

“Capacity Building and Strengthening Institutional Arrangement”

Workshop: Quantitative risk assessment of oil and gas plants

**APAT Experiences on Tools for  
Assessing Risks Preventing  
Accidents**

**Ms. Fausta Delli Quadri**

APAT

Agency for Environmental Protection and Technical Services

# Italian methodologies for major hazards quantitative risk assessment

## Hazards identification in industrial risk assessment

THE RISK IDENTIFICATION METHODOLOGIES  
MAY BE SUBDIVIDED INTO THE  
FOLLOWING FOUR CATEGORIES :

- HISTORICAL ANALYSIS
- CHECK LIST
- STRUCTURED TECHNIQUES
- ( • INDEX TECHNIQUES )

**THE HISTORICAL ANALYSIS  
IS BASED ON THE FOLLOWING  
SOURCES OF INFORMATION:**

- PLANT OPERATING EXPERIENCE
- ACCIDENT DATA BANKS
- SPECIALIZED LITERATURE
- PRESS

**THREE DIFFERENT TYPES OF CHECK-LISTS  
ARE NORMALLY USED:**

- GENERAL (CONSISTING IN A WIDE SURVEY OF THE GENERAL PROBLEMS RELATED TO THE SAFETY). THEY MAY BE SUBDIVIDED:
  - FOR EVENTS AT THE BATTERY LIMITS OF THE UNIT BEING EXAMINED
    - CAUSES EXTERNAL TO THE WORKS
    - CAUSES INTERNAL TO THE WORKS
  - FOR EVENTS INTERNAL TO THE UNIT BEING EXAMINED

THE CHECK LISTS BELONGING TO THIS TYPE ARE VERY QUICK TO APPLY, BUT NORMALLY QUITE SHALLOW, AND THEIR USEFULNESS IS CONSEQUENTLY LIMITED.

- DETAILED (FOR INSTANCE, THE ONES PROPOSED BY THE AICHE), DEALING WITH ALL THE SINGLE ASPECTS RELEVANT TO THE SAFETY OF THE PLANT, ITEM BY ITEM, FROM SEVERAL POINTS OF VIEW (DESIGN, OPERATION, MAINTENANCE, ETC.).

CHECK-LISTS OF THIS TYPE MAY BE VERY ONEROUS, AT THE SAME LEVEL OF SOME STRUCTURED TECHNIQUE. AT THE SAME TIME THEY WILL NOT GIVE EQUIVALENT ANALYTICAL AND CREATIVE CAPABILITIES. IN COMPENSATION THEY DO NOT NEED SO A HIGH EXPERIENCE.

- SPECIFIC, DEALING IN GREAT DETAIL SOME PARTICULAR SAFETY FEATURE OR DIRECTED TO A SPECIFIC DISCIPLINE (FIRE FIGHTING, PREVENTION OF ACCIDENTS AT WORK, INSURANCE, ETC.) OR ACTIVITY (AUDITS, INSPECTIONS, COMMISSIONING, ETC.). NORMALLY THEY ARE NOT VERY USEFUL IN THE RISK ASSESSMENT. THEY MAY BE REGARDED MORE PROPERLY AS INSTRUMENTS FOR RISK MANAGEMENT.

NECESSITY OF AN ANALYTICAL AND  
COMPREHENSIVE ORGANIZATION OF  
THE LARGE (TO BE HOPE FOR)  
QUANTITY OF INFORMATION.

A FIRST CLUSTERING TO REDUCE  
THE IDENTIFIED ACCIDENTS  
TO POSSIBLE ACCIDENTS:

- CLUSTERING ACCORDING INITIAL EVENTS,  
ACCIDENTAL SEQUENCES AND TOP EVENTS
- ELIMINATION OF THE HISTORICAL ACCIDENTS  
NOT APPLICABLE OR NOT CREDIBLE BECAUSE  
OF THE SITUATION OF THE ACTUAL PLANT

THIS LEVEL OF CLUSTERING CONTRIBUTES  
TO BUILD UP ACCIDENT FAULT TREES,  
GIVING THE CONTRIBUTION OF  
HISTORICAL EXPERIENCE AND CHECK-LISTS  
(EVENTUALLY TO BE INTEGRATED WITH  
OTHER CONTRIBUTIONS, SUCH AS  
FROM STRUCTURED TECHNIQUES)

A SUBDIVISION ACCORDING THE TYPE  
OF INITIAL EVENT MAY BE USEFUL,  
AS EACH ONE MAY REQUIRE  
A DIFFERENT ASSESSMENT TECHNIQUE  
IN THE FURTHER PHASES OF THE STUDY:

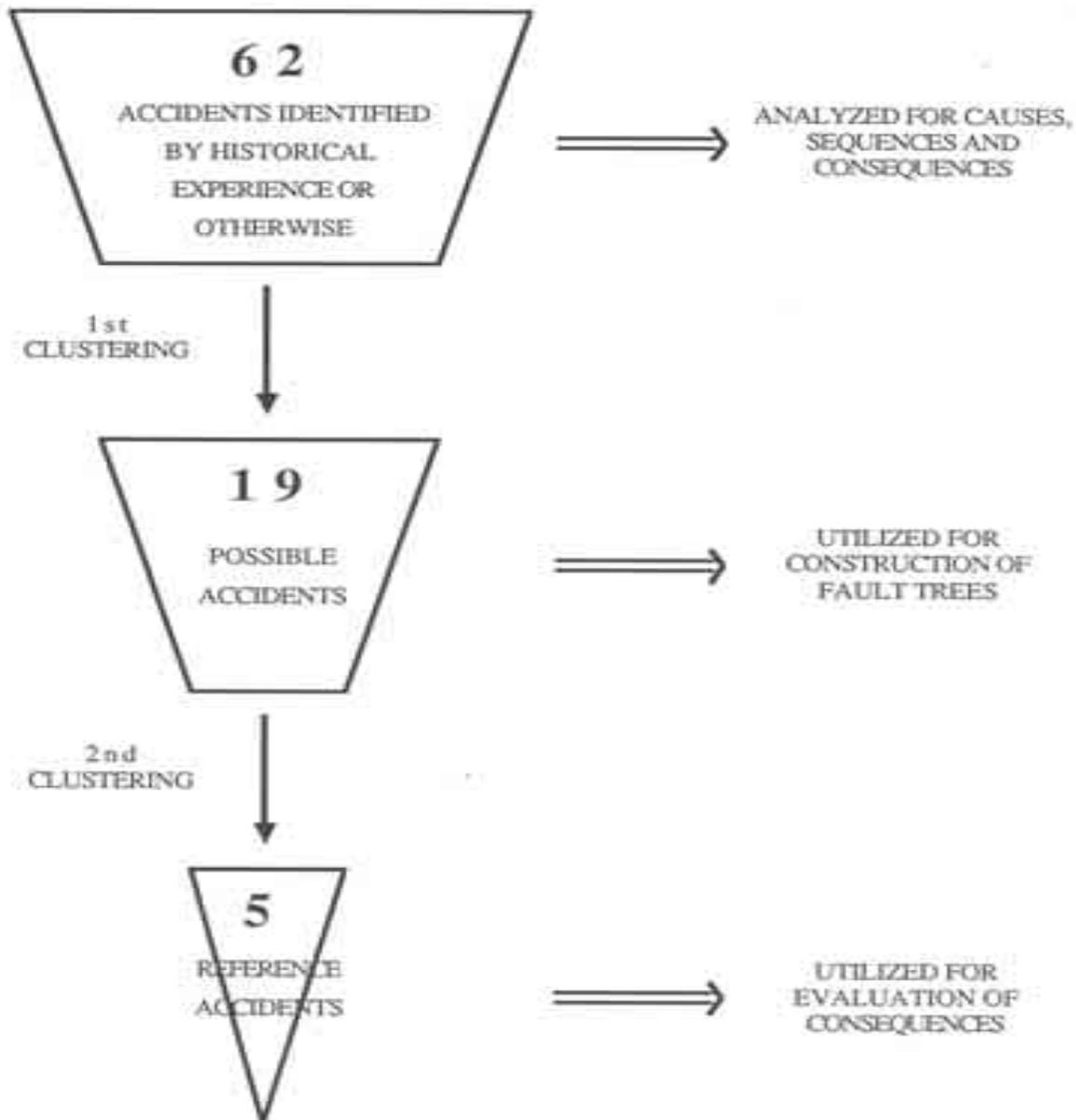
- A. ACCIDENTS DUE TO EXTERNAL NATURAL  
EVENTS
- B. ACCIDENTS DUE TO EXTERNAL ARTIFICIAL  
EVENTS
- C. ACCIDENTS DUE TO RANDOM EVENTS
- D. ACCIDENTS DUE TO PROCESS CAUSES OR  
HUMAN FACTORS

A SECOND CLUSTERING TO REDUCE  
THE POSSIBLE ACCIDENTS  
TO REFERENCE ACCIDENTS:

- CLUSTERING BY TYPOLOGY OF TOP EVENTS,  
UNIFORM BOTH PHENOMENOLOGICALLY  
AND QUANTITATIVELY

THE EVALUATION OF CONSEQUENCES  
MAY BE CARRIED OUT LIMITING TO  
ANY ONE OF THE REFERENCE ACCIDENTS,  
DEFINED AS ABOVE.

AS AN EXAMPLE,  
IN THE SAFETY STUDY  
OF A REFINERY TANK FARM,  
THE FOLLOWING DID RESULT:



**THE MAIN STRUCTURED TECHNIQUES  
OF HAZARD IDENTIFICATION ARE:**

**\* HAZOP**

( HAZARD AND OPERABILITY STUDY )

**\* FMECA**

( FAILURE MODE, EFFECT  
AND CRITICALITY ANALYSIS )

**BOTH ARE BASING ON THE TYPICAL  
FRAME OF A PROCESS PLANT, BASED  
ESSENTIALY ON TWO KIND OF ELEMENTS:**

**\* EQUIPMENT**

**\* PIPING**

BASICALLY THEY ACT AS A SORT OF  
MNEMONIC KEY, TO BE EXTENSIVELY  
USED IN ORDER TO CENTER THE  
ATTENTION OF THE ANALYSTS  
SUCCESSIVELY ON EACH ONE OF  
THE ELEMENTS FORMING THE PLANT.

THE ADEQUATE APPLICATION OF  
SUCH TECHNIQUES REQUIRE A DEEP  
KNOWLEDGE OF THE PROCESS AND  
THE SPECIFIC FEATURES OF THE PLANT,  
AND A GREAT EXPERIENCE IN  
GENERAL ENGINEERING.

THE TECHNIQUES THEMSELVES CANNOT  
IN ANY WAY MAKE UP THE LACK  
OF EXPERIENCE OR SPECIFIC KNOWLEDGE.

THE COMPONENTS OF THE TEAM  
WILL BE, AS A MINIMUM:

- \* AN EXPERT IN THE APPLICATION OF  
THE METHODOLOGY
- \* A PROCESS ENGINEER
- \* AN EXPERT IN OPERATION/MAINTENANCE
- \* EVENTUAL SPECIALISTS (PART TIME)

## HAZOP

(HAZard and OPerability study)

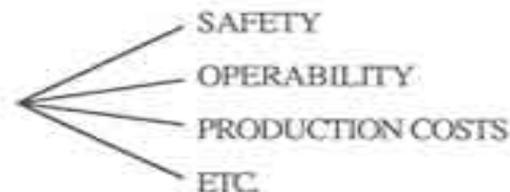
ANALYZES THE PLANT  
 LINE BY LINE,  
 EQUIPMENT BY EQUIPMENT,  
 TAKING IN CONSIDERATION  
 FOR EACH ONE OF THESE ELEMENTS:

\* INTENTIONS

\* DEVIATIONS

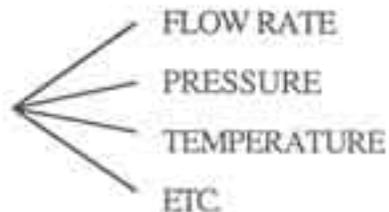
\* CAUSES

\* CONSEQUENCES



**BY APPLYING TO:**

\* **PROCESS CONDITIONS**



\* **ACTIVITY**

\* **SUBSTANCES**

\* **PHASES**

( \* **TIME** )

( \* **PLACE** )

( \* **REASON** )

**PRIMARY RESULTS**  
**OF A HAZOP ANALYSIS:**

- \* INTERVENTIONS AND MODIFICATIONS  
TO BE MADE TO INCREASE THE LEVEL  
OF SAFETY, OPERABILITY, ETC.
  
- \* IDENTIFICATION OF THE POSSIBLE  
ACCIDENTAL EVENTS, TO BE FURTHER  
ANALYZED IN THE NEXT STEPS.

OTHER POSSIBLE RESULTS:

- \* INDICATION, FOR ANY ANALYTICAL STEP, OF THE POSSIBLE EVENTS ACTUALLY MEANINGFUL.
  
- \* GROUPING OF THE EVENTS, TO SHOW THE POSSIBLE DIFFERENT SEQUENCES LEADING TO A STATED ACCIDENT.
  
- \* LOGICAL SYNTHESIS (CLUSTERING) OF THE VARIOUS POSSIBLE ACCIDENTAL SEQUENCES IN ORDER TO ENABLE THE DRAWING OF THE COMPLETE FAULT TREE.

**PRELIMINARY HAZARD ANALYSIS**  
**(PHA)**

- LIST OF RISK TYPOLOGIES
- LIST AND LAY-OUT OF HAZARDOUS SUBSTANCES AND/OR EQUIPMENT, PER EACH TYPOLOGY OF RISK
- ANALYSIS CAUSES/CONSEQUENCES/ACTIONS

**EXAMPLE**

RISK:

- RELEASE OF FLAMMABLE MATERIAL
  - CONFINED EXPLOSION
  - RELEASE OF TOXIC MATERIAL
  - RUNAWAY REACTION
  - ETC.
- |                  |   |                      |
|------------------|---|----------------------|
| H <sub>2</sub> S | } | REFER<br>TO<br>TABLE |
| HF               |   |                      |
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**COMPARATIVE APPLICATIONS,  
TO SHOW THE DIFFERENT COMPLETENESS  
THAT THE VARIOUS TECHNIQUES  
OF HAZARD IDENTIFICATION  
MAY OFFER.**

**DEPENDING ON THE PERSPECTIVE,  
THE RESULTS OF SUCH AN ANALYSIS  
MAY DIFFER, AS THREE DIFFERENT  
TYPE OF INFORMATION  
MAY BE TAKEN INTO ACCOUNT:**

- ACCIDENTAL EVENTS
- DEVIATIONS OR INITIATING CAUSES
- CONTROL ACTIONS

**AS A GENERAL EXPERIENCE (GAINED  
IN A NUMBER OF APPLICATIONS):**

**DEGREE OF COMPLETENESS ACHIEVABLE  
BY A HAZOP PERFORMED IN DETAIL:  
(1-3 DAYS / P&I)**

**70-80% FOR CONTINUOUS PROCESSES  
50-60% FOR BATCH PROCESSES**

**DEGREE OF COMPLETENESS ACHIEVABLE  
BY A HAZOP PERFORMED ACCORDING  
A LOWER STANDARD:  
(2-4 HOURS / P&I)**

**IDENTIFIABLE  
2/3 OF ACCIDENTAL EVENTS  
1/3 OF DEVIATIONS AND ACTIONS  
WITH RESPECT TO THE ONES OBTAINED  
BY A DETAILED HAZOP.**