

**TOTAL PETROCHEMICALS**

## **Operator reliability**

**taking automation to the next level**

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### **Symptomatic 20st century joke in the world of Process Automation**

▶ Question :

*How many resources do you need to run a refinery ?*

▶ Answer : **Two : one operator and one dog**

*The operator is there to feed the dog*

*The dog is there to make sure*

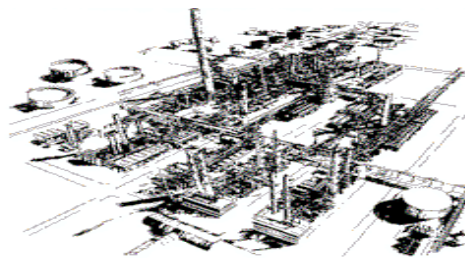
*that the operator doesn't touch anything...*



The 20st century  
Automation Engineers' heaven :

100% automated plants  
No more operators, no more human errors  
Infinite workforce productivity

***Just a matter of time and resources...***



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## **Just a matter of time and resources ... ?**

### **► Major investment effort**

- Digitalize all controls
- Develop software applications and optimizers
- 2003, voting systems, UPS, ...
- Fool-proof SIS, Layers of Protection, risk matrix ...
- ...

### **► In the meantime, human errors continued to happen with evolving diagnosis**

- ~1970 : "Humans are not machines"
- ~1980 : "residual problem from the past, will soon be solved"
- ~1985 : "need more detailed procedures for remaining human interventions"
- ~1990 : "problem to transfer competency to new generation operators"
- ~1995 : "need behavioral program ... so that procedures are followed"
- ...

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## 21<sup>st</sup> century : several wake-up calls



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## Human Performance Error in operations and maintenance functions = still major risk contributor

Selection of reported accidents and near misses, 2007 - 2009

2007-065	2008-026	2008-028	2008-059	2008-061
Burns by caustic soda during operator intervention at a pump	Worker spread with sulphuric acid	Working on a blind while system still in service	Worker spread with sulphuric acid	Ethylene ship connected to propylene loading arm

2008-065	2008-070	2008-072	2009-014	2009-020
Isobutane cloud after rupture of nitrogen hose during startup	Large benzene spill in pipeway	Hot quench oil spread on operator after manometer removal	Large fuel oil spill after contractor opened purge	Fire during furnace startup

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## Classical (20st century) approach of Automation

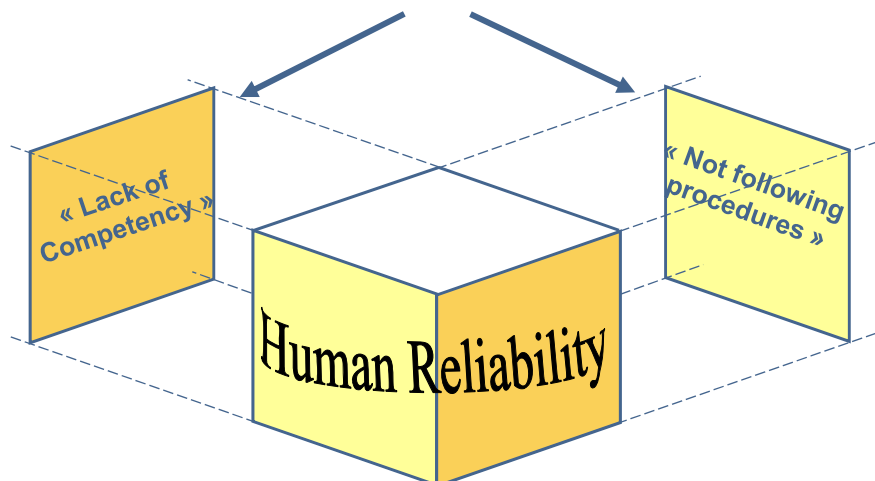
Operator = (un)avoidable source of errors and losses

- ▶ Human errors are at the origin of many incidents of process safety, reliability, ...
- ▶ Automation objective = avoid depending on human intervention
- ▶ Technology = a tool to reduce the exposure of the process to human intervention and errors
- ▶ Operator error = caused by not following procedures and / or lack of competency

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## Human error : 2 most observed root causes



*Just aspects of a more complex reality*

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# « Humans are not machines... »

... so we cannot do anything ...

Let's do **AT LEAST** what we, engineers, do for machinery :

- ensure utilisation in their optimum operating range
- install alarming and overload protection
- ensure long lifetime with a maintenance plan
- design an adapted control scheme to influence their functioning
- use our expertise to constantly enhance their **RELIABILITY**

= the ('hard') science of  
**Human & Organisational Factors**



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## Human & Organisational Factors : domain

### ► Basis = brain functioning

- Handling of conflicting priorities
- Tunnel effect
- Types of memory
- Mental modes of operation
- ...

### ► Understanding of human error mechanisms and influencing factors

### ► HARD science : fully quantified

### ► Applied science : nuclear industry, aviation industry, military ...

#### 3 ways to manage situations



##### Knowledge based

Occurs when an individual faces a completely novel situation. The worker would have to exert considerable mental effort to assess the situation, and after each control action, the worker would need to review its effect before starting further action.



##### Rules based

Application of rules (IF - THEN form). Situations already experienced by the worker and (or?) for which he has been trained



##### Skill based

The skill based mode refers to the smooth execution of highly practiced, largely physical actions in which there is virtually no conscious monitoring. Routine situations that require less attention

© TOTAL Petrochemicals - Keys points of an HOF approach - 1st June 2010

From Pleasman - SPS Model

#### "near misses"

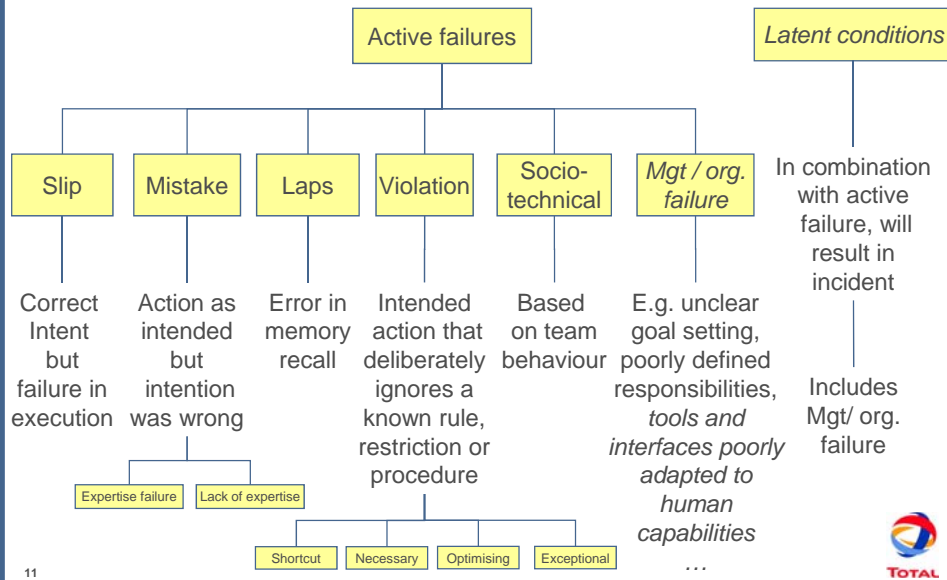
15,000 observed work errors



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## Human Error typology in the Process Industry :

Classification according to CCPS



## The human 'control loop' of the operator

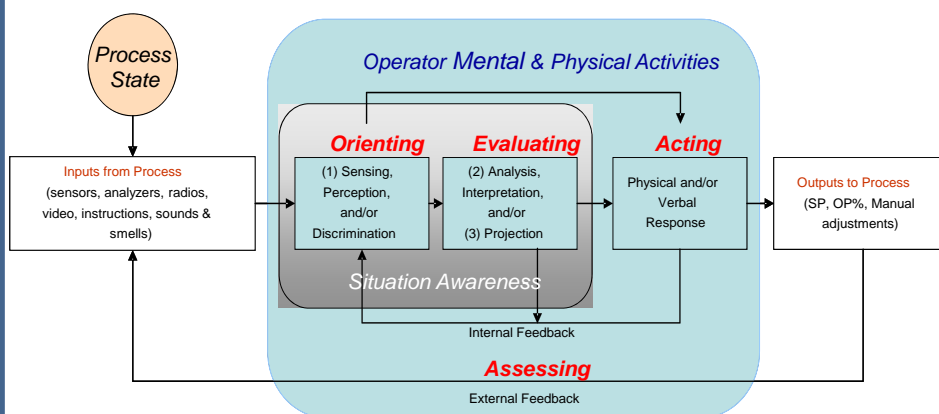
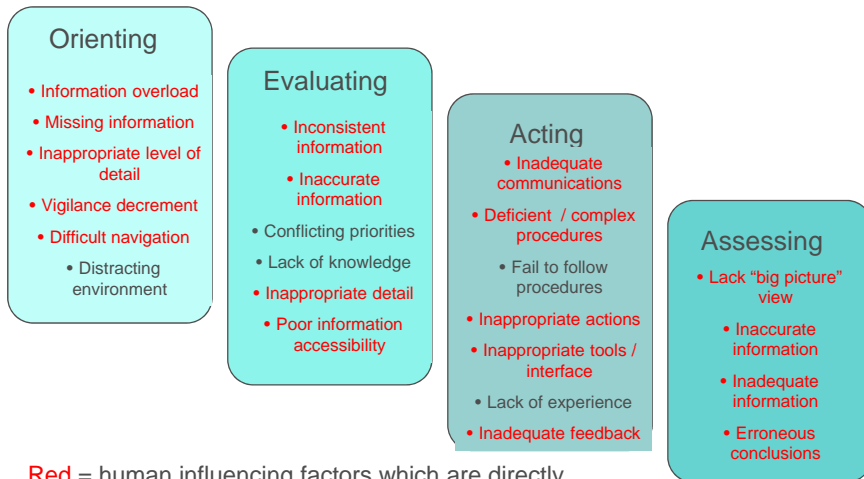


Figure from the ASM Consortium

Adaptation of Supervisory Control Activity models of Jens Rasmussen and David Woods - CMA.

## Factors which influence the overall intervention success of the operator



Red = human influencing factors which are directly impacted by available automation technology + already applied in nuclear, aviation, ...



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## 21<sup>st</sup> century approach of Automation

Operator = unavoidable source of errors and losses

- ▶ Human errors are at the origin of many incidents of process safety, reliability, ...
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- ▶ Technology = a tool to reduce the exposure of the process to human intervention and errors
- ▶ Operator error = caused by not following procedures and / or lack of competency

Operator = unique source of safety and reliability

- ▶ Unique human contribution = *manage abnormal situations* (anticipate, detect, respond) in **process safety, reliability, ...**
- ▶ Automation objective = maximize the operator's impact on his process
- ▶ Technology is a tool to boost the *Human Reliability* of the operator
- ▶ Operator error = failure of operational and technical *management* to adapt work to human characteristics of operator



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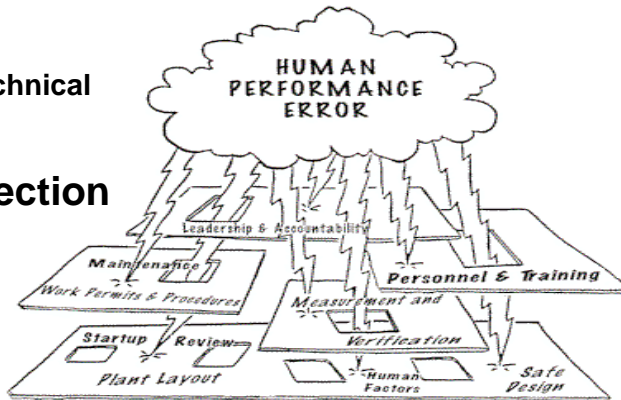
**Human limitations for reliable alarm response**  
(norm EEUMA, measured by the ASM Consortium as upper bound)

Type of problem	Maximum target <i>per operator</i>
Standing alarms	<10
Background alarms	<10 per hour
Alarm flooding	<10 in first 10 minutes of upset

Beyond these limits, human operator response **is structurally unreliable**

Allowing such installation to operate without compensating measures **is a management failure**

The role of Operational and Technical Management = installing **Layers of Protection**



Effective alarm management = a vital **Layer of Protection**

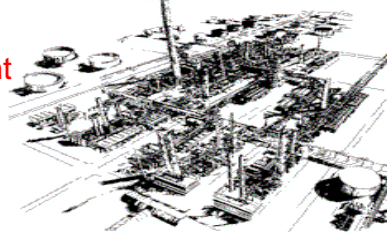
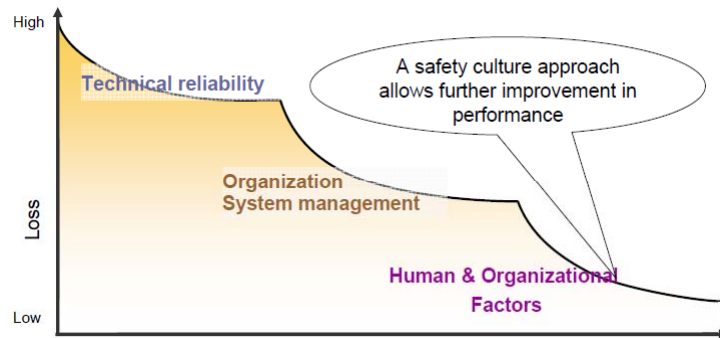


Figure from CCPS website



## Alarm Management : part of Process Safety Culture and Operational Excellence

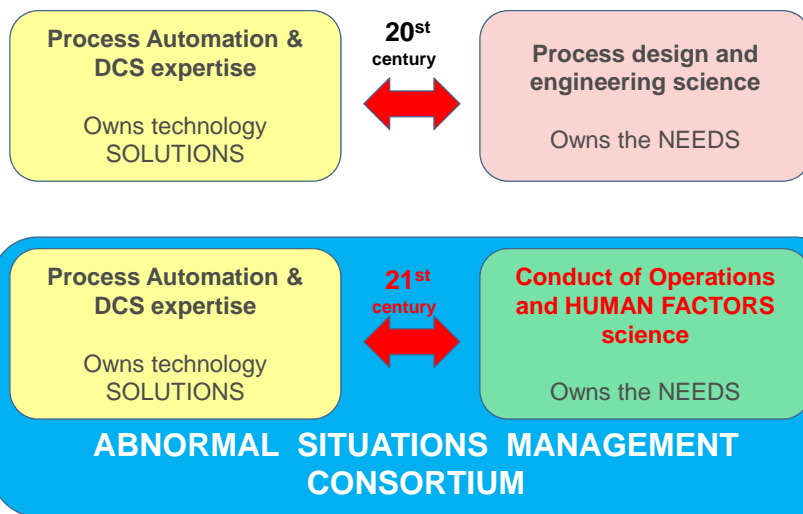
- ▶ Supporting the operator as unique source of safety and reliability
- ▶ Operations-centered approach : technology boosts human performance
- ▶ Operational professionalism as core competency



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## Transverse competencies remain THE *key element* for Automation success in the 21<sup>st</sup> century



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## The state-of-the-Art “lab” for technology - enhanced Human Reliability of the Operator : Abnormal Situation Management® Consortium

**ExxonMobil**

**sasol**  
reaching new frontiers



**ConocoPhillips**

**Human Centered Solutions**  
Helping People Perform



**Honeywell**  
Process Solutions  
Advanced Technology Labs  
Specialty Materials



**UCLA**



### R&D consortium of 15 companies and universities

- Initially co-funded by US Govt (NIST) +\$16M for first 4 years
- Jointly invested +50M\$ over 15 years
- Creating knowledge, tools and products designed to **prevent, detect and mitigate abnormal situations** that affect process safety in the control operations environment

### Charter

- Stage 1 (1994-1998) : Research
- Stage 2 (1999-2001) : Prototyping
- Stage 3 (2002-2004) : Development
- Stage 4 (2005-2008) : Deployment

### Deliverables

- Technology, prototypes, guidelines, best practices, metrics, application knowledge, workshops, products.

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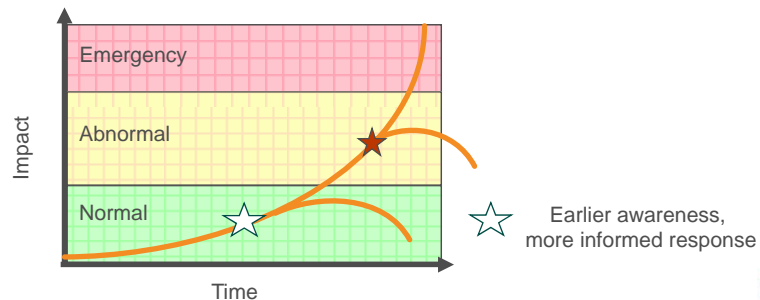


## R&D domain of the ASM Consortium

### Technology to radically enhance the operational teams' capability to :

- Error-free **DETECT** indicators and precursors
- Error-free **DECIDE** on appropriate course of actions
- Error-free **RESPOND** and execute corrective actions

in order to **PREVENT** or **MITIGATE** any abnormal situation



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## How ?

- ▶ By focusing on following 7 areas

1. **Understanding ASM** - Focuses on issues that may lead to a better understanding of current incident causes providing insight to reduce future abnormal situations and to prepare operations teams accordingly
2. **Management Structure & Policy** - Focuses on the impact of management structure and policy on the ability of the operations team to prevent and respond appropriately to abnormal situations
3. **Training & Skill Development** - Focuses on the impact of training and skill development in preparing and coping with abnormal situations
4. **Communication** - Focuses on communication issues among plant personnel on the use of information technology under normal, abnormal and emergency situations
5. **Control & Operations** - Focuses on all aspects of procedures used to accomplish important tasks at an industrial site, particularly startup/shutdown
6. **Control & Operations Environment** - Focuses on the impact of process monitoring, control and support applications for effective operations. It includes such aspects as alarm management and early event detection.

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## Conclusions :

1. After decades of automation, the human operator's unique and irreplaceable contribution has become to manage abnormal situations.
2. Automation solutions, interfaces and tools will only be effective if they take into account the 'hard' science of Human Factors. This science should become a core competency for automation engineers.
3. The challenge for the Process Automation profession in the 21<sup>st</sup> century will be, to use technology for a radical enhancement of the operator's *human reliability* and his impact on the process in all normal and abnormal situations.
4. The Abnormal Situation Management Consortium plays an essential role in advancing technology to boost the human reliability of the operator. In its pursuit for operational excellence, Total is proud to contribute as a member.

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***Process Safety is why you do it, ...***

***Reliability is how you pay it !***