PRESIDENT MESSAGE

In our last Newsletter, we had two articles on the catastrophic accident that occurred at the BP Refinery at Texas City on March 23. 2005. In this note, I would like to refer to the 3 key areas that were identified by the James Baker Inquiry as system failures that led to the catastrophe.

These 3 key areas were,
(1) Corporate Safety Culture;
(2) Process Safety Management; and
(3) Performance Evaluation, Corrective Action, and Corporate Oversight.

Of these 3 areas, Corporate Safety Culture drew a great deal of attention in the US as "Safety Culture" is rarely identified as a major root cause of catastrophic accidents in the history of process industries. It raised several questions.

What is "Safety Culture"?
What is considered as the right Safety Culture for a company?
Are there any yardsticks to measure Safety Culture or any numbers assigned to gauge Safety Culture?

Most managers and professionals would probably know what "culture" means. But how does "Safety Culture", especially at the corporate level, seriously affect the integrity of the safety program of operating units when these units are remote from the company's headquarters. The answer to this question may be discered from the following.

Do any of the following statements from the Baker Report sound familiar to you?

- The company has not adequately established process safety as a core value across its five U.S. refineries.
- The company has not provided effective leadership on or established appropriate operational expectations regarding process safety performance at its five U.S. refineries.
- The company has emphasized personal safety but not process safety.
- The company mistakenly used improving personal safety performance (i.e., personal injury rates) as an indication of acceptable process safety performance at its five U.S. refineries. Its reliance on this data and inadequate process safety understanding created a false sense of confidence that it was properly addressing process safety risks at those refineries.
- The company's five U.S. refineries have had high turnover of refinery plant managers, and process safety leadership appears to have suffered as a result.
- The company has not established a positive, trusting, and open environment at some of its U.S. refineries with effective lines of communication between management and the workforce, including employee representatives.
- The company does not have a designated, high-ranking leader for process safety dedicated to its refining business.
- The company has not always ensured that the resources required for strong process safety performance at its five U.S. refineries were identified and provided.
- The company's corporate initiatives have overloaded personnel at its five U.S. refineries, to the possible detriment of process safety.
- The company's operations and maintenance personnel at its five U.S. refineries sometimes work high rates of overtime, which the Panel believes impacts their ability to perform their jobs safely and increases process safety risk.
- The company's decentralized management system and entrepreneurial culture have delegated substantial discretion to U.S. refinery managers without clearly defining process safety expectations, responsibilities, or accountabilities.
- The company has not demonstrated that it has effectively held executive management and refining line managers and supervisors, both at the corporate level and at the refinery level, accountable for process safety performance at its five U.S. refineries.
- Each of its five U.S. refineries has its own separate and distinct process safety culture. Some are far more effective than others in promoting process safety, but significant process safety culture issues exist at each of its five U.S. refineries, not just Texas City.
- Instances of a lack of operating discipline, toleration of serious deviations from safe operating practices, and apparent complacency toward serious process safety risks existed at each of its five U.S. refineries.

After reading these findings, it behooves us to embark on a detailed assessment of our own operations and our "safety culture" shortfalls. Where gaps are uncovered, action should be taken to eliminate them. We often neglect the very basic foundation of our EHS and loss prevention program – our Safety Culture – the way we do things and our collective values, beliefs, attitude and behavior on “how safe is safe”. Even if you think that you have the right safety culture, you should assess whether there is a **robust system** in place to ensure **operating discipline** across the board.