RESUMED [4.00 pm]

30 COMMISSIONER: It's 1600. We'll reconvene and I welcome Mr Peter Wilkinson from Noetic Group. Counsel.

MR DOYLE: Mr Wilkinson is the general manager of risk for Noetic, a firm providing professional advisory services across a range of industry sectors,
35 including national security and defence, infrastructure, mining, oil and gas. Mr Wilkinson specialises in the management and corporate governance of low probability but high consequence events associated with process safety risks in the oil, gas, chemical and mining industries. Mr Wilkinson was also involved in the design of the Australian regulator for offshore petroleum and has
40 provided many years of consultancy to government and industry in operational risk and safety management in hazardous industries.

COMMISSIONER: Thank you for joining us, Mr Wilkinson, and it's that issue of low probability, high risk activities that I want to start with today.
45 Because of your industry knowledge, what in your view is the key to

developing a safety culture at the top level of the organisation?

MR WILKINSON: Well, I think you partly answer the question in how you framed it. These are leadership issues, and the key for leaders in this area, because they are very low probability events, the sorts of disasters that we're talking about, is that they must believe that their source of disaster could happen to them. Failure to do so invariably sends a signal, maybe unintended signal, down through the organisation that the things that you have to attend to to prevent these sorts of disasters are unimportant. So it's a leadership issue and it's about maintaining what some people call chronic needs or a sense of vulnerability to these sorts of events and this is difficult to do because the events are very rare.

COMMISSIONER: So are there appropriate tools and techniques that managements typically use in these sorts of scenarios?

MR WILKINSON: Well, there are, but there's no one magic tonic for this or fantastic pill that solves all these problems, it's about hard work, consistent hard work and, in particular, when you get to the operational phase, which after all is where the serious events happen, they may have the roots in design partly, but in the operational phase there's no substitute about being absolutely clear what the, if I may call them risk barriers or risk controls - people use different terminology - what are the barriers to prevent bad things happening and who is accountable for them, and careful measurement and monitoring, and also this requires an excellent reporting culture because if people don't feel empowered and able to freely report that things aren't as they should be, well, the information can't get to a level that enables it to be dealt with, so it's a reporting culture as well.

COMMISSIONER: So if I was to, not to name companies, but to think about the characteristics of good tight leadership team managing low probability, high consequence events, what would be some of the characteristics that you have seen in your time?

MR WILKINSON: I think there's a very interesting one, and that is that if you ask senior leaders, and I was a senior executive in Caltex Australia, so I have experience of being sat at the top table, but if the leaders don't have a realistic mental model of how these things can happen, what are the causes of these disasters, it's really difficult to progress beyond that and a mistake that's been made time and time again in parts of the oil and gas industry is the focus on where you get feedback, and where you get feedback is on the higher frequency, lower consequence events, personal injuries, slips, trips and sprains.

You don't want those to happen plainly, because you're a caring organisation and caring employer, but if you put all your attention there and not on these

things that are less easy to see, you make yourself much more vulnerable to this big and rare event. So to answer your question directly, you have to be clear, absolutely clear what these controls are and how well they're working in practice.

MR DOYLE: It might be exploring a related topic, but is there a distinction between measuring injury frequencies or outages and measuring process safety, and how do you go about measuring the latter?

MR WILKINSON: Well, you have put two ideas together there. The main dichotomy that I would draw your attention to is that measuring injuries is self-evidently unlikely to offer you much of an insight into how these more complex system-type events occur, because they invariably have some component of design, some latent failures hidden in the design that only become apparent in operations when somebody makes a mistake or there's a poor process. So they will always involve this combination of engineering issues, procedural issues and frequently an individual human error.

So actually you mentioned outages. Outages of equipment or failures in reliability actually might be weak signals that there is some latent defect lurking there, and that gives you the clue as to how you have to deal and manage these low probability high consequence events. It's being alert to those signals, amongst all the other data and information that's coming to you as a middle manager or leader, being alert and knowing what to look for that is sending you a signal that something isn't working as it should, and that should require - demand investigation.

MR DOYLE: How do you go about dividing responsibility for safety issues between the different levels of management and operation within a business that's operating in this hazardous context?

MR WILKINSON: Well, I think the responsibilities should naturally fall out. But, if I may, I'll draw you to a weakness that not infrequently exists, and by that I mean it's not realistic to expect the board of a company to personally know the detail of how somebody at the front line has to construct a flange on a high pressure pipeline. But the person doing that must know that, and the immediate supervisor must know that. So there is a hierarchy really of knowledge that is expected.

So let me take this one stage further. So I've talked about the front line worker plainly must know how to do it. The supervisor must also know how to do it because how can he or she effectively supervise the work without having an insight as to how it's supposed to be done. Now, the manager of this front line worker, I wouldn't necessarily expect him or her to have the detail, but they must know that flange assembly when handling high pressure hydrocarbons in

a process plant is a critical activity.

So I would expect from a leadership perspective that manager to go and talk to the supervisor and ask the supervisor, "How do you know people are doing this properly," and also make more occasional visits to the front line to find out himself. Indeed in some areas in the military that's a definition of leadership from one perspective. So does that answer your question in terms of how there is a hierarchy there from different levels of knowledge, but each successive level needs to look down not just one level but two levels at least to find out what's going on. Preferably occasionally to the front line.

MR DOYLE: Well, given that leaders1 at the top level can't have that detailed knowledge, what are the practical ways in which leaders can begin to instil a safety culture in an organisation that might have previously lacked it?

MR WILKINSON: The safety culture issue is one I would say I would assert is clouded by lots of complex and often academic work, however I'd suggest that there are some organisations who have got this really pretty well nailed down and know what works. I'm not saying there isn't great value in further academic research there, but I would suggest a focus on the practices that people follow is an easier way to change behaviours and get people aligned, and by that I mean if you only focus on values, and I'm not saying values are unimportant, they plainly are, but if you only focus on values, it still leaves people in doubt about practices.

So for critical controls, critical tasks, we should have those nailed down explicitly. What is the task? What is needed of that, if it is a task. It might be a piece of equipment. What is required of the critical control to ensure it does the job it's intended to do. What supporting systems, such as management systems, are needed, maintenance management systems, for example, to make this work properly, and how can we check? We have to actively monitor that critical controls are being implemented correctly, and I would suggest to you that from my experience of investigating a large number of incidents and of being involved in some globally significant ones, for example I'm still currently under contract to the US Government on the BP Macondo disaster. A common feature is that critical controls haven't been effectively monitored in the operation phase.

MR DOYLE: Well, given the importance, in your view, of ensuring that practices are adhered to and continually improved upon, where does the responsibility lie within an organisation for reviewing the adequacy of those practices? In hazardous industries that be organic changes coming from the front line itself, or is that a matter that requires a comprehensive external review?

MR WILKINSON: That's an interesting question. A key part of my answer would be leadership but I felt I've covered that so I won't talk about leadership. But I would just like to talk about nearer the front line and I mentioned in passing the importance of engendering a culture that allows

5 people to report things but it's not just about reporting things. As we go through that hierarchy of an organisation, the more senior one is the greater the responsibility, I think, to solve a problem as well. So if a quite senior leader goes to the board and say we've got a problem here and expects to be welcomed with that bad news, in the absence of a solution, well I think that's

10 unrealistic. But if it's a front line worker who says look I really think there's a problem here but I don't know what to do about it. Well, that warrants reward and by reward, I don't necessarily mean money, I mean recognition that that person has taken the initiative.

15 I have seen at the front line, one company in the north sea in the 1990s was rewarding – give a specific example, there was a problem with a piece of water treatment plant and contrary to what most people think, big oil and gas platforms are mainly water handling plants. It's the biggest issue they have, how do they handle all those liquids. There was a problem with the water

20 handling plant and an operator, with his colleague, designed a solution to a problem. Did their own mini hazard study, wrote it up and presented it to the production superintendent. Actually they didn't know that an engineered solution had already been decided upon on the beach, as we say, back in the office but nevertheless the production superintendent rewarded those

25 individuals with a cheque made out to the charity of their choice. So I thought that was an act that tangibly made people at the front line feels comfortable about taking responsibility. In that case, beyond what was needed but very good behaviour.

30 MR DOYLE: You mentioned earlier the notion of having multiple barriers for hazardous events. Have you come across any instances of systems which have involved too many controls and how do you manage the right balance between the Swiss cheese concept of multiple layers of control but not permitting safety to become an impediment to the effective uptake of what you want the workers

35 to do?

MR WILKINSON: Well, you're plainly familiar with reasons Swiss cheese models which I'm delighted, that saves some time. Look this is a complex area because people articulate what their controls are but it is far from uncommon to

40 find they've articulated controls at quite a high level. So let me give an example. If you're operating an underground coalmine where there's methane explosion risks that can lead to coal dust explosion risks and we've seen these continue to happen around the world, including the developed world, in New Zealand, Pipe River and in Astoria in northern Spain in 2013 in Turkey

45 and so on, so these aren't things that have gone away. I've been to coal mines

in Australia where they've said yes we've got that nailed down, here is our bow tie diagram, listing a 100, 80, 100, 108 controls, I think on one that I saw. And slightly flippantly I said, "Do you make coal as well?" And the point I'm making is that there's so many apparent controls, if they were genuinely important controls how could you possibly monitor the efficacy of all of those controls. However, it's not quite as bad as that because when you looked more closely, it was evident that many of these things were hazard management plans, it had a coal dust hazard management plan. Well, actually, buried within that hazard management plan were certain details that were really important, were genuinely critical. The whole plan wasn't critical. They needed a plan, but what was actually critical was a smaller subset.

Another example was its ventilation system. Well, plainly a ventilation is vital to maintain a concentration of methane below an explosion limit, however, only certain parts of that ventilation system are really critical. So the issue is, yes, you can have too many controls and it becomes unmanageable, but really if you focus on what's really critical you can normally, in my experience, get down to a critical few that you have to rigorously manage.

MR DOYLE: We might now move from a discussion of how one advances safety concepts within an organisation to the role of a regulator, and having particular regard to the challenges that face the establishment of a regulator and either a new application of an existing context or a new context entirely. The first thing I would suggest that the regulator needs to do is to clarify its role and the extent to which it's responsible for safety. What are the considerations or the ambiguities that arise in defining the role of the regulator?

MR WILKINSON: One of the difficulties is allied to the point I made earlier about so-called occupational health and safety incidents, slips, trips and sprains, so you get lots of feedback there, lots of incidents reported, and it's tempting from the regulatory perspective to go and investigate them, and there is a report I recently wrote for the New South Wales government that's been published that articulates the position that the regulator wasn't looking as stringently as those areas where there hadn't been an incident but, of course, just because there hadn't been an incident doesn't mean that everything is working okay. So this is back to this controls issue.

So the regulator has to be, in my view, in the high hazard industries has to be explicitly set up to say, "Look, the role here isn't just occupational health and safety, it's dealing with all those things." Whatever label you put on it, you might call it reliability, asset integrity, process safety, whatever is the right lingua franca for the particular industry, because the regulator has to appear further up the chain beyond a ladder that somebody may have fallen off, they have to look deeply into repeated software fails in a control system, they may be indicating a problem, so the regulator needs to check that the company

managing these high hazard industries has actually got that under control.

So the question could arise, well, what is the regulator doing poking around looking at these points of detail in our systems that only have a marginal impact on safety, and this takes us back to the mental model of how incidents are caused, and they always generally involve these latent issues often associated with design or construction commissioning and active failures on the part of people trying to implement the system, so the regulator, I think, has to be set up explicitly to be clear what its role is.

MR DOYLE: How does the regulator define its role in relation to safety in an industry where it might be unachievable in an absolute sense?

MR WILKINSON: Well, everything has some risks, so that needs to be made clear to start with. In the high hazard industries there's generally a preference amongst regulators experienced in this area to have something approaching a safety case, a more licence based approach - I'll use the word "safety case" because it's the one I'm most familiar with and, for example, that's used in offshore oil and gas in the UK and in Australia, onshore major hazards, again UK and Australia, and in most of Europe via the Seveso Directive, but it is also used in the aviation world, satellites, air traffic control, railways and other environments, and in essence that puts the onus on the person creating the risk to demonstrate that they understand the hazards, the risks, the controls and how they are managed, and if they are articulated, the role of the regulator is usually to make a fundamental judgment on what's been articulated. Does this system, does this approach, does this case for safety stand up? Does it appear to have the capability to deliver the outcome you want, the goal you want from the regulator, and if it does when you get into the operational phase then the role of the regulator is twofold. One is to say well are they doing what they said they would do in this document but, secondly, also to check fundamentally is this still the right way of achieving that goal.

MR DOYLE: So what are the perceived advantages of approaching regulation of hazardous industries by the adoption of a safety case, as distinct from other approaches such as a prescriptive approach?

MR WILKINSON: Well, the safety case is normally associated with a so-called goal setting approach, and in the English speaking language that's most associated with the legal principle of reducing risks to as low as is reasonably practicable. The main advantage is that it allows technological evolution without having to keep changing the legislation, and the history of this comes from an organisation I worked for for 27 years, the United Kingdom's Health and Safety Executive, and Lord Robings was appointed to an inquiry to look at how safety was legislated in the UK, and made the obvious but predictable point that parliament never kept up with changes in

industry, and we see that on a day-to-day basis with these so-called disruptive technologies or different ways of ordering taxis, and the legislation follows thereafter.

5   So by saying, "Well, look, you're creating the risk. It's your responsibility to identify the risk, not ours, and you're the people best equipped to do it and to bear the cost and responsibility of that," that's the main advantage so it allows technological advance. An example in Australia is Australia will have the world's first ever floating liquified natural gas facility, the Shell's Prelude. No
10   changes to the law are needed. Now, if that was going to go into the United States Gulf of Mexico, they would have to write a whole new set of prescriptive legislation to cover new technology, which they haven't done.

       MR DOYLE: So what's been the resistance, if there has been resistance, to
15   moving away from a prescriptive approach in some of those foreign regulators?

       MR WILKINSON: Well, that's a difficult question for me to ask. I think there's some deep cultural issues, not to say problems in getting legislation through congress. I'm not really sure how far you want to go there.
20
       MR DOYLE: It's not that far.

       MR WILKINSON: No, I don't think I should. But it is a concept that's certainly more accepted in Anglophone type countries. There is a downside
25   though of course. On the downside it's more complex for regulators to make a decision what does as low as is reasonably practicable mean? In practice - and there's excellent guidance on the definition of this on the UK Health and Safety Executive web site. I checked just before I came in, and it really doesn't mean much more than what's good practice. But if you've got something novel, yes
30   we do good practice so far as we know, then we expect a greater application of those fundamental techniques that we've used, and always used, to deal with new things.

       So we look for a deeper, more fundamental approach to assessing the hazards
35   and risks, so it's more expensive, more time-consuming. However, it gives a - safety case gives a document which is more attuned - is attuned to the specific hazards and risks that can be used as the template for both the company and regulator to check. So the final advantage I've mentioned, it brings two pushing in the same direction rather than a regulator applying prescriptive
40   rules. So it is often said that Occidentals Piper Alpha Platform largely metal prescripts it legislation but Lord Cullen said in the Public Health Piper Alpha Inquiry that that wasn't good enough to stop the disaster happening and 167 men lost their life in July 1988. So for high hazard, relatively high cost technologies, safety case type approaches are generally thought to be more
45   effective.

MR DOYLE: And does the safety case approach, plainly it occurs at a design phase and the licensing phase of the regulatory regime but how does that translate in to the monitoring of ongoing safety procedures at a particular plant or facility?

MR WILKINSON: Well, a key part of any safety case is a – wasn't often called a formal safety assessment but I should just caution you, there is no one safety case approach. Every jurisdiction, country, industry has taken the principles I articulated at the start about hazard risk control and how they are managed, has taken those principles to apply them to the platforms, facilities, technology that they're dealing – sorry, I've forgotten the start of your question.

MR DOYLE: Just really asking about how the concept of a safety case, which tends to conjure up the idea of a static document - - -

MR WILKINSON: Yes.

MR DOYLE: - - - lives and breathes throughout the operation of a plant that - - -

MR WILKINSON: Yes.

MR DOYLE: - - - that might have been intended to have a 60-year, 80-year life?

MR WILKINSON: Well, there's two aspects to the safety case. One is often a staged approach to concept selection and design but as I say all these safety case regimes differ, so in some areas and technologies you would say here's our design safety case, or here's our concept and that allows interrogation by the regulator around the basic principles and concepts, particularly if it's something new. In the operational phase, because the safety case has to identify the hazard risk and controls, those controls are the things that we expect the company to implement and the regulator, in my view, a key role for the regulator is to go and check in practice, are they doing what they said they were doing. And maintaining those controls, actively maintaining those controls is the biggest challenge because of waxing and waning of profitability in the oil and gas industry. We see changes in personnel, company takeovers, there are all sorts of pressures but I can only speak from a – really can only speak from an oil and gas and large industry perspective.

MR DOYLE: And in monitoring compliance, what are the tools available to a regulator given that it's unlikely to have the capacity on a person to person basis to be monitoring compliance closely?

MR WILKINSON: Well, this really goes back to the role of the regulator, doesn't it? Where, what are your expectations of a regulator? We can't have 15 men on a team marking another 50 men trying to get the ball in the opposite direction. That's plainly not going to work; it would just lead to proxy. So that means we need to have a smaller group of people and it means they have to be selective. I would argue that the – what they are selective about – what they choose to do, they should be able to articulate that very clearly. The regulator should be able to say, from a transparency perspective, this is why we've chosen to look at these, but we can't look at everything. So that selection decision of what they look at, the frequency they look at, in my view should be made transparent and plainly. I think that should focus on the preventive measures but as you will have heard from earlier witnesses, things do go wrong and we have to have recovery measures in place. Some of that time must also be spent on looking as we might say in my world, the right hand side of the bow tie once the bad thing has happened, how you deal and manage that event. But it would have to be about the two and I personally would put more than 50 per cent of my activity as a regulator on the left hand side, on prevention. But we still have to look at something on the right hand side. But there's no one answer. There's no right or wrong answer to this, except my view is that mostly prevention but you also have to deal with the mitigation side.

MR DOYLE: Is there any role in these very hazardous industries for private sector involvement in monitoring or certification of operation or design of plants?

MR WILKINSON: That's an interesting question because sometimes there is a connotation of private sector bad because how can they be independent, but it's hasn't been our experience, if I talk about the North Sea or upstream offshore petroleum in Australia, and the reason for that goes back several hundred years to the ship classification societies that have provided pretty effective service typically in the area of technical efficacy of the ship's hull, the deck plates, are the engines working and are their bilge systems working and so on, so we tend to focus on the engineering issues, but in the North Sea the ship classification societies prior to Piper had a significant role, and after Piper the new regime that we've got in place explicitly required third party - or it could be second party, but normally third party verification of what were called safety critical elements.

Safety critical elements is no more than a technical word for critical control, so I use the common language "critical controls", technical language in the legislation is safety critical elements. So the company is forced to spend money on generally third party company, some are offshoots of the classification societies, but that need not be the case, to provide very well-known and established service and provide those reports to the company.

One of the things the regulator can do is to go and audit those third parties, are they doing the job properly, and when they visit facilities or go in the offices will show what the third parties are finding, because there's nothing to stop the regulator going in to check, "Is that correct?" So if the regulator finds things that aren't being found by the third party, well, that would lead to action presumably in relation to both parties.

MR DOYLE: You mentioned a moment ago "second party" regulation. Does that have any prevalence in the hazardous industries context?

MR WILKINSON: In the North Sea, the second party was permissible, they just had to demonstrate there was sufficient independence, so I know one very large global company used its well engineering team in Houston to come to the North Sea and there was sufficient separation of those management chains - obviously they all come together at the top in The Hague or London or both, but there was judged sufficient separation to permit that, however, I believe - I haven't checked prior to this hearing - that Shell have moved back to a third party, but in principle it could work.

MR DOYLE: All right. We might move now to some of the particular challenges for regulators in new industries and industries where there might be a small number of participants. Firstly, in establishing a new regulator, how does one go about populating the regulator with the relevant expertise and what are the key learnings from your experience in this area?

MR WILKINSON: Well, I've had an unusual experience of leading a group of people that developed a brand new regulator from scratch with no bums on seats before we started, we had to go and find all those people, and there are a number of factors here. I think there's some things that I won't dwell on, but it's obvious you have to have the technical skills relevant to the entity that's being regulated, so if we're regulating shipping it's inevitable we're going to have some marine engineers, naval architects and ship's masters.

However, when we set up offshore safety division after Piper in some of the teams we consciously had a more eclectic approach to recruitment. So, for example, we hired a former fast jet test observer who was an aeronautical engineer, but aeronautical engineers know a lot about light but very strong structures, known as wings. Well, these are very relevant to offshore petroleum structures. Our believe was that we needed good quality people, able to make decisions, sometimes without much support from a fundamental basis and there was no one right background. So yes, we needed all those technical expertise, so in nuclear it's obvious what they would be, but I would strongly urge that if somebody was approaching that task and if they asked me for advice, I said yes do what you think you need to do in terms of mechanical

engineers, nuclear physicists, radiation experts of course. You must have that,
however don't make yourself vulnerable to a common mode failure by not
having some people who can approach these problems from a slightly different
angle. And from my perspective, a large proportion of the operational

5 incidents that I've been involved with, have very significant human
organisational factors. So we've had an example where the
Royal Australian Navy had some ships that weren't fit to go to sea when
people thought they were, after some – what was described as hollowing out of
the engineering function. So it's not – and that is a failure in leadership and

10 management of an organisation.

People with other sorts of skills can detect problems going on in an
organisation, looked at from a different perspective and the most obvious one
is the human organisational factors, discipline of human factors well known to

15 the military aviation and some other areas, less well applied in manufacturing
industry, or say coalmine, partially applied in oil and gas. So there's a range of
skills beyond the particular engineering skills of the industry needed.

MR DOYLE: All right. Well, a moment ago you mentioned that in the

20 context of a goal setting based regime, rather than a prescriptive regime, that
the concept of making risks as low as reasonably practicable, often devolves in
to an analysis of comparison with best practice. How does a regulator judge
best practice in a domestic industry that might have one or two participants?

25 MR WILKINSON: So I think the point you're making is a good one. And that
is that regulation isn't as simple as taking a ruler to the height of the table, if
it's goal setting, it's prescriptive law and this table has to be a metre, we can
take a ruler and measure that. It's less easy to make those complex judgments
in a goal-setting environment, particularly if you have new technology. How

30 do you do it if you haven't seen that technology before? So that suggests
strongly to me, that regulation isn't just absolute, it's also a comparative task.
We have to look and be able to form a professional judgment about what good
looks like. What is accepted good practice? And if you haven't got that
experience locally, well you have to then get it another way and the two main

35 ways that are used, so in offshore oil and gas we have the
International Regulators Forum and regulators between a number of nations
with offshore petroleum meet once or twice a year to exchange good and bad
practice, lessons learnt and so on. And the other way is to explicitly have peer
review of facilities. And that peer review can take place at two levels. One

40 peer review of regulators and I believe there's an existing International Atomic
Energy Authority programme for that. But also, I would suggest that – I have
no first hand knowledge of what I am going to say next, but I believe it to be
true, the American system involves a peer review between facilities, so if there
are similar facilities of (indistinct) Australian facility, well I would suggest

45 arrangements should be entered in to to try and facilitate a similar type of peer

review with comparable facilities wherever they exist.

MR DOYLE: Now the answer to this question may involve some similar themes but it's in the nature of a low probability high consequence industry that one doesn't have a large data set to work from in terms of judging the success of a regulator and equally a failure may not necessarily be the consequence of a failing on the part of the regulator. So how do regulators in these industries go about judging their own performance? And if they don't judge them, who does?

MR WILKINSON: In a sense, that's a difficult question for me to answer because – to ask me, because I've just had to do that very task in relation to NOPSEMA and I think the operational review of NOPSEMA's involved three people, of which I was one, was tabled in the senate a month or so ago. There isn't an easy measure because the absence of an incident isn't the same as saying that neither the company nor the regulator are doing everything well. It might be chance, particularly with very low probability events, but what about the converse. If there is a serious incident does that mean the regulator's at fault. But the regulator isn't the person with their hands on the levers, press the buttons. So it's a more subtle and complex relationship. And I think it falls in to the area where there can be some hard data, so some of the hard data that we looked at in the review of NOPSEMA, the operational review, were losses of containment of hydrocarbons because if you keep the hydrocarbons, the oil and gas on the facility, in the pipe, you can't – difficult to have a fire or explosion. So we can make some judgment about data but again, this is complex. Does an increase in losses of containment mean that things are getting worse, or does it mean that people are reporting more and they're feeling comfortable?

So this is all quite a complex area. So I'm sorry to say, there isn't an easy black and white answer. I think the only way is to inquire in to those sorts of precursor type data, if it's available and you have to find that. Secondly, it's a qualitative one, you have to go and talk to the people doing the regulating, what they go about? Look for evidence of what they do? What do they look at? Are they looking at critical controls? So my report in to mining regulation in Australia, I found it difficult to find evidence that they're looking at critical controls, or how can they be offering advice, feeding back to industry as a whole, if they haven't been looking at those critical controls? So that's an area. And finally, there's a range of stakeholders. You have to take what stakeholders say with a pinch of salt of course because there are always personalities involved in here and the company that feels raked over, might have been raked over justifiably and its standards and processes and systems might've been called in to question and they might feel aggrieved about it. Doesn't mean the regulator's wrong.

So it's not an easy issue. But there is long history of doing that and published models of doing it. As I say, there is some hard data. Have to treat it carefully. You have to go and talk to people and you make some value judgments. It's not quite – I hesitate to say this, because it's a difficult notion to persuade other people on, but these are quite expert judgments in general. Not easy to make.

MR DOYLE: Just one final topic Mr Wilkinson, we've heard in earlier evidence the concern that is constantly to be guarded against of an alignment of interest between industry and the regulator and the dangers of over familiarity - - -

MR WILKINSON: Mm.

MR DOYLE: - - - but from your experience of the front line of regulation - - -

MR WILKINSON: Yes.

MR DOYLE: - - - is there a sense in which it's necessary to strike a balance of where familiarity can breed disclosure?

MR WILKINSON: Well, I could reframe what you said completely and say there are dangers in unfamiliarity. So a personal test, that I applied with the explicit agreement of my most senior manager, when I was a regulator in these southern north sea for a time, was that if I went offshore with my – one of my staff who have accountability for those companies and those facilities and he didn't know the offshore installation manager on first name terms, it would cause me to ask why he didn't know. How often was he going? And more, I want him to know the first name teams of the key supervisors because he has to sit down with them and find out what they're doing. You cannot go in with a clipboard in front of them and writing down things because the only way you can find out what's going on, is by inferring what's going on from talking to people. Because you cannot see the molecules going down the pipe. You can't see the inside of the pipes, you have to infer what's going on on the platform from a quite subtle mix of hard evidence produced in reports of non-destructive testing of piping, dosing rates for anti-corrosion materials but crucially, what people tell you is happening and you need to find that out at all levels.

So you have to get close to people to find out what's going on. You have to be trusted because they don't tell you things if you don't. So your question is how do we guard against over familiarity and being captured, well a couple of things. One is practice with rotating people, leaving them long enough to get to know them and be productive but you need to change, different people have different views inevitably on both sides, regulated and the regulator. There are some processes you can put in. I mentioned peer review in a different context but peer review is an important tool that can be used. I mean genuine peer

review, peer, not top down. But you can also have top down views. Why did you take that judgment? Why did you make that judgment on this day in relation to that issue? And you should inquire in to those judgments on both sides. Why did you take action and say that wasn't very good? And why did

5   you not take action on this, and why did you think that was good? And those sorts of post facto reviews are crucial part of maintaining credibility with the regulator and there's one final that some regulators have developed a quite sophisticated tool which is referred to as an enforcement management model. NOPSEMA in the past have used this. I can't recall if it's currently used. It's

10   also used in the UK, and in essence, again, used after the event but it's a tool can say look this is the situation you found and this is what you did about it and it has a series of – it's a decision tree. A set of gates that helps to calibrate decision taking. Called the enforcement management model. It's generally used afterwards because it can never quite deal with the subtleties of individual

15   decisions on individual issues. It would be too complex to make it a perfect decision tree, but it's very useful about honing decision taking skills, how people take decisions, why they take particular decisions and plays a role in having a more homogeneous, a more consistent approach from a regulator. So they do have to get close to people because they won't find out stuff if they

20   don't. But you have to manage that and the knowledge that people can get too close.

MR DOYLE: Thank you.

25   COMMISSIONER: Mr Wilkinson, thank you very much - - -

MR WILKINSON: Thank you.

COMMISSIONER: - - - for your very practical evidence.

30
MR WILKINSON: Thank you.

COMMISSIONER: We will now adjourn until tomorrow morning when we will take on topic 10. Thank you very much.

35
MATTER ADJOURNED AT 4.48 PM UNTIL
THURSDAY, 22 OCTOBER 2015

40