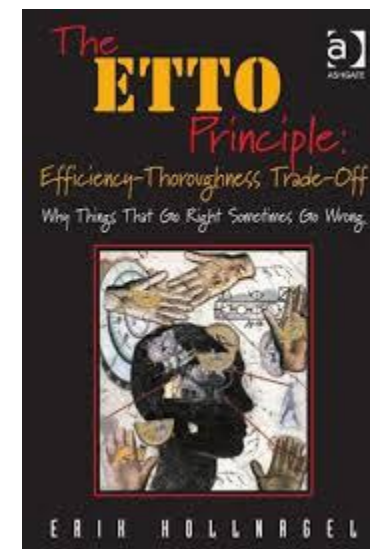
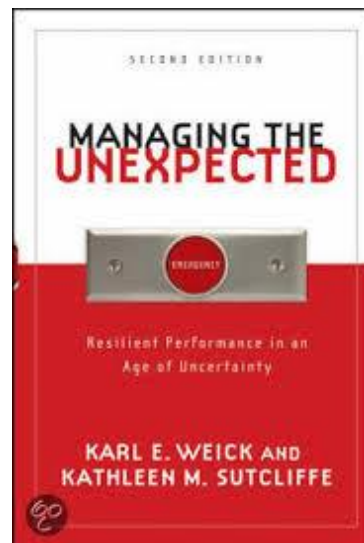
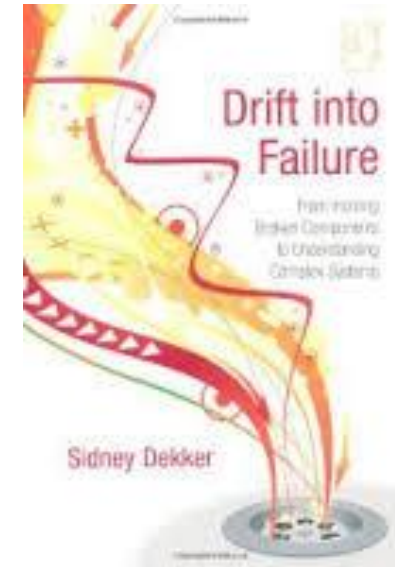
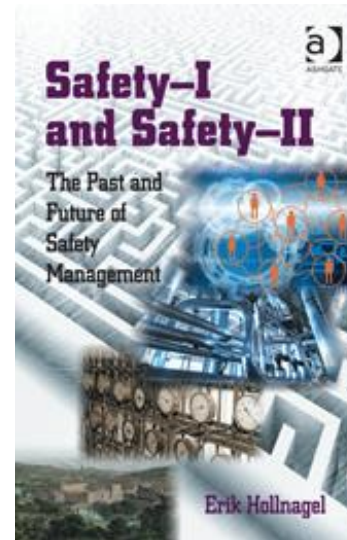
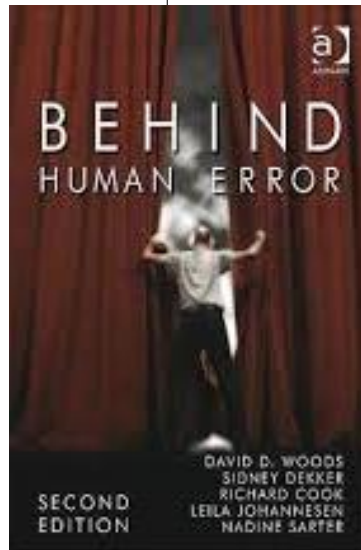


High reliability organisations (HRO)

- › Preoccupation with failure
- › Reluctance to simplify interpretations
- › Sensitivity to operations
- › Commitment to resilience
- › Deference to expertise
- › Redundancy built in



Suggested reading





18
December 16, 2014
Raphaël Gallis
A different perspective?

TNO innovation
for life

6TH SYMPOSIUM ON RESILIENCE ENGINEERING

Managing resilience, learning to be adaptable
and proactive in an unpredictable world



22-25th June
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Conclusions

This is not the final verdict

Take home message:

- › Be vigilant: is what we do today sufficient for the challenges of tomorrow?
- › Try to recognize weak signals
- › You cannot engineer complexity out of a system, however, you may tame it (slightly)
- › Learn from things that go well
- › In CAS there is no point in looking back for the 'golden rivet' (emergent properties)
- › Maybe we need to apply the precautionary principle more
- › Good luck!
- › Thank you for your kind attention

