Learning from incidents – Summary of the tripartite committee

Background
The Ministry of Labour and Social Affairs appointed a tripartite working group in 2016 to study and arrive at a common assessment of HSE conditions and trends in the Norwegian petroleum industry (report from the tripartite group, 2017). This followed a number of safety challenges and certain serious incidents in recent years which created a need to put HSE conditions in the sector on the agenda. Questions were also raised over whether efficiency improvements, downsizing and restructuring in 2013-17 had affected the level of safety in the industry. The report, which formed an important basis for the most recent White Paper on HSE in the petroleum industry (Report no 12 (2017-2018) to the Storting), stated that there was "a high level and positive trend over time with regard to health, safety and the environment in the industry, while challenges also exist". However, a need was also seen to improve experience transfer in the industry, learn from incidents and systematise these processes among other actions. The Report from the tripartite group delivered to the Ministry of Labor and Social affairs in 2017 stated the following:

> To lay the basis for continuous improvement, one important requirement is that a good system exists in the industry for experience transfer and learning from incidents, and for applying this knowledge to further development. The working group recommends that an assessment be made of learning by the parties after incidents with a view to improving this further.
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> Many meeting places and arenas currently exist where HSE is discussed, and a great range of knowledge is available to be shared. However, better systematisation of this knowledge is required to ensure good learning from incidents. The industry must use and maintain arenas for transferring experience from investigations and the like, so that all players become familiar with this. For example, transferring knowledge of a hydrocarbon leak could lead to engineering departments developing more robust design solutions which help to prevent such escapes. Norwegian Oil and Gas will therefore invite a cross-disciplinary tripartite working group to assess how knowledge-sharing can be made more efficient and systematic in a long-term perspective.
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> (Report from the tripartite group, 2017: p. 106)

Tripartite working group – Learning from incidents (2018-2019)

To follow up on this recommendation, The Safety Forum established a tripartite working group on 4 April 2018 to

review experience transfer and learning from incidents in the petroleum sector. This was organised in two sub-groups, one chaired by Norwegian Oil and Gas and the other by Working Together for Safety.

The following have participated in these working groups:

Working group chaired by Norwegian Oil and Gas		
Name	**Representing**	**Employer**
Dag Yngve Johnsen	Norwegian Confederation of Trade Unions (LO)	LO administration
Janne Lea (chair)	Norwegian Oil and Gas	Wintershall
Dan Meland	Norwegian Oil and Gas	AS Norske Shell
Anne-Britt Ornæs	Norwegian Shipowners Association (?)	Teekay
Willy Røed	Secretariat	Norwegian Oil and Gas (hired from Proactima)
Marie Røyksund	Secretariat	Norwegian Oil and Gas (hired from Proactima)
Jorunn Elise Tharaldsen	Petroleum Safety Authority Norway (PSA)	PSA
Working group chaired by Working Together for Safety		
Henrik Solvorn Fjeldsbø	Norwegian Union of Industry and Energy Workers (Industry Energy)	Industry Energy administration
Roy Erling Furre	Norwegian Union of Energy Workers (Safe)	Safe administration
Hugo Halvorsen (chair)	Working Together for Safety	Working Together for Safety
Steinar Kobbeltvedt	Corrosion, insulation and scaffolding (CIS)	Beerenberg
Anne Gro Løkken	PSA	PSA
Hedyeh Malkamy	Norwegian Oil and Gas	Equinor
Hanne Størksen	Norwegian Oil and Gas	ConocoPhillips

Mandate

The purpose of the tripartite work was to contribute to experience transfer and learning from incidents, so that the knowledge contributes to change and continuous HSE improvement in a long-term perspective.

The following questions have been central to its work:

1. Which arenas and information sources/databases for sharing experience are available in the petroleum sector today, and how do these function?
2. What represents good/best practice for learning from incidents?
3. Does the industry have examples of good investigatory methods which ensure that key causes are identified and followed up, and contribute to change?
4. What projects have been implemented/initiated which have contributed/are contributing to important and useful knowledge about learning lessons from incidents?
5. What should be improved in terms of learning from incidents?

These questions and the mandate for the working group assumes a broad review of the way the petroleum industry learns from and shares experience and information following undesirable incidents.

An important prerequisite in the work has been that learning means that something is changed – a work assignment being performed differently from before, for example. Sharing information and other forms of experience transfer are important steps towards it, but are not learning in themselves. Only when something changes has a lesson been learnt.

Question two has been answered in a separate delivery from Working Together for Safety and is therefore not addressed in the report.

Summary of the working group's recommendations

This report presents recommendations which are intended to contribute to **improved experience transfer** and **learning** from incidents in the Norwegian petroleum industry. The table below presents the working group's recommendations.

Recommendations from the working group.

RECOMMENDATIONS	
The companies and the government should improve their methods for investigating and learning by implementing the following recommendations.	
Recommendation 1	The investigation team should have expertise on human factors (HF), organisational conditions and enterprise management which is on a par with technical expertise.
Recommendation 2	The companies and the government should also utilise investigatory methods where

	the question to be answered by the investigation is "why did it make sense to act as they did?" rather than "what did they do wrong?".
Recommendation 3	The companies should make greater use of learning sessions in order to choose measures after an incident, and thereby avoid a larger learning potential being dissipated in many small and local measures.
Recommendation 4	The companies should formulate measure which make provision for follow-up and evaluation of the measures. For example in line with the Smart[1] principle.
Recommendation 5	The companies should draw up a plan for how and when the effect of the measures are to be evaluated.
Recommendation 6	The companies and the government should conduct more thematic analyses.
The Safety Forum should decide whether an industry initiative is to be established for further work on the following recommendations.	
Recommendation 7	The industry should utilise the scope provided by digitalisation to continue developing a common platform for experience transfer, so that users have efficient access to relevant information tailored to their learning needs.
Recommendation 8	The industry should make greater use of existing learning arenas to share, evaluate and discuss experience on how information can contribute to changes in practice.

Based on discussions in the Safety Forum, the biggest challenge is considered to be methodology and systematics rather than lack of knowledge.

[1] SMART = Specific, Measurable, Achievable, Relevant, Timebound.