

## Seminar closing speech

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Following two days of intense exchanges and debate, I would like to take this opportunity to thank all those who contributed to making this event a success. I would like to extend special thanks to:

✓ the Prefect of the Basse-Normandie Region, Mr. Cyrille Schott who welcomed us yesterday, the Basse-Normandie, DRIRE, its Director, Mr. Alain Louis Schmitt for his personal involvement and that of his team in the organisation and warm welcome, and the Barpi agents for the overall coordination and documents provided.

✓ I would particularly like to thank the various participants who accepted to share their presentations with us: the Classified Installations inspectors and labour inspectors. They presented their cases and the lessons learned in a clear and informative manner.

✓ I thank the participants in the round-table discussions:

- Mr. LECOQ, Mayor of Gonfreville,
- the DRIRE, Mr. Alain Louis Schmitt,
- Mr. GUEYDAN, Director of the Calvados Prefect's office,
- Colonel BIZET, Director of the Manche SDIS ("Service Départemental d'Incendie et de Secours", county fire and emergency service),
- Mr. PIERRAT, Assistant Director of the UIC,
- Mr. BONNEMAIS of the "Robin des Bois" Association,
- and our colleague, P. CRENN, Classified Installations Inspector in Le Havre.

✓ I would also like to thank all the participants who contributed through their questioning and personal experience.

Without reiterating all of the technical aspects presented during these two days, I feel that it would be useful to comment on a few specific points:

1. The importance of the human factor in the fundamental causes of accidents
2. How accident feedback can orient the Inspectorate's work
3. The need for greater openness as regards the public

#### **First: The very significant role that the human factor plays in the fundamental causes of accidents**

✓ After analysis, the wide variety of accidents reveals already well-known technical causes (exothermic reaction, tank implosion, dust explosion...) but which escaped the control of the operators.

✓ The lack, insufficiency or disregard for intervention or operating instructions and occasionally even neglect of pre-incident indicators are often at cause. These elements are not likely to be identified in the danger study, but they are frequently at the heart of accident mechanisms. Whether it is the operational phase itself, transitory phases or steps associated with operations, etc., the "human factor" does not concern the operator exclusively. The organisation plays a major role in accident mechanisms, beyond technical failures.

This point was made clear in a number of presentations, regardless of the technical aspects in question (periodic verifications of threaded connections, follow-up of instructions, loading/unloading operations or unit lock-out procedures...).

The analysis of fundamental causes often enables a reorganisation of sites and concrete improvement. Reducing the number of accidents greatly depends on this.

These observations are corroborated by the 1992-2004 study of technological accidents recently published by the DPPR.

## **Second: how can accident feedback orient the Inspectorate's work?**

Several orientations merit further development:

- ✓ Firstly, though risk analysis and danger studies are indispensable prerequisites for improvement (to avoid common-mode electrical failures, for example), they are insufficient to provide safety throughout the life of the unit.
- ✓ Concrete elements of internal and external feedback must also be included on a regular basis in these theoretical studies. This is an experience-based continuous improvement process including the recording and analysis of incidents, the development of countermeasures and the long-term follow-up of their efficiency.

Beyond discussions with site safety officers about installation and equipment, scheduled or spot field inspections must be conducted to ensure that all those participating in the daily operations or during repair/installation work, be they salaried employees or subcontractors, respect the management requirements in terms of safety. Numerous cases presented during these two days illustrated this need.

During our inspections, we must verify the process which is meant to ensure that the pertinent information reaches the concerned operational level. Through this type of inspection, we urge the operator to create a reasonable balance between the time spent on the danger study and that reserved for management, training, information and verifications or internal audits.

This concern for balance between theoretical studies and practical applications is a fundamental element of feedback. It is certainly one of the key parameters for safety. It concerns everyone: be it the operators, management or the Inspectorate. In this respect, appendix III-6 of the order of May 10, 2000 (application order of the SEVESO directive in France), clearly emphasizes the importance of feedback management based on the analysis of incidents, the development of countermeasures and the long-term follow-up of their efficiency. This is a "continuous improvement process".

## **And last but not least: the need for greater openness as regards the public**

The social context in which the various risk prevention players intervene must also be more closely considered.

Generally speaking, the lack of information and communication on the realities and difficulties of risk prevention exacerbates the crisis, because when an accident occurs, there is often a serious problem of comprehension among the public.

Also, it is essential to rise above the dialogue of technicians and ensure that the specialized commissions are periodically informed: the County Health Council (CDH) which has become the County Council for the Environment and Health and Environmental Hazards (CODERST), the Permanent Office for the Prevention of Industrial Pollution (S3PI) and the Local Information and Joint Action Committee (CLIC). We must also communicate the results and the difficulties of our actions more widely in activity reports or thematic publications. It appears that communication and information provided to the public must be developed. It also offers major leverage regarding difficult situations, as shown by several cases examined yesterday.

Of course, the role of the players in risk prevention consists of reducing the frequency and seriousness of consequences through appropriate technical and organisational measures. But it is also their role to build confidence with society as a whole and to promote the emergence of a culture that is better protected against technological risks so that the public can further participate in managing the risks to which it is exposed.

For the Inspectorate, it is clear that operators should be urged to immediately report their noteworthy incidents or those perceived outside the facility. Several examples were mentioned yesterday. They demonstrate the advantages of providing information as quickly as possible. Extensive work is required in this field: if public relations communication is systematically based on these principles and the improvements are made, a better understanding may be achieved with the local population. The nuclear example is significant in this respect; it benefits from a good public image of safety, thanks to the openness of its representatives in handling incidents.

This dialogue should be established when incidents happen, without waiting for an accident, as the public is more receptive to explanations in the absence of notable consequences that could alter their perception. A dangerous materials index was developed to complete this communication by shedding light on the source of the incident – because the terminology generally used is poorly understood by the population. This is also the general spirit of the

provisions of Article L 125-2 of the environmental code which requires that the CLICs be informed of incidents or accidents.

Encouraging operators to provide information about their incidents or accidents and on the measures taken constitutes an essential element of transparency. Their key principles are:

- ✓ Reveal the crisis and avoid being suspected of trying to conceal it,
- ✓ Take the initiative and thereby avoid a defensive posture of justification,
- ✓ Prevent rumours and controversies from spreading due to a lack of information.

Failing that, when the next major accident occurs (and we certainly can't "maintain the illusion that risk will be eradicated" as the Minister reminds us in the brochure), the system will be confronted with even greater difficulties stemming from the public's insufficient knowledge of technological risks. This was one of the main lessons learned from the Toulouse catastrophe. But, you may ask, what about the day-to-day concerns? It is precisely through better understanding that we can achieve a more calm and objective climate of exchange, for example as concerns consultation for authorizations or modifications.

It is an extremely important point that must be handled calmly. And I particularly appreciated the round table discussion on this theme yesterday. The collaboration of the various participants allowed us to better identify the expectations of the parties involved. The Inspectorate, often called upon in these circumstances, must learn to position itself in relation to the emergency services and to organise its efforts according to missions provided for by the law. From the practical standpoint, the "Crisis Task Force", organised within the scope of the DRIRE's quality approach, has developed guidelines for the Inspectorate in these situations. Excerpts of these guidelines are available on the BARPI website.

I would once again like to thank you all for your contributions which have enriched our seminar. I hope that our work will be able to orient the work of the Inspectorate on a daily basis. I am referring of course not only to the analysis of danger studies, but also to your other missions:

- ✓ Field examination of the concrete application of the safety management system,
- ✓ Urge operators to communicate more spontaneously in the event of an incident,
- ✓ Develop a dialog with the various parties involved in specialised CDH (CODERST), SPPI and CLIC commissions.

They contribute to improving risk prevention and to a better public understanding of our action.

Before closing, I would like to insist on one last point. Traditionally, our seminar is an important phase in the life of the IMPEL network for European inspectors owing to the presence of colleagues from numerous countries. The tradition was again upheld this year and even improved; inspectors from 12 member states brought with them a considerable sum of experience.

An ever-growing number of foreign inspectors have asked to present accidents: 7 requests for 5 presented, but we were faced with deadline requirements for this meeting. I am hoping that we will be able to increase foreign presentations by 50% for our next seminar. So please respond promptly when the next call for papers is issued... I hope that the contacts and exchanges established during these two days will continue beyond the seminar so that the work of the Inspectorate's network will be continually improved.