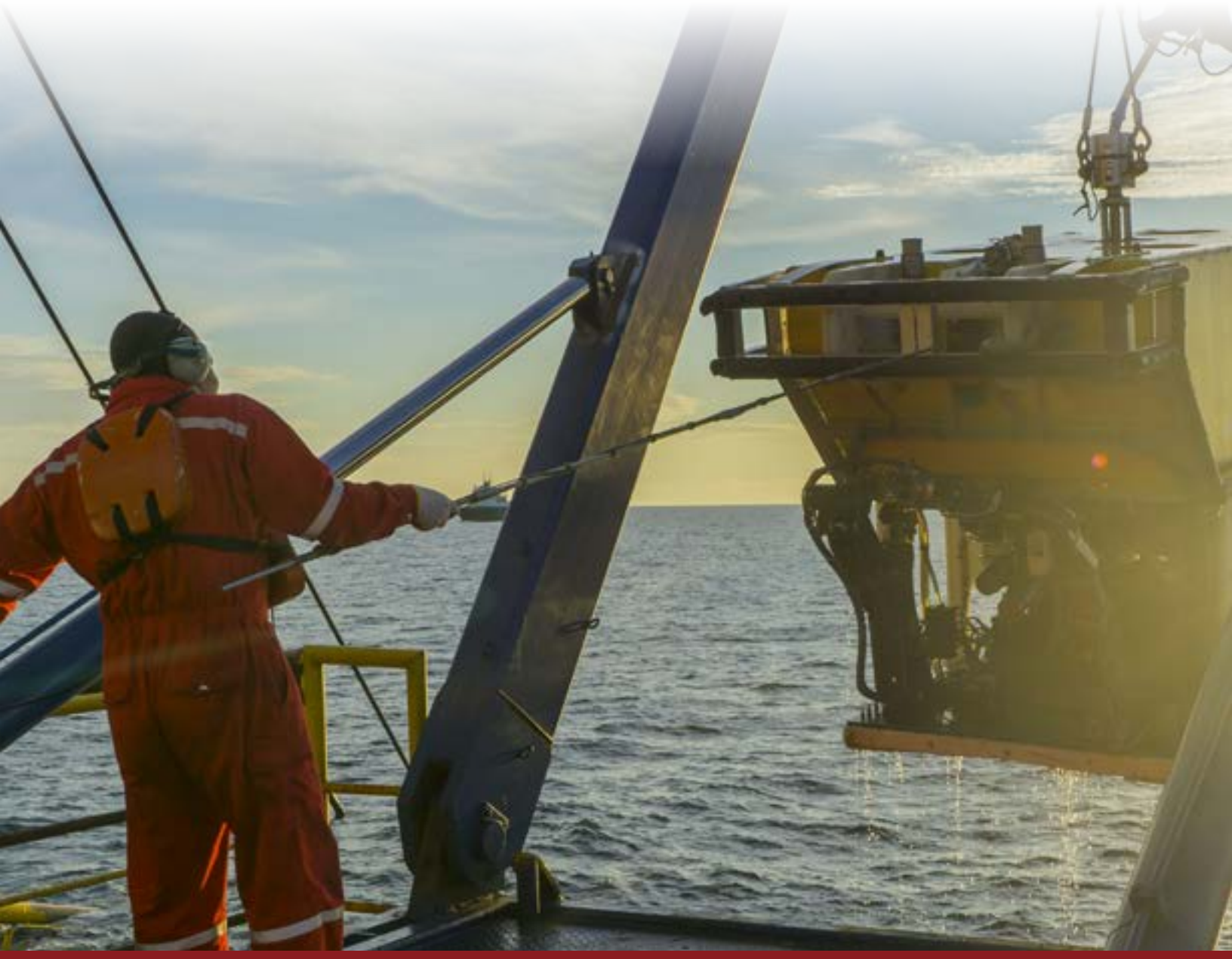
Human Performance and Risk Management at BP

We sat down with**Hugo Ashkar**, Global Risk Manager and **Diane Chadwick-Jones**, Director of Human Performance at **BP** to discuss how they are establishing a Human Performance framework at the global energy giant.



Truly understanding the connection between human performance and operational risk allows organisations operating in hazardous industries to better understand why errors occur and help them to manage and mitigate the severity of those errors. In addition to preventing incidents, the tools of Human Performance can be leveraged to drive continuous improvement, increase productivity, identify operational efficiencies and drastically improve business performance. BP – one of the worlds largest companies with close to 100,000 employees– is taking an innovative approach to driving operational excellence and risk management using the principles of human performance and operational risk management.

In the lead up to the **Operational Excellence in Oil & Gas Summit**, we sat down with BP's **Hugo Ashkar**, global Risk Manager and **Diane Chadwick-Jones,** Director of Human Performance. In this exclusive case study, we look at the work that BP is doing to create a Human Performance Framework within the organisation as well as how the company views the relationship between Human Performance and Operational Risk Management.

Hugo and Diane answer the questions: What do the current learnings of recent incidents tell us? How can we merge safety rules with industry practices for better alignment, and thus expand our learning base? What can we learn from our project risk management efforts?

In 2018, BP saw a reduction in the number of tier 1 and tier 2 process safety events.

Source: BP

What is Human Performance and Risk Management?

"Human performance is about understanding and improving how people interact with the plant, processes, and each other to create a safe state environment. In hazardous industries like oil and gas, it is unrealistic to believe we can be 100% safe. The best we can aspire is to work in what we call a 'safe state.' We need to understand incidents from an individual's perspective – which is the next step in the understanding of incidents. In previous years, investigating incidents meant asking who was involved and who was at fault. Now, our experts' believe we should shift our focus onto what happened and why. The end goal is to learn better because we are not learning from incidents – evidently – because they keep occurring. Now is the time to get better at this."

"Building better internal collaboration on enhancing safety management is to embed a deeper understanding of the modern view of incident causation in the leadership and then throughout the organisation. There is a popular belief that incidents are caused by human failure. However, when we ask why human failure occurred we often realise that there are organisational factors behind it. These two views have a big impact on how leaders react to incidents and how well organisations learn. The latter view is more likely to demonstrate care and lead to a speak-up culture. This type of organisational transformation means that capability development initiatives need to be employed such as engagement workshops and formal and informal training. This includes role-modelling from leaders, not assuming human error, and looking for any contributory underlying issues."

How did you personally get involved in Human Performance?

"In my role as Global Risk Manager, I saw it as the next step in the evolution of applied risk management principals in the oil and gas industry. It's a personal area of research that involves understanding a linkage between safety incidents and barrier weaknesses – barriers meaning risk management barriers. Our experts' research into a human performance deal with two of the three types of barriers we generally see; passive, active ad procedural barriers. Passive systems barriers do not require human intervention. Active and procedural barriers do require human intervention, so it is in those two barrier groups where further research is warranted. We hope to learn from these incidents and their relationship to weak barriers, so we can use risk management tools and principles to prevent future incidents."

"Looking at the concept of defect elimination is the source of it. Whilst I was in operations there were complicated issues that were quite hard to resolve. Moving into the safety department gave me another way to look at the complexity and underlying conditions that may have contributed to those issues. When I moved into looking at the behavioural side, I could see that in the same way we have operational issues with many interacting underlying factors, the behaviours of the workforce are influenced by many factors within the workplace environment. To give a generic example, a person may not follow a procedure correctly, not because they don't want to, but because a procedure may be unclear, or because the plan is not quite right for the job. It is this that I've been working on for the past few years – the behavioural and cultural side of safety. It starts with leadership setting the expectations and resources, and when it comes to procedures there can be two paths – to say 'follow the rules or there will be consequences'; or to say 'follow the rules and if for any reason you can't, speak up and we'll see how we can fix this.' When things don't go to plan, helping leaders to understand the problem without focusing too much on the individual is key. It's about looking deeper as to why things go wrong. Companies have analysed incident investigations or used the 'Just Culture' process to see what proportion of the time people intentionally disregard the rules, and typically it's very small. Usually, the system of the process has unidentified error traps in design that in real-life conditions could catch users out. People come to work to do their best, so we need to ask ourselves as leaders what we can do to improve the systems or processes to help prevent mistakes."

What are the first steps organisations should take to reduce operation risk?

"We can learn from human error by making 'learning' the focus of the investigation, rather than assigning blame. Organisations need to develop an approach specifically designed to understand the actions of humans in complex systems. The first thing I think organisations need to accept is that human error occurs because of something beyond negligence, like focusing on a task, but overlooking the potential hazards associated with said task. Another key element of understanding this is looking at how we, as leaders, react to these incidents. How we respond as leaders are important because it determines how well we're going to learn and prevent future incidents. When leaders choose to listen and learn, people tend to be much more open and it builds a foundation of trust. Our experts believe that when another incident occurs in the future, those involved will be much more comfortable in having a dialogue with their leaders, which helps everyone better learn from the incident. If we have leaders who work alongside their teams to solve problems, we create what is known within BP as a culture of care. We get to see the activity set from the worker's point of view, and we begin to understand what can truly go wrong and how to prevent it."

"When it comes to creating this sustainable culture a key lever is recognising people for strong safety leadership behaviours, because this helps to embed the understanding that safety is about the presence of safety inputs, like looking for risks and learning from near misses, and working to identify and eliminate-related weaknesses. We know that people are the solution, not the problem – it's just an illusion that people are the main cause of incidents. The last person to touch the equipment when something goes wrong is very often only the last component in a chain of weaknesses – so recognising people for speaking up and looking out for each other sets the expectations in the organisation that we want to know about those difficult-to-see risks, and resolve them."

What is BP doing to help improve Human Performance?

"At BP, our human performance experts have developed a framework around human performance and it includes the elements against which we will eventually measure ourselves and our performance. First, we must acknowledge that people will make mistakes. That's a fact. With that in mind, we must realize that people's actions are not inherently malicious. Those actions usually make sense to individuals leading up to and during the incident. With those acknowledgements in place, then we can evolve into understanding the underlying condition and systems that led to that incident, rather than assigning blame. The way we behave as leaders in BP helps shape the conditions that influence what people do and how they do it. The Human Performance Framework continues to evolve as our experts' reach into the fields of health & safety, and risk management for further clues. What do the current learnings of our incidents tell us? How can we merge safety rules with industry practices for better alignment, and thus expand our learning base? What can we learn from our project risk management efforts? These are the questions we strive to answer soon. Our work in this space continues."

"Over the years I've worked on various safety culture assessment and improvement programs and I've found that it only takes an organisation so far to look at the safety culture on a site-by-site basis. Companies need to have safety as a core value that is role-modelled by the senior leadership, communicating that it is possible to have an incident-free workplace and to make decisions through the lens of safety. What is seen in many studies across industries is that the places that have best implemented those kinds of values, or the way that leaders talk and the way that leaders prioritise safety, are the places with the highest workforce engagement? These places are not only some of the safest but the most productive also. A key first step in building better internal collaboration on enhancing safety management is to embed a deeper understanding of the modern view of incident causation in the leadership and then throughout the organisation. In terms of systems and processes, there are adjustments to be made to identify system vulnerabilities through updating common processes like incident investigation, 'Just Culture', self-verification, behavioural-based safety and assurance."

BP's approach to safety includes: preventing incidents, monitoring security and keeping people safe

Source: BP