Deepwater

On April 20th 2010 the Deepwater Horizon drilling rig, operated by Transocean, exploded and 11 men lost their lives. But four months earlier in the North Sea on another Transocean rig, there had been a near miss with eerie similarities. Tragically the lessons from the near miss were not learned.

In this hard hitting AKT Safety programme we see the dramatic events onboard the Deepwater Horizon on the day of the disaster, and we follow the investigations as they uncover negligence, poor regulation, inadequate maintenance, catastrophic decision making and what the US authorities described as 'a reckless disregard for safety'.

Key Themes

- **Leadership**
- **Reputation and Risk**
- **Partnership/Joint Ventures**
- **Process Safety**
- **Culture**

Deepwater

2 hour online workshop

Introductions and context, why we are here.

Act One - The North Sea, before Deepwater Horizon

Facilitation - What are we dealing with here?

Group discussion followed by plenary feedback.

- Confirmation Bias
- Normalisation of deviance
- Assumptions
- Quality conversations (management)
- Human Performance Tools that could have made a difference – how?
- Transfer of learning
- Distractions

Act Two – The Macondo Well

Facilitation. Group discussion followed by plenary feedback

- Confirmation Bias
- Sunk cost bias
- Groupthink
- Competence
- Management Walk-Arounds/Distractions
- Awareness of Pre-cursors to Process Safety
- Process/Personal Safety focus

Plenary

- Your equivalents of process safety incidents? (Actual or potential)
- The outcomes? (Actual or potential)
- How does the learning from *Deepwater* relate to us? What can we take from this?
- What will our next challenges be?
- How will we overcome them?

Act Three – After the event, the outcomes

Personal Commitments

- What will you do next?
- What might get in the way of that?
- How will you overcome this?
- What further help do you need?
- How will you know when you have achieved this?
- What's in it for you?

Close