

Striking the Balance

Getting Value Out of Bowtie Diagrams

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ProSafe
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R4Risk

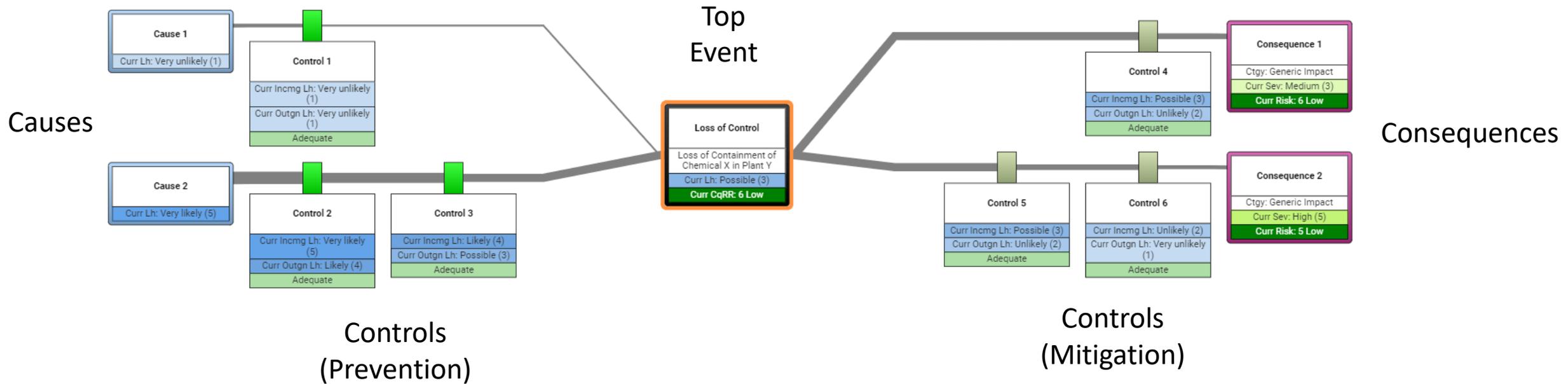
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1. What are we trying to achieve?
2. What is a bowtie diagram?
3. What makes a good bowtie?
4. What are some common problems?
5. Conclusions

- Manage our risk issues
 - Major hazard safety
 - Material risks etc.
- Achieve this by identifying:
 - Hazards
 - Causes and outcomes
 - Controls
 - Relationship between the controls and causes / outcomes



- Simple, clear and easy to understand
- Can be used to analyse a wide range of scenarios
- Clear linkages between controls and the causes / consequences
- Good communication tool

- Clarity
- Simplicity (or at least, not undue complexity)

- Top Events that are not significant
- Trivial or vague causes
- Poor control selection

- Exclude causes that cannot result in the Top Event
- Ensure that causes are excluded on consequence and not likelihood

Tube Corrosion
Rejected
Rejected - Under normal conditions it is unlikely that the pitting corrosion mechanism would sufficiently weaken the tube to result in a rupture.

Tube Corrosion
Rejected
A pinhole leak would result rather than a tube rupture in the Absorber (A-001). A pinhole leak is not of a sufficient magnitude to result in an MI. Therefore, this scenario has been rejected as a cause of an MI.

- Avoid vague cause descriptions
- Ensure that the cause description is clear and direct

All credible causes (non specific)

Curr Lh: Likely (4)

Causes include leaks, corrosion, etc. Assume leak/spray from flange or valve packing, open valve, sample point, etc. Expected to be a 1 in 2 year event.

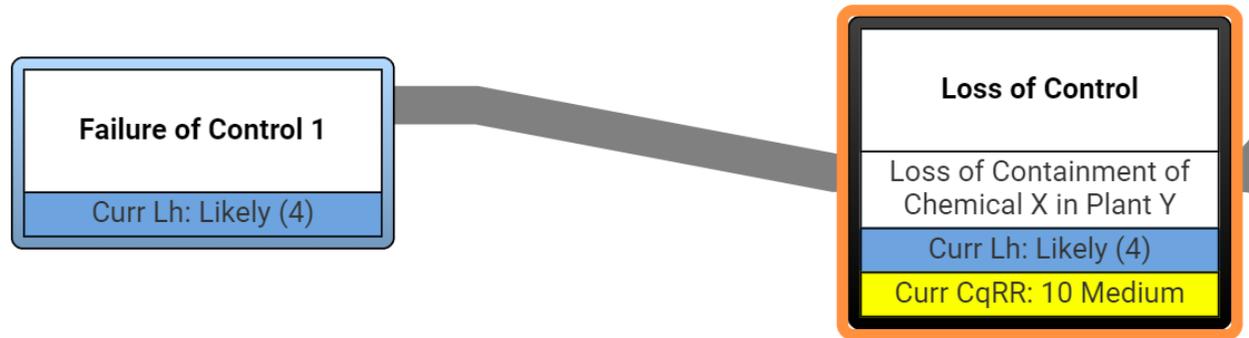
Tank (T-101) overflow due to inlet valve (V001) passing

Curr Lh: Very unlikely (1)

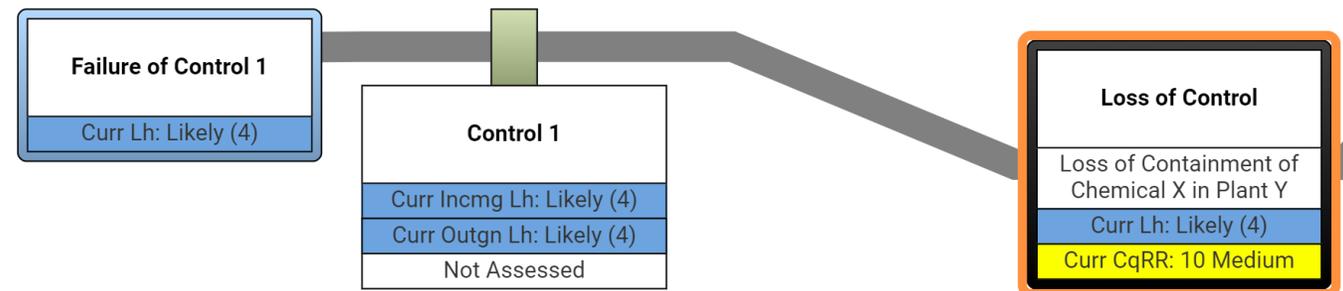
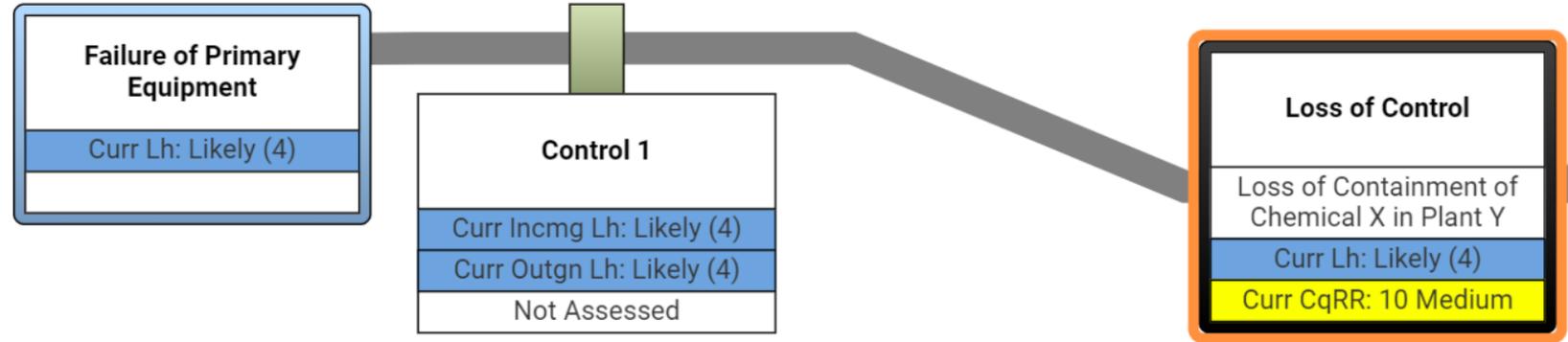
This cause refers to the inlet valve (V001) on Tank (T-101) passing and leading to overflow of Chemical X from the tank's overflow pipe. The overflow of Tank (T-101) is contained within a bunded area.

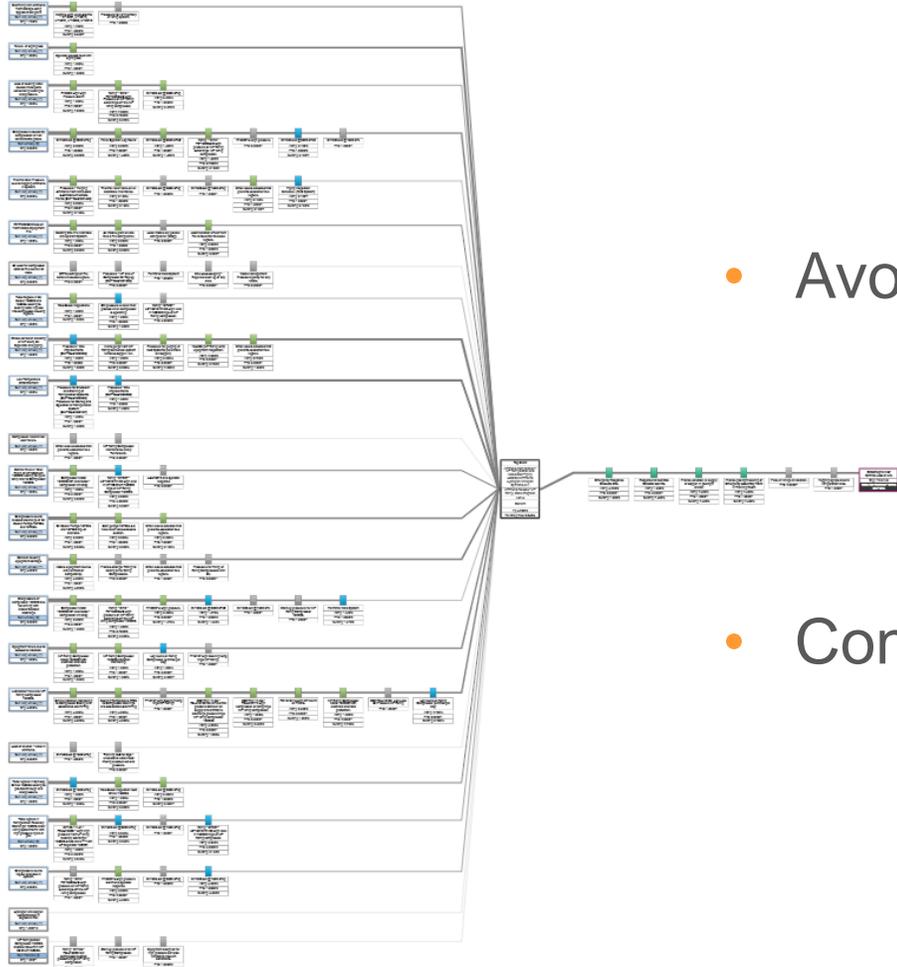
The likelihood of the valve passing is based on industry failure data of 1/10 years. An additional factor of 1/10 is applied for an operator to be in the bund during the event. Therefore, the likelihood of an MI occurring is 1/100 years.

- Avoid defining a cause as the “failure of a control”



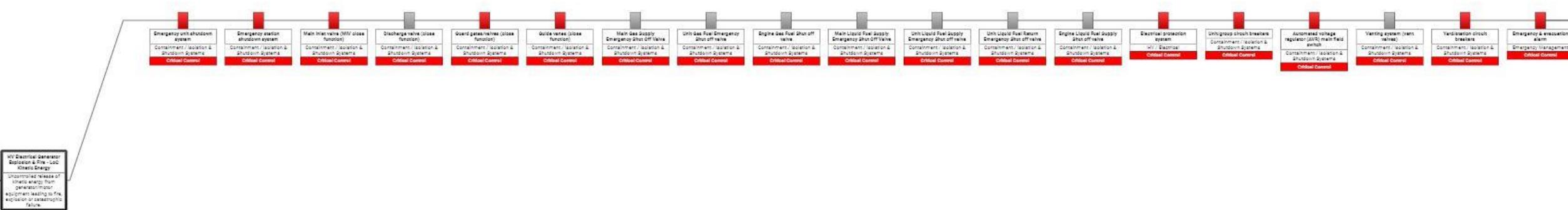
- Redefine the cause
- May often relate to the failure of primary equipment
- If unavoidable, include the control as a barrier (without risk reduction credit)





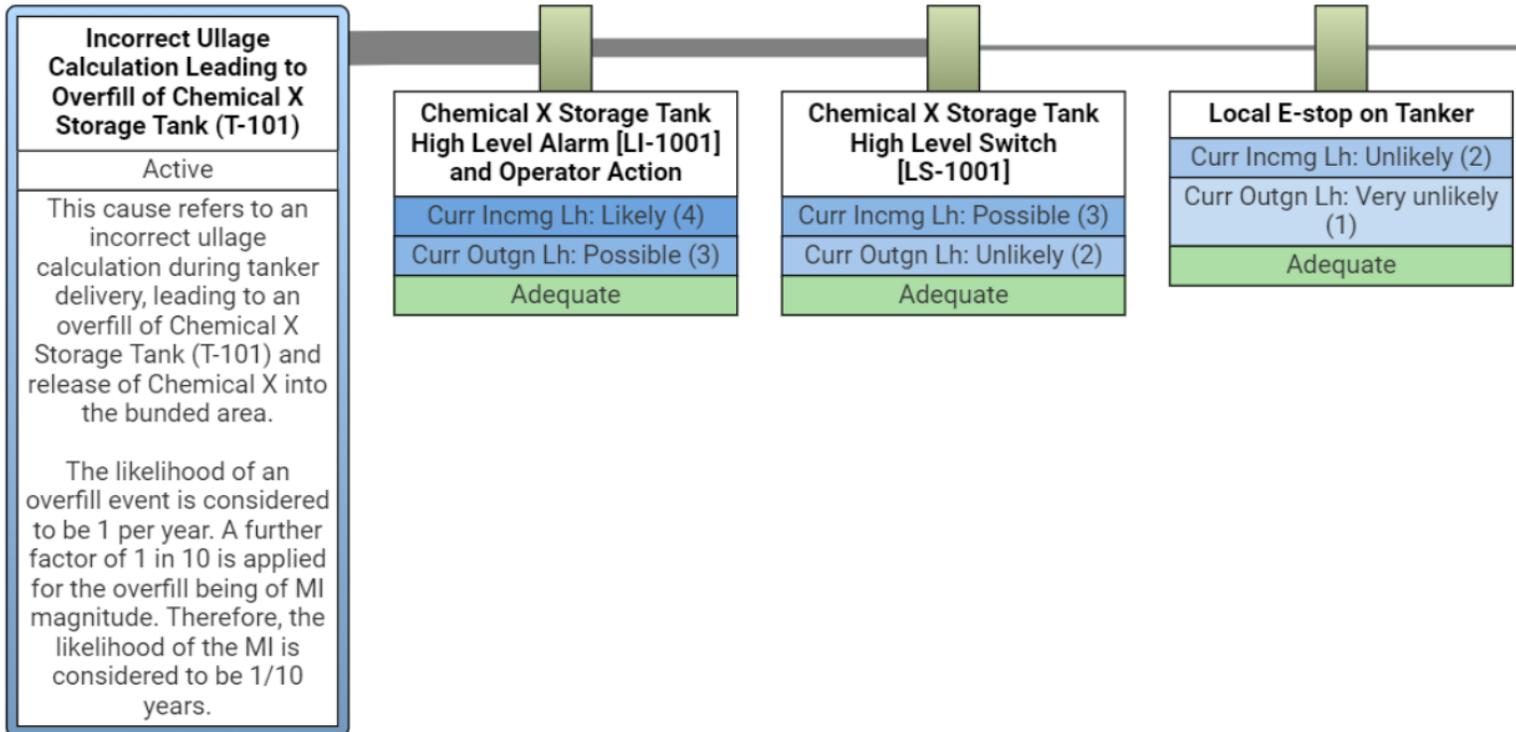
- Avoidance of excessively large number of causes
- Consider using a “General” or “Site-wide” bowtie

- More controls is not better
- Limit things to “real” controls

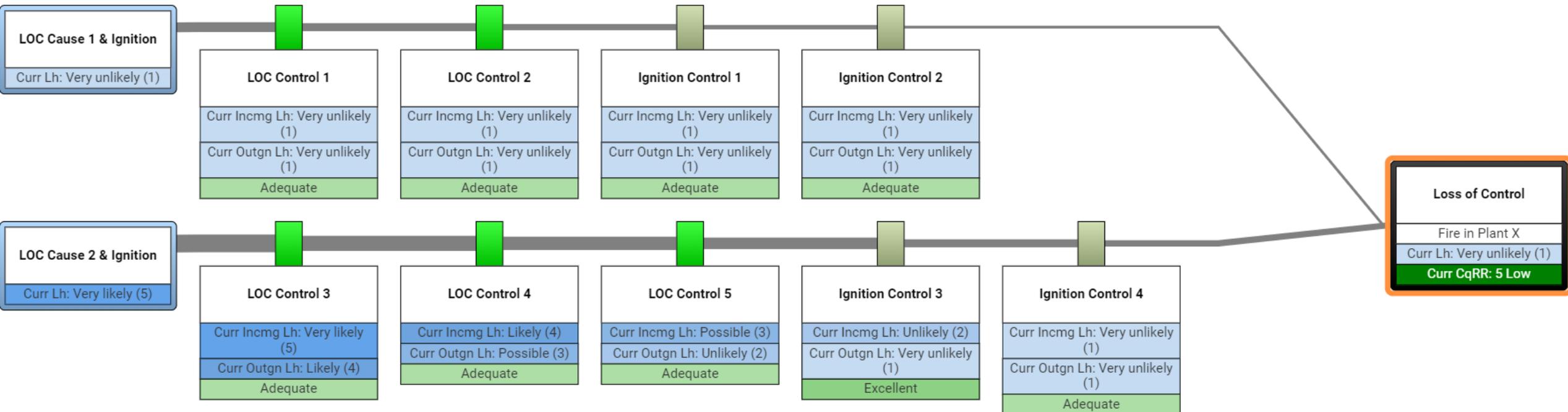


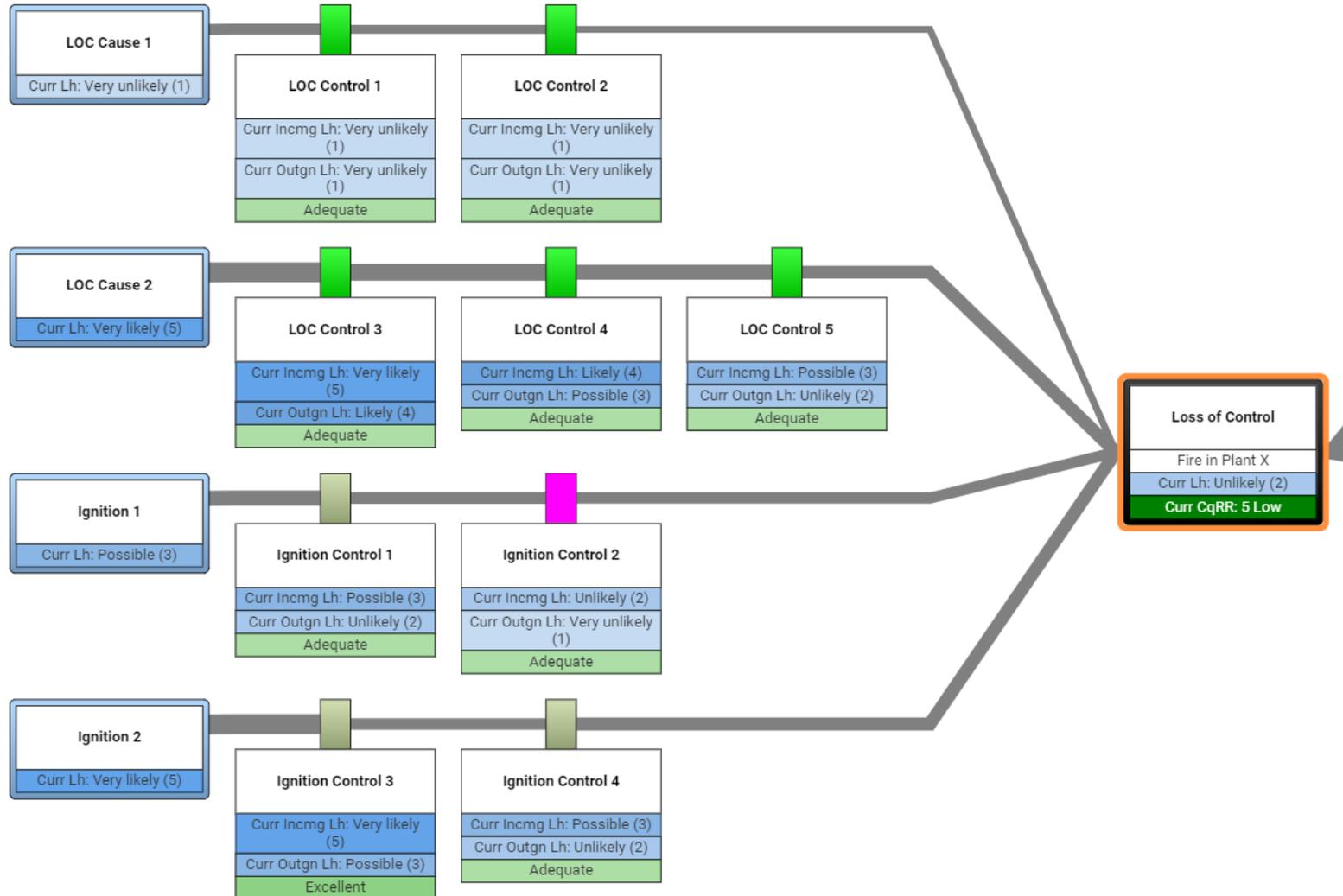
- **Implemented** The control must be fully implemented, i.e. the control must be in place.
- **Effective** The control must be effective – if the control functions as intended, it should prevent the Top Event or significantly mitigate its consequences.
- **Reliability** The control should be sufficiently reliable, i.e. it should have a low probability of failure on demand.
- **Auditable** It should be practical to audit the control so that its performance may be established.
- **Monitored** Systems should be in place to monitor the performance of the control, to ensure that it remains functional.

- Be specific!
- Linkages to the cause / outcome



- Definition of the Top Event as an outcome





- Some tools used will have limitations, some will be powerful

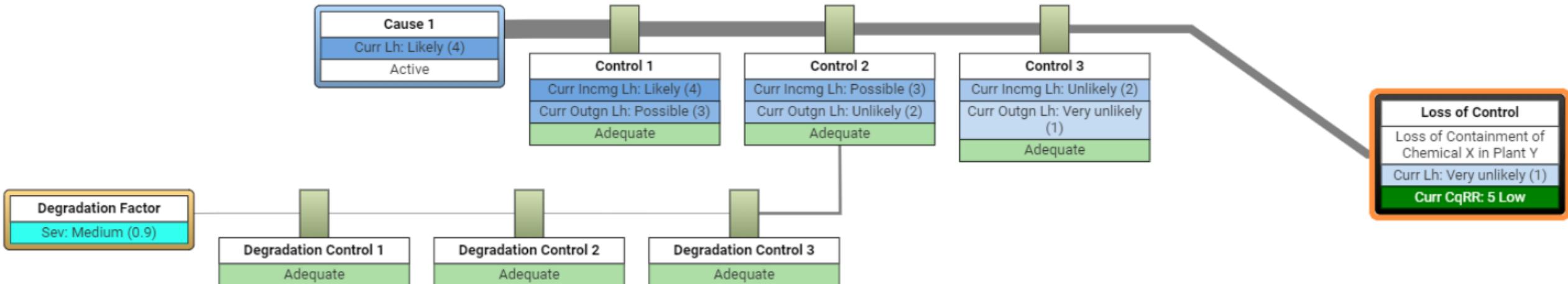
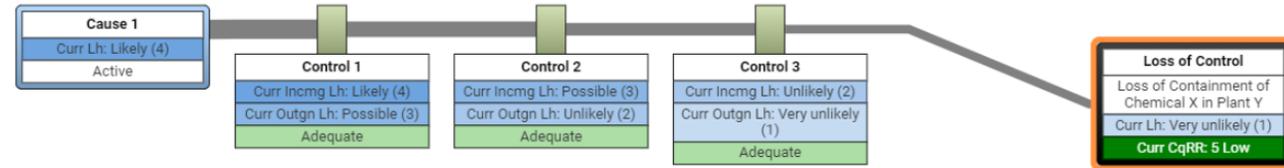
“All modelling is wrong, it’s just that some modelling is useful”

- A bowtie may not be able to precisely represent every hazard
- OR
- A perfect representation of a hazard may result in an overly complex bowtie

- Powerful bowtie software tools are available

- Able to undertake complex analysis

- Just because you can, doesn't mean you should*



- Develop a clearly defined ruleset
- Use it to test the suitability of causes, controls etc.
- Should cover:
 - Study Boundaries
 - Minimum impact threshold
 - Controls
 - Control criteria
 - Control adequacy (quantitative / semi-quantitative analysis)
 - Risk assessment
 - Methodology
 - Tolerability criteria

Rule #1 – Keep your eye on the prize!

- Keep things as simple as practical
- Add complexity only where it adds value
- Be specific in descriptions
- Ensure linkages are clear
- Everything must have a purpose