HM Naval Base Clyde
Toolbox Talk / Team Dialogue
Safety Stand Down April 2010

Introduction

This communication is intended for all employees at HMNB Clyde.

Aim

Director of Submarines (DSM) has mandated a Safety Stand Down/Team Brief following a serious incident on a number of T Class Submarines. A presentation was given to management on 27 April 10 with the requirement for the key messages from the incident to be cascaded to all personnel. As many personnel as possible are to receive this Toolbox Talk or Team Dialogue with ANY feedback to be passed through line management to Lt Matt Williams, EA SFM (3440) or Joyce MacGinley, Babcock PR & Communications Manager (5953) by close of play Monday 3 May 10.

STEAM GENERATOR DISCHARGE SYSTEM HULL BLANKS
Event 19720 – HMS TURBULENT/HMS TIRELESS

What happened?

- Hull valve test blanks fitted under Nuclear Procedural control during RAMP were not subsequently removed from two submarines
- Both submarines operated PSA and critical without overpressure protection on Steam Generators
- Time between undocking and discovery was more than 2 years for TURBULENT and more than one year for TIRELESS
- COMOPS directed inspection/confirmation within 48 hours

Why did it happen?

- Procedure Authorisation Group was attempting to facilitate two separate repair/test sequences:
  - Leak Testing of hull and back-up valves (MS419/420/421/422)
  - Strength test and leak test of repaired relief discharge system upstream of hull valves
  - Blank was essential for Leak Test and useful (but not essential) for system test

How did it happen?

- Procedures were weak and ambiguous
- Procedures did not ensure explicit transfer of hull valve status from one procedure to another
- Despite there being several potential safety nets, none succeeded in identifying and arresting the events before the submarines undertook PSA operations
- Blanks were not tagged consistently not were they subject of enduring system isolation – ripout discipline poor

Was it avoidable?
YES

- Explicit wording of procedures
- Tagging of blanks
- Application of Single Tag System

Would that have been enough?
POSSIBLY NOT

- No process is 100% foolproof
- Questioning attitude essential
- Do we recognise impact of complexity and length of RAMPs?
- Handover is not a formality, it is a certificated, auditable statement of configuration
- Sod's Law applies

What HMNB DEVONPORT has done?

CONTROL OF WORK

- Redraft part of some procedures
- Required all blanks to be tagged
- Apply single tag system in RAMP for control of work

SAFETY NETS

- Include undocking waiver list in Platform Sea Clearance process

What next?

- Rebriefing of Project Managers, DTO, PAG Chairmen, Production (cf Haddon-Cave/NIMROD)
- Download to all company personnel through Time Out For Safety Briefings
- Upload to Directors
- Incorporate lessons for TRENCHANT RAMP
- Maintain pressure and awareness of the correct safety culture

Challenges

- We need to recognise the impact of increasing complexity and length of RAMPs
- We need to understand the technical and managerial skills required and get the manning right
- We need to guard against over reliance on processes and procedures
- Everyone needs to know the state of the submarine
- We all have a role to play in improving Safety Culture
- The changes we make need to be enduring

Question to Everyone

- What should Clyde do as a result of this incident?

Finally

"If you are convinced that your organisation has a good safety culture, you are almost certainly mistaken"

Please fill in the attached feedback sheet with any comments, ideas, suggestions, remarks from you and/or your team and return to Lt Matt Williams, EA SFM (3440) or Joyce MacGinley, Babcock PR & Communications Manager (5953) by close of play Monday 3 May 10.

Department Heads / Senior Managers / Line Managers are to ensure that all personnel under their direct responsibility are suitably briefed