



# Modelling hazardous events for decision support

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Thank you to S.Haugen and X.Yang for valuable comments



## The presentation is about

- A brief introduction to operational risk analysis
- Case study: modelling event scenario (storage tank overflow)
- Summary
- Q & A

# Point of departure

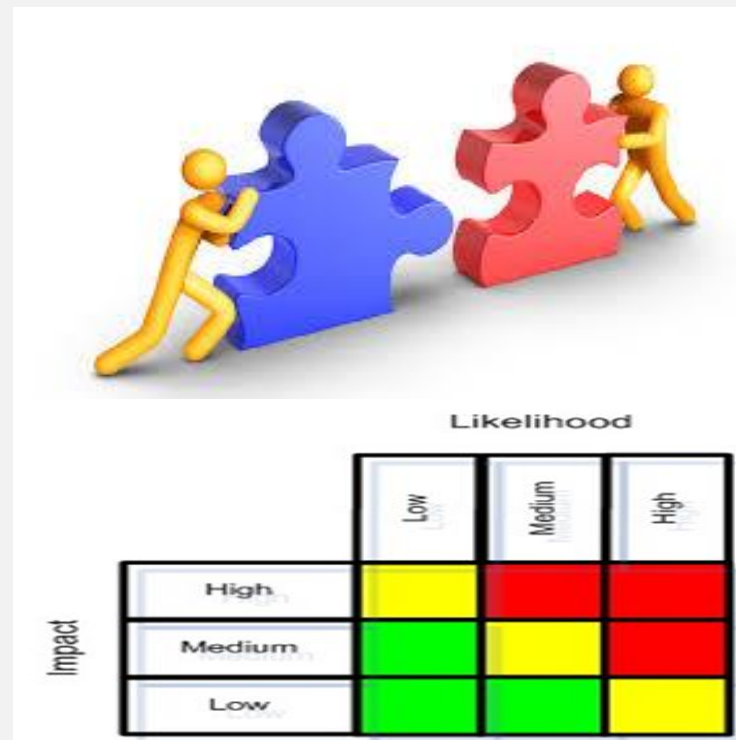
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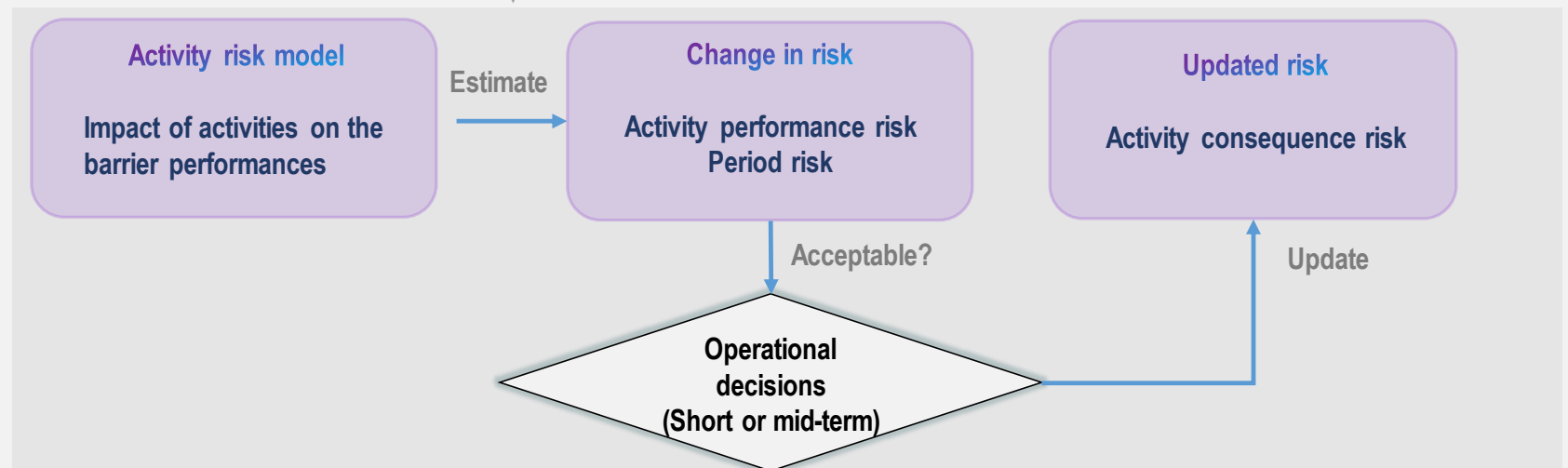
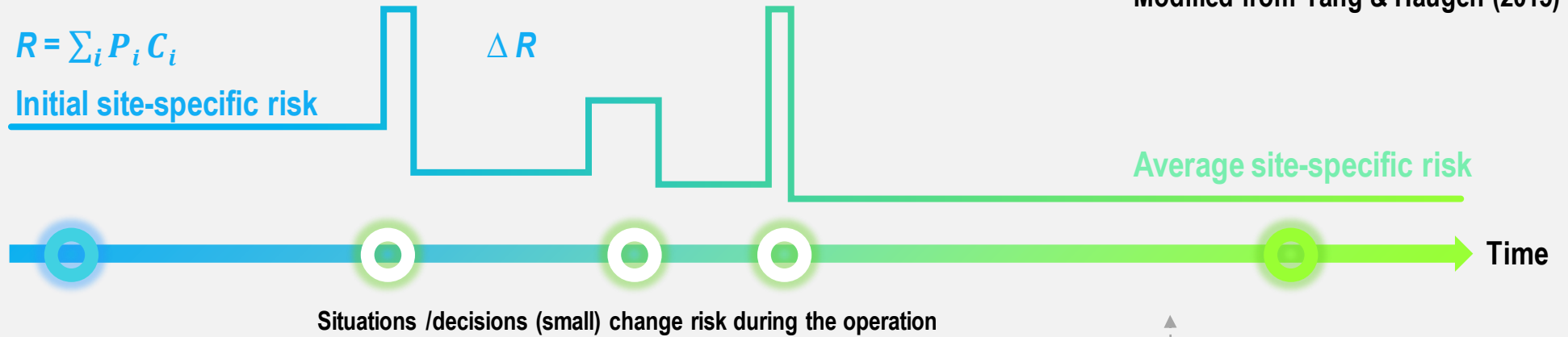


## Operational risk analyses (Vatn & Haugen, 2013)

- Different from strategic risks analysis for strategic decisions
- An example of strategic risks analysis : Quantitative Risk Analysis (QRA) for safe design and procedure (risk level for the entire installation)
- QRA is not effective for operational decisions (more specific)
- An operational risk analysis is performed in limited problem area, typically decisions during planning (e.g. replace a detector)

# Point of departure

Modified from Yang & Haugen (2015)



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# Objectives

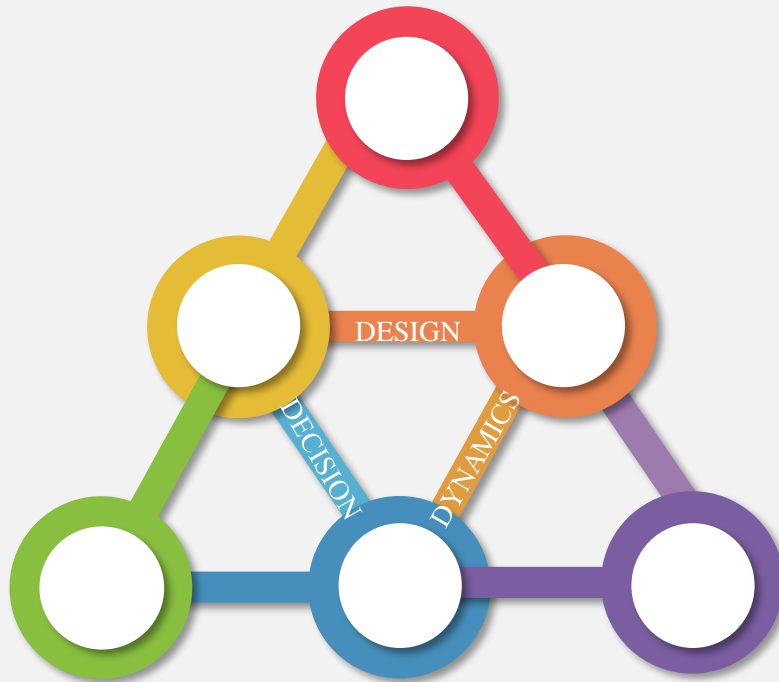
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## One way to improve

- Detailed scenario analysis, make use of available information
- The need for sufficient focus on **assumptions** of an event scenario and a model that describes **sequences of events** (Aven, 2016)

## Main interests

- Visualize detail event scenarios (sequence) that might be missed in quantitative risk analysis
- Dependencies between decisions/activities and barrier failures
- Address potentials of such approach to support operational decisions

# Case study

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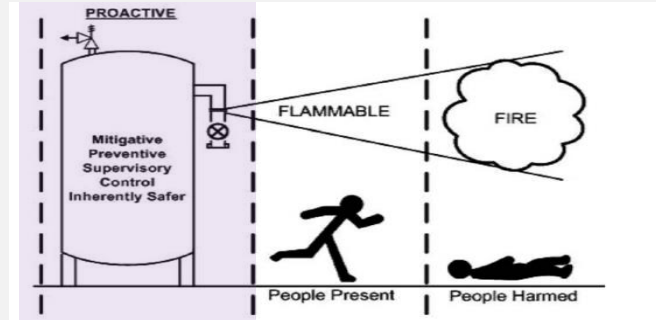
## Tank overfill accidents

- Tank operations are similar around the world, and accidents are reoccurring (Myers & Roos, 2015).
- The overfill of atmospheric storage tanks is a common event, even with the systems for overfill prevention (Casey, 2016).
- After the Buncefield (2005), emphasis put on the use of risk analysis in design and operation

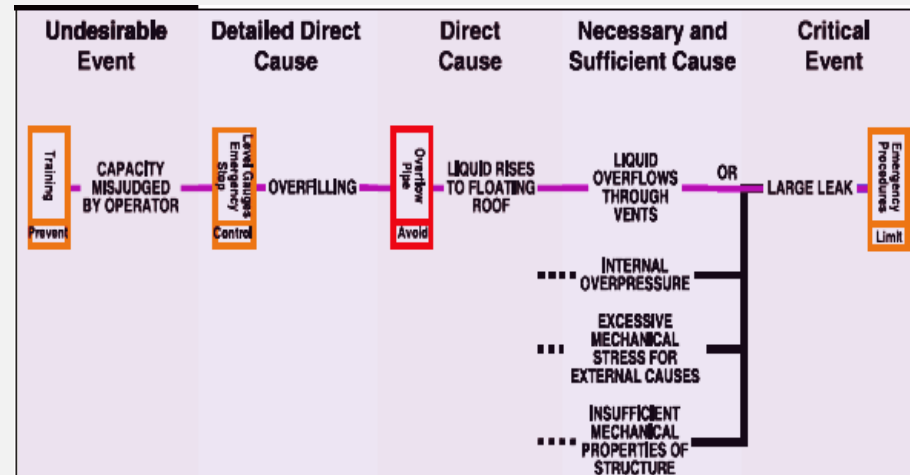
# Safety Barriers

## Bow-tie

Hazardous event :major spill from overflow

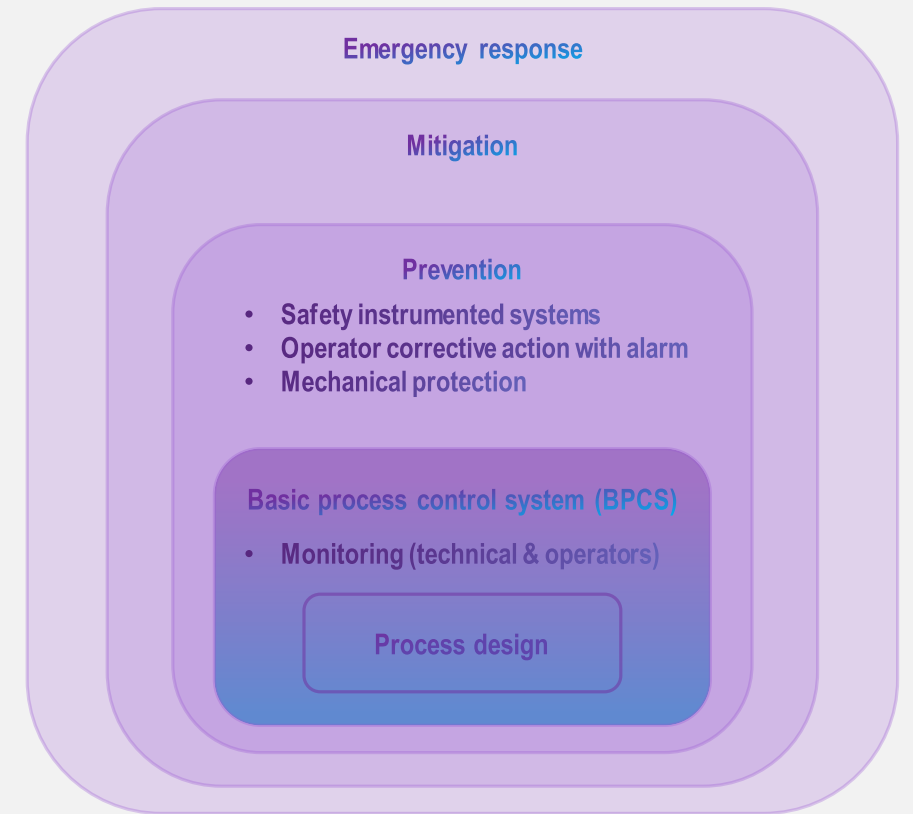


summers et al. (2012)



Left-hand side of bowtie of Buncefield case (Paltrin et al. ,2012)

## Layers of protection analysis (LOPA)



IEC 61511 (2012)

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# Safety instrumented system

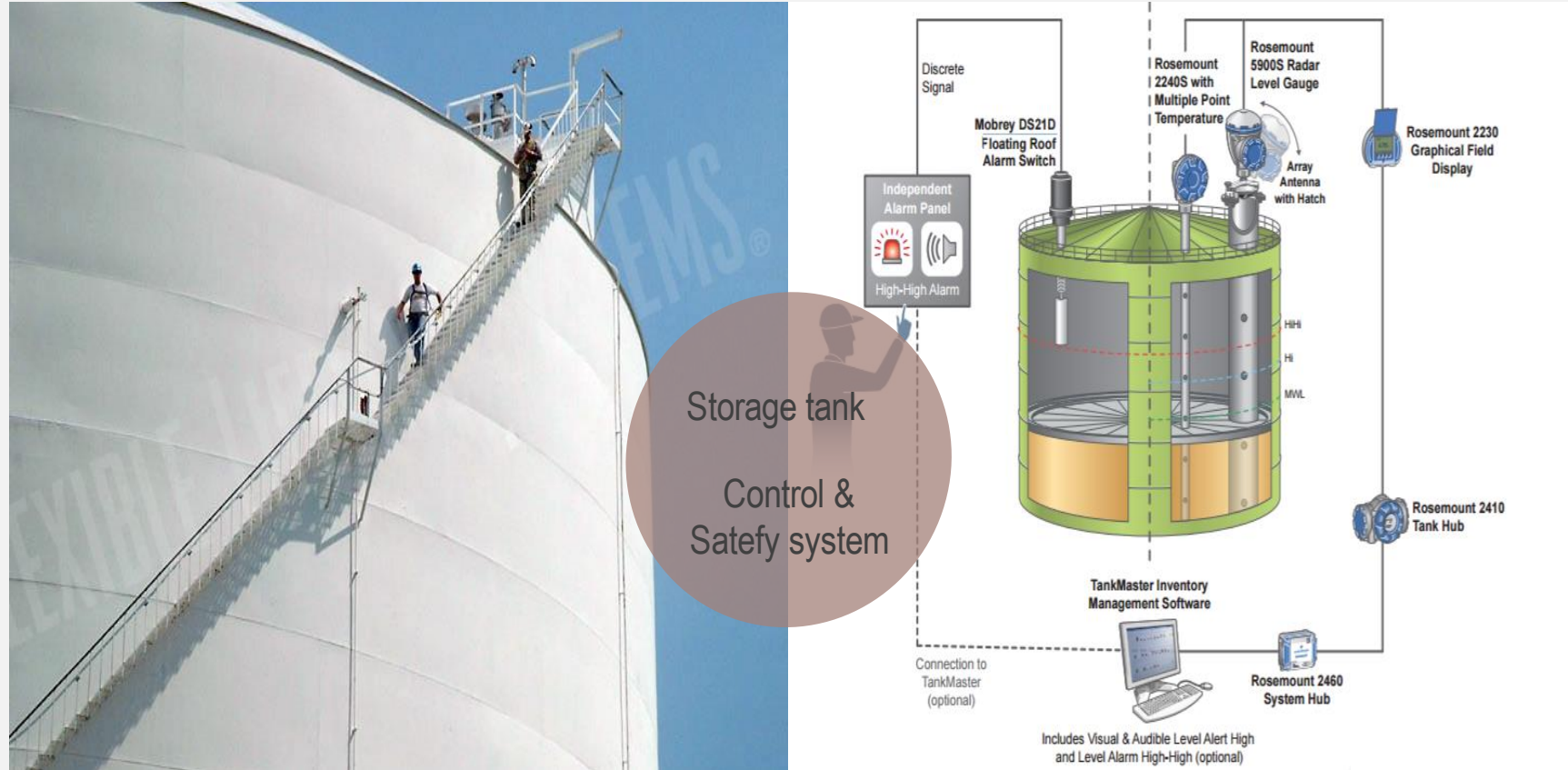
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Myers & Roos (2015)

*“Many tank overfill incidents resulted from faulty instrumentation. In addition, it is common that operators did not believe the correct alarms because of past experience”*



# Safety instrumented system

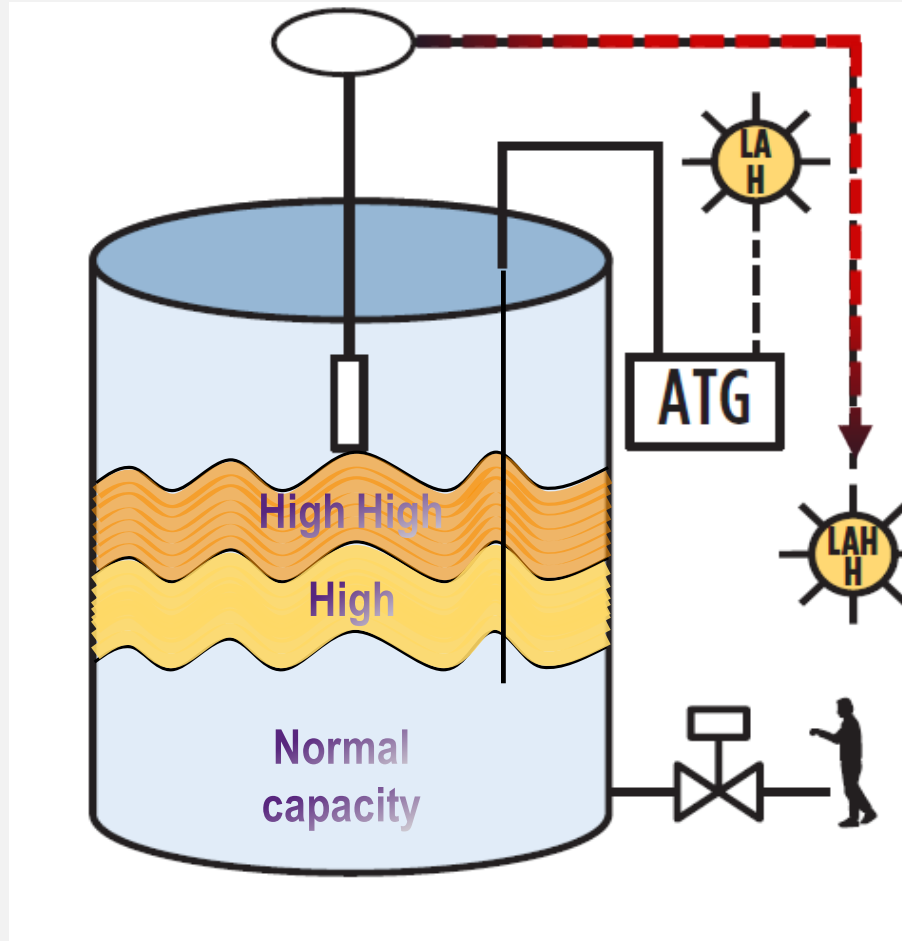
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## Automatic gauging system (ATG)

- Tank levels may be read using ATG with ability to transmit a signal and/or trigger H alarm
- ATG failure - loss of information on the levels  
→ H alarm is dependent on ATG

## Level switch


- Independent from ATG
- Triggers H-H alarm or close the shutdown valve

## Shutdown valve

- Manual intervention by local and/ or remote operator or automated shutdown

# Case study

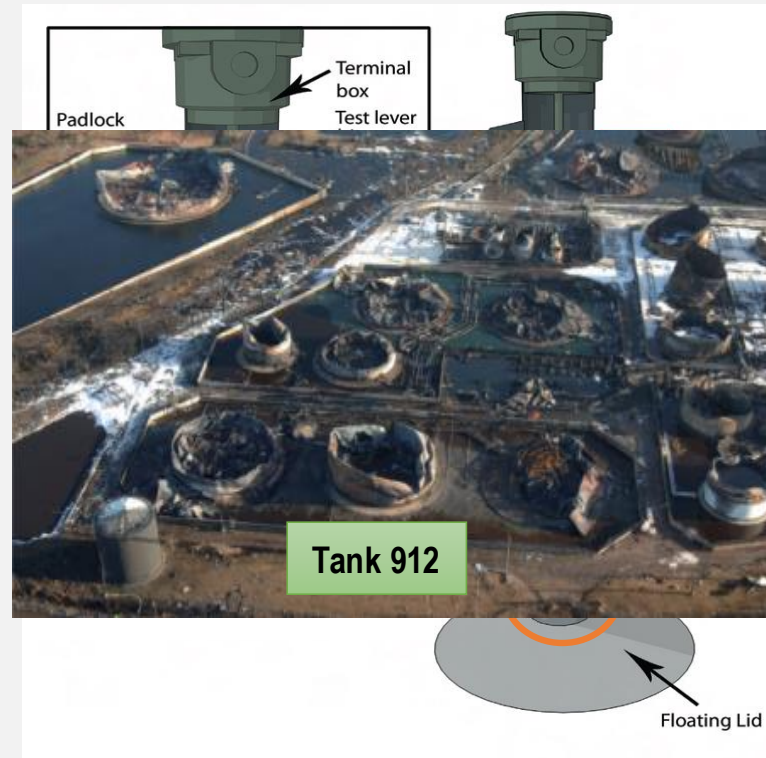
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High-level switch

## Buncefield (2005)

### Technical barriers


- The **level gauge** remained the same position  
→ no alarms
- High-level switch did not close the shutdown valve

### Operational barriers

- No actions to repair the level gauge:  
The same problem occurred 14 times in 4 months.
- The maintenance crews did not fit the padlock after testing.
- Poor communication between two companies  
(Designer / maintenance)

# Modelling

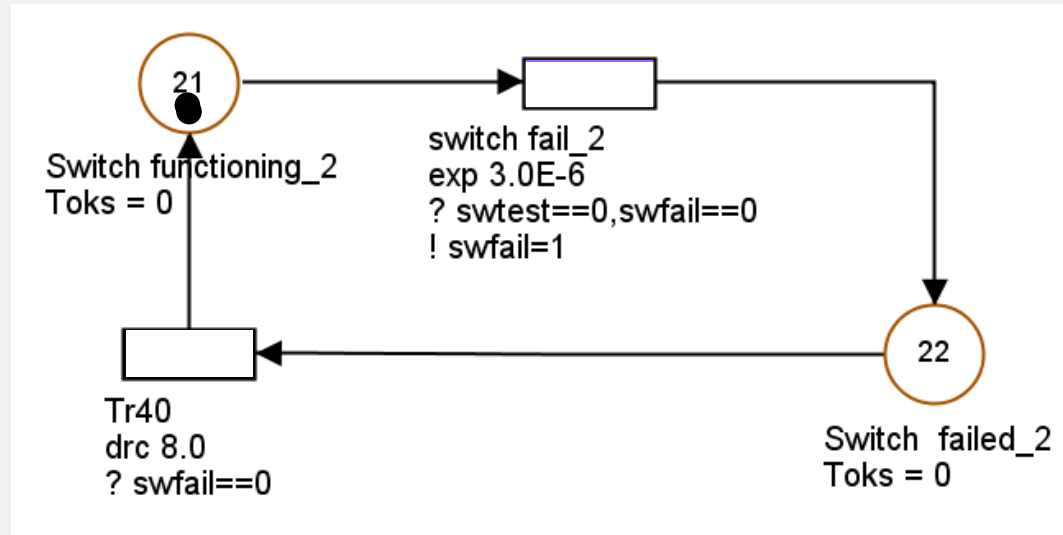
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## Petri nets

- Dynamic behavior of the system in a particular state (Not limited to binary events)
- Express dependencies : support fault tree or event tree analysis
- Compact, flexible and easy to use
- Monte Carlo Simulations gives approximate value

# Petri Net with marking

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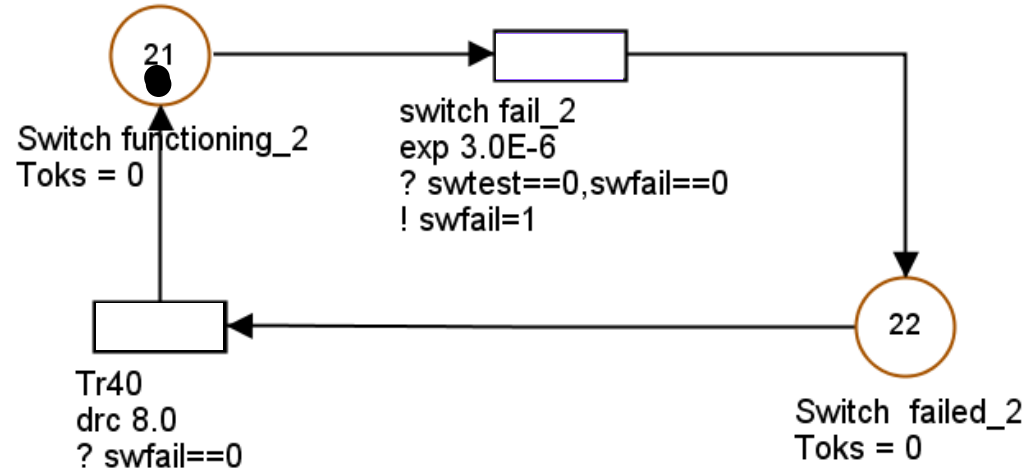
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## Component state (Availability)

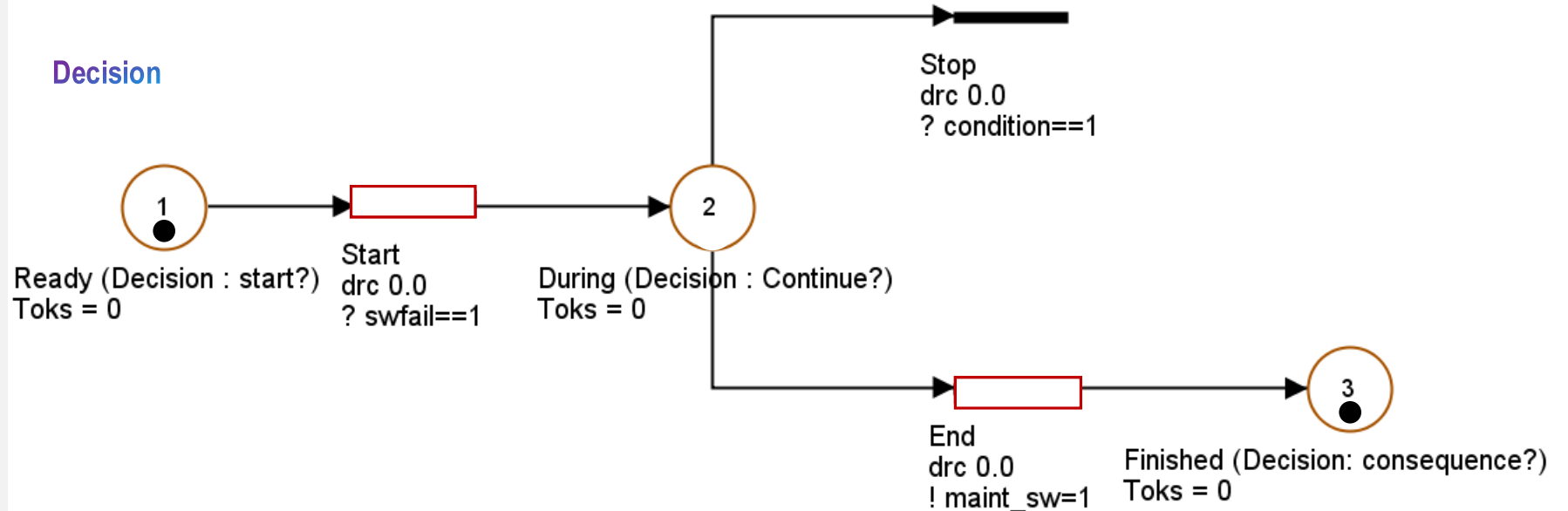


## Elements of Marked Petri Nets

- Place with Token(s)
- Transitions
- Arc
- Predicate, assertions

*'Petri Net is static network but a token is dynamic (Rausand, 2011)'*

## Decision



# Modelling

## Event/activity influence barriers

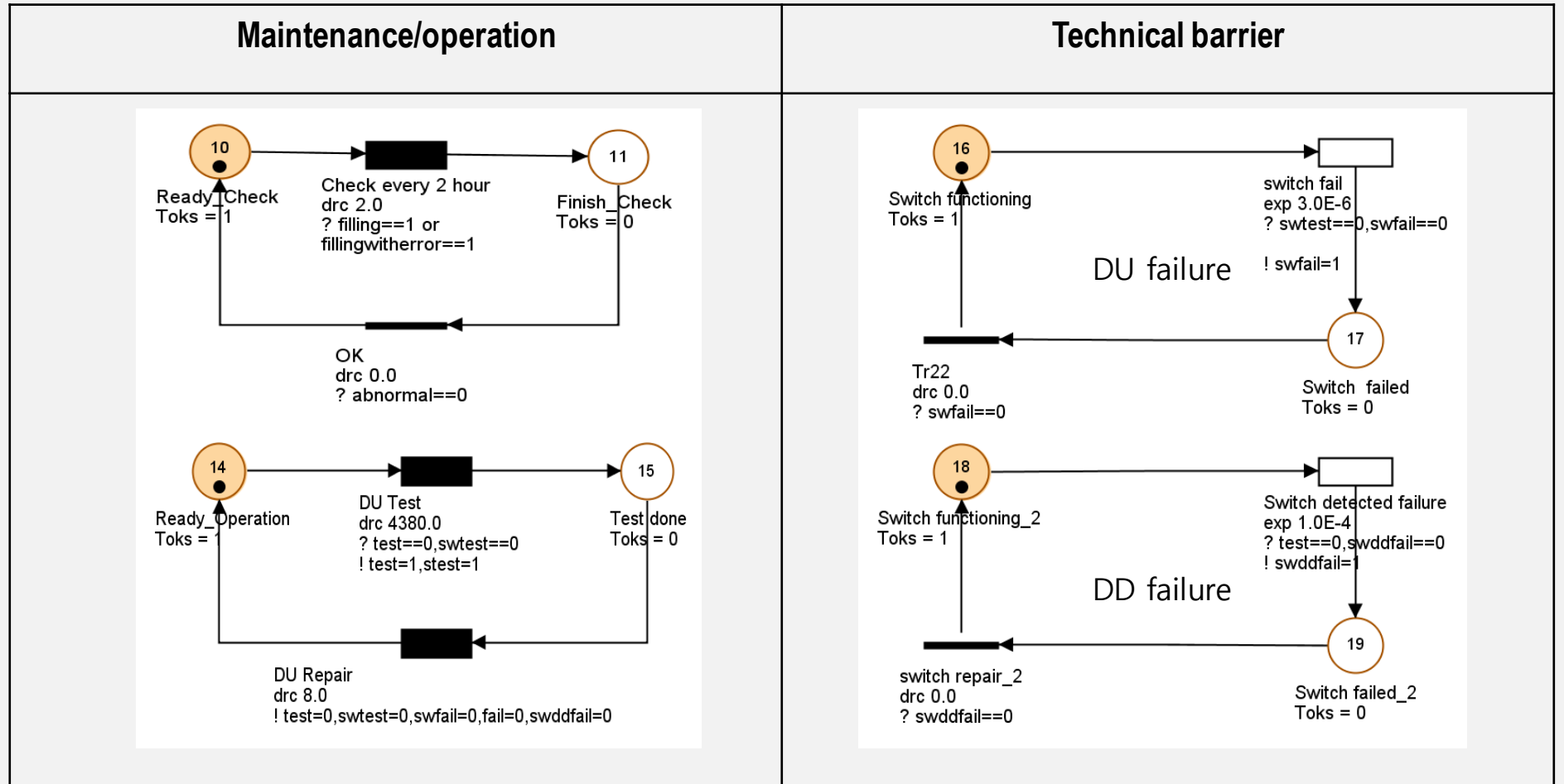
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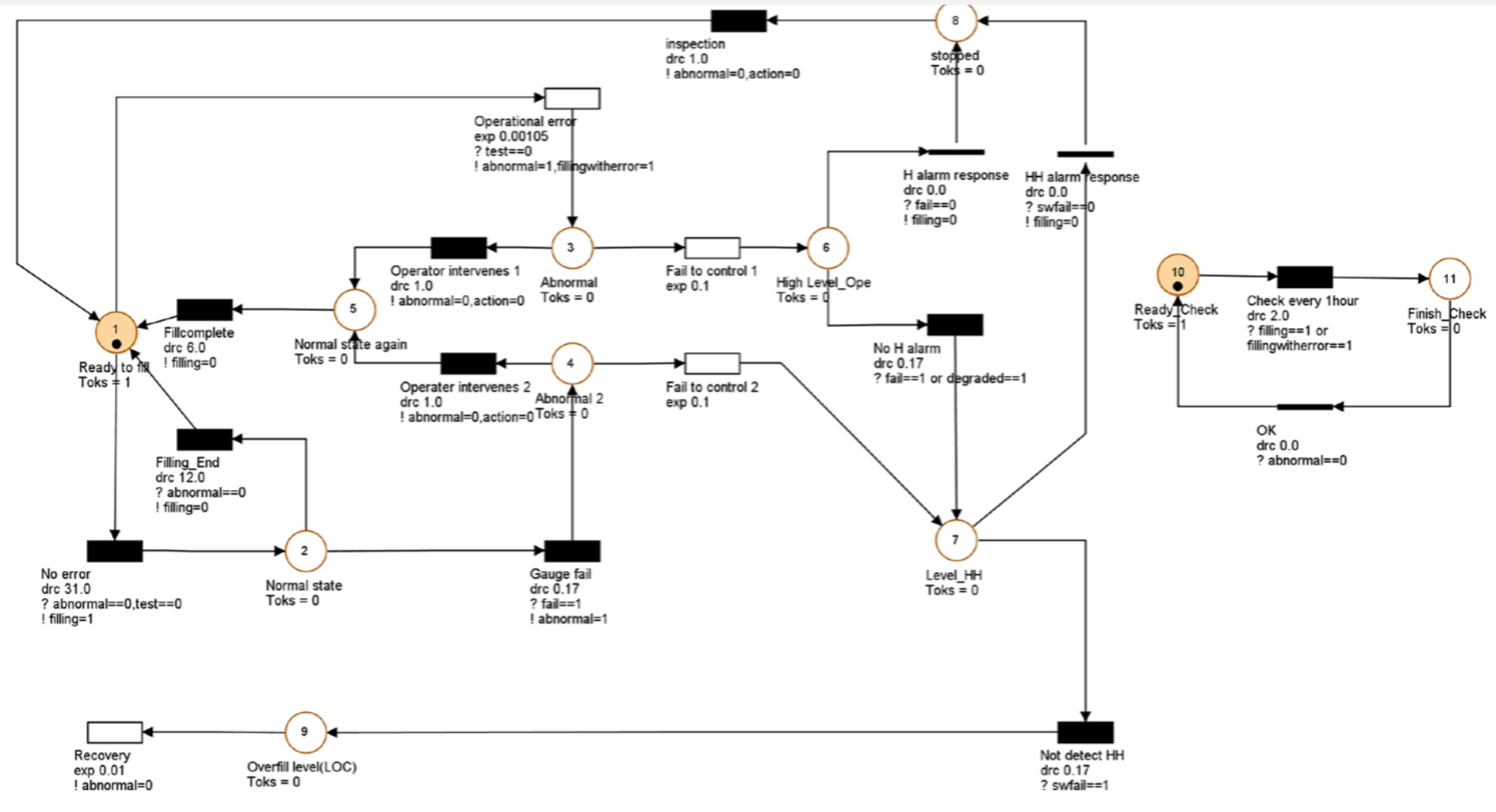
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# Modelling

## States of the storage tank

Figure 5 The petri net modelling of the tank filling level



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# Simulation result

What and when are the events triggered during 3 months?

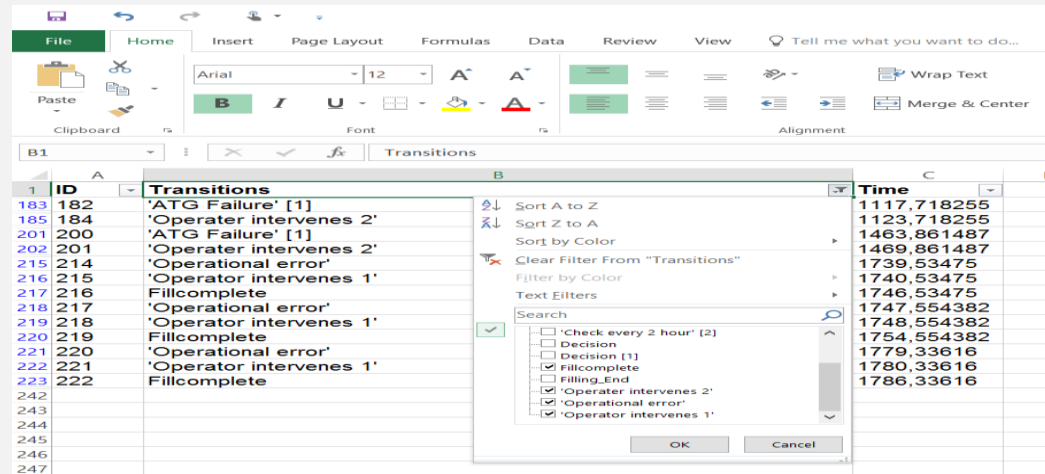


Figure 1

- What are probabilities of each state?

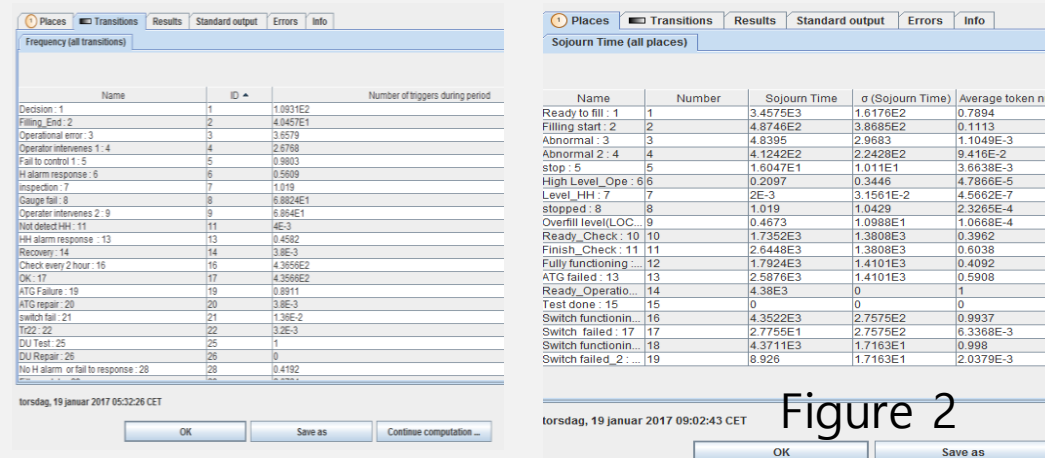


Figure 2

Provide a piece of information for decision support

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# Data

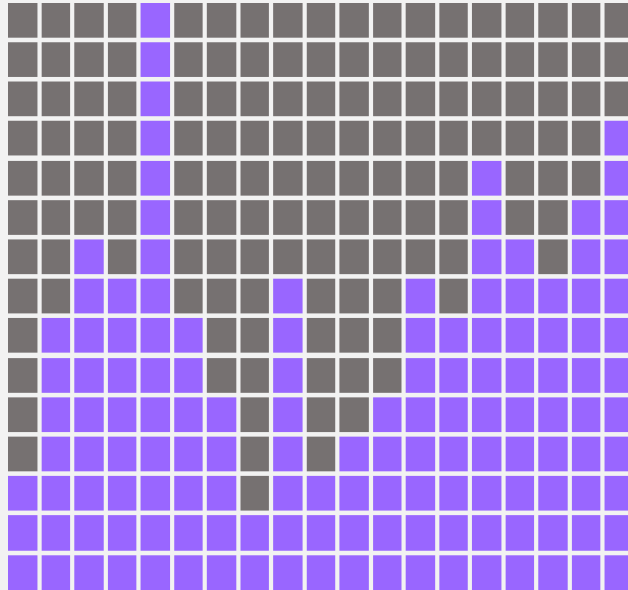
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Operational barrier	Technical barrier												
<p><b>Generic values</b></p> <ul style="list-style-type: none"> <li>Operator error probability</li> <li>Response time</li> </ul>	<ul style="list-style-type: none"> <li>Tank filling frequency</li> <li>Failure rate of components</li> <li>Demand rate</li> </ul>												
<p>Table F.4 – Typical protection layer (prevention and mitigation) PFDs</p> <table border="1"> <thead> <tr> <th>Protection layer</th> <th>PFD</th> </tr> </thead> <tbody> <tr> <td>Control loop</td> <td><math>1,0 \times 10^{-1}</math></td> </tr> <tr> <td>Human performance (trained, no stress)</td> <td><math>1,0 \times 10^{-2}</math> to <math>1,0 \times 10^{-4}</math></td> </tr> <tr> <td>Human performance (under stress)</td> <td>0,5 to 1,0</td> </tr> <tr> <td>Operator response to alarms</td> <td><math>1,0 \times 10^{-1}</math></td> </tr> <tr> <td>Vessel pressure rating above maximum challenge from internal and external pressure sources</td> <td><math>10^{-4}</math> or better, if vessel integrity is maintained (that is, corrosion is understood, inspections and maintenance is performed on schedule)</td> </tr> </tbody> </table> <p>IEC 61511 (2012)</p>	Protection layer	PFD	Control loop	$1,0 \times 10^{-1}$	Human performance (trained, no stress)	$1,0 \times 10^{-2}$ to $1,0 \times 10^{-4}$	Human performance (under stress)	0,5 to 1,0	Operator response to alarms	$1,0 \times 10^{-1}$	Vessel pressure rating above maximum challenge from internal and external pressure sources	$10^{-4}$ or better, if vessel integrity is maintained (that is, corrosion is understood, inspections and maintenance is performed on schedule)	 <p>Health and Safety Executive</p> <p><b>A review of Layers of Protection Analysis (LOPA) analyses of overfill of fuel storage tanks</b></p> <p>Prepared by Health and Safety Laboratory for the Health and Safety Executive 2009</p> <p>Chambers et al., (2009), COMAH (2011)</p>
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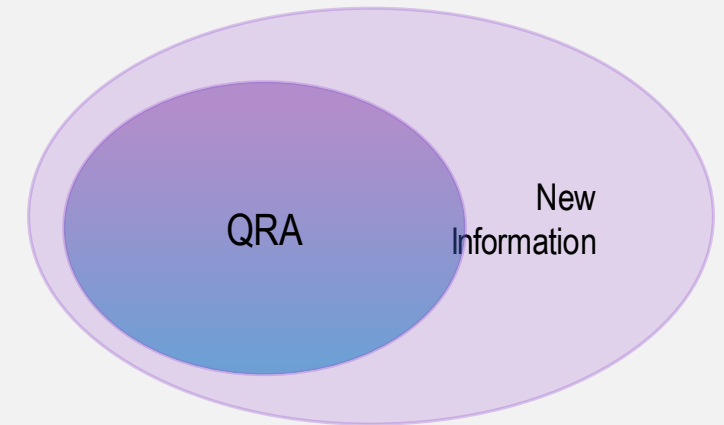
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- The purpose of a risk analysis is **not to address** each and every possible chain of events. (Factors that influence are more focused)
- However, we try to pay attention to sequence of events sets that are considered to **be safety-critical**
- Select a **specific path** in a bow tie
- Illustrate how to use Petri nets to model the states of components or operators
- Visualize assumptions behind the events

## Changes in risk over time



# Summary and conclusion

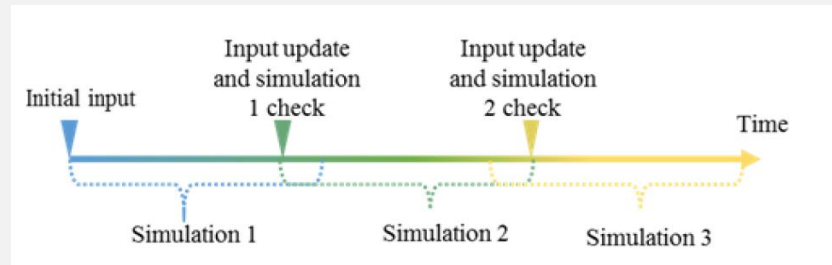
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## Decision support


- **Support understanding of operational situations**
- Modify the elements of Petri net based on work orders, maintenance activities, work permits
- **Practical value** : when we have identified **possible event sets**, the model gives a realistic probability value to avoid unnecessary precaution measures

# Summary and conclusion

## Limitations and potential improvements

Limitations	Improvements
<ul style="list-style-type: none"><li>• Requires <b>good understanding</b> of both technical systems and operational situations</li><li>• <b>Weak links</b> to the severe accident</li><li>• Does not embrace risk influencing factors</li><li>• Big Petri nets are not good in communication</li></ul>	<ul style="list-style-type: none"><li>• Include risk influencing factors by using <b>Bayes rule</b> to update the parameter in a stochastic distribution (e.g. failure rates)</li></ul>

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Thank you 😊