

CRM Inspection Issues A Federal Perspective

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What is Covered in this Presentation – Federal Perspective

- State and Intrastate Facilities
- Objectives of the Federal Rule
- Federal Resources
- General Overview of Inspections
- Detailed Summary of Inspections from 2011/2012/2013 and CRM Pilot Exit Interviews 2011
 - Federal and State
 - Gas and Liquid
 - Distribution and Transmission



Reminder

• States can and may have adopted more stringent requirements than the existing federal regulations,

» As a result

- If you have intrastate facilities, gathering only within the state, or storage facilities that are not connected to interstate facilities, please make sure that you have knowledge of these requirements.
 - State requirements will not be presented or discussed in this presentation



Objectives of the Rule

- Create an environment to help assure controllers will be successful in maintaining pipeline safety and integrity
 - Assure pipeline operators are addressing fatigue risks in the control room
- Verify that procedures, systems and equipment are well thought out, and function as designed.



PHMSA CRM WEBSITE http://primis.phmsa.dot.gov/crm/

- Lots of Information
- Reference Materials
- Background Documents and PPTs
- Frequently Asked Questions
 - Several FAQs Currently in Development
- Inspection Guidance
 - Version Number 3, Date is 3/1/2012
- Accident/Incident Question Assistance









^{4/1/2013}





General Information

- Each inspection is based on a Control Room, not operator ID, or inspection unit
- Some paper-based inspections still happening
- More electronic use during II Inspections in 2013
- 10-25% of a Region's Inspections in 2013
- Typical duration: 3.5 days to 2 weeks
- Controller Interviews Can Be Part of the Process



General Information

•Can be a significant commitment of resources with many functions present depending on how the control room is organized

- -Gas and Liquid
- -Transmission and Distribution
- -Laterals
- -Field Locations also



General Information

•Don't Wing It:

- Have people there that know the control room & those that perform support functions
 - Provide SCADA or IT programming support
 - ✓ Training
 - Controllers that really know
 - ✓ Supervisors that are relevant
 - ✓ Those responsible for hours of service
 - Those who wrote and use the plans:
 CRM, Alarm management, MOC, Fatigue, etc.



General Observations

Procedures and connections not fully developed

- Emergency Procedure Crosslink
- •O&M Procedure Crosslink
 - -Abnormal, Normal, Specific
 - -Enhanced Level of Detail
 - -More than Generic Company Wide Procedures



General Observations

- Procedures and connections not fully developed (continued)
 - OQ Ties
 - Forms to Procedure Connections
 - •Control of Approved Versions of Plan and Procedures
 - •Try to eliminate terms in procedures with vague or conditional meaning

-Examples: "understanding"; "competency";

"communication guidance"

Procedures not available to the Controllers



General Observations

•Training

- •Field
- •Controller
- •OQ Ties
 - -Task Specific AOC
 - -Generic AOC
- Table Tops or Simulations
- Cross Training Complications Consistency
- •Who Reviews Effectiveness
- •How will effectiveness be measured so training can be done associated with these measures



General Observations

•Make sure:

- -Define who would have final authority for certain aspects of the Control Room Management plan
- -Some operators had not specifically identified in the roles and responsibility documents if the controller could shut down the pipeline
- Remember the supervisor functions
 - Emergency?
 - •Shutdown?



General Observations

 Records need to be available for investigators to review to substantiate that the rule requirements have been met and procedures have been followed

-In some cases, 3 years may not be sufficient

-Check other record requirements with internal procedures to the operator as well.

•When writing procedures, annual or yearly is not the same as "calendar year not to exceed 15 months". These are not synonymous.



General Observations

•Emails may not be adequate documentation as this may not confirm implementation

•Owners and operators are covered by the regulations

•Controller should have access to the applicable pressure limits, including the MOP or MAOP and any reduced operations pressure restrictions



General Observations

 Setpoint limitations should be set at any reduced operating pressure value so that confusion is prevented on behalf of the controller

-If not, some notification should be provided to the controller when setpoints were implemented above the current reduced operating pressure restrictions

-Remember special permit restrictions is applicable





IT I



Section A – General Applicability Where are your Control Rooms?

- Many operators have not done a detailed review
- Procedures should exist to determine where a control room is located.
 - Should match other sources
 - O&M
 - Mapping for example
 - Facilities manuals
- All regulated assets should be addressed by detailed review



Section A – General Applicability

Where are your Control Rooms?

- •Are you seeking out control room locations or assuming you know where they are?
 - -Laterals
 - -Storage Fields
 - -Gathering
 - -Field Locations
 - -LNG that operate pipelines
 - -Offshore



Section A – General Applicability

If you are gas operator, are you assuming Fatigue only?

- Based on what detailed review?
- Information available to support Fatigue only?
- •What about Compliance and Deviations also?

Substantiation is required and State Partners are the decisive regulatory agency in various cases



Section A – General Applicability

 Operators will be asked to fill out the asset form in Section A

-Should know which console or control room cover what Op ID

Procedures should address how new assets will be reviewed



Section B – Roles and Responsibilities



•Operators were not reviewing the O&M and Emergency Procedure requirements when developing controller Roles and Responsibilities

-Abnormal Operations

versus

-Abnormal Operating Conditions

 Information about what positions equipment fails in (power off) had not been provided to controllers

•Procedures did not address how alarms are handled when there is a need to step away or sudden illness



- Clarify if a Controller can shut down the pipeline
- If duplicative consoles exist- procedures did not define who does what, where, when
- Does one Controller remain in the Control Room at all times if high traffic areas?
 - -Only qualified individuals assume control per console and how this was achieved was not identified
 - -Whether or not Supervisors were qualified was not clear
 - If not, cannot perform certain tasks
 - Periodically on the console for back-up

•Procedures did not define if a Controller can leave console before completing and observing result of command actions?

-Remember during Normal as well as Emergency

• Different authority and responsibility on various systems existed but not defined

•Authority and responsibility to change certain alarm setpoints was unclear

•Responsibility was not addressed when other Companies or parties require interaction

-Such as valve closures at a delivery by other operating company personnel



Shift Change

-Controller should not be responsible for finding replacement

-Controller outgoing specific requirement to turn over to someone that is fit for duty

• If controller coming in for shift exchange is not fit for duty, procedures did not address actions to be taken

-Controllers did not Log out and Log in so control is established in timely fashion and responsibility clearly established in documentation



- Shift Change did not:
 - -Identify who is responsible when
 - Date and time
 - Names regarding exchange
 - -Remember trainees
 - -Forms were not adjusted per console
 - •Unique per console in most cases
 - -Consider Cross-Training implications



Section B – Roles and Responsibilities

- Training on shift change form did not occur (explaining what goes where)
 - Example: Pig run listed under notes, maintenance, or ongoing activities, etc.



Section B – Roles and Responsibilities •Shift Change

-Going out and coming back in not documented

-Short breaks not defined

-Process did not define what should be covered

•Example: DRA concerns?

–Leak Detection Alarms were not addressed even if cleared on previous shift

-Field activities that could impact controller such as stopples were not considered

• Emergencies

-Procedures did not clarify what controllers do versus field personnel

-Communications between controllers and field personnel issuing commands was not documented

- Good idea to test during drills
- -Controllers should not be the last notified
- –Who invokes disaster recovery moves not defined
- -To back-up or other location, When to return

- Emergency Procedures
 - -Confirm that controllers roles and responsibilities include expectations and requirements for emergencies (who calls local responders?)
 - -In one example, procedures required texting supervisors but roles and responsibilities did not include provision
- Responsibilities should cover expectations during loss of communication, SCADA failure, transferring to manual operational control and return to normal



- Manual operations
 - -May need to include manual data collection of operational data
- •Responsibility was not specifically identified and allocated that controller is to keep operating pressures below MAOP, MOP or other pressure restrictions
- •Did not allow only qualified controllers to log into the console


Section B – Roles and Responsibilities

- •When multiple roles existed in the control room, frequently roles and responsibilities were not clear.
- Did not identify role of 911 notifications versus local emergency responders and that of the controller



Section C – Adequate Information

Section C – Adequate Information

- Safety Related Point List
 - -Process to determine
 - -All point list versus safety related point list
 - -Defined as those that can affect pipeline integrity
 - -Can be more than the FAQ
 - -All safety related points are not required to have alarms



Section C – Adequate Information

Point to Point

-Did not define what added, moved, and other changes affecting pipeline safety means by procedure and types of activities

-Procedures for Point to Point not being followed



Section C – Adequate Information

 Procedures require point-to-point verification through entire loop

-Timing in FAQ

-Calibrations for liquid including range/scale, display range, engineering units, alarm settings, final value

•As found, as left documentation

-Like-kind replacement



Section C – Adequate Information

•Communications plan has specifics about who is the decision maker to transfer to (and from) back-up location

Please note: If an operator assumes one hour of communication loss before manning is required, how is this substantiated

•Test and verify adequate means for manual operation plan

 Re-routing data communications to backup SCADA server while still running from primary control center is not considered an adequate test of back-up communications

Section C – Adequate Information

- Test specifics should include:
 - Procedures that define a process which tests performance
 - Documentation that describes the actual test and performance experienced
 - Documentation that identifies any needed corrections and implementation.
- Identify which locations are manned



Section C – Adequate Information

•Test back-up once each calendar year not to exceed 15 months.

 If an operator has a requirement in a contract with the OEM/Vendor that the equipment received is required to comply with API 1165, the operator is to assure compliance

•An internal process/procedure by which this aspect of the specification is confirmed

Compliance is validated

•If you as an operator have reviewed existing displays against API 1165, take credit for it and identify how you plan to implement any noted discrepancies



use

Section C – Adequate Information Consistency Software Color choices Cross-training Review for conflicting color use Back-up supports similar processes and systems Review for symbol use, and symbol with color



Section C – Adequate Information

- If Color for Alarms Only
 - •Verify Controller can distinguish colors used
 - •Cross-training
 - •Are other colors or priorities introduced
 - •Reviewed over time as color recognition can change with age



Section C – Adequate Information • If Audible for Alarms Only

•Verify Controller can detect and distinguish correctly

Cross-training

•Are other frequencies used on other console?

Reviewed over time

•Hearing can change over time



Section C – Adequate Information

Short break access

•How does the controller assigned received alarms while away – someone else responsible?

•Point poll time considerations were not evident in all operators programs.





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Section D – Fatigue

- Occasionally a formal fatigue plan did not exist
- Hours of Service not documented well
 - Timesheets not capturing shift exchange
 - Shift exchange signature not accounting for time or being done first
 - Did not match log-in information
- Plans to confirm Hours of Service were not in place

- Who is responsible for reviewing and making changes to schedule was in question

• Procedures did not mention when fatigue will be investigated as contributory to accidents/incidents and how this investigation would be performed



Section D – Fatigue

- No mention of heightened risk and specific mitigation measures
 - 2-6 am
 - 9-12th hours of the shift
 - 3rd consecutive night
 - Single controller operation
- Exceeded the recommendations of maximums per week
- Did not realize a sliding 7 day scale
- Did not have adequate staffing (absentees not considered)
- Did not have confirmation of shift turnover time requirements



Section D – Fatigue

- Did not include commute time in review of 8 hours of sleep
- Plan did not include measures, elements or methods used to reduce the risk of fatigue
- Total hours did not include all worked for the controller, including other duty assignments and training
- Allowed maximum hours to be exceeded for reasons other than safety
- Did not schedule controllers with 8 hours of sleep planned
- Schedule upsets & Domino effect not considered



Section D – Fatigue

- Future fatigue training mentioned but not employed or determined how it would be employed
- No mention of fatigue mitigation effectiveness review
- Procedures need to mention all shift lengths
 - If have relief controllers and they only work 8 hours, this should be identified in your plan
 - Back-up controllers and hour tracking not thought out nor on-call considered
- If using forms to help track fatigue information, review the form against procedures
- Operators should include what happens if a controller self reports





- •Key Issues
 - -Definition of Control
 - -Alarms versus Alerts, Events, Notifications
 - Alerts are alarms if a controller response is expected
 - Operators had alerts, notifications, informational indications, interim alarms, cautions, warnings, emergency alarms and alarms.

- •Key Issues (cont)
 - -Alarm priority specifics not well described
 - •Color, tone, both?
 - •Are all alarms, even those of different priority, the same color? A concern!
 - -Definition of Safety Related
 - Other points than FAQ can be safety related alarms
 - -Safety Related parameters versus points



- •Key Issues (continued)
 - -Definition of False, Stale, Manual, Forced, Off scan, Inhibit
 - -Operators need a process for reporting alarms that do not work as intended.
 - -All tags (or points) had seldom been reviewed
 - -Remember modes of control:
 - Flow and Pressure discussion



- •Key Issues (cont)
 - -Manual" can mean multiple things:
 - •Equipment positions (such as engine control panel is in manual and only allows local start commands) or
 - •Override or manually entered values (such as a "manual" valve status), etc.



Section E – Alarm ManagementKey Issues (cont.)

-Still being developed in some cases

-Procedures needed further development in several cases

–Many operators included metrics similar to ISA 18.2

-Alarm database for the entire system was not available for review in several cases

-Will be asked for

-Effectiveness of program missed

-More specifics on this later

Section E – Alarm Management

•Key Issues (cont.)

-Safety related alarms that have been taken offscan should be documented

If the operator considers this an appropriate action, include training around specific conditions and documentation

-Safety related alarm setpoints and descriptors not verified once each calendar year not to exceed 15 months

Alarm management plan not required to be reviewed once each calendar year not to exceed
15 months



•Controllers should have input into alarm descriptors

•Controllers could not tell where auto-close valves were located on the pipeline

•Effective controller response to alarms was not defined.

•All procedures were not reviewed for consistency with the alarm management plan and conflicts existed

•Role of specific individuals in the plans were not well defined.



Key Definition Concerns

- Control either by directly sending SCADA commands to field equipment, or prompting others to action
- Safety related any operational factor that is necessary to maintain pipeline integrity or that could lead to the recognition of a condition that could impact the integrity of the pipeline, or a developing abnormal or emergency situation (FAQ A.16). -



Definition Concerns

- Safety Related parameters are NOT the same as Safety Related points.
 - Parameters can exist on any point in the system and are items such as:
 - Hi-Hi, Hi, Lo-Lo, Lo, Deviation, ROC
 - Deadbands, etc.
- Regarding alarms, safety related points can include items beyond those identified in FAQ C.01.
 - Examples: Rectifier status, Server load status or server or software function operational notification alarms.



- Not all operators included inhibited alarms
- •Forced values can occur at the RTU/PLC level or within the SCADA system
 - Not addressed by all operators
- •False, stale, off-scan, and forced values were not included in the plan by all operators
- •Inhibited, Off-scan, Forced, Manual, Stale values were not all noted on displays in a unique manner and could not be distinguished
- •Operators had not included education for controllers on soft or calculated points



•Operators had not yet established documentation to track points taken off-scan

- -Point tag and description
- -When taken off-scan
- -Duration of outage
- -Why (may need to be documented)



Section E – Alarm Management

•Which alarm limits controllers can change when and under what circumstances was not well defined in most cases

•LoLo and HiHi limitations and settings on pressures not being changed by controllers was discussed with a few operators

•Master alarm database or alarm setpoint review documentation including as found as left requested

 Program effectiveness was not tied to the results of alarm reviews

-How will the operator evaluate effectiveness?



- Metric tracking has not yet had an opportunity to be reviewed
- •Effectiveness does not mean a consistent reduction in the number of alarms per console
- •Alarm screen should be available
- Suggest just reviewing displays for the obvious from time to time
- Gas and Liquid plans and the same control room
- LAUF and/or Leak Detection should be addressed



Section E – Alarm Management

• Documentation regarding deficiency identification during alarm reviews (nuisance, maintenance, false) should include the date discovered, tracking of response including the recording of activities to correct the deficiency and correction date or correction plan if has not yet occurred

 Documentation did not prove addressed or planned to address (implementation)

Remember chronic issues should also be looked for



Section E – Alarm Management

- Rationalization really has not been done extensively
 - Systems and District differences
- Remember: Maintenance not being completed at certain locations on the pipeline can cause more work for the controllers.
 - This could impact the Work Load studies and task reviews and complexity of a console

•Controller should have access to the applicable pressure limits, including the MOP or MAOP and any reduced operations pressure restrictions

-If Supervisor changes alarm limits/setpoint, how are controllers notified of this change?

- •Safety related alarm limit changes should be approved and documented
 - -Procedures exist for how these will be reviewed
 - –Training or notification completed and documented when changes implemented
 - -Safety related alarm parameters defined
 - -Imp changes to setpoints?

- Console Work Load studies and reviews were just starting
 - Detailed task reviews were being discussed
 - Moments or averages in time sampling would not capture all assigned tasks but may help with time allocations
 - Were not able to illustrate workload specifics per console
 - Controllers were not always provided enough time to respond adequately



•Procedures needed to clearly define a process of monitoring the volume and content of general activity directed at the controller

- -Night versus day
- -Seasonal
- -Console specific

•As a reminder:

-Leak Detection and Shutdown Pipelines


Section F – Change Management



Lessons Learned Bellingham, WA 1999

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Section F – Change Management

- Remember: People Process Pipeline
 - All components can have changes that impact the control room
 - If the operator has an MOC committee, define the members
- Operators did not have procedures explaining when to contact the control room
- Documentation did not exist that the control room had been contacted (field personnel, IT, SCADA support, major projects or engineering)
- The control room contact should be timely.
 - For example, regulatory was notified of a leak by field personnel before the control room by procedure



Section F – Change Management

- Key functions were not included in MOC process:
 - How a MOC was initiated not defined
 - How the MOC documentation was tracked
 - Unique electronic file names did not exist, so key documents supporting MOC progress were destroyed when one copy was saved over top of another with the same file name
 - What it takes for final approval was not defined
 - What training had occurred or should be occur as a result of the MOC was not available
 - The implementation date of the MOC was not available.
 - What was actually implemented associated with a MOC was not available.

– GAS:

- Appeared to lack consistent consideration for control room requirements for training when placing new facilities on line.
- Seems to be a radical departure from their previous business practice
 - Appear to routinely implement changes without training first being implemented
- Timing should also allow for training



- Almost all departments can influence the control room operations
 - Maintenance, Operation Management, IT, Asset Management, Reliability/Integrity, Business Development, Scada, Scheduling, etc.
 - More than one MOC procedure
 - Must be careful to identify how this will stay coordinated
- Documentation lacking for Control Room Representation in meetings discussing significant hydraulic or configuration changes



- Procedures did not all require advance planning in time for training
- Development system used to test changes associated with instrumentation or displays
 - If do not have development system,
 - Strong procedural controls, formal reviews, oversight of changes as go into production, careful monitoring of system performance after changes go into production, immediate QC verification of changes



- Procedure needed to include point of contact for control room involvement in design or maintenance activities and sharing
- Should remember to include control room when field work occurs (placing in local control as example), data communications infrastructure is impacted, and when leaving/entering monitored facilities that may have security requirements
- Contractors may need to contact the control room if their activities can affect the controllers as well.
 - Training should reflect this

- Procedure define significant hydraulic changes (49CFR192 gas)
 - Purpose of this is to obtain controller input so that changes support safe pipeline control

- Should have a formal change management form

 Make sure the process and various steps can be followed in documentation



- Procedures cover unusual and emergency circumstances as well as changes required due to new equipment
 - Mergers and acquisitions
- Consistency of training on process or procedure across the operator's departments





- Operators appear to have focused on reportable events initially
 - Called Operating Experience for a reason
- More than several operators were not verifying that the lessons learned from accidents/incidents or other items such as "near miss", "close-calls" or system problem response actions were shared with all controllers.
- Don't forget what can be learned from NRC reports or SRCR

- Some operators accident/incident investigation procedures had not been revised to incorporate CRM
- Operators had not included in procedures how deficiencies that are identified in RCFA investigations relative to the control room will be communicated
- Procedures should identify and explicitly address the contribution of erroneous training
- Fatigue was not being reviewed

- Procedures and documentation did not identify how training is impacted by lessons learned, close calls or near miss events
- Remember a contributory factor may provide training and procedure revision insights
- Documentation was lacking on how deficiencies found in accident/incident investigations have been corrected
- Documentation did not exist to support how lessons learned are shared with all controllers



FAQ:

Does "include lessons learned from the operator's experience in the training program required by this section" apply only to accidents/incidents/events in which the controller caused or contributed to the event? Applicable to Gas and Liquid

- Answer: No. Applicable to all accidents, incidents, events, and circumstances that could better inform and train controllers to:
 - Safely Control the pipeline
 - Recognize and Correctly Respond to

-Abnormal, Unusual, Emergency conditions.

Proper controller reaction is the outcome desired





Section H – Training

Simulators & Table Tops

- Key Takeaway:
 - If the operator implements simulators or table tops, are these modified to incorporate learning from:
 - RCFA after an accident
 - Controller input as the result of accident/incidents, near miss, or controller concerns
 - Does documentation exist to support that these modifications have occurred and training or involvement has been changed for the controller as a result?
 - Operators did not clarify which consoles used which technique – simulator, table top or both

Section H – Training

 Procedures did not identify how training improvements were found and implemented (lesson learns, etc)

- "Periodic and infrequently" used was not addressed or defined
- Procedures to address infrequent setups initially appeared to be lacking
- •Reverse Flow, Slack line or low flow conditions, and cross training considerations were missing
- Manual Operations training was not found
- Loss of Power at facilities and equipment status was not addressed



Section H – Training

- Training records were not always available:
 - -Procedures
 - -Course material
 - -Test material and Passing test criteria
 - -Attendance records
 - -Content of OJT and associated records

 Procedures did not define how the training program review would be documented and implemented



Section H – Training

 Verification did not exist that individuals dictating how the system is configured, operated, or shutdown during emergencies are qualified to do so

•Alarm log history had not been reviewed along with incidents/accidents to identify potential abnormal operating conditions that are likely to occur simultaneously or in sequence for which controllers should be trained



Section H – Training

•Liquid and Gas differences were not accounted when control room covered both

•Procedures did not define how effectiveness of the training program would be determined

•Training programs did not cover back-up center activities or transfer requirements

•Controllers that are considered "back-up" or "day" controllers were not specifically considered in the training program and yet were absent from the console for extended periods





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Section I – Compliance

- •Procedures to document compliance with requests for information from PHMSA or State regulatory agencies were missing
- •Point of contact responsible for providing response to request was not defined
- •No reference to O&M or Emergency procedures that may be linked







Section J – Deviation

 Procedures did not address documentation of deviations from CRM procedures

- -Storage of documents and integrity of these documents was not found
- -Retention time was in question
- –What forms can be found in what repository location needed clarification
- –Who is responsible for record retention was not defined
- -Version control did not exist
 - (avoid over-writing electronic records)



Section J – Deviation

- Deviations were not documented
- Deviations were not justified as being necessary for safe operation
- Deviations had not been reviewed for cyclical behavior and frequency
 - -If found, work to eliminate



Objectives of the Rule

- Create an environment to help assure controllers will be successful in maintaining pipeline safety and integrity
 - Assure pipeline operators are addressing fatigue risks in the control room
- Verify that procedures, systems and equipment are well thought out, and function as designed.

Objectives of the Rule

Ask:

 CAN THE CONTROLLER SUCCEED AT THE ROLES AND RESPONSIBILITIES ASSIGNED IN CURRENT ENVIRONMENT?

- WILL THIS AFFECT THE CONTROLLERS OPPORTUNITY TO SUCCEED?

- Don't Know:
 - Ask a controller, we will.



QUESTIONS?