# Incident Investigation Bp

Hearing Before the Committee on Education and Labor, U.S. House of Representatives, One Hundred Tenth Congress, First Session, Hearing Held in Washington, DC, March 22, 2007
Deepwater Horizon Accident Investigation Report
Deepwater Horizon Accident Investigation Report
Incident Specific Preparedness Review (ISPR) Final Report
Prison and Jail Administration
A Practitioner’s Experiential Approach
Macondo Well Deepwater Horizon Blowout
Are the Minerals Management Service Regulations Doing the Job? : Oversight Hearing Before the Subcommittee on Energy and Mineral Resources of the Committee on Natural Resources, U.S. House of Representatives, One Hundred Eleventh Congress, Second Session, Thursday, June 17, 2010
Management Obligations for Health and Safety
Operational Safety Economics
Semiotics and Verbal Texts
Run to Failure: BP and the Making of the Deepwater Horizon Disaster
The Gulf Oil Disaster : Chief Counsel's Report
Process Safety
What Went Wrong? : Hearing Before the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, House of Representatives, One Hundred Ninth Congress, Second Session, September 7, 2006
Organizational Accidents Revisited
Human Rights Obligations of Business
Guidelines for Investigating Process Safety Incidents
BP Deepwater Horizon Oil Spill
BP's Pipeline Spills at Prudhoe Bay
Macondo: The Gulf Oil Disaster, Chief Counsel's Report, 2011
Talent, Transformation, and the Triple Bottom Line
Columbia Accident Investigation Board: (issued with CD-ROM)
Key Concepts and Practical Approaches
Physical Security in the Process Industry
Guidelines for Investigating Chemical Process Incidents
Oilfield Survival Guide, Volume One: For All Oilfield Situations
The Deepwater Horizon Incident
How the News Media Construct a Crisis
How Could This Happen?
Laboratory Biorisk Management
Columbia Accident Investigation Board, Report Volume 2, October 2003, * (NOTE: DISTRIBUTION LIMITED TO REGIONAL LIBRARIES ONLY).
Investigation Report
BP Deepwater Horizon Spill
Biosafety and Biosecurity

BP Amoco Polymers, Inc. Thermal Decomposition Incident
Columbia Accident Investigation Board Report
U. S. Air Force Aerospace Mishap Reports
UK deepwater drilling - implications of the Gulf of Mexico oil spill
Offshore Risk Assessment Vol. 1



## MELTON BAKER

**Hearing Before the Committee on Education and Labor, U.S. House of Representatives, One Hundred Tenth Congress, First Session, Hearing Held in Washington, DC, March 22, 2007** Gulf Professional Publishing
Describes how to make economic decisions regading safety in the chemical and process industries Covers both technical risk assessment and economic aspects of safety decision-making Suitable for both academic researchers and practitioners in industry Addresses cost-benefit analysis for safety investments

**Deepwater Horizon Accident Investigation Report** IGI Global
Process Safety Management and Human Factors: A Practitioner's Experiential Approach addresses human factors in process safety management (PSM) from a reflective learning approach. The book is written by engineers and technical specialists who spent the last 15-20 years of their professional career looking at behavioral-based safety, human factor research, and safety culture development in organizations. It is a fundamental resource for operational, technical and safety managers in high-risk industries who need to focus on personal and occupational safety management to prevent safety accidents. Real-life examples illustrate how a good, effective understanding of human factors supports PSM and positive impacts on accident occurrence. Covers the evolution and background of process safety management Shows how to integrate and augment process safety management with operational excellence and health, safety and environment management systems Focuses on human factors in process safety management Includes many real-life case studies from the collective experience of the book's authors

Deepwater Horizon Accident Investigation Report Butterworth-Heinemann
Managing the Risks of Organizational Accidents introduced the notion of an ’organizational accident’. These are rare but often calamitous events that occur in complex technological systems operating in hazardous circumstances. They stand in sharp contrast to ’individual accidents’ whose damaging consequences are limited to relatively few people or assets. Although they share some common causal factors, they mostly have quite different causal pathways. The frequency of individual accidents - usually lost-time injuries - does not predict the likelihood of an organizational accident. The book also elaborated upon the widely-cited Swiss Cheese Model. Organizational Accidents Revisited extends and develops these ideas using a standardized causal analysis of some 10 organizational accidents that have occurred in a variety of domains in the nearly 20 years that have passed since the original was

published. These analyses provide the 'raw data' for the process of drilling down into the underlying causal pathways. Many contributing latent conditions recur in a variety of domains. A number of these - organizational issues, design, procedures and so on - are examined in close detail in order to identify likely problems before they combine to penetrate the defences-in-depth. Where the 1997 book focused largely upon the systemic factors underlying organizational accidents, this complementary follow-up goes beyond this to examine what can be done to improve the 'error wisdom' and risk awareness of those on the spot; they are often the last line of defence and so have the power to halt the accident trajectory before it can cause damage. The book concludes by advocating that system safety should require the integration of systemic factors (collective mindfulness) with individual mental skills (personal mindfulness).

**Incident Specific Preparedness Review (ISPR) Final Report**

Independently Published

This book provides a valuable reference tool for technical and management personnel who lead or are a part of incident investigation teams. This second edition focuses on investigating process-related incidents with real or potential catastrophic consequences. It presents on-the-job information, techniques, and examples that support successful investigations. The methodologies, tools, and techniques described in this book can also be applied when investigating other types of events such as reliability, quality, occupational health, and safety incidents. The accompanying CD-ROM contains the text of the book for portability as well as additional supporting tools for on-site reference and trouble shooting. Note: CD-ROM/DVD and other supplementary materials are not included as part of eBook file.

Prison and Jail Administration Jones & Bartlett Learning

HR Professional's guide to creating a strategically sustainableorganization Employees are central to creating sustainable organizations, yetthey are left on the sidelines in most sustainability initiativesalong with the HR professionals who should be helping to engage andenergize them. This book shows business leaders and HRprofessionals how to: motivate employees to create economic,environmental and social value; facilitate necessary culture,strategic and organizational change; embed sustainability into theemployee lifecycle; and strengthen existing capabilities anddevelop new ones necessary to support the transformation tosustainability. Talent, Transformation, and the Triple Bottom Line alsodemonstrates how leading companies are using sustainability tostrengthen core HR functions: to win the war for talent, tomotivate and empower employees, to increase productivity, and toenliven traditional HR-related efforts such as diversity, healthand wellness, community involvement and volunteerism. Incombination, these powerful benefits can help drive businessgrowth, performance, and results. The book offers strategies, policies, tools and specific actionsteps that business leaders and HR professionals can use to getinto the sustainability game or enhance their effortsdramatically Andrew Savitz is an expert in sustainability and has workedextensively

with many organizations on sustainability strategy andimplementation; he and Karl Weber wrote The Triple BottomLine, one of the most successful books in the field Published in partnership with SHRM and with the cooperation ofthe World Business Council for Sustainable Development Forward by Edward Lawler III This book fills a gaping hole in both the HR and sustainabilityliterature by educating HR professionals about sustainability,sustainability professionals about HR, and business leaders abouthow to marry the two to accelerate progress on both fronts.

**A Practitioner's Experiential Approach** Elsevier

Institutional Corrections Surveys history and current status of jails and various types of adult prisons with emphasis on punishment rationales, institutional programs and procedures, inmates' social structures, correctional officers, and contemporary issues.

Macondo Well Deepwater Horizon Blowout CRC Press

Discusses how the CEO of British Petroleum, John Browne, helmed one of the greatest corporate comebacks in history only to have it fall apart due to deadly accidents and environmental crimes, culminating in the Deepwater Horizon disaster--

**Are the Minerals Management Service Regulations Doing the Job? : Oversight Hearing Before the Subcommittee on Energy and Mineral Resources of the Committee on Natural Resources, U.S. House of Representatives, One Hundred Eleventh Congress, Second Session, Thursday, June 17, 2010** Academic Press

This is a print on demand edition of a hard to find publication. On April 20, 2010, a well control event allowed hydrocarbons to escape from the Macondo well onto Transocean¿s ¿Deepwater Horizon,¿ resulting in explosions and fire on the rig. This is the report of an internal BP incident invest. team. It presents an analysis of the events leading up to the accident, 8 key findings related to the causal chain of events, and recommend. to enable the prevention of a similar accident. The invest. team worked separately from any invest. conducted by other co. involved in the accident, and it did not review its analyses, conclusions or recommend. with any other co. or invest. team. Other invest., such as the U.S. Coast Guard, U.S. Justice Dept., and Bur. of Ocean Energy Mgmt., and the Pres. Nat. Comm. are ongoing.

Management Obligations for Health and Safety Springer

On 20 April 2010, a blowout of BP's Macondo well in the Gulf of Mexico led to the deaths of 11 workers on Transocean's Deepwater Horizon drilling rig, and the release of an estimated 4.9 million barrels of oil. The European Commission called for a moratorium but the UK government decided its regulatory controls were fit for purpose. However a full review of the oil and gas environmental regulatory regime would be undertaken. The Committee believes that the UK has high regulatory standards - as exemplified by the Safety Case regime that was set up in response to the 1988 Piper Alpha tragedy in 1988. The blowout in the Gulf of Mexico could have been prevented if the last-line of defence - the blind shear ram on the blowout preventer had activated and crushed the drill pipe. Given the importance of this equipment the committee recommends prescribing specifically that blowout preventers

should have two blind shear rams and that simple, potential failures mustn't be left unchecked. The Committee also recommends that the Bly report conclusions, BP's internal investigation, be considered alongside observations of other companies involved. They believe that should an oil spill resulting from drilling activities occur in the UK there needs to be an absolute clarity as to the identity of the responsible party, and that liability legislation needs to ensure prompt compensation. They conclude that any calls for increased oversight of the UK offshore industry should be rejected in favour of multilateral approaches to regulation and oil spill response

**Operational Safety Economics** John Wiley & Sons

In recent years, the safety management field has placed leadership and commitment at the center of effective workplace health and safety programs. At the same time, personal liability for workplace health and safety has increased, resulting in poor outcomes for individual managers. Discussing the minimum expectations that courts and tribunals have of managers, Management Obligations for Health and Safety examines the relationship between those expectations and effective safety performance. The book looks at safety management from the perspective of management obligations. What expectations are placed on managers at all levels of an organization to ensure that the workplace and systems of work are safe, and how are these expectations considered and analyzed by courts and public inquiries? As importantly, the book explores how management actions in relation to these obligations and expectations influence, positively or negatively, the safety performance of an organization. With examples drawn from legal and quasi-legal processes, one of the more enlightening and thought-provoking features of this book is the extensive use of cross examination taken from various proceedings. No one person reacts the same to finding him- or herself responsible for managing the aftermath of a death at work, or having to deal with the immediate pressure of being subject to interviews and investigation by safety regulators (much less the drawn-out experience of the legal process), but one of the most constant reactions is "Why didn’t anybody tell me about this?" Stressing the importance of safety culture, this book details the true nature of the expectations that are placed on managers by virtue of their obligation to provide a safe workplace.

Semiotics and Verbal Texts John Wiley & Sons

Spearheaded by a BP investigative team, this report summarizes the events of the 2005 Texas City refinery explosion.

Run to Failure: BP and the Making of the Deepwater Horizon Disaster DIANE Publishing

Deepwater Horizon Accident Investigation ReportDIANE Publishing

The Gulf Oil Disaster : Chief Counsel's Report The Stationery Office

Save Money, Time, and Lives with the Real-World Oil & Gas Experience of Others. Learning the Hard Way in the Oilfield can Cost You Millions, sometimes Billions of Dollars in addition to Injury and Loss of Life. Cut Through the Noise to Focus on the Most Critical Aspects of Working in the Oil and Gas Business. Based on over 1,000 Oil and Gas Situations involving Drilling, Cementing, Fracking, Wireline, Coil Tubing, Snubbing, Running Tools, Welding, Production, Workover, Logging, Trucking,

Geology, Land, Engineering, Resource Development, Executive Management and much, much more. Expand Your Value Creation Opportunities by Learning from the Real-World Experience of Others. Whether you work in the office or in the field, work as a Company Man, Engineer, Driller, Tool Pusher, Roughneck, Geologist, Landman, Truck Driver, Frac Hand, Treater, Cementer, Lawyer, Flowback Hand, Welder, Geophysicist, Snubber, Pumper, Equipment Operator, Derrick Man, Mechanic, Petrophysicist, Roustabout, Manager, Director, VP, or Executive, consider adding Oilfield Survival Guide to your toolbox of knowledge. In other words, if you work hard for your money in the oil business, this book is for you. The oil & gas industry is one of the most capital-intensive businesses today. As a result, mistakes/situations can be expensive, in addition to injury and loss of life. To prevent undesirable situations, Oilfield Survival Guide was created, based on over 1,000 oil & gas situations. The ultimate guide for all oil and gas situations: ● Tactics ● Procedures ● Fatalities ● Short Stories ● Train Wrecks ● Disaster Avoidance ● Court Cases ● Life Savings Skills ● Checklists ●Troubleshooting ● Problem Job Prevention ● Oilfield Survival Guide is the ultimate oil industry resource to help manage oilfield risk and avoid mistakes by increasing your oil and gas knowledge and intelligence, utilizing a variety of methods, including: Tactics: Short and to the point guidelines to reduce risk and instill work principles to be successful in the oil industry, from the field to the office. Short Stories: Experience from the mistakes of others. Fatalities: Detailed analysis of oil and gas tragedies. Court Cases: Jury trials, expert witness testimony, and legal opinions on a variety of oil and gas cases. Procedures: Step-by-step process to create oilfield procedures and checklists, along with multiple examples. Operations Analysis: Oil and gas operations post-mortem, highlighting key learnings, practical knowledge, useful tips, and best practices. Over 1,000 oil and gas situations analyzed to create Oilfield Survival Guide.

*Process Safety* National Academies Press Headquarters Air Education and Training Command released its Accident Investigation Board report from the aircraft accident involving an F-16C at Holloman Air Force Base, New Mexico, Jan. 31, 2017. Members of the board found that the cause of the mishap was pilot error. The investigation also identified that the instructor pilot's failed supervision and instruction were significant contributing factors for the mishap.The board determined that the incident, which left one civilian contractor deceased and one trainee injured, involved the use of training projectiles.The Accident Investigation Board President (AIB BP) found, by the preponderance of evidence, that the cause of the mishap was pilot error. The MP misperceived that the ground element's location was the intended target. The MP misinterpreted his instruments and failed to follow his on-board systems directing him to the proper target. The AIB BP found, by the preponderance of evidence, the MIP's failed supervision and instruction substantially contributed to the mishap. Specifically, that his failed cross-monitoring of the MP's performance during the MP's fatal strafing attack, his task misprioritization (focusing on coordinating and controlling other aircraft while the MP was performing the strafing attack), and his overconfidence,

complacency and overaggresiveness during the mishap sortie substantially contributed to the mishap.

**What Went Wrong? : Hearing Before the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, House of Representatives, One Hundred Ninth Congress, Second Session, September 7, 2006** W. W. Norton & Company

Methods in Chemical Process Safety, Volume 1, publishes fully commissioned reviews across the field of process safety, risk assessment and management and loss prevention. It aims to serve as an informative tool and user manual for process safety for both engineering researchers and practitioners. Publishing one themed volume a year, the publication provides a resource detailing the latest methods in the field of chemical process safety. Helps acquaint the reader/researcher with the fundamentals of process safety Provides the most recent advancements and contributions on the topic from a practical point-of-view Presents users with the views/opinions of experts in each topic Includes a selection of the author(s) of each chapter from among the leading researchers and/or practitioners for each given topic

**Organizational Accidents Revisited** Government Printing Office

The first comprehensive reference work on error management, blending the latest thinking with state of the art industry practice on how organizations can learn from mistakes. Even today the reality of error management in some organizations is simple: “Don’t make mistakes. And if you do, you’re on your own unless you can blame someone else.” In most, it has moved on but it is still often centered around quality control, with Six Sigma Black Belts seeking to eradicate errors with an unattainable goal of zero. But the best organizations have gone further. They understand that mistakes happen, be they systemic or human. They have realized that rather than being stigmatized, errors have to be openly discussed, analyzed, and used as a source for learning. In How Could This Happen? Jan Hagen collects insights from the leading academics in this field – covering the prerequisites for error reporting, such as psychological safety, organizational learning and innovation, safety management systems, and the influence of senior leadership behavior on the reporting climate. This research is complemented by contributions from practitioners who write about their professional experiences of error management. They provide not only ideas for implementation but also offer an inside view of highly demanding work environments, such as flight operations in the military and operating nuclear submarines. Every organization makes mistakes. Not every organization learns from them. It’s the job of leaders to create the culture and processes that enable that to happen. Hagen and his team show you how.

**Human Rights Obligations of Business** Springer

"This is the Incident Specific Preparedness Review for the response to the BP Deepwater Horizon oil spill. This report was chartered by the Coast Guard Commandant on June 14, 2010. The Charter provided direction for ISPR team membership, scope of the review, and reporting deadlines. The purpose of this report is to examine the implementation and effectiveness of the preparedness and response to the BP Deepwater Horizon incident as it related to the

National Contingency Plan, Area Contingency Plans, and other oil spill response plans"--Preface.

*Guidelines for Investigating Process Safety Incidents* Oilfield Books

"This book discusses the causes of a major explosion at the Texas City Oil Refinery on March 23, 2005. The explosion killed 15 workers and injured more than 170 others. Failure to Learn also analyses the similarities between this event and the Longford Gas Plant explosion in Victoria in 1998"--Provided by publisher.

BP Deepwater Horizon Oil Spill

Deepwater Horizon Accident Investigation Report

In recent years, the UN Human Rights Council has approved the 'Respect, Protect, and Remedy' Framework and endorsed the Guiding Principles on Business and Human Rights. These developments have been welcomed widely, but do they adequately address the challenges concerning the human rights obligations of business? This volume of essays engages critically with these important developments. The chapters revolve around four key issues: the process and methodology adopted in arriving at these documents; the source and justification of corporate human rights obligations; the nature and extent of such obligations; and the implementation and enforcement thereof. In addition to highlighting several critical deficits in these documents, the contributing authors also outline a vision for the twenty-first century in which companies have obligations to society that go beyond the responsibility to respect human rights.

*BP's Pipeline Spills at Prudhoe Bay* John Wiley & Sons

Over the past two decades bioscience facilities worldwide have experienced multiple safety and security incidents, including many notable incidents at so-called "sophisticated facilities" in North America and Western Europe. This demonstrates that a system based solely on biosafety levels and security regulations may not be sufficient. Setting the stage for a substantively different approach for managing the risks of working with biological agents in laboratories, Laboratory Biorisk Management: Biosafety and Biosecurity introduces the concept of biorisk management—a new paradigm that encompasses both laboratory biosafety and biosecurity. The book also provides laboratory managers and directors with the information and technical tools needed for its implementation. The basis for this new paradigm is a three-pronged, multi-disciplinary model of assessment, mitigation, and performance (the AMP model). The application of the methodologies, criteria, and guidance outlined in the book helps to reduce the risk of laboratories becoming the sources of infectious disease outbreaks. This is a valuable resource for those seeking to embrace and implement biorisk management systems in their facilities and operations, including the biological research, clinical diagnostic, and production/manufacturing communities.

Related with Incident Investigation Bp:

• Dragon Quest Xi Trophy Guide : click here