



Process Safety Management

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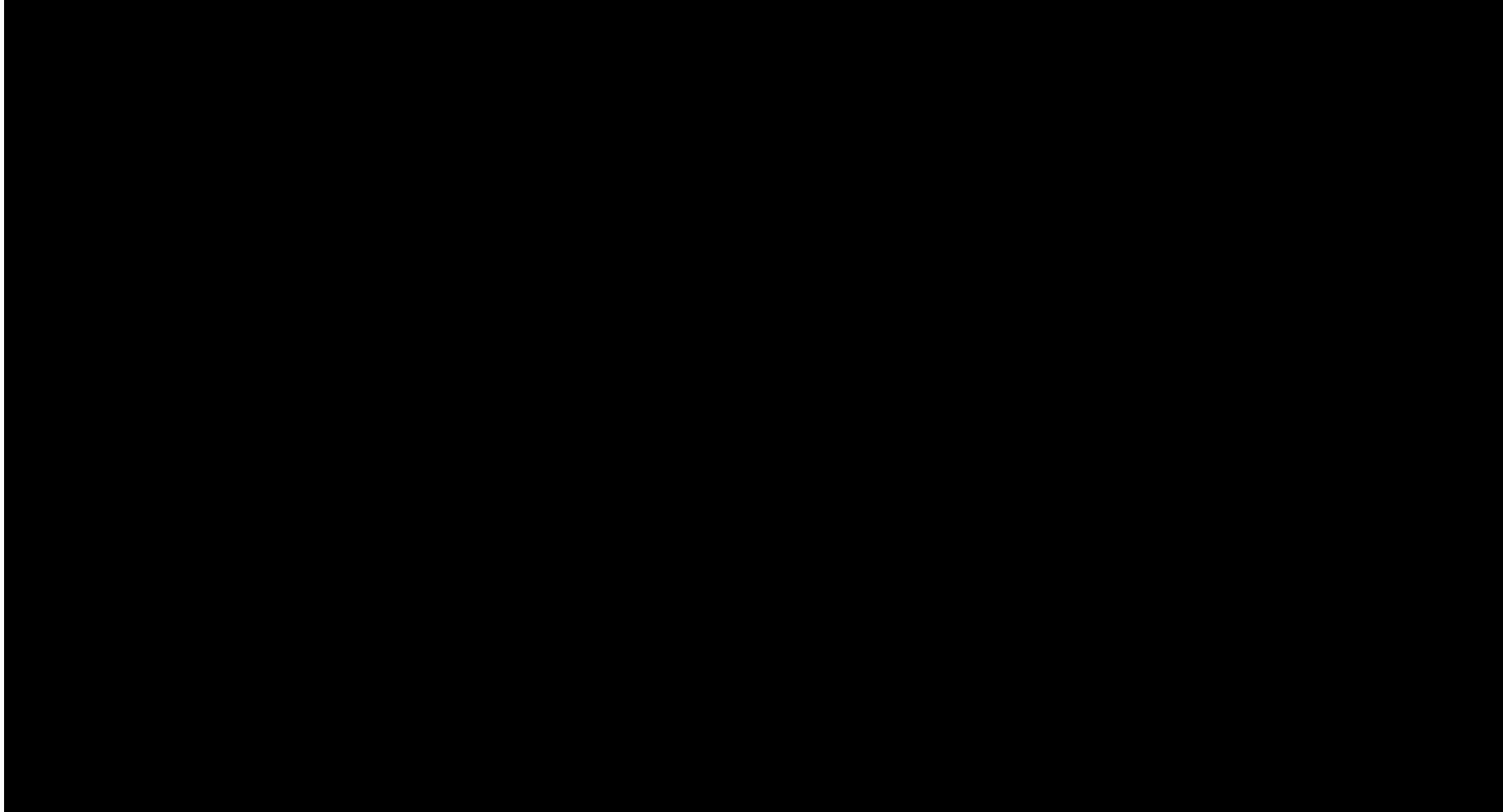
Process Safety & ASU Technology Lead-South Asia

Making our world more productive



What is Process Safety?

A definition by Reynold Training Services



You can further check @ <https://youtu.be/i1pKYhFQJvM>

Disasters in Industry



Flixborough	What went wrong:- <ul style="list-style-type: none"> • Modifications made without proper risk assessment • Operating practices were modified 	Fatality	A photograph showing a massive plume of dark smoke rising from an industrial facility, with labels for "REACTOR 1, 2, 3, 4, 5, 6" and "REACTOR 3" visible.
1974		~ 28	
Bhopal	What went wrong:- <ul style="list-style-type: none"> • The storage refrigeration system was down • The high temperature alarm was disabled • Scrubbing system was not available 	Fatality	A photograph of industrial storage tanks and structures, with a fire or explosion visible in the background.
1984		> 3000	
Bintulu	What went wrong:- <ul style="list-style-type: none"> • Hydrocarbon contamination in Re-bolier • Low purge of liquid Oxygen 	Fatality	An aerial photograph of an industrial facility with several large storage tanks and a fire burning in the background.
1997		Lucky !!!	
BP Texas	What went wrong:- <ul style="list-style-type: none"> • Level transmitter malfunctioned • Operating practices were not followed • Location of temporary trailers very close to vent stack 	Fatality	A photograph of an industrial facility with a large fire or explosion visible in the background.
2005		~ 15	
Henan	What went wrong:- <ul style="list-style-type: none"> • Leakage in cold box leading to O2 enrichment in insulation • Operation continued despite of leakage & crack on cold box • Operating procedure not followed 	Fatality	A photograph of an industrial facility with a large fire or explosion visible in the background.
2019		~ 15	

Root Cause & Learnings



Flixborough

1974

Bhopal

1984

Bintulu

1997

BP Texas

2005

Henan

2019

Root Cause:-

- No Engineering Management of Change
- Operating practices were not followed

Root Cause:-

- Lack of Engineering Management of Change
- Ineffective Emergency Preparedness and Community Notification
- Inadequate Mechanical Integrity and Maintenance

Root Cause:-

- Ineffective Employee training
- Lack of Hazard Awareness

Root Cause:-

- Lack of Engineering Management of Change
- Inadequate Mechanical Integrity and Maintenance
- Inadequate incident/near miss investigation process

Root Cause:-

- Inadequate Hazard Awareness
- Not following operating procedures

Learning

- Awareness & Evaluation of Hazards and Risks involved in day to day operations.
- Review and Document Design and Operational Procedure changes.
- Competency development, Training & Assessment.
- Develop & adherence to Maintenance schedules
- Develop & adhere to Standard Operating Procedures.
- Develop Emergency Preparedness

Risk Reduction

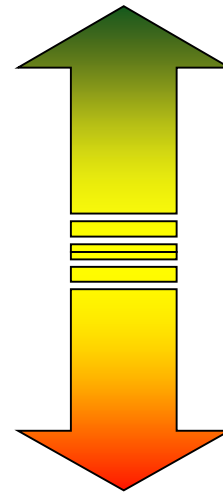


- Risk Reduction is the art of applying controls to reduce risk
 - No “Risk Control” is completely fail safe unless the hazard can be eliminated
 - Process controls must be selected according to their effectiveness
 - Generally, more than one **layer of protection** should be applied, particularly for major hazards or where the risk is high

- Control Hierarchy

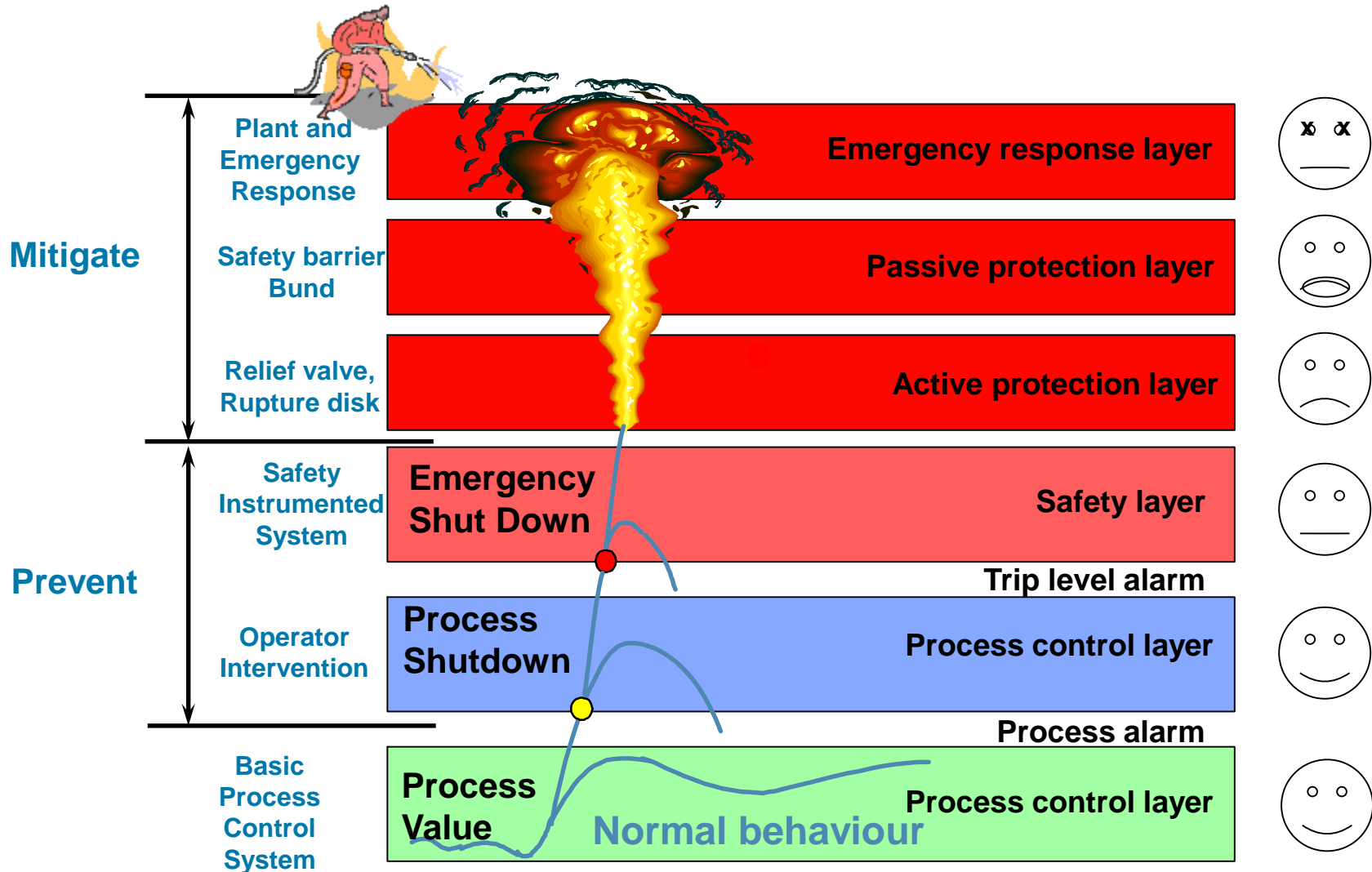
- Eliminate the hazard
- Substitution or inventory reduction
- Engineering controls
(safety valves, process trips, interlocks, etc)
- Isolation of the hazard
(blast shields, barriers, insulation, etc)
- Procedural or administrative controls
(work instructions, training, signs, etc)
- Personal Protective Equipment
- Accept the risk

More Effective



Least Effective

Control of process hazards - “Layers of Protection”



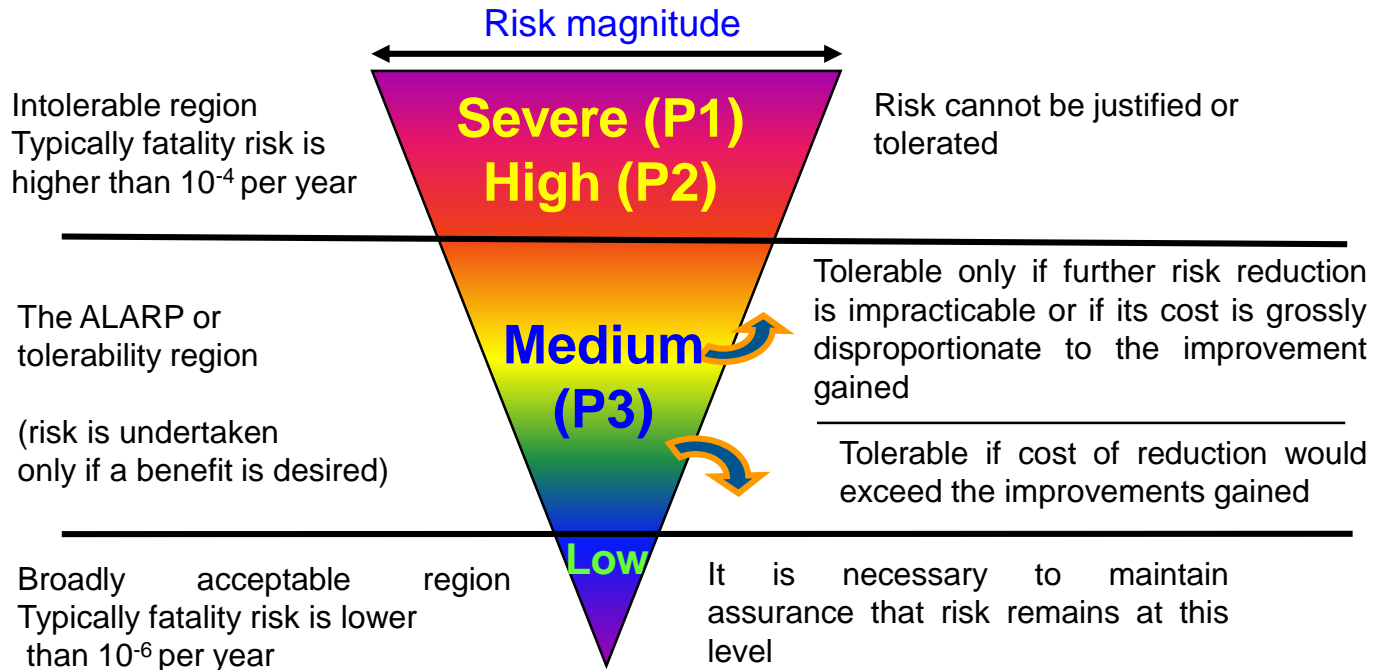
What is an acceptable level of Risk?



Organisations have a legal & moral responsibility to reduce risks

'As Low As Reasonably Practical' (ALARP)

ALARP boundaries for individual risks: Typical values.



This principle applies to Design, Operation & Maintenance activities

Process Safety Management system Elements



- Wake up call for industry to improve Process Safety
- Many systematic, organizational and technological failures identified which still remains as the underlying causes for the major incidents

1. Organisation and Personnel (Competency, Awareness, Culture & Practise)
2. Process and Material Information (Threshold Quantities, Data sheets etc.)
3. Hazard Identification and Evaluation (Process Hazard Analysis, HAZOP, Risk Assessments)
4. Operational Control (Robust Procedures, Procedure Check & Compliance)
5. Safe Systems of Work (PPE, Risk Identification, Work Permit)
6. Mechanical Integrity and Reliability (Inspection, Maintenance, Re-validation, Calibration)
7. Competency development (Training & Assessment)
8. Engineering Management of Change (Risk Assessment & Documentation)
9. Pre Start-Up Safety Reviews (Look for hidden Hazards in changed situations)
10. Emergency Planning and Response (Define Emergency Situations, DO's & DON'Ts in emergency)
11. Incident Handling (RCA, Tools and techniques, Communication - Lessons from Loss)
12. Process Safety Performance (Define Process Safety KPIs – Reporting Targets)

Finally, Audit – Checks & Balances

Ways to learn???????



- Learning from accidents ???
 - : Pain / Fatalities / Injuries / Failures/Business Impact
- Learning from incidents ???
 - : Injuries / Cost / Failures / Business Impact
- Learning from others' incidents
 - : Free Learning for us, may not be for "others"
- Learning from near misses
 - : Free Learning for us, may not be for "others"

*The most important way to learn is from "Sharing"
Best Practices across industries.
Many lives can be saved.....*

Stay Safe; Act Safe; Keep Safe – Make our world more productive

Making our world more productive



Thank you