# Taking the Blinkers Off

2022 THOMAS ASHTON LECTURE

DAME JUDITH HACKITT DBE FRENG

# July 2013 – Piper Alpha 25 conference in Aberdeen

**“There are no new accidents just different people making the same mistakes because of a failure to learn”**

- *Judith Hackitt Chair of HSE 2007-2016*

# July 2013 – Piper Alpha 25 conference in Aberdeen - revised

**“There are no new accidents just different people making the same mistakes because of a failure to *recognise the relevance to them of other people’s experience and therefore not* learning”**

# A personal journey

- Flixborough taught me about the moral obligation to operate safely
- Exxon at Fawley taught me about truly embedding safety in everything
  - “TAS” – Time , Ability, Safety
  - Design standards
  - Change Management
  - Accurate and complete records
  - Thorough review and challenge
- CIMAH/COMAH and the importance of openness and transparency
- Regulatory frameworks very important in driving the right behaviours and culture

# Major Accident Legislation – the safety case approach

- The principles have proven to be effective
- Performance across industry much improved – but not incident free by any means
- Continuous improvement is embedded in the process – regular reviews and updates allowing further learning
- Driver of culture change
- Adopted in many parts of the world and across different sectors

# A personal journey - continued

- Flixborough taught me about the moral obligation to operate safely
- Exxon at Fawley taught me about truly embedding safety in everything
  - “TAS” – Time , Ability, Safety
  - Design standards
  - Change Management
  - Accurate and complete records
  - Thorough review and challenge
- CIMAH/COMAH and the importance of openness, transparency and continuous improvement
- CIA – from process safety concerns to product safety concerns
  - Listen to concerns and answer the real question
  - Taking responsibility – or face legislation

# Learning from mistakes of the past

- Ammonium Nitrate – a catalogue of disasters over decades
- Learning is easiest for those who see/experience what happens
- Learning is harder for those who hear about it later
  - Focus of the story  has become about WHAT happened not WHY it happened
- Addressing failure of individuals and organisations is hard to talk about
- Blame gets in the way of learning

# From “WHAT” to “WHY”

**<u>What</u> happened?**

- Clamour for immediate answers
- Temptation to jump to conclusions
- Who is to blame?
- Focus on specifics
- Quick answers and quick fixes

**<u>Why</u> did it happen?**

- Why did people act as they did?
- What were the pressures on them?
- How robust was the system ( including regulation) ?
- Systems approach to change
- Longer term but more sustainable solutions

# Applying learning in a different environment – Building Safety

The chemical engineer's questions:

- who is responsible for design?
- who ensures that what is designed is what gets built?
- who reviews and approves changes?
- who decides it is safe to commission the completed building?
- who manages safety in operation?

WHY did failure occur?

- Inadequate review of design and no assessment of inherent safety features
- Fire risk assessments focussing on minor issues not on the whole picture or worst case
- Lack of clarity about responsibilities for system safety
- Failure to manage and review changes
- Failure to consider buildings as complex systems
- Lack of understanding of safety critical features
- Failure to take opportunities to make improvements
- And more…….

# Blinkers and silos

- Learning was/is taking place in other sectors ( even if siloed and sometimes re-learning)
- What happened in Construction?
  - Siloes even within different parts of Civil Engineering
  - Infrastructure and major construction has a different culture – why?
  - Extent of fragmentation in built environment sector a real challenge and barrier to learning and feeling responsible
- Hard to see the relevance of “events”
- Noone asks “what would be the equivalent sort of event in my industry”
  - Not “could that happen here?”

# Safer Complex Systems

- The challenge continues to grow
- Siloes and blinkers are a real problem in complex, interdependent, interconnected systems of systems
- Need to pool our knowledge
- Develop new tools and techniques
- Promote education and debate
- Confront the barriers to learning

# Summary

- We fail to learn when we take a narrow view
- Quick fixes and leaping to assign blame fail to get to root causes and sustainable solutions
- WHAT happened there couldn't happen here, but WHY that happened there could very possibly happen here
- LISTEN and learn
- Sharing and interdisciplinary learning are critical
- Getting to real root cause is vital
- Courage and honesty is needed to admit to real causes of failure and not to blame "the system" or "someone else"

# CORE Values

Safety

Leadership

Respect

Integrity

Thank you for listening.

Any questions or observations?