A Meta-analysis of CAST Investigations of Accidents Related to Diverse Sociotechnical Systems (STSs)

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Outline

✓ Short Introduction to "my ideas"

Short Description of Accidents

Some Preliminary Thoughts and Ideas

A very crude and bold Assumption

New Sociotechnical Systems Old, well
established
Socio-technical
Systems

< 0.1 %

>99.9%

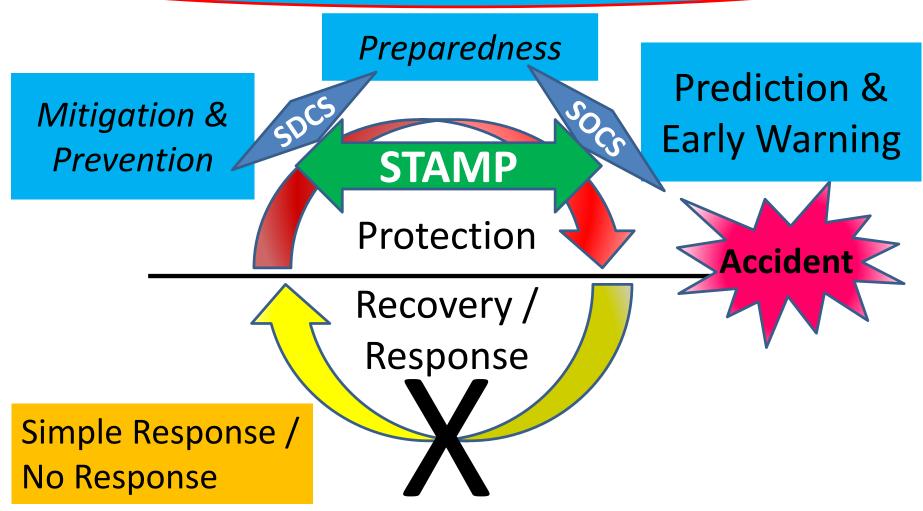
Accident

STPA needed, but...

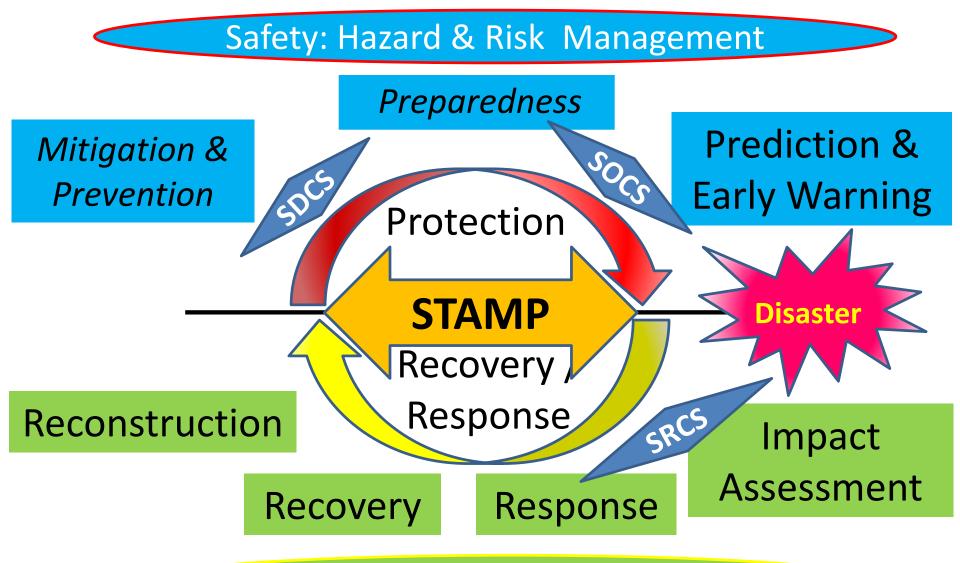
STAMP & STPA not wanted as long as...

Loss Event / Accident Lifecycle

Safety: Hazard & Risk Management



Disaster / Accident / Loss Event Lifecycle

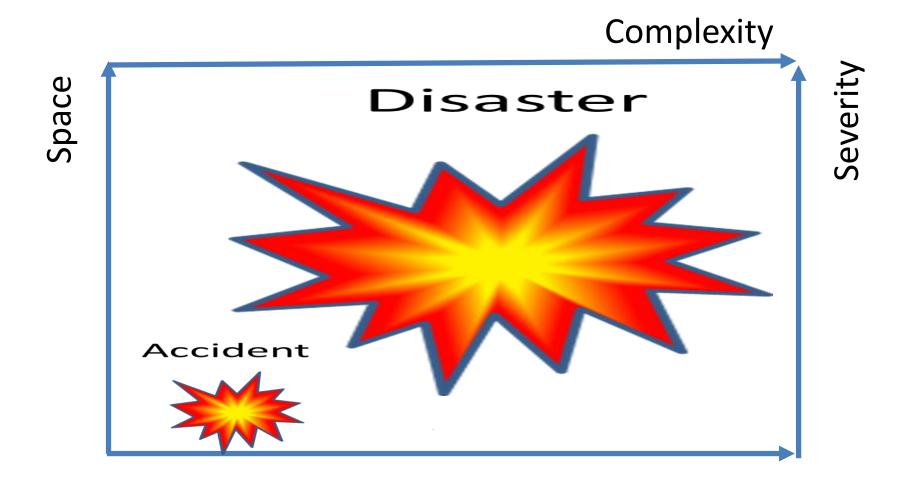


Crisis / Response Management

STAMP, Sociotechnical Systems Lifecycle Safety, Accidents & Disasters

End of System System Development Operation System Value Chain: From Cradle Grave to Operation Design Build Concept Requirements Disposal **Accidents**

A New view of Loss Events Classification



Time

Relationship between **Accidents and Disasters**

Accidents	Disasters
Time Limited	Time Limited - Unlimited
Space Limited	Space Limited - Unlimited
Complexity Limited	Complexity Limited - Unlimited
Severity Limited	Severity Limited - Unlimited
Simple Response	Complex Response

Another view of Accidents Classification

Tangible

Nontangible

"Known"
Accidents
Feedback loop

reedback loop
accomplished
AND
Known

"Hidden" Accidents

Feedback loop
Not
accomplished
OR
Not Known

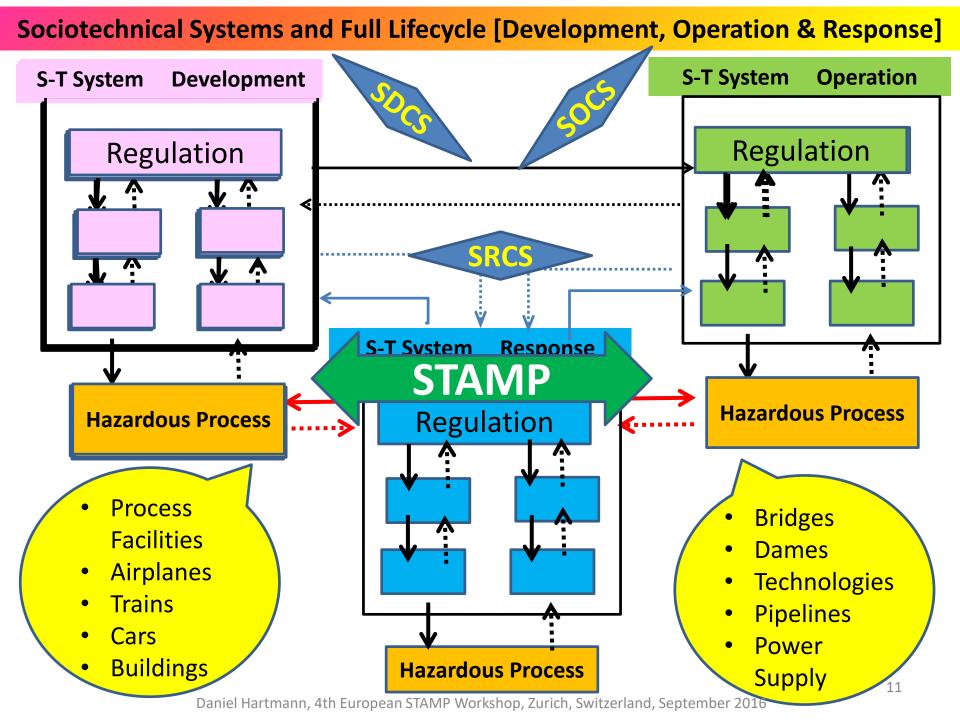
Fast Exposure

Slow Exposure

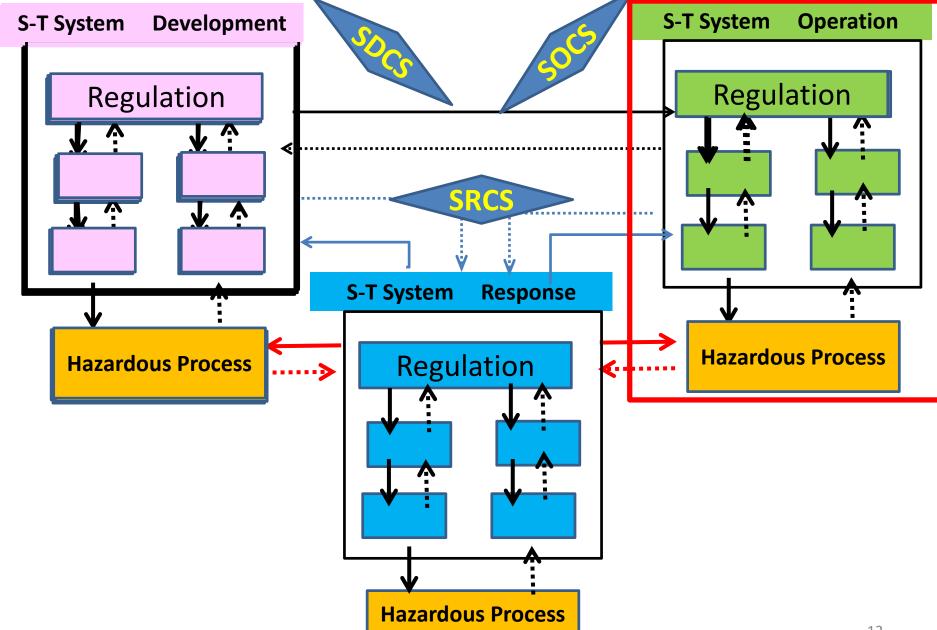
Systemic Event

Some Sociotechnical Domains with Hidden Accidents

- Justice System
 - Criminal Justice
- Health Systems
 - Health treatment
 - Drug treatment
- Nourishment System
 - Critical Food
 - Food
 - Water / Beverage
- Environmental System
- [bad] Decisions Making



Sociotechnical Systems and Full Lifecycle [Development, Operation & Response]



Stages in System Operation Control Structure (SOCS)

- System (new) Initiation (Stephanie)
- System Routine Operation
- System Non-Routine Operation (Kanarit)
- System Shutdown
- System Maintenance
- System Repairs
- System Startup (after Maintenance / Repairs)

Safety Lifecycle of Sociotechnical Systems [Development, Operation & Response]

S-T System Development	S-T System Operation	S-T System Response
Legislation	Legislation	Legislation
Regulation	Regulation	Regulation
Corporate Management	Corporate Management	Complex "Corporate" Management
Company Management	Company Management	Complex "Company" Management
Project Management	Project Management	Project Management
Manufacturing Management	Operation Management	Operation Management
Manufacturing: Hazardous Processes	Operating Process: Hazardous Processes	Operating Process: Hazardous Processes

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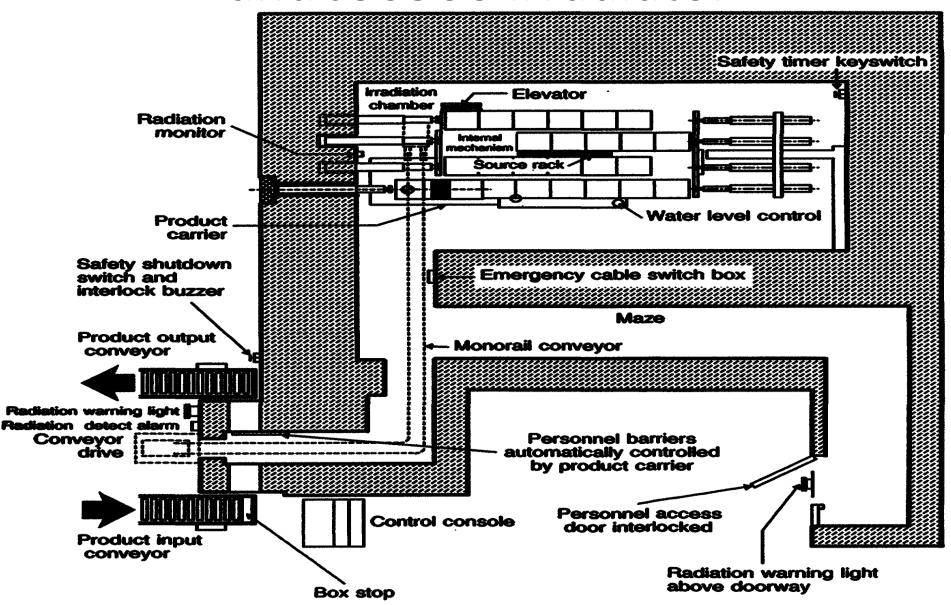
The Radiological Accident in Soreq

An Accident in a System Operation Control Structure (SOCS) - System Routine Operation

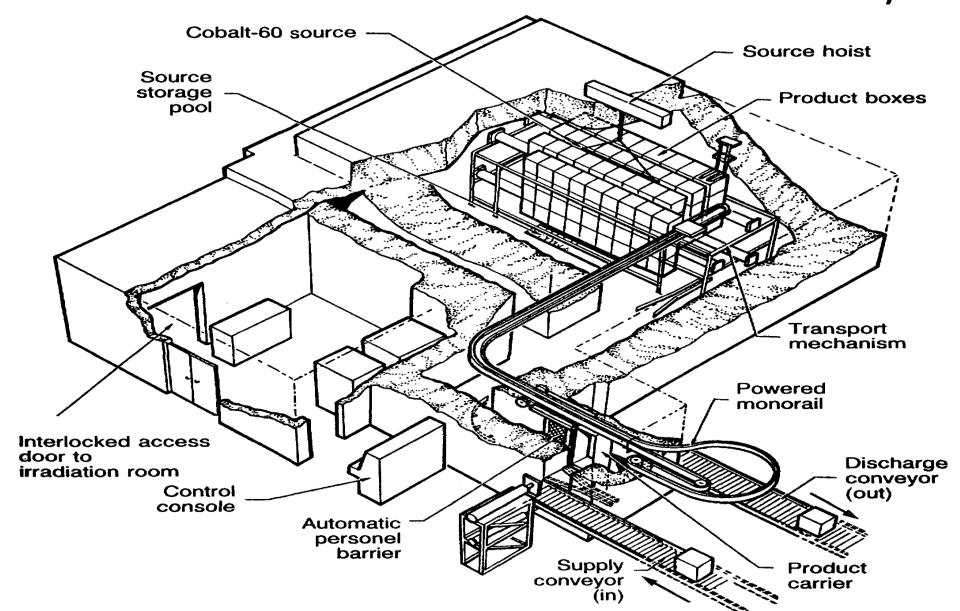


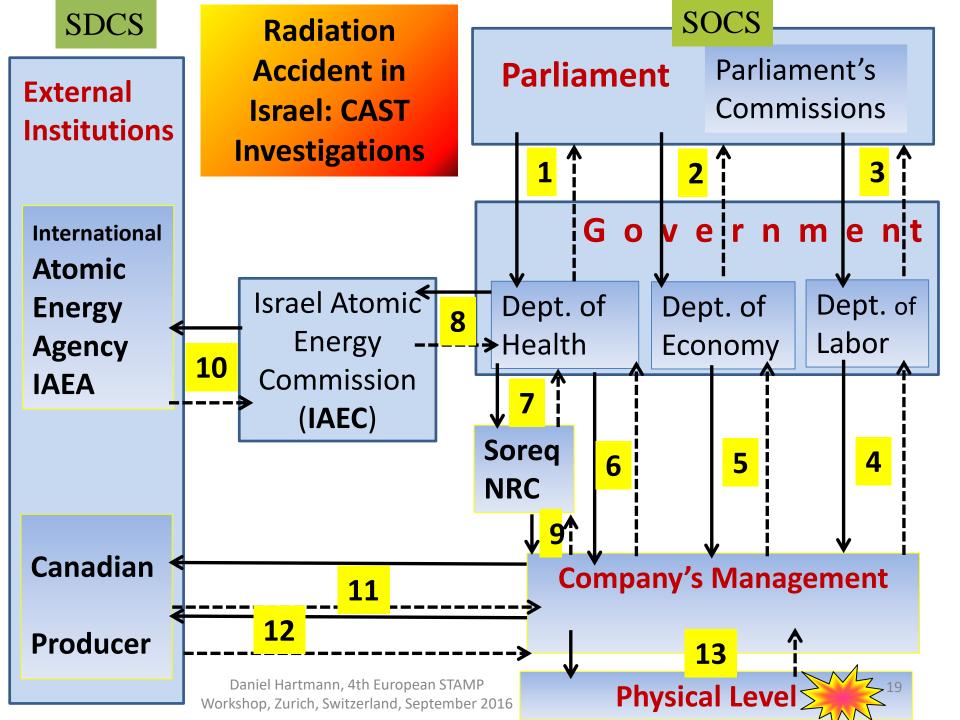


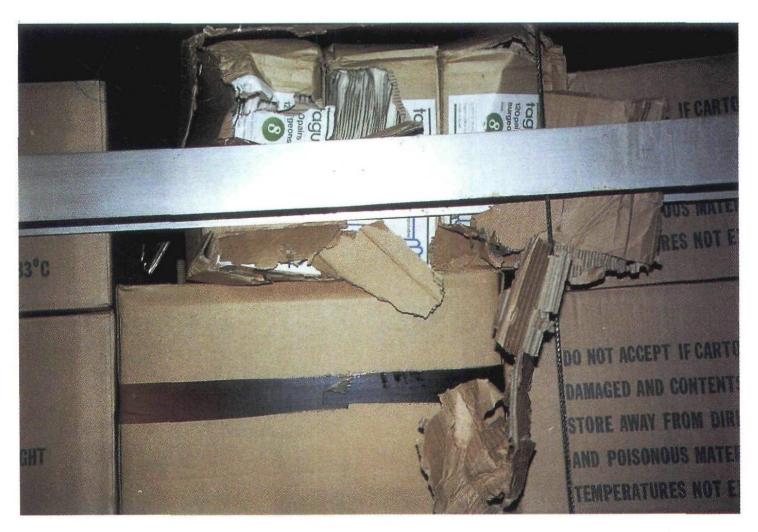
A floor plan of the irradiation facility and JS6500 irradiator



A cutaway three dimensional diagram of the JS6500 irradiator and the irradiation facility







3. The carton on the inner lower conveyor that obstructed the source rack. Also shown are the steel guide bar and the source hoist cable.

Radiation Accident in Israel: Official & CAST Investigations Results

S-T System Levels	Loop Number	Official Results	CAST Results
State – Regulation	1, 2, 3	0	3
State – Professional Regulation	4, 5, 6, 7, 8, 9	3	6
External Institutions	10, 11, 12	0	5
Management & Operation	13	2	3
Physical Level		2	4
Total Re	sults	7	21
Total i	n %	100%	300%

Accident's Dimensions

• <u>Time</u>:

- Proximal Event: Seconds Minutes
- t Δ between Design and Accident: > 20 years
- Space: few square meters
- Severity
 - Tangible & Direct: One fatality
 - Intangible & Indirect: N/A
- Complexity
 - Internal (PE): very Simple
 - External (SOCS): very Simple
- Response: very Simple

An Accident in a System Operation Control Structure Within the SOCS stage: System Startup (after Maintenance / Repairs)



View of D/E/F NHT Heat Exchanger Bank Before Accident (CSB Animation)



Catastrophic Rupture of Heat Exchanger (Seven Fatalities)

Tesoro Anacortes Refinery

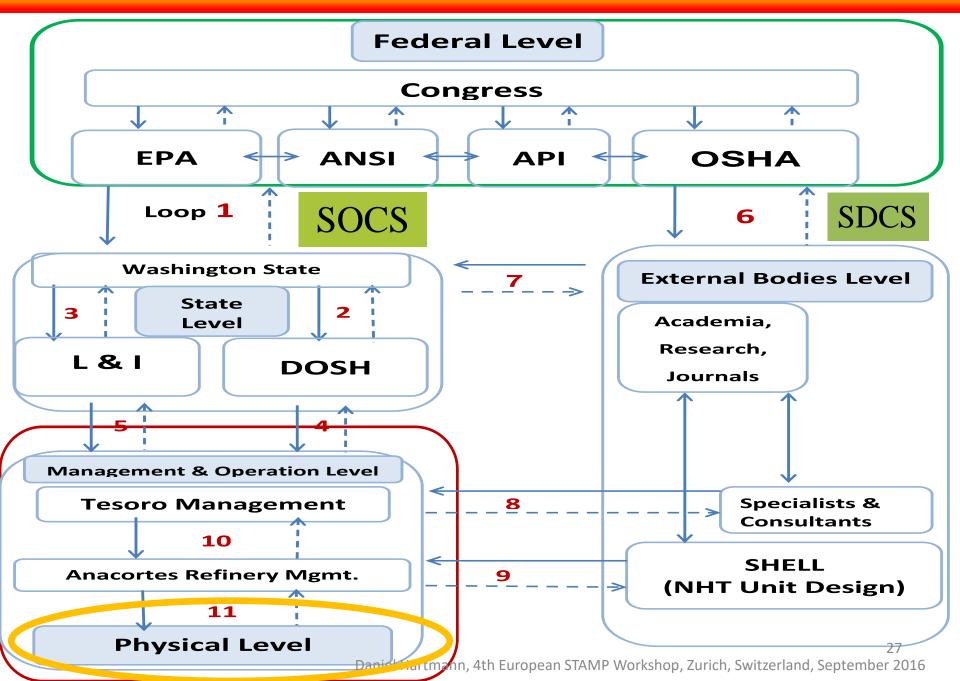
Anacortes, Washington (State), April 2, 2010



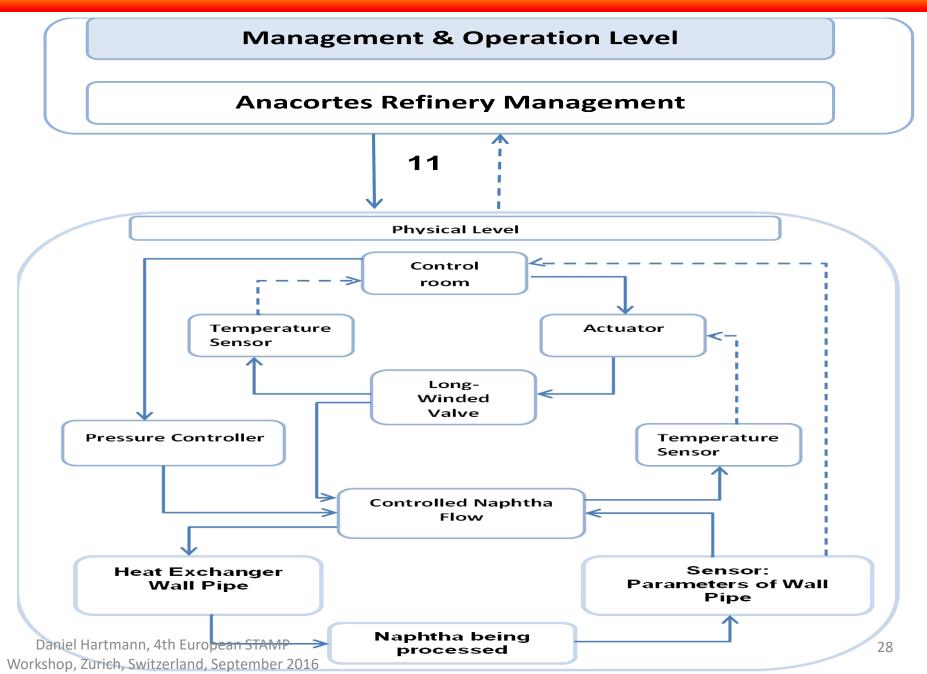
Post-Incident View of D/E/F NHT Heat Exchanger Bank



Sociotechnical Hierarchical control Structure - Anacortes Accident



Sociotechnical Hierarchical control Structure – Anacortes Accident



Anacortes Accident: CSB & CAST Investigations Results

S-T System Levels	Loop Number	CSB Results	CAST Results
Federal – Regulation	1	6	8
State – Regulation	2, 3, 4, 5	5	8
External Institutions	6, 7	0	1
External Experts	8, 9	2	5
Management & Operation	10, 11	10	14
Physical Level		9	14
Total Re	sults	32	50
Total i	n %	100%	156% 29

Daniel Hartmann, 4th European STAMP Workshop, Zurich, Switzerland, September 2016

Accident's Dimensions

• <u>Time</u>:

- Proximal Event: Seconds Minutes
- t Δ between Design and Accident: ~ 40 years
- Space: few hundred square meters
- Severity
 - Tangible & Direct: Seven fatalities
 - Intangible & Indirect: mainly financial

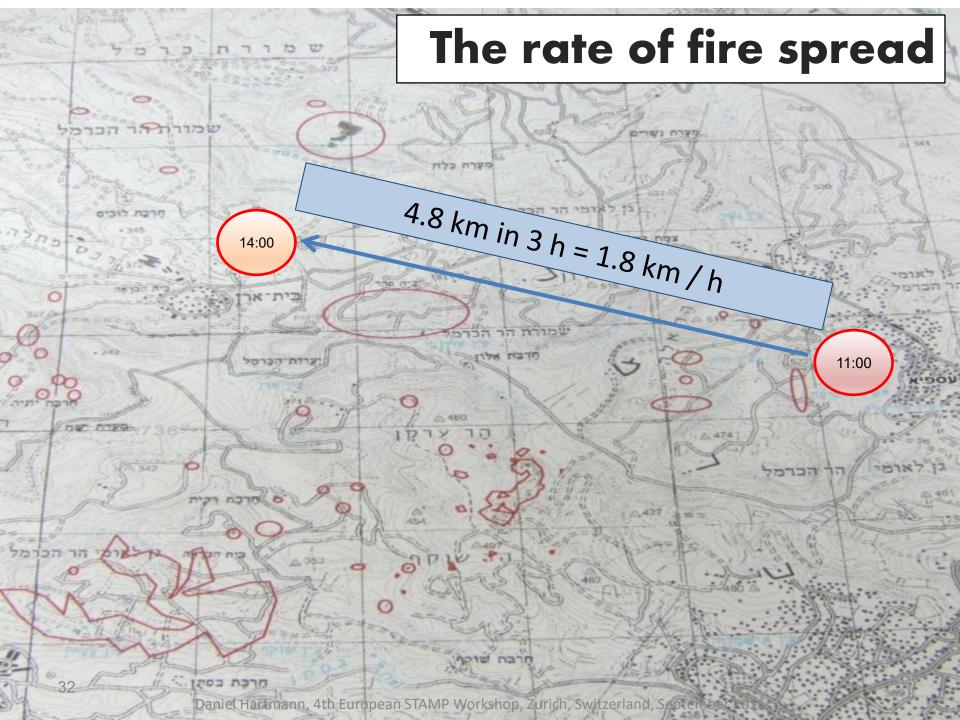
Complexity

- Internal (PE): very Simple
- External (SOCS): Simple
- Response: Simple

The Carmel Forest Fire Disaster (CFFD), Israel (2010)

An Accident in a System Response Control Structure (SRCS)





Carmel Mountains – Road 721





The Carmel Forest Fire Disaster (CFFD), Israel (2010)

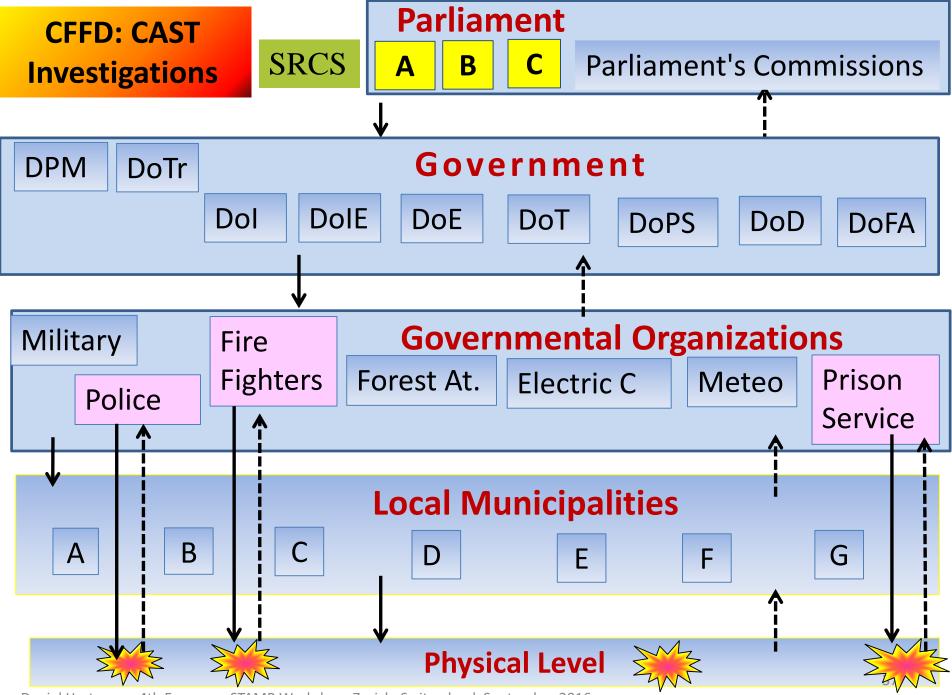
Daniel Hartmann, 4th European STAMP Workshop, Zurich, Switzerland, September 2016



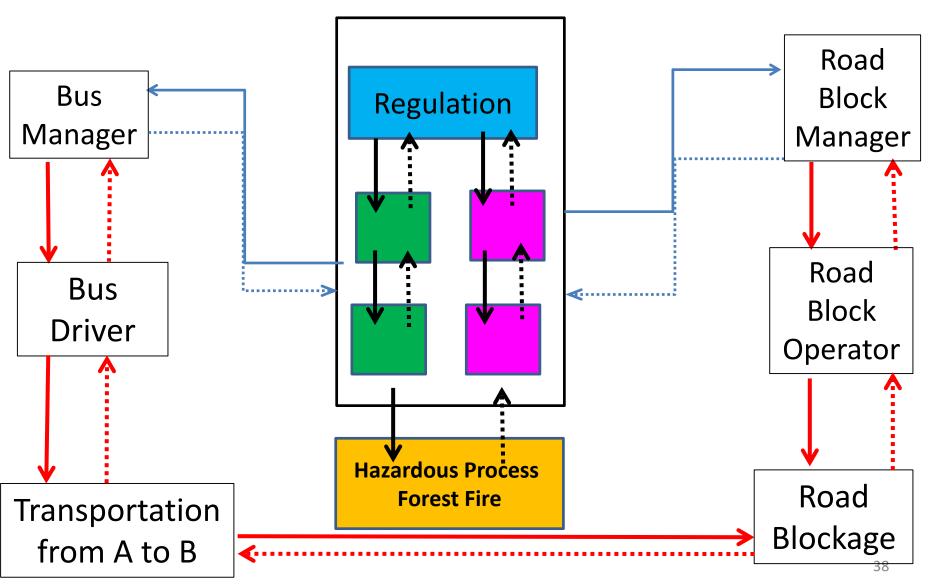
The Carmel Forest Fire Disaster (CFFD), Israel (2010)

Mount Carmel [Israel] forest fire (2010): a very expensive lesson in risk management and safety





CFFD partial S-T System Response Control Structure



CFFD Accident's Dimensions

• <u>Time</u>:

- Proximal Event: many hours few days
- t Δ between Design and Accident: ~ 50 years
- Space: many dozens square kilometers
- Severity
 - Tangible & Direct: forty four fatalities
 - Intangible & Indirect: immense

Complexity

- Internal (PE): very Complex
- External (SRCS): very Complex
- <u>Response</u>: very Complex

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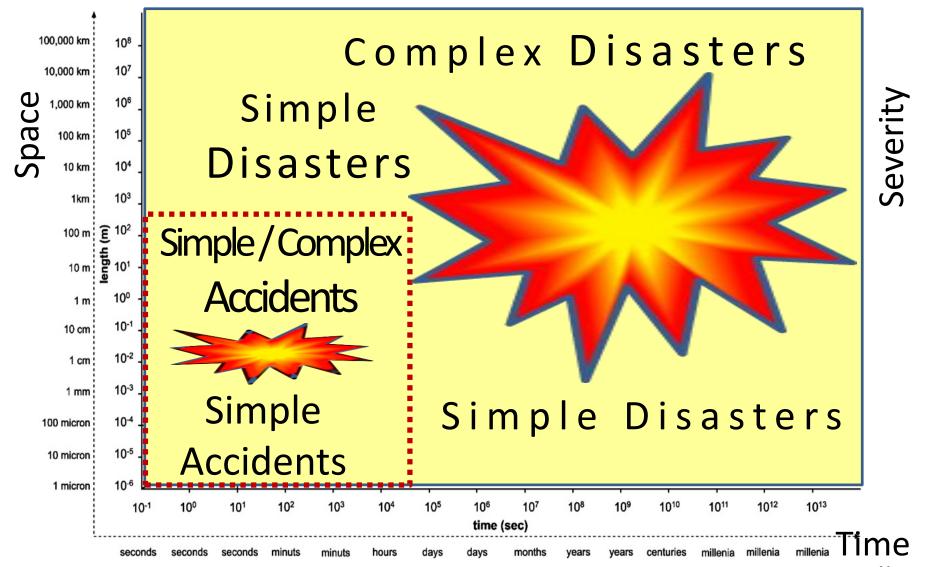
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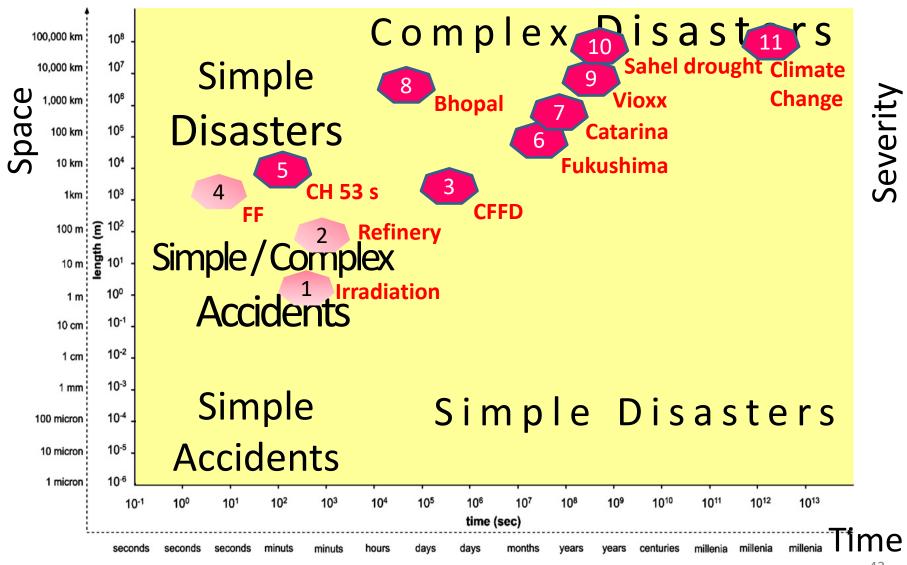
Classification of Loss Events [Accidents and Disasters]

Complexity



Mapping of Loss Events [Accidents and Disasters]

Complexity



Some Preliminary Conclusions

- The key parameters building STAMP, CAST & STPA should be defined in a more precise scientific way.
- To avoid "spaghetti problems", one should be strict with the division between SDCS, SOCS, SRCS and their sub-divisions.
- Large scale and numerous CAST analysis are needed to understand the variability and the patterns of loss events in various STSs.
- For most existing STSs, CAST analysis has to be the precursor for any STPA analysis.



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